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SELLERS DORSEY DIGEST

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NAVIGATION

Summary of Key Updates

On August 24, the House passed a $3.5 trillion budget resolution, including a measure to begin the reconciliation process and a compromise to vote on the $1 trillion infrastructure bill by September 27 (New York Times, August 24; Inside Health Policy, August 24; CNN, August 24).

On August 23, the Food and Drug Administration (FDA) announced its approval of the Pfizer-BioNTech COVID-19 vaccine for individuals ages 16 and older (Politico, August 23).

The Centers for Medicare and Medicaid Services (CMS), in collaboration with the Centers for Disease Control and Prevention (CDC), has announced an emergency regulation that will require COVID-19 vaccinations for staff at nursing homes receiving Medicare and Medicaid funding. The vaccine mandate is a condition for those facilities to continue receiving federal funds (CMS, August 18; Associated Press, August 18; Inside Health Policy, August 18; LeadingAge, August 23).

On August 20, a federal judge for the U.S. District Court of the Eastern District of Texas issued a preliminary injunction against CMS to enjoin the agency from implementing its April 16 letter rescinding approval of Texas' 1115 waiver renewal. In the order, the judge found CMS' recission of the waiver was "likely unlawful." The decision leaves in place a 10-year renewal of the state's 1115 waiver that CMS initially approved in mid-January (U.S. District Court, Eastern District of Texas, August 20; Modern Healthcare, August 22; Texas Tribune, August 20; Politico, August 20).

From August 17 to August 23, CMS approved three Section 1915(c) Appendix K waivers and 13 SPAs, one of which is a COVID-19 disaster relief SPA.

Sellers Dorsey recently released an updated state budgets summary analysis as a special issue of the Sellers Dorsey Digest. The following states have been added to the summary: Colorado, Georgia, Missouri, and Ohio. We will continue to summarize more state budgets as they are enacted in future Digest issues.

Federal Updates

News

- On August 24, the House passed a $3.5 trillion budget resolution, including a measure to begin the reconciliation process and a compromise to vote on the $1 trillion infrastructure bill by September 27. The reconciliation process will essentially "fast-track" the budget, shielding certain components of the bill from a filibuster, despite potential opposition in the Senate. If enacted as proposed, the budget bill will extend enhanced Affordable Care Act (ACA) tax credits, expand Medicare benefits, and close the Medicaid coverage gap (as funded by drug-pricing reforms). The budget resolution sets a target date of September 15 for committees to submit their reconciliation language (New York Times, August 24; Inside Health Policy, August 24; CNN, August 24).
- The Health Resources and Services Administration (HRSA) updated its webpage providing information on the Provider Relief Fund created by the CARES Act. HRSA provided updates indicating it has roughly $24 billion in unallocated Provider Relief Funds and posted a reminder to providers of the $8.5 billion appropriated for rural providers through the American Rescue Plan (ARP) Act. HRSA will provide updates on the availability of these funds (HRSA, August 24).
- CMS is providing additional payments to health care providers for administering COVID-19 vaccines to multiple Medicare beneficiaries in one home setting or communal setting of a home. Providers will now receive up to five times the standard payment amount if they administer COVID-19 doses to fewer than 10 Medicare beneficiaries on the same day at one location, such as small group homes, assisted living facilities, and other group residences. Providers could receive up to $35 more per vaccination. Medicare previously increased the total payment amount for at-home vaccination from $40 to approximately $75 per vaccine dose, in certain circumstances (CMS, August 24; Modern Healthcare, August 24).
- The Center for Medicare and Medicaid Innovation (CMMI) released an evaluation, authored by Mathematica, of its Medicare Prior Authorization Model for Repetitive, Scheduled, Non-Emergent Ambulance Transport (RSNAT). In December 2014, CMS launched this model in states where ambulance expenditures were high. The RSNAT Prior Authorization Model requires free-standing suppliers with ambulances to obtain prior authorization for RSNAT services from their Medicare Administrative Contractors (MAC), or resulting claims will be subject to prepayment review. The goal of the model is to reduce improper use of the service while maintaining quality of care. In 2014, New Jersey, Pennsylvania, and South Carolina implemented the model, and by 2016, Washington DC, Delaware, Maryland, North Carolina, Virginia, and West Virginia joined. Findings released for years 2014-2019 show the model dramatically reduced both RSNAT service use (72%) and expenditures (76%), resulting in a reduction of about $750 million in RSNAT service expenditures and total Medicare savings of $1 billion for beneficiaries. In December 2020, the model transitioned to Section 515 of the Medicare Access and CHIP Reauthorization Act of 2015 authority. In September 2020, CMS announced the model will be expanded nationwide once the public health emergency subsides (Mathematica, May 2021).
- CMMI released the fourth annual evaluation of its Home Health Value-Based Purchasing (HHVBP) Model, which assesses how shifts in financial incentives influenced the quality and delivery of home health care in a sample of agencies over a four-year period. The HHVBP Model, launched in a nationally representative sample of home health agencies (HHAs) throughout Arizona, Florida, Iowa, Massachusetts, Maryland, Nebraska, North Carolina, Tennessee, and Washington in January 2016. The HHVBP Model was designed to test the impact of providing financial incentives to HHAs by adjusting Medicare payments upward or downward based on their Total Performance Score (TPS), a composite score of an agency's quality achievement or improvement. The evaluation observed the following impacts of the first four years of the model, including the first two payment adjustment years:

  - A $604.8 million cumulative Medicare spending reduction (a 1.3% decline relative to the 41 non-HHVBP states) in HHVBP states during and 30 days after home health episodes of care, as measured by the average spending per day among fee-for-service (FFS) beneficiaries receiving home health services:
    - $381.4 million (2.4%) reduction in inpatient hospitalization stay spending
    - $164.9 million (4.2%) reduction in skilled nursing facility services spending
    - $65.3 million (6.1%) increase in outpatient ED and observation stay spending
    - No effect on Medicare spending for home health care
  - Total Performance Scores 8% higher than HHAs in non-HHVBP states in 2019
  - A decrease in unplanned hospitalizations, ED visits leading to inpatient admission, and skilled nursing facility use by FFS beneficiaries using home health
  - A continued trend toward improvement in functional status, including two new composite measures offset by modest unintended changes due to HHVBP:
    - 2.6% increase in outpatient ED visits
    - 0.3% decrease in two of five measures of patient experience: communication and discussion of care with patients
  - No effect on overall agency entries or closures, use of home health services, or access to home health services. Agencies continue to view the model as complementary to other CMS quality initiatives and report leveraging data analytics in coordination with staff training to improve performance and care delivery (Arbor Research Collaborative for Health, May 2021; CMMI, August 23).

- A JAMA Health Forum study released on August 20 found combining accountable care organizations (ACOs) and bundled payments can save more money and deliver better outcomes for patients than bundled payments alone. The cohort study of over nine million Medicare beneficiaries concluded that post-discharge spending for those with a medical condition was 5%, or $323, lower on average for patients participating in both an ACO and a bundled payment system simultaneously than for those using a bundled payment system alone. Patients with a medical condition and those undergoing surgery also had significantly lower readmissions if they participated in both an ACO and a bundled payment model. The combination of an ACO and bundled payments had no meaningful impact on spending for surgical episodes. The study's authors inferred that ACOs and bundled payments may deliver better results in tandem because each type of payment model encourages providers to make different investments in care. However, critics of the combined payment models argue that the overlap may create conflicting incentives for providers. This study is the first of its kind to yield evidence that multiple total cost-of-care models may yield better results than individual models on their own, which comes as CMMI plans to simplify its approach to value-based care by rolling out fewer models in total (Modern Healthcare, August 20).

Federal Regulation

- CMS, in collaboration with the CDC, has announced an emergency regulation that will require COVID-19 vaccinations for staff at nursing homes receiving Medicare and Medicaid funding. The vaccine mandate is a condition for those facilities to continue receiving federal funds. The nursing home industry was quick to respond to the new regulation; LeadingAge, the country's largest association of nonprofit aging services providers, warned that vaccine mandates for nursing home facilities would worsen the industry's labor shortage and financial challenges. As of August 8, about 61% of the nursing home staff are currently vaccinated nationally (CMS, August 18; Associated Press, August 18; Inside Health Policy, August 18; LeadingAge, August 23).

COVID-19

- On August 23, the FDA announced its full approval of the Pfizer-BioNTech COVID-19 vaccine for individuals ages 16 and older. The vaccine had been available under an emergency use authorization for this age group and will continue to be available under the emergency use authorization for individuals ages 12-15. The agency's decision comes after the delta variant has spread nationwide and increased COVID-19 hospitalizations across the country. The full FDA approval will accelerate plans for vaccine mandates across state/local governments, private businesses, and universities (Politico, August 23).
- On August 18, the Biden administration released its plan to distribute booster shots of Pfizer's and Moderna's COVID-19 vaccines beginning September 20. The rollout will be dependent on FDA authorization and CDC's vaccine recommendations. Once approved, the first round of boosters will be offered to those who were vaccinated in the first phase of the initial vaccine rollout including health care provider staff and nursing home residents and will be administered to individuals starting eight months after their second dose. The booster plan currently only provides booster recommendations for those who are fully vaccinated with Pfizer's or Moderna's COVID-19 vaccine and have yet to provide guidance on Johnson & Johnson's vaccine pending new data to come in the next few weeks (Inside Health Policy, August 18).
- Maryland has announced it will require all employees of the state's nursing homes and hospitals to show proof of COVID-19 vaccinations or adhere to regular COVID-19 screening and testing. The Maryland Department of Health issued a directive ordering that all employees of nursing homes and hospitals will be "required to show proof of first dose or single dose of COVID-19 vaccination by Wednesday, September 1, 2021." Facilities that fail to comply with the mandate will be subject to increased fines, civil penalties, and enforcement actions. Many of the state's largest hospital systems, including University of Maryland Medical System, Johns Hopkins Medicine, MedStar, and GBMC Healthcare, have already mandated vaccines for staff (Maryland Office of the Governor, August 18; National Law Review, August 20).
- A Kaiser Family Foundation (KFF) analysis released on August 19 found 72% of large private health plans are no longer providing cost-sharing waivers for COVID-19 treatments as of this month, and another 10% of health plans expect to phase out the waivers by the end of October. These decisions come as earnings for major insurers returned largely to normal in the second quarter after massive profits during the same period in 2020. Analysts attribute these decisions to a rebound in health system utilization from lows exacerbated by the pandemic, as well as a decline in public pressure to continue waiving costs for COVID-19 treatment in the aftermath of widespread vaccine adoption. Many patients hospitalized for COVID-19 who have private insurance will likely receive high medical bills for their treatment as more waivers expire, while the federal government currently covers all COVID-19 treatment costs for uninsured patients (Fierce Healthcare, August 19).

Waivers

- Section 1115
    - On August 9, Connecticut submitted a request to CMS to reimburse for inpatient treatment services provided to eligible enrollees of Medicaid or CHIP who have been diagnosed with a substance use disorder (SUD). The waiver has a proposed effective date of October 1, 2021. The application requests that Institutions for Mental Diseases be paid for as a Medicaid-covered setting, with a corresponding state plan amendment that will ensure reimbursement for SUD treatment. The state's goal is to provide SUD treatment in the most appropriate setting and provide members with a comprehensive continuum of SUD treatment services. The services for which the state is seeking coverage would meet the American Society of Addiction Medicine's criteria for outpatient and residential treatment. This demonstration does not seek to change

the delivery system of services, eligibility criteria, or cost-sharing requirements. CMS will accept comments on the waiver application through September 19.

- Section 1915(c) Appendix K
    - District of Columbia
        - Temporarily allows for the electronic delivery of certain services and expands services that can be provided remotely; allows payment for Companion Services rendered by family caregivers or legally responsible individuals; modifies training requirements for direct support professionals (DSPs) and makes available a supplemental payment to eligible waiver providers employing DSPs for the Intellectual and Developmental Disabilities and Individual and Family Support waivers.
    - Louisiana
        - Temporarily assists agencies with completing level of care evaluations, re-evaluations, and person-centered service plans and utilizes the state's Long Term Care Access contractor to conduct initial level of care evaluations to fill slots and reduce waitlists for the Community Choices and Adult Day Health Care waivers.
    - Minnesota
        - Modifies the expiration date to August 30, 2021, for the previously approved flexibility allowing parents of minors and spouses to provide more than 40 hours per week of personal assistance under consumer directed community supports for the Brain Injury, Community Alternative Care, Community Access for Disability Inclusion, Developmental Disabilities, and Elderly waivers.

SPAs

- Service SPAs
    - Georgia (GA-20-0008, effective January 1, 2021): Adds Silver Fluoride Diamine (HCPCS Code D1354) as a covered service.
    - Nebraska (NE-21-0003, effective October 1, 2020 – September 30, 2025): 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.
    - Oklahoma (OK-21-0014, effective July 1, 2021): Updates Oklahoma's Alternative Benefit Plan (ABP) to remove the 24-day visit limitation for inpatient physician services, adds MAT and enhances dental services for adults.
    - Tennessee (TN-21-0004, effective July 1, 2021): Allows for limitation on amount, duration, and scope of medical care and services provided for prescribed drugs through value-based and supplemental rebate agreements with drug manufacturers for drugs provided to Medicaid beneficiaries.
    - Virginia (VA-21-0014, effective July 1, 2021): Allows coverage of up to a 12-month supply of contraception under the National Medicaid Pooling Initiative.
- Payment SPAs
    - Georgia (GA-20-0010, effective August 14, 2020): Provides a 1% rate increase for certain primary care codes.
    - Maine (ME-17-0016, effective September 6, 2017): Updates the fee schedule rates for personal care services.

  - New Jersey (NJ-21-0002, effective January 1, 2021): Updates the fee schedule rates for 2021, including an increase for certified nurse midwives.
  - Utah (UT 21-0004, effective July 1, 2021): Updates the durable medical equipment (DME) fee schedule.
  - Utah (UT-21-0007, effective July 1, 2021): Updates the utilization trend for the outpatient hospital Upper Payment Limit (UPL) in state fiscal year 2021.
  - Utah (UT-21-0008, effective October 1, 2021): Updates the reimbursement methodology for disproportionate share hospital (DSH) payments for Federal Fiscal Year 2022.

- Eligibility SPAs
  - Connecticut (CT-21-0001, effective August 16, 2021): Adds the optional eligibility group of individuals who are eligible for state plan Home and Community-Based Services (HCBS) and meet the requirements for an approved section 1915(c) waiver, but do not otherwise receive HCBS waiver services. This provides a Medicaid eligibility pathway for individuals who meet the coverage requirements for the Connecticut Housing Engagement and Support Services Initiative State Plan HCBS Benefit pursuant to Section 1915(i) of the Social Security Act.

- COVID-19 SPAs
  - Connecticut (CT-21-0017, effective April 28, 2021): Rescinds SPA CT 20-0015 which authorized: (1) exceptions to the limit on home and hospital leave days; and, (2) private non-medical institutions for adults need only to conduct one Random Moment in Time study (where two time studies are otherwise required each state fiscal year). This time-limited COVID-19 SPA terminates at the end of the public health emergency.

State Updates

- On August 20, a federal judge for the U.S. District Court issued a preliminary injunction order against CMS to enjoin the agency from implementing its April 16 letter rescinding approval of Texas' 1115 waiver renewal. In the order, the judge found CMS' recission of the waiver was "likely unlawful and causes prospective harm to plaintiffs that can be avoided by an injunction." The decision leaves in place a 10-year renewal of the state's 1115 waiver that CMS initially approved in mid-January. While Texas' 1115 waiver renewal, which includes new charity care funding pools, will remain in place pending the final outcome of Texas' lawsuit, CMS and the State must still negotiate separately on several new state-directed payment programs described in the waiver that make up a large part of the waiver's new funding framework but which are subject to a separate CMS approval process (U.S. District Court, Eastern District of Texas, August 20; Modern Healthcare, August 22; Texas Tribune, August 20; Politico, August 20).

- On August 18, a unanimous 1st U.S. Circuit Court of Appeals panel rejected a claim made by a group of Puerto Rico hospitals that the federal government systematically underpays them under Medicare program funding for DSH. The court ruled HHS was correct in calculating aid using a formula based on the share of hospital patients eligible for Medicare and Supplemental Security Income (SSI), even though residents of Puerto Rico are not eligible for SSI. In their lawsuit, the hospitals alleged since the territory's residents are not eligible for SSI, applying the formula shortchanges the hospitals and does not reflect the patients' true incomes. In rejecting the hospitals' arguments, the court ruled the statute was "neither ambiguous nor open to plausible differing interpretations" (NBC News, August 20).

- States must decide by August 28 if they will join the proposed $26 billion opioid settlement with McKesson Corp, Amerisource Bergen, Cardinal Health, and Johnson & Johnson. Funding from the settlement is intended to help states fund treatment and other services. Some states are facing local

resistance, with concerns the amount is not sufficient to address the damage done by the addiction epidemic. The settlement's formula envisions at least 44 states joining, but ultimately the companies can decide whether to finalize the deal based on participation. The companies deny any wrongdoing, stating the drugs were approved by the FDA and that responsibility lies with others, including doctors and regulators (Reuters, August 19).

- Georgia Governor Brian Kemp announced the state will spend $125 million to fund 1,500 health care workers through the beginning of December. This increase in funding and staffing comes amid a surge in COVID-19 cases that has forced hospitals to turn patients away. The state has previously allocated $500 million for 1,300 staff members at 68 hospitals. Georgia hospitals have reported shortages of nurses, respiratory therapists, and ICU personnel. The additional funded staff will open up an additional 450 beds at nine regional hospitals (Modern Healthcare, August 17).
- The New Jersey Office of the State Comptroller (OSC) announced the state has recovered almost $6.5 million from health care groups that have self-disclosed Medicaid overpayments. Providers must notify the state within 60 days of finding overpayments, and this self-reported amount accounts for approximately 15% of the Medicaid dollars identified for recovery over the last three fiscal years. OSC believes this finding demonstrates that the OSC's self-disclosure tool is successful in combating fraud, waste, and abuse within New Jersey's Medicaid program (Politico, August 19).

Private Sector Updates

- Medicare Advantage (MA) plans are under pressure to ease up on prior authorization restrictions that make it harder to transfer appropriate patients to post-acute care facilities. While some payers suspended prior authorization at the start of the pandemic, many have not. State emergency laws stop most insurers from interfering with transfers of hospital patients, but "the same patient protections do not apply to MA plans that continue to issue prior authorization denials and require peer-to-peer reviews." This situation is critical in Gulf State facilities where ICUs are full of patients with the delta variant of COVID-19. CMS strongly encouraged all MA plans to waive or relax prior authorization requirements and utilization management processes. America's Health Insurance Plans (AHIP) supports the CMS request because it aids hospitals in making room for additional patients due to the COVID-19 pandemic. CMS does not address the potential costs to MA plans other than stating the costs are not the agency's problem. The rules governing CMS's payments to MA organizations remain unchanged and are not affected by this information (Health Payer Specialist, August 25).

Sellers Dorsey Updates

- In case you missed it, last week Sellers Dorsey released an updated state budgets summary analysis on August 20 as a special issue of the Sellers Dorsey Digest. The following states have been added to the summary: Colorado, Georgia, Missouri, and Ohio. To date, we have analyzed 22 states and found many used their state general funds to expand substance use disorder and behavioral and mental health services, invest more into nursing homes and long-term care facilities, broaden telehealth abilities, and cover doula services. We will continue to summarize more state budgets as they are enacted in future Digest issues.
- Next month, Sellers Dorsey team members will be attending and sponsoring America's Essential Hospitals Medicaid Summit, where we'll be engaged in conversations about ongoing initiatives to advance health equity through impactful, quality-based Medicaid financing initiatives that address population health issues and health disparities in communities across the U.S. We are excited to attend several other conferences in September. Check out all the events our team will be attending here.

- Sellers Dorsey offers expansive knowledge of the evolution of long-term services and supports (LTSS) within Medicaid, including LTSS delivered through managed care (MLTSS). Our team members have decades of experience operating programs in various states. We offer a variety of perspectives stemming from work with non-state government entities, state and federal agencies, provider associations, and other stakeholders in health care delivery for vulnerable populations. Our experience and offerings include developing MLTSS policies and programs in collaboration with public and private entities, as well as creative alternative concepts to MLTSS to best suit a diversity of states' and constituents' goals. Learn more about our experience in LTSS.

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