sellers dorsey
realize the opportunity.

SELLERS DORSEY DIGEST

Issue 47 | August 19, 2021

NAVIGATION

Summary of Key Updates

CMS published a blog post outlining its goals for value-based pilots in the Medicare and Medicaid spaces over the next 10 years. CMS will continue to engage providers in various models but with a renewed focus on equity and scaling successful pilots (Health Affairs, August 12; Fierce Healthcare, August 13; Modern Healthcare, August 13).

In a letter to states, CMS has extended timeframes for states to complete pending eligibility and enrollment actions until 12 months after the conclusion of the public health emergency (PHE) and clarified that states may not terminate Medicaid beneficiaries who were determined ineligible during the PHE, but not terminated, until they complete a redetermination for those beneficiaries post PHE (CMS, August 13).

From August 10 to August 16, CMS approved three Section 1915(c) Appendix K waivers and nine SPAs, two of which are COVID-19 disaster relief SPAs.

Sellers Dorsey helps provider clients like hospitals, physicians, and others see opportunities within Medicaid finance challenges to move the needle on access, quality, and other key issues. Our innovative collaborations supply providers with essential reimbursement while supporting state objectives to better serve complex populations and advance the vision of health equity. Learn more about the impact of our work with providers.

Federal Updates

News

- On August 13, the Biden administration released a two-pronged brief detailing immediate steps that will be taken to address COVID-19 and its Build Back Better agenda (also called the reconciliation package) in rural America. The administration is making the following American Rescue Plan (ARP) funding and projects available to help rural communities continue to meet immediate needs due to the COVID-19 pandemic and improve the health of rural communities.
    - HHS is providing $8.5 billion in ARP funding to compensate health care providers who provide services to rural Medicare, Medicaid, and CHIP patients for lost revenue and increased expenses associated with COVID-19.
    - HHS is providing $52 million in ARP funding to train new rural health care providers, including community health workers and respiratory therapists and to expand telehealth services. In FY 2022, HHS will support a demonstration project to expand access to pulmonary rehabilitation services in Critical Access Hospitals that serve rural communities.
    - The U.S. Department of Agriculture (USDA) is using $500 million in ARP funding to create the Emergency Rural Health Care Grant Program which will provide at least $350 million to rural hospitals for access to COVID-19 vaccines, testing, medical supplies, telehealth, food assistance, and renovation or construction of facilities. The program will provide $125 million in grants for planning and implementation grants to support the long-term viability of rural providers.
    - The Department of Veterans Affairs will implement the Rural Interprofessional Faculty Development Initiative, a two-year training program designed to provide teaching and training skills for clinicians in rural settings.
    - The National Institutes of Health (NIH) will hold public workshops to identify ways to improve rural health through telehealth-guided provider-to-provider communication.

  To implement the Build Back Better agenda, Congress must allocate funds through the budget bill (The White House, August 13).
- In a blog post published August 12, CMS Administrator Chiquita Brooks-LaSure and other top health officials outlined the Center for Medicare and Medicaid Innovation's (CMMI) vision for the next 10 years of value-based care. The vision was guided by a review of the more than 50 models launched by the CMMI since its creation over 10 years ago, which generated the following key takeaways:
    - Models to date have been largely Medicare-oriented and drawn only for those with resources and capital to apply and participate, resulting in limited attention to Medicaid and safety net providers. CMMI will use an equity lens in future pilots and recruit more safety net providers (including those in racially diverse and rural areas) to participate in models.
    - Testing too many models at once creates opposing incentives and burdens model participants with figuring out the model hierarchies and interactions, limiting opportunities for systemic, scalable transformation. CMMI intends to launch fewer models and focus on scaling the most successful ones to become a core piece of Medicare and Medicaid programming.
    - Voluntary models can limit potential savings and participants' full ability to test an intervention.
    - Providers find it challenging to accept downside risk if they do not have the tools to enable and empower changes in care delivery.
    - Challenges in setting financial benchmarks have resulted in overpayment, undermining the models' effectiveness.

  - Innovation Center models can define success as encouraging lasting transformation and a broader array of quality investments, rather than focusing solely on each individual model's cost and quality improvements.
  - CMMI also committed to improving its business conduct by increasing the transparency and accessibility of its data and strengthening relationships with state Medicaid programs, payers, purchasers, providers, patient advocates, and community-based organizations. CMMI plans to offer more details on how to install its vision for value-based care in the coming months. For now, it is engaging with stakeholders to develop short- and long-term objectives (Health Affairs, August 12; Fierce Healthcare, August 13; Modern Healthcare, August 13).

- August 15 marked the deadline for consumers to participate in a special enrollment period for private health coverage on the Affordable Care Act (ACA) marketplace, HealthCare.gov. The Biden administration reopened the marketplace on February 15 to provide additional opportunities to enroll in health coverage during the COVID-19 pandemic. In April, the passage of the $1.9 trillion COVID-19 relief package provided a temporary boost in ACA subsidies: The average monthly premium decreased by 40% and the median deductible decreased by 90% from $450 to $50 during the special enrollment period. Over 2.5 million people signed up for coverage since the marketplace reopened in February. The regular ACA enrollment season begins November 1, and the enhanced subsidies are slated to end in 2022, but the Biden administration is pressing Congress to make the subsidies permanent (Associated Press, August 13; The Hill, August 14).

Federal Regulation

- CMS is giving hospitals more time to adjust to its price transparency rule, refraining from penalizing providers thus far. More than 90% of hospitals have not met one or more of the Trump-era requirements to disclose standard charges for items and services as required by a final rule published in November 2019. When initially published, the American Hospital Association (AHA) and other groups claimed CMS was overstepping its authority, but the final rule survived a lawsuit and appeal in 2020. Instead of modifying the rule, the Biden administration has proposed tougher sanctions, such as increasing the penalty to at least $300/day for smaller hospitals and $10/bed for larger hospitals but no more than $5,500/day. AHA argues that the policy is moving in the wrong direction. When, after an audit of hospital website, CMS determines that the hospital is noncompliant, CMS will give the hospital a written warning or request a corrective action plan. Hospitals have 90 days to address the alleged violations. While CMS sent approximately 165 warning letters through this summer, AHA suggests the rate of compliance is much higher than what compliance reports from outside groups might predict. According to AHA, the rule is burdening hospitals and a workforce that are already under immense pressure because of the COVID-19 pandemic. However, CMS leadership believes that price transparency will lead to lower and more uniform prices, supporting the larger goal of closing the equity gap in care (Bloomberg Law, August 16).

Federal Litigation

- On August 10, the U.S. Chamber of Commerce (Chamber) filed suit in the Eastern District of Texas U.S. Federal Court challenging the HHS Transparency in Coverage rule finalized in October 2020. The suit, joined by the Tyler Area Chamber of Commerce (TX), is centered on a provision in the rule requiring nearly all insurers and self-insured plans to post three machine-readable files on their websites starting in 2022: the first file will show negotiated rates for all covered items and services among plans and in-network providers; the second file will show historical payments to, and billed charges from, out-of-network providers; the last file will lay out the in-network negotiated rates and historical net prices for covered prescription drugs by plans or issuers at the pharmacy level. The Chamber calls for striking the entire provision due to an ACA mandate declaring that information disclosed by payers be provided "in

plain language," which it claims is inconsistent with the rule requirement that plans disclose machine-readable data intended to be read by a computer. The Chamber also claims the provision violates the Administrative Procedure Act (APA) due to the agency's omission of the requirement that payers provide historical net prices for drugs in its proposed rule, depriving stakeholders of the chance to provide comment. The Chamber claims HHS further violated the APA when it did not address stakeholder comments urging the administration to delay the rule's January 2022 effective date. If the courts do not strike down the rule or delay its implementation, payers will have to provide prices for 500 of the most "shoppable services" by January 1, 2023 and all other services by January 1, 2024 (Inside Health Policy, August 11; Modern Healthcare, August 12).

COVID-19

- The American Health Care Association/National Center of Assisted Living (AHCA/NCAL) sent a letter to HHS on August 10 urging the Department to immediately release the next distribution of provider relief funds and allocate $13 billion in COVID-19 relief to long-term care providers. The AHCA/NCAL claim that funding is needed to prevent thousands of facilities from closing due rising labor costs, decline in residents, increased spending on personal protective equipment for COVID-19. A recently published GAO report found nearly $44 billion in unallocated provider relief funding left in the $178 billion fund. The AHCA/NCAL letter comes shortly after a request from AHA to not repurpose unallocated provider relief funds based on the growing number of delta variant cases (Inside Health Policy, August 11).
- On August 13, CMS released a letter to State Health Officials that provides updated guidance relating to the planned resumption of normal state Medicaid, CHIP, and BHP operations upon the conclusion of the COVID-19 PHE. The letter updates the previous guidance released in December 2020 as states have raised concerns that they will need additional time to complete the growing backlog of pending work. The following are the updates in the revised letter:
    - States will have 12 months from the month in which the PHE ends to complete pending eligibility and enrollment. The initial letter granted states up to six months to complete pending verifications and redeterminations.
        - States are encouraged to reassess their risk-based approach to prioritize pending work and adjust their plans to restore routine operations after the PHE ends, as appropriate.
        - States must consider ways to ensure that their risk-based approach promotes continuity of coverage for eligible individuals and limits delays in processing actions for individuals who become eligible for new or more comprehensive coverage.
    - States must complete an additional redetermination for individuals determined ineligible for Medicaid during the PHE. States may not terminate coverage for any individual determined ineligible for Medicaid, but not terminated, during the PHE, including individuals who failed to respond to a request for information, until the state has completed a redetermination after the PHE ends (CMS, August 13).

Waivers

- Section 1915(c) Appendix K
    - Minnesota
        - Temporarily permits certain relatives of waiver participants to provide extended personal care assistance services.
    - Alabama
        - Temporarily increases provider rates to account for increased risk factors, overtime, and to ensure that essential services remain available for service recipients.
    - Oklahoma

- Temporarily implements a COVID-19 add-on payment that cannot be applied to retainer payments to accommodate potential issues with staffing shortages and the need for service provision outside of approved services. Applies to the ADvantage Waiver, In Home Supports Waivers, and the Community and Homeward Bound Waivers.

SPAs

- Service SPAs
  - Iowa (IA-21-0006, effective October 1, 2020): Adds medication-assisted treatment (MAT), associated counseling and behavioral health therapies to treat opioid use disorders as a mandatory benefit in the Medicaid State Plan pursuant to 1905(a)(29) of the Social Security Act and Section 1006(b) of the SUPPORT Act. The benefit is effective until September 30, 2025.
  - North Carolina (NC 21-0010, effective July 1, 2021): Removes the prior authorization requirement from solid organ and stem cell transplants.
- Payment SPAs
  - New York (NY-21-0022, effective April 1, 2021): Authorizes temporary rate adjustments for the outpatient services for specific Critical Access Hospitals.
  - Minnesota (MN-21-0011, effective July 1, 2021): Increases the state's current per diem rate for Youth ACT services.
  - Oklahoma (OK-21-0033, effective July 1, 2021): Establishes a $4 copay amount per visit for non-emergency dental services provided to non-exempt individuals under the state plan.
- Administrative SPAs
  - Illinois (IL-21-0010, effective April 1, 2021): Provides for three months of enrollee deductions of nursing home and medical expenses prior to Medicaid application as part of the Post-Eligibility Treatment of Income process.
- Eligibility SPAs
  - Wyoming (WY 21-0009, effective April 1, 2021): Removes the optional eligibility group for Program of All-Inclusive Care for the Elderly participants.
- COVID-19 SPAs
  - Colorado (CO-21-0023, effective June 1, 2021): Provides a one-time per member per month COVID-19 workload targeted case management payment in consideration for additional workload imposed on case managers. This time-limited COVID-19 SPA terminates at the end of the PHE, though the single round of payments occurred in June 2021.
  - Virgin Islands (VI-21-0001, effective March 1, 2020): Adds coverage for Personal Care Attendant Services for all Medicaid eligible clients. The Virgin Island Department of Health has created a fee schedule for personal care services and included a rate for nurses providing an initial nursing orientation, assessment, and plan of care development. This time-limited COVID-19 SPA terminates at the end of the PHE.

State Updates

- On August 13, Ohio Department of Medicaid Director Maureen Corcoran announced that Buckeye Health Plan will join the six previously announced managed care organizations (UnitedHealthcare, Humana, Molina, AmeriHealth Caritas, Anthem, and CareSource) to provide services to Medicaid beneficiaries in the state's Next Generation managed care program. This announcement was made after settlement of a lawsuit filed by the Ohio Attorney General against Buckeye Health Plan and other entities related to

Buckeye's pharmacy benefit management structure. Ohio Medicaid's Next Generation managed care organizations will begin covering beneficiaries in 2022 (Ohio Department of Medicaid, August 13).

- In a federal court filing last week, U.S. Acting Assistant Attorney General Brian Boynton obtained a temporary stay of the litigation challenging the TennCare Waiver while the government reopened a 30-day public comment period on the TennCare demonstration waiver beginning August 10. Tennessee is the first state approved to receive lump sum funding for its Medicaid program. The TennCare Waiver will remain in effect during the comment period. President Biden, an outspoken opponent of Medicaid block-grant efforts, can rescind the TennCare Waiver but has not indicated whether his administration will reverse or modify the Trump administration's decision approving the program (Modern Healthcare, August 15).
- The Milbank Memorial Fund published an Issue Brief containing a 50-state analysis of each state's legal and administrative frameworks for assessing health care transactions for anticompetitive behavior. The Issue Brief also identifies key elements to creating a comprehensive state merger review authority to prevent further health provider consolidation and improve oversight of approved transactions. The Issue Brief recommends that state regulators should protect consumers and maintain competition in the health care provider market through the following regulatory changes: requiring broad pre-transaction notice; allowing sufficient time to review transactions using substantive review criteria; mandating the ability to approve, conditionally approve, or block transactions administratively; and finally, creating the means to oversee conditionally approved transactions (Milbank Memorial Fund, August 5).

Private Sector Updates

- Purdue Pharma is entering the final phase of settling thousands of lawsuits over its production and distribution of OxyContin and other opioid prescription painkillers. Once approved by all parties, the company's settlement could be worth $10 billion. Several opponents of the previous agreements signed onto the new settlement after the company agreed to make its records public and Sackler family members agreed to accelerate and increase payments to a total of $4.5 billion in the form of cash and control of a charitable fund. Settlement dollars could be used to fund treatment programs and education campaigns, in addition to other harm reduction measures. Some settlement funds would also go to individual victims and their families with payouts ranging from $3,500 to $48,000 (Associated Press, August 12).
- Aetna is launching a new nationwide primary care solution, Aetna Virtual Primary Care, that is backed by Teladoc Health's physician-led care team model and uses Aetna's provider network and other services provided by CVS Health, its parent company. Patients will have access to continuous visits with a virtual primary care doctor, which begins through a 30-to-45-minute initial visit. Members can also connect to a diverse array of physicians and specialists depending on their needs. There will be a $0 copay for select virtual and in-person services at CVS MinuteClinics (Fierce Healthcare, August 10).

Sellers Dorsey Updates

- Sellers Dorsey helps provider clients like hospitals, physicians, and others see opportunities within Medicaid finance challenges to move the needle on access, quality, and other key issues. Our innovative collaborations supply providers with essential reimbursement while supporting state objectives to better serve complex populations and advance the vision of health equity. Learn more about the impact of our work with providers.
- August has been a busy month for conferences! Sellers Dorsey staff is excited to attend the Virtual 2021 Health Care Investing Summit on August 24-25. We are looking forward to learning more about key

trends and opportunities in health care investing from health care industry experts. Learn more about upcoming events that Sellers Dorsey will be attending here.

- Sellers Dorsey helps clients realize opportunities to enhance lives by delivering high-quality, accessible care to all. It is essential to have the right talent and subject matter expertise to assist our clients. The Sellers Dorsey team includes several former Medicaid directors from across the U.S. who have hands-on experience and passion for serving vulnerable populations. Learn more about our leaders here.

Follow Sellers Dorsey to stay up to date.