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SELLERS DORSEY DIGEST

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NAVIGATION

Summary of Key Updates

The Senate passed a $3.5 trillion budget package resolution along party lines. The bill includes expanding Medicare benefits and eligibility and funding for home-and community-based services, though at lower levels than the Biden administration proposed. The bill next returns to the House where, if adopted, lawmakers will begin the reconciliation process. Stakeholders predict another lengthy set of negotiations before finalizing the bill (The New York Times, August 11; Health Payer Specialist, August 11; Health Payer Specialist, August 5; Politico, August 5; Inside Health Policy, July 22).

The Senate passed a $1 trillion infrastructure package focused on physical infrastructure. Lawmakers proposed implementing the often-delayed Medicare sequester cuts as a means for funding $8 billion of the bill (The Washington Post, August 10; Politico, August 10; Fierce Healthcare, August 10).

On August 13, CMS is scheduled to publish the Hospital Inpatient Prospective Payment System (IPPS) final rule requiring hospitals to report on four broad categories of health data, an increase from the previously required two categories, to better track future public health threats (Politico, August 2).

CMS revoked 1115 waivers in Ohio, Utah, and South Carolina for their inclusion of Medicaid work requirements in the waivers (Politico, August 10; Inside Health Policy, August 9).

From August 4 to August 10, CMS approved one Section 1915(c) Appendix K waiver and 10 SPAs, one of which is a COVID-19 disaster relief SPA. Of note, Pennsylvania has received CMS approval for two new hospital supplemental payment programs, and MN-21-0006 rescinds a COVID-19 flexibility previously authorized in MN-20-0021.

In case you missed it last week, Sellers Dorsey published an updated FY22 state budgets summary analysis to include the following states: Alaska, Arizona, California, Delaware, Massachusetts, Nebraska, Ohio, and Pennsylvania. This document focuses on states' overall budgets and key Medicaid expenditures. We will continue to summarize more states in future Digest issues as states continue to enact their budgets. The document will also be regularly updated here.

Federal Updates

News

- In an August 11 letter to CMS Administrator Chiquita Brooks-LaSure, the National Association of Medicaid Directors (NAMD) expressed concern over the potential cost to state Medicaid programs for the new Alzheimer's drug aducanumab, should Medicaid be the primary source of coverage for the drug. NAMD requests CMS issue a National Coverage Determination requiring Medicare coverage of the drug or a Coverage with Evidence Development program. NAMD also recommends adding aducanumab to the list of drugs subject to restricted coverage under the Medicaid Drug Rebate Program, which would allow states some flexibility to "scale back or pause coverage until more reliable evidence of efficacy emerges" (NAMD, August 11).
- CMS released new data showing more than 2.5 million people enrolled in health coverage on HealthCare.gov and state marketplaces during the 2021 Special Enrollment Period (SEP), which closes on August 15. A record high of 81.7 million people now receive coverage through Medicaid and CHIP as of March 2021. The SEP report also shows the American Rescue Plan (ARP) Act has lowered health care costs for Americans. The ARP's expanded premium tax credits have reduced premiums, increased savings, and given consumers access to quality, affordable health care coverage through the Marketplace. In the final week of July, HealthCare.gov experienced a 64% week-over-week increase, the second-highest week since February 15 (Medicaid.gov, August 10).
- On August 10, the Biden administration released a statement expressing the urgent need to lower health care costs through the passage of its Build Back Better Agenda. The statement outlines the Agenda's Medicare priorities, which include granting Medicare the authority to negotiate prescription drug prices, penalizing drug companies that raise Medicare drug prices faster than inflation, capping out-of-pocket drug expenses for Medicare beneficiaries, and expanding Medicare coverage to include dental, vision, and hearing benefits. The statement also calls for an extension of enhanced Affordable Care Act (ACA) premium tax credits and the provision of federally-administered Medicaid coverage in states that chose not to adopt Medicaid expansion to close the Medicaid gap in several holdover states. Build Back Better is the Biden administration's three-part agenda that includes the ARP, the American Jobs Plan, and the American Families Plan. The most recent statement urges the passage of Build Back Better via budget reconciliation (The White House, August 10).
- A study published by the Boston-based Brigham and Women's Hospital found the facility's hospital-at-home program significantly boosted inpatient capacity and access to care. The hospital-at-home program treated 65 acutely ill patients with infections or complications associated with heart failure, chronic obstructive pulmonary disease, or asthma over a three-month period during the pandemic. Brigham and Women's provided daily in-home or remote visits, two daily in-home visits from nurses, and 24-hour physician coverage and remote monitoring tools. The study did not compare patient outcomes but found that home hospital care has similar quality, safety, and experience metrics as inpatient hospital care and is 38% less expensive than traditional inpatient treatment. Brigham and Women's is one of over 145 hospitals to offer a hospital-at-home program after CMS expanded it as a pilot payment model in November 2020 (Modern Healthcare, August 6).

Federal Legislation

- On August 11, the U.S. Senate passed a $3.5 trillion budget resolution along party lines (50-49) that includes new dental, vision, and hearing benefits for Medicare recipients and reduces the age of Medicare eligibility. Other changes include boosting home and community-based services (HCBS) through the ACA and lowering prescription drug costs. Much of the spending would be paid for with higher taxes on the wealthy and corporations, which Republican senators unanimously oppose. Despite the health

care-heavy package clearing opposition in the Senate, President Biden's plan to include $400 billion for Medicaid home care services may ultimately be hindered due to a lack of funding. Top Congressional leaders have stated there will not be enough funding in the final budget bill to cover all health policy priorities identified by the Biden administration and are in discussions over what to include. Aging and disability services providers are urging Congress to deliver the full funding for HCBS, as stakeholders stress that the temporary 10% increase in Medicaid federal matching funds from the ARP is not enough to support the proposed HCBS spending. Biden's $400 billion plan would need to be funded for at least 10 years to be implemented as the administration intended. The bill will go to the House of Representatives when members return from summer recess on August 23, and committees in both chambers will begin to flesh out the details of the budget blueprint. Senate Majority Leader Schumer (D) hopes to have the legislation completed by the week of September 15, but stakeholders expect another lengthy round of negotiations before enacting the bill (The New York Times, August 11; Health Payer Specialist, August 11; Health Payer Specialist, August 5; Politico, August 5; Inside Health Policy, July 22).

- On August 10, the Senate passed (69-30) a roughly $1 trillion infrastructure package that is intended to improve the nation's roads, bridges, pipes, ports, and internet connections. The bipartisan passage of the bill ends a lengthy stretch of negotiations across the aisle and advances a historic federal investment in the country's aging infrastructure. Nearly half of the package constitutes new spending and to pay for the bill, the Senate looked to several health care policies. The package would reinstall sequester cuts, a two percent payment cut to all Medicare payments to providers, starting in 2022 through 2031. The sequester cuts will add approximately $8 billion for the infrastructure bill. The package calls for an additional three-year delay of the rule that eliminates the safe harbor for Medicare Part D drug rebates. The rebate rule was originally expected to go into effect in 2022 but was already delayed by the Biden administration until 2023. The bill includes some Biden administration health care priorities such as the requirement for the federal government to only purchase personal protective equipment (PPE) from domestic manufacturers and for any contract that buys PPE to run for at least two years, but removed significant investments in HCBS spending earlier in the negotiations. The infrastructure bill now heads to the House for approval (The Washington Post, August 10; Politico, August 10; Fierce Healthcare, August 10).

Federal Regulation

- On August 13, CMS is scheduled to publish the Hospital Inpatient Prospective Payment System (IPPS) final rule requiring hospitals to report on four broad categories of health data, an increase from the previously required two categories, to better track future public health threats. The FY22 final rule requires inpatient hospital facilities operating under electronic health record incentive rules to file lab, case, and immunization reports, along with data describing patients with symptoms of concern, such as flu-like symptoms. Participating hospitals that do not report on all four data categories will lose points in CMS' formula for electronic health record use, resulting in reduced reimbursement rates. The final rule responds to the public health system's struggle to obtain useful data during the coronavirus pandemic, including case counts and hospital capacity data (Politico, August 2).
- On August 10, CMS published a proposed rule that rescinds the Most Favored Nation (MFN) Model interim final rule published under the Trump administration in November 2020. The MFN Model was a Trump-era demonstration aimed to reduce prices for Medicare Part B drugs and biologics by tying payments to other wealthy countries' drug prices. A federal judge blocked implementation of the MFN Model earlier this year, and it has been on hold ever since. The MFN Model was highly opposed by hospitals, drugmakers, and fiscal conservatives; the latter two arguing it is a form of price control that can stifle innovation and access to new cures. Comment on the proposed rule is due October 10, 2021 (Federal Register and CMS, August 10; Modern Healthcare, August 6).

COVID-19

- Novavax is delaying their application for Emergency Use Authorization (EUA) of their COVID-19 vaccine until the fourth quarter of this year. The company originally planned to file for an EUA in the third quarter for their vaccine candidate, which is 90% effective. Novavax has an agreement with the United States to provide 100 million doses and has received $1.6 billion for development and manufacturing (Politico, August 5).
- The Food and Drug Administration (FDA) is expected to approve Pfizer's COVID-19 vaccine by early September, a move that health officials hope will nudge hesitant Americans towards getting vaccinated. The FDA issued EUA of the Pfizer vaccine for individuals aged 16 and over in December 2020, a designation that expires with an emergency declaration and indicates only a potential benefit to the vaccine. By contrast, full FDA approval marks the agency's official designation of a product as "safe and effective." Recent polling from the Kaiser Family Foundation indicates 30% of unvaccinated people would be more likely to get a fully approved vaccine than an emergency authorized vaccine. However, many respondents did not know the difference between EUAs and FDA approved vaccines, or thought the vaccines were already FDA approved, suggesting this benchmark could be a proxy for skeptics' broader concerns (Politico, August 4).
- Given the rise in COVID-19 variants and recent evidence of diminishing vaccine protection six months after the final dose, the FDA plans to release a COVID-19 vaccine booster strategy by early September, particularly for immunocompromised individuals and those aged 65 and older. Concurrently, the World Health Organization (WHO) called for a moratorium on boosters until all countries are able to vaccinate at least 10% of their populations. Moderna is currently testing three booster candidates and is expected to complete the rolling submission of its application for full FDA approval this month (The Wall Street Journal, August 5; Politico, August 5; The New York Times, August 4).

Waivers

- Section 1115
    - On August 10, CMS issued a letter informing Tennessee of its intent to open a new 30-day federal comment period using the procedures set forth in 42 CFR 431.416(b) to receive input from the public on the special terms and conditions (STCs) of the final version of the TennCare III demonstration. This solicitation of public comments will not delay or prevent implementation of the demonstration, which went into effect on January 8, 2021, the date of CMS approval. The STCs will be posted for public comment on Medicaid.gov.
- Section 1915(c) Appendix K
    - Maine
        - Temporarily expands the service description and scope of Community Supports through the addition of Community Membership services during the public health emergency.

SPAs

- Service SPAs
    - Kansas (KS-21-0007, effective October 1, 2020): Proposes the addition of medication-assisted treatment (MAT) as a mandatory benefit in the Medicaid State Plan. In compliance with the SUPPORT Act, the benefit will expire on September 30, 2025.
- Payment SPAs
    - Connecticut (CT-21-0018, effective April 1, 2021): Updates the durable medical equipment fee schedule to incorporate the April 2021 HCPCS changes to remain compliant with the HIPAA. New

added codes are priced using a comparable methodology to other codes in the same or similar category.

- Missouri (MO-21-0017, effective July 20, 2021): Revises the reimbursement methodology for outpatient services.
- New York (NY-18-0042, effective January 1, 2019): Eliminates payment for bed reserve days for hospitalizations for all nursing facility residents over 21 years of age, with exceptions for persons on hospice and therapeutic leaves.
- North Dakota (ND-21-0008, effective July 1, 2021): Implements an increase to the professional fee schedule for vaccine administration under the Pediatric Immunization program.
- Pennsylvania (PA-21-0014, effective May 9, 2021): Authorizes an additional class of disproportionate share hospital (DSH) payments to facilities treating a high number of COVID-19 patients. Specifically, qualifying hospitals will receive a payment by multiplying the hospital's number of Medicaid inpatient acute care days by either:
  - $127.50 for qualifying hospitals with at least 90% Medicaid dependence percent ranking
  - $102.00 for qualifying hospitals with at least 75% Medicaid dependence percent ranking
  - $76.50 for qualifying hospitals with at least 50% Medicaid dependence percent ranking
  - $51.00 for qualifying hospitals with less than 50% Medicaid dependence percent ranking
- Pennsylvania (PA-21-0016, effective June 20, 2021): Provides a new supplemental payment to Philadelphia hospitals treating a high volume of patients under the age of 18.

- Administrative SPAs
  - Wyoming (WY-21-0008, effective July 1, 2021): Requests an exception of the State's requirement to contract with a Medicaid Recovery Audit Contractor. *Approval documents for this SPA are not currently available.*
  - Oklahoma (OK-21-0025, effective July 1, 2021): Annotates that the state requires providers to bill liable third parties when services covered under the Plan are furnished to a member on whose behalf child support enforcement is being carried out. *Approval documents for this SPA are not currently available.*
- COVID-19 SPAs
  - Minnesota (MN-21-0006, effective February 9, 2021): Rescinds a temporary rate increase for personal care assistance service, effective February 9, 2021. This time-limited COVID-19 SPA terminates at the end of the public health emergency.

State Updates

- On August 10, CMS Administrator Chiquita Brooks-LaSure sent letters to health officials in Ohio, Utah, and South Carolina notifying them the Biden administration is revoking their 1115 waivers that mandate work requirements for Medicaid enrollees. In the letters, Brooks-LaSure writes that work requirements do not promote the objectives of Medicaid. Previously, CMS revoked 1115 waivers that impose work requirements in six states: Arkansas, Arizona, Indiana, Michigan, New Hampshire, and Wisconsin (Politico, August 10; Inside Health Policy, August 9).
- The Delaware State Legislature passed sweeping health care legislation that awaits the signature of Governor John Carney (D). The bill, modeled after similar reforms in Rhode Island, hinges on the premise that a greater investment in primary care will root out patient health problems earlier, leading to better outcomes and less spending, especially since early studies in Rhode Island have found the model successful. The legislation incentivizes insurers to boost investment in primary care through a three-pronged approach:

  - Insurers will be required to spend a defined percentage of their total health care spend on services such as annual checkups and the management of chronic care.
  - Fully insured payers with more than 10,000 members will be able to set caps on hospital price growth in their contracts to divert spending to primary care. Price growth for non-professional hospital services will be the greater of three percent or core consumer price index (CPI) plus one percent by 2022 and two percent or core CPI plus one percent by 2023.
  - Certain payers will be required to tie just under half of their business to alternative payment models by 2023 and establish shared accountability for both the cost and quality of care (Healthcare Dive, August 9).

- State economists predict five million Florida residents will be covered by Medicaid by the end of the current fiscal year, according to a report in the *Tampa Bay Times*. The estimated enrollment is up 11% from the 2020-2021 fiscal year, which ended June 30. The anticipated rise in Medicaid beneficiaries stems partially from the continuing effects of unemployment caused by the COVID-19 pandemic. One of the biggest jumps in Medicaid enrollment is in children ages 14 and older who qualify because they or their families are eligible for the Temporary Assistance for Needy Families program. Lawmakers could adjust their budgeting strategy during FY22 based on the new enrollee estimates. For FY22, the budget allocates almost $35 billion in state and federal dollars to fund Florida's Medicaid program. The state will likely tap additional federal funding through the end of the year, which will prevent the state from removing enrollees, even if their status changes and they are ineligible for Medicaid. In the longer term, economists predict the Florida Medicaid population will decrease beginning with the elimination of the federal Public Health Emergency (Health Payer Specialist, August 9).

Private Sector Updates

- Versant Health, acquired by MetLife in September 2020, has seen an increased interest in vision care from its current clients. Versant has over 36 million members across the country and their new vision unit has added six percentage points of growth to the company's U.S. group premiums, fees, and other revenues in Q2. Versant Health is one of many companies currently focusing on parts of the health insurance landscape, such as dental and vision, that require less capital-intensive investments, lower liabilities, and large opportunity for growth (Health Payer Specialist, August 9).
- Despite pressure from the Justice Department (DOJ), UnitedHealth Group will move forward with its $8 billion acquisition of Tennessee-based analytics firm Change Healthcare. In March, two months after the deal was announced, the DOJ requested additional information from both firms and extended its review of the deal beyond the 30-day standard period. The DOJ is now considering filing a lawsuit to block the acquisition and is seeking private attorneys to lead any litigation against UnitedHealth Group and Change Healthcare (Health Payer Specialist, August 9).

Sellers Dorsey Updates

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- Sellers Dorsey continues to seek great talent across the U.S. to join our ever-growing team. We are hiring for several positions across various departments. Check out all our career opportunities here.
- Sellers Dorsey team members are having a great week connecting with industry experts and colleagues at the HIMSS21 and MESC 2021 conferences. If you missed us and want to connect, contact us here.

- Medicaid programs, providers, and managed care organizations alike wish to leverage the potential of value-based care, and Sellers Dorsey is a capable partner in this important area. With a deep knowledge of Medicaid managed care programs, we have experience to implement proven concepts and insight to develop effective new approaches. For providers, our experts can help translate state-led reform initiatives around policy, operations, and financing, and we assist in leveraging alternative payment model requirements and opportunities. Learn about our work in this key area of expertise.

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