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SELLERS DORSEY DIGEST

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NAVIGATION

Summary of Key Updates

On August 30, the Centers for Medicare and Medicaid Services (CMS) announced three new appointees who will lead important divisions within the agency: Dr. Ellen Montz, Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight; Dr. Natalia Chalmers, Chief Dental Officer in the Office of the Administrator; and Dara Corrigan, Deputy Administrator and Director of the Center for Program Integrity (CMS, August 30).

On August 26, CMS published a notice in the Federal Register announcing the start dates for the nationwide expansion of prior authorization for regular, non-emergency ambulance transportation services (Modern Healthcare, August 26).

CMS will not immediately remove nursing homes from Medicaid and Medicare program participation if they do not adhere to the staff vaccination requirement that is expected to take effect in September. Instead, CMS will phase in progressive remedial measures, first notifying nursing homes they are not in compliance, assessing civil monetary penalties, denying payment, then removal from the program if they do not comply (Modern Healthcare, August 25).

From August 24 to August 30, CMS approved 33 SPAs, three of which are COVID-19 disaster relief SPAs. CMS did not approve any new waivers.

Next week Sellers Dorsey will release another special edition of the Digest highlighting several state budgets that were recently enacted. You can check out our latest state budget summary here.

Federal Updates

News

- On August 30, CMS announced three new appointees who will lead important divisions within the agency:
    - Dr. Ellen Montz will serve as the new Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight (CCIIO). The CCIIO manages the Healthcare.gov and the federal insurance Marketplace.
    - Dr. Natalia Chalmers will be CMS' first Chief Dental Officer and will guide the agency in advancing oral health in Medicaid, Medicare, CHIP, and the Marketplace under the Biden administration's commitment to prioritize whole person health.
    - Dana Corrigan will serve as the Deputy Administrator and Director of the Center for Program Integrity (CPI). CPI oversees Medicare, Medicaid, and CHIP fraud, waste, and abuse protection processes (CMS, August 30).
- The Department of Health and Human Services (HHS) has enlisted several firms to audit billions of dollars sent to health care providers due to the COVID-19 pandemic. The selected firms include Grant Thornton, Creative Solutions Counseling, PricewaterhouseCoopers, and KPMG (providing program integrity support). The audits will focus on providers who received at least $750,000 in federal financial assistance last year, including Provider Relief Fund (PRF) dollars. The first audits are set to begin September 30, which is the end of the reporting period for providers who received PRF money in the spring 2020. In turn, lawmakers urged HHS Secretary Xavier Becerra to quickly distribute the remaining PRF dollars to give more providers a fair chance to spend their allocations (Modern Healthcare, August 27).
- On August 27, CMS published a notice in the Federal Register announcing the intended start dates for the nationwide expansion of prior authorization for regular, non-emergency ambulance transportation. CMS will kick off the six-phase rollout of the new requirements on December 1, 2021 and expects implementation in all states by August 1, 2022. The prior authorization documentation is the same as it is for Medicare payment, and providers can voluntarily request prior authorization from the Medicare Administrative Contractor for each instance of regular, non-emergency ambulance transportation services. If providers do not voluntarily request prior authorization, CMS will review claims involving patient trips before the fourth-round trip within a 30-day period. CMS identified prior authorization reduced unnecessary ambulance transportation and spending by over 70% (cutting Medicare spending by 2.4%) under pilot programs in Delaware, Maryland, New Jersey, Pennsylvania, North Carolina, South Carolina, Virginia, West Virginia, and Washington D.C. CMS hopes that by expanding this policy nationwide, Medicare will continue to save more money in the future (Modern Healthcare, August 26).
- On August 25, CMS announced Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program (MSSP) in 2020 earned performance payments totaling nearly $2.3 billion while saving Medicare approximately $2 billion after subtracting shared savings, marking the fourth consecutive year of net savings for Medicare. MSSP ACOs are provider groups that voluntarily enter coordinated care arrangements for Medicare beneficiaries designed to mitigate the duplication of services and prevent medical errors. Participating ACOs agree to take on financial risk and share in Medicare program savings if they meet certain quality and spending benchmarks. Participating ACOs may also be required to repay a portion of losses to Medicare if the care provided increases spending or does not meet certain quality metrics. The 513 participating ACOs generated $390 in gross savings per beneficiary in 2020, with 345 out of the 513 receiving shared savings. ACOs in models with downside risk were significantly more likely to earn performance payments than those without, with just 55% of ACOs in one-sided risk models receiving shared savings compared to 88% in two-sided risk models. The ACOs

had an average quality score of nearly 98%, and 60 ACOs received a perfect score. The program report comes as new legislation introduced in the House aims to stem a recent slide in MSSP participation by raising the amount of shared savings an ACO can achieve through MSSP. Additionally, a nationwide shift toward greater reliance on total cost-of-care models like ACOs which push providers to take on more financial risk, aligns with the Center for Medicare and Medicaid Innovation's vision for the next decade of value-based care (CMS, August 25; Fierce Healthcare, August 25; Modern Healthcare, August 25).

- On August 27, the Substance Abuse and Mental Health Services Administration (SAMHSA) announced its decision to award $74.2 million in first-year grant funds to two mental health programs for youth intended to enhance the system of care for delivering services and support to the Nation's children . The first program, Project AWARE, supports state and local government coordination efforts to increase awareness of mental health issues among school-aged youth, provides training for school personnel and other adults who interact with school-aged youth to detect and respond to mental health issues, and connects school-aged youth who may have behavioral health issues – including serious emotional disturbance (SED) or serious mental illness (SMI) – and their families to services. Seventeen grantees across 17 states, including two Native American tribes, will receive $54.3 million in total first-year funds, $36.5 million of which is Coronavirus Response and Relief Supplemental Appropriations Act funding. The second program, the Comprehensive Community Mental Health Services for Children and their Families Program (aka the Children's Mental Health Initiative) supports the implementation, expansion, and integration of a system-of-care approach, creating sustainable infrastructure across an array of entities to deliver community-based services to improve the mental health outcomes of individuals up to 21 years of age with SED. Twelve grantees across 11 states, two of which are Native American tribes, will receive a total of $19.8 million the first year of a four-year grant cycle. In addition to the funds, SAMHSA released several web-based mental health resources that address mental health and resiliency in school settings to support students and school staff (HHS, August 27).

Federal Regulation

- CMS' proposed 2022 Home Health Prospective Payment System Rule will not claw back overpayments in 2022 due to the COVID-19 pandemic but has left the door open to recouping funds in future years since the law requires new payment approaches that do not increase or decrease Medicare spending when compared to past ways of payment calculations. Home health agencies are threatening to sue CMS if the agency attempts to claw back overpayments with future changes. Additionally, some providers are unhappy with how CMS evaluated the payments' budgetary impact and the potential future impact to provider reimbursement (Modern Healthcare, August 30)

Federal Litigation

- On August 26, the U.S. Chamber of Commerce and the Tyler (TX) Area Chamber of Commerce voluntarily withdrew a lawsuit filed against HHS, CMS, the Labor Department, the Treasury Department, and the IRS earlier this month in U.S. District Court for the Eastern District of Texas. The initial U.S. Chamber and Tyler Area Chamber filing alleged the CMS Transparency in Coverage Rule provision requiring payers to post machine-readable files containing their in-network rates negotiated with providers and out-of-network rates violates the Affordable Care Act (ACA) mandate that information disclosed by payers be written in "plain language." The suit's withdrawal comes after the Biden administration's August 20 announcement to delay enforcement of the Transparency in Coverage Rule by six months, giving insurers until July 1, 2022, to comply due to the time and effort required to publish machine-readable files. Pending new rulemaking, the administration announced it would indefinitely delay a provision of the rule requiring insurers to post prescription drug rates in light of new prescription drug reporting requirements Congress included in its year-end spending package. U.S. Chamber leadership indicated the Biden administration's decisions were positive responses to its filing, but it remains open to future litigation (Modern Healthcare, August 26; Wall Street Journal, August 26).

COVID-19

- CMS will not immediately remove nursing homes from Medicaid and Medicare program participation if they do not adhere to the staff vaccination requirement that is expected to take effect in September. Instead, CMS will phase in progressive remedial measures. CMS will first notify nursing homes that they are not in compliance. Nursing homes will then be assessed civil monetary penalties and payment denials, and then finally will be removed from the program if they do not comply. Both CMS and Centers for Disease Control and Prevention data show a strong relationship between the increase of COVID-19 cases among nursing home residents and the rate of vaccination among nursing home workers. As of August 8, 62% of nursing home staff were vaccinated. At the state level, the rate ranges from 44% to 88%, according to CMS. The vaccine mandate will affect more than 15,000 nursing homes, which employ about 1.3 million workers and serve about 1.6 million nursing home residents, according to the White House (Modern Healthcare, August 25).
- According to a Kaiser Family Foundation (KFF) analysis, an estimated 70% of Medicaid enrollees nationwide are eligible for the COVID-19 vaccines. However, Medicaid enrollees' vaccination rates in many states are low and lag far behind those of the general population. State Medicaid agencies and private health plans that cover most of the state's low-income residents are scattered in their immunization efforts primarily due to the lack of access to state data on member immunization status. In California, 49% of eligible Medicaid enrollees are at least partly vaccinated, compared with 74% of all state residents. This trend is seen across multiple states: Florida (34% Medicaid enrollees vs. 67% statewide), Utah (43% in Medicaid vs. 68% statewide), and Louisiana (26% in Medicaid vs. 59% statewide) (Modern Healthcare, August 27).
- Most private insurers including Kaiser Permanente, UnitedHealth Group, and Anthem are no longer waiving cost-sharing for COVID-19 treatments due to the widespread availability of vaccines that render the illness largely preventable. Out of the largest insurers in each state and the District of Columbia, 72% are no longer waiving COVID-19 treatment cost-sharing, and another 22% of plans are phasing out cost-sharing waivers by the end of the year, according to a KFF analysis. Plans initially implemented cost-sharing waivers as a sign of goodwill during the early days of the pandemic and to avoid Medical Loss Ratio related rebates from otherwise lower than expected health care spend. Conversely, Medicare will continue to waive cost-sharing until the end of the public health emergency (PHE) (Modern Healthcare, August 24).

SPAs

- Service SPAs
    - Arkansas (AR-21-0005, effective January 1, 2022): Extends benefit limits for Acute Crisis Unit and substance abuse detoxification services.
    - New Jersey (NJ-19-0005, effective January 1, 2019): Adds office-based addiction treatment and care coordination to the state's Alternative Benefit Plan (ABP).
    - Ohio (OH-21-0018, effective April 1, 2021): Adds prior authorization requirements for medically necessary urine drug tests involving 22 or more drug classes.
    - Oregon (OR-21-0012, effective January 1, 2022): Expands rehabilitation services to include additional substance use disorder services in order to align state plan services with those under the state's approved 1115 SUD demonstration waiver.
- Payment SPAs
    - Iowa (IA-21-0013, effective July 1, 2021): Increases reimbursement rates for home health agency services based on the Medicare low utilization payment adjustment methodology.

- Mississippi (MS-21-0008, effective July 1, 2021): Increases the fees for Independent Laboratory and X-ray services by 5% to restore the fees to those in effect during fiscal year 2021.
- Mississippi (MS-21-0009, effective July 1, 2021): Increases the fees for podiatry services by 5% to restore the fees to those in effect during fiscal year 2021. .
- Mississippi (MS-21-0012, effective July 1, 2021): Restores the fees for physicians services to those in effect during fiscal year 2021 and adjusts coverage for vaccine reimbursement to the preventative services category.
- Mississippi (MS-21-0013, effective July 1, 2021): Increases the fees for ambulatory surgical center services by 5% to restore the fees to those in effect on October 1, 2020.
- Mississippi (MS-21-0015, effective July 1, 2021): Restores the fees for hospital outpatient services to those in effect on July 1, 2021, and allows rural hospitals that have 50 or fewer licensed beds that opt to not be reimbursed using the OPPS payment methodology to be reimbursed at 101% of the rate established under Medicare for a two-year period.
- Mississippi (MS-21-0020, effective July 1, 2021): Restores the fees for targeted case management early intervention services to those in effect on July 1, 2021.
- Mississippi (MS-21-0024, effective July 1, 2021): Increases the fees for rehabilitative services by 5% to restore the fees to those in effect on April 1, 2020.
- Mississippi (MS-21-0025, effective July 1, 2021): Increases the fees for chiropractic services by 5% to restore the fees to those in effect during fiscal year 2021.
- Mississippi (MS-21-0026, effective July 1, 2021): Restores the fees for clinic services to those in effect for fiscal year 2021, and adds language addressing cost reports that are not timely filed.
- Mississippi (MS-21-0027, effective July 1, 2021): Restores the fees for dialysis services to those in effect on January 1, 2021.
- Mississippi (MS-21-0029, effective July 1, 2021): Restores the fees for family planning services to those in effect on July 1, 2020.
- Mississippi (MS-21-0030, effective July 1, 2021): Increases the fees for hearing aids by 5% to restore the fees to those in effect for fiscal year 2021.
- Mississippi (MS-21-0031, effective July 1, 2021): Increases the fees for home health services and durable medical equipment and medical supplies by 5% to restore the fees to those in effect as of October 1, 2020, and July 1, 2020, respectively.
- Mississippi (MS-21-0032, effective July 1, 2021): Increases the fees for dental and orthodontic services by 5% to restore the fees to those in effect for fiscal year 2021 except for a 5% rate increase for diagnostic and preventative services in fiscal years 2022, 2023, and 2024.
- Mississippi (MS-21-0033, effective July 1, 2021): Increases the fees for therapy services by 5% to restore the fees to those in effect for fiscal year 2021.
- Mississippi (MS-21-0034, effective July 1, 2021): Increases the fees for midwife services by 5% to restore the fees to those in effect for fiscal year 2021.
- Mississippi (MS-21-0036, effective July 1, 2021): Increases the fees for respiratory care for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) beneficiaries by 5% to restore the fees to those in effect for fiscal year 2021. .
- Mississippi (MS-21-0037, effective July 1, 2021): Increases the fees for Christian Science services by 5% to restore the fees to those in effect for state fiscal year 2021.
- Mississippi (MS-21-0038, effective July 1, 2021): Increases the fees for Targeted Case Management for Individuals with Intellectual Disabilities by 5%.

  - Mississippi (MS-21-0044, effective July 1, 2021): Increases the fees for eyeglasses by 5% to restore the fees to those in effect for state fiscal year 2021 in compliance with Mississippi Code § 43-13-117, amended by MS Senate Bill 2799.
  - Mississippi (MS-21-0045, effective July 1, 2021): Increases the fees for dentures for EPSDT beneficiaries by 5% to restore the fees to those in effect for state fiscal year 2021 in compliance with Mississippi Code § 43-13-117, amended by MS Senate Bill 2799.
  - Missouri (MO-21-0026, effective July 1, 2021): Increases the maximum allowable reimbursement rate for Personal Care, Private Duty Nursing, and HCY Home Health Services.
  - Texas (TX-21-0027, effective April 1, 2021): Updates the family planning fee schedule.

- Administrative SPAs
  - Louisiana (LA-21-0010, effective April 1, 2021): Amends provisions governing third-party liability to clarify language around the wait and see period for child support enforcement and third-party recovery for accident and health claims.
  - Missouri (MO-20-0025, effective November 1, 2020): Removes or replaces obsolete processes, language, and terms; clarifies State plan language; allows an extension for cost report filings for good cause shown; amends when cost reports are required for terminating providers or changes in providers; amends when payments will be withheld for late cost report submissions and terminating providers; establishes a required prior authorization process for any out-of-state nursing facility to be reimbursed for nursing facility services; and, revises the methodology for determining prospective rates.

- COVID-19 SPAs
  - Missouri (MO-21-0021, effective July 6, 2021): Increases nursing facility and HIV nursing facility per diem reimbursement rates by $10.18 per day due to the COVID-19 PHE, effective for dates of service July 1, 2021, through the sooner of June 30, 2022, or the end of the PHE.
  - Texas (TX-21-0025, effective December 11, 2020): Sets the reimbursement rate for the administration of COVID-19 vaccines at a fee equal to the amount approved for the vaccine administration in a physician's office and outside of the daily case mix rate of nursing facilities. Sets reimbursement rates for vaccines administered on or after March 15, 2021, equal to the national Medicare rate. This time-limited COVID-19 SPA terminates at the end of the PHE.
  - West Virginia (WV-21-0010, effective June 1, 2020): Designates local health departments as qualified entities for purposes of making presumptive eligibility determinations during the COVID-19 PHE. This time-limited COVID-19 SPA terminates at the end of the PHE.

State Updates

- New Hampshire estimates at least 30,000 current Medicaid enrollees no longer qualify for assistance in the state. However, states agreed to keep all Medicaid beneficiaries enrolled throughout the duration of the PHE, which is set to end on October 30, but could be extended longer. New Hampshire is receiving $350 million in government funding through the end of 2021 to offset the economic impact of the PHE on the state. However, the state estimates that there is a significant cost to keeping ineligible Medicaid beneficiaries enrolled ($10.5 million per month), and has begun to investigate, hiring a private contractor to help remove ineligible beneficiaries once the PHE ends (Health Payer Specialist, August 30).
- On August 26, a group of attorneys sent Missouri Governor Mike Parson (R) a letter accusing the state of violating federal law in its failure to process Medicaid applications within 45 days and going against a previous court order directing the state to not block enrollment for individuals in the expansion population. Under a state judge's order, the Missouri expansion process was supposed to start July 1 but

did not. A series of appeals followed, and on August 10, a federal judge ordered the process to begin immediately. However, the state recently disclosed that October 1, 2021, is the target enrollment date due to pending software updates and a lack of adequate resources. (Health Payer Specialist, August 30; St. Louis Post-Dispatch, August 27).

- Two state Medicaid contract bid deadlines are coming this week: Louisiana and Tennessee. Louisiana's $21 billion Medicaid contract bids are due September 3, and the state Medicaid agency will announce the award on November 5. The new contract will cover 1.6 million enrollees. Louisiana's contracts have been in legal limbo since the state procurement officer challenged bids awarded in early 2020. Tennessee's $12 billion Medicaid contract bid deadline is August 31, and the state Medicaid agency will announce the award on October 8. The new contract will provide coverage for 1.5 million enrollees covering 20% of the state's population and 50% of its child population (Health Payer Specialist, August 30; KATC, January 2020).

Private Sector Updates

- Cigna, the number 8 nationally ranked payer, is expanding its ACA marketplace in Georgia, Mississippi, and Pennsylvania, placing the payer in a position to reach 1.5 million more customers. Once the offerings receive regulatory approval, the payer will provide individual and family plans in 313 counties and 13 states. Cigna remains focused on providing access to high-quality and cost-effective health care coverage while closing critical coverage gaps. Customers enrolling will have access to services such as free virtual wellness screenings; no cost sharing on chronic conditions like asthma, chronic obstructive pulmonary disease, and diabetes; prescription copays ranging from $0 to $3; and coverage for specialized services. Open enrollment begins on November 1, 2021, and closing dates vary by state (Health Payer Specialist, August 26).
- Virtual health services, employee burnout, and expanded access to mental health care are top priorities for employers next year. A Business Group on Health survey shows that out of 186 large employers that provide health benefits, 87% have accelerated initiatives to improve mental health access and services this year, with 84% prioritizing expanding virtual health services. The intensified focus on mental wellbeing will make 2022 the first year that many employers create an anti-stigma campaign raising awareness about mental health issues. Additionally, employers believe that virtual health services will have a significant impact on how care is delivered moving forward. More than half of large employers currently waive or have reduced cost sharing for telehealth services (Modern Healthcare, August 25).

Sellers Dorsey Updates

- Check out our newest Staff Spotlight Q&A with Virginia Brown, Senior Strategic Advisor. Virginia joined Sellers Dorsey after working for the Commonwealth of Pennsylvania for nearly 15 years. A managed care and long-term care expert, she provides subject matter expertise and strategic guidance to clients. Learn more about Virginia and what she has worked on this year.
- Next week Sellers Dorsey will release another special edition of the Digest highlighting several state budgets that were recently enacted. Make sure you subscribe to the Digest so that you don't miss out on any of our issues. You can check out our latest state budget summary here.
- Sellers Dorsey staff members are excited to attend multiple conferences this month to hear insights from experts on health care trends, policy developments, whole-person care, and more topics. We are proud to sponsor America's Essential Hospitals Medicaid Summit. Our experts, Leesa Allen, Gabe Roberts, and Karla Richardson will be speaking on state success stories in value based care. We are also proud sponsors of the MHPA21 Conference. Gary Jessee, Managing Director, will be moderating a panel with three state Medicaid directors September 24 to talk about current trends in state policy. If you would like

to connect at these events or any of the many others we will be attending this fall, contact us. Hope to see you there!

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