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NAVIGATION

Summary of Key Updates

The Centers for Medicare and Medicaid Services (CMS) created a new webpage compiling each state's plan to enhance, expand, and strengthen home and community-based services (HCBS) with the state funds freed up by the additional ten percent Federal Medical Assistance Percentages (FMAP) for HCBS under the American Rescue Plan Act (ARP). The webpage includes each state's spending plan proposal, as well as CMS' approval letters (CMS, October 21).

The Center for Medicare and Medicaid Innovation (CMMI) released a white paper outlining its updated vision for advancing accountable value-based care in Medicare and Medicaid. Five key strategic objectives guide the models and top priorities include: driving accountable care, advancing health equity, supporting innovation, addressing affordability, and partnering to achieve system transformation (Modern Healthcare, October 20).

From October 21 to October 27, CMS approved one Section 1115 waiver, two 1915(c) Appendix K waivers, and four SPAs, none of which are COVID-19 disaster relief SPAs. The SPAs reflect approved documents uploaded to the CMS website as of October 27.

Medicaid managed care is a critical focus area for nearly every health care organization working with Medicaid. Our experts at Sellers Dorsey partner with managed care organizations, hospitals, states, and others to connect funding, programming, and outcomes. To learn more about our expertise in Medicaid managed care and connect with our subject matter experts, visit here.

Federal Updates

News

- In a letter sent to the Department of Health and Human Services (HHS) Secretary Xavier Becerra on October 20, a bipartisan group of senators urged HHS to follow the letter of the law with respect to the ARP rural funding authorized, stating that rural health care providers must remain at the forefront of efforts to combat COVID-19 and need immediate assistance. HHS currently bases ARP payments on the amount of care providers delivered to patients who live in rural areas, not whether the providers themselves are located in rural areas. Consequently, large hospitals in big cities can access the funding. The letter also notes that at least 19 rural hospitals closed in 2020, exacerbating access to care issues in rural America and that despite the need, rural providers are often excluded from accessing federal funds because of flawed definitions used to determine provider eligibility for rural health grants from the Health Resources and Services Administration (Modern Healthcare, October 20).
- CMS opened Healthcare.gov on October 25 for consumers to shop ahead of the November 1 launch for Plan Year 2022 enrollment that runs through January 15. According to CMS, consumers will have access to 213 issuers, which is 32 more plans than 2021. Consumers will also find lower premiums by comparing plan options and accessing premium tax credits, which will be more generous for people earning up to and above 400% of the federal poverty level (FPL) because of the ARP policy that runs through December 31, 2022. CMS also added new features to Healthcare.gov, including guidance to help consumers complete their applications and new hints that can help them shop and better compare plans. CMS will also provide an extensive outreach and education program that will include traditional broadcasts and targeted digital marketing and investments in partnerships that can help serve harder-to-reach populations (Inside Health Policy, October 25).
- CMMI aims to accelerate participation in value-based care through accountable care organizations (ACOs) and other models, outlining its updated vision in a white paper. To do so, CMMI is launching a new strategy with the goal of achieving equitable outcomes through high-quality, affordable, person-center care. Five key strategic objectives guide the models and top priorities – driving accountable care, advancing health equity, supporting innovation, addressing affordability, and partnering to achieve system transformation. CMMI continues to work towards the expansion of successful models that reduce program costs and improve quality and outcomes for Medicare and Medicaid beneficiaries across the country (Modern Healthcare, October 20).
- On October 21, CMS launched a "one-stop shop" webpage for state Medicaid agencies and stakeholders to share and expand innovation for HCBS. Through the webpage, state Medicaid agencies and stakeholders can access information about states' plans to enhance, expand, and strengthen HCBS across the country with ARP funding. CMS encourages states to use this webpage to strengthen their own HCBS plans and continue to innovate in response to the pandemic (CMS, October 21).

Federal Legislation

- Congress and the White House are working to reach an agreement on the Build Back Better Act, the Biden administration's comprehensive health and social spending package, by the end of this week. The bill's price tag decreased from $3.5 trillion to roughly $2 trillion after weeks of negotiations in the House and Senate, resulting in probable cuts to the bill's proposed health care spending provisions. The bill initially endeavored to cover dental, vision, and hearing benefits for Medicare beneficiaries, but current reporting suggests that the dental benefit is likely to manifest in $800 annual vouchers as opposed to full coverage. The bill's provision empowering Medicare to negotiate drug prices based on international standards and make those prices available to those on private insurance plans may likely be scaled back to apply to only a smaller set of drugs under Medicare Part B, drugs with expired patents, or drugs

covered under Medicare and not private insurance plans if the provision withstands the final round of negotiations. The Affordable Care (ACA) subsidies, scheduled to expire in 2022, and a proposed federal Medicaid program providing coverage to eligible populations in non-expansion states may likely be funded for three or four years, which is a sharp turn from initial proposals establishing these programs in perpetuity. The House approved funding for less than half of President Biden's proposed $400 billion HCBS spending plan, and that number is expected to be further reduced as negotiations conclude. If a tentative deal is reached this week, lawmakers will likely need several additional weeks to finalize the package (Politico, October 25).

Federal Regulation

- On October 20, HHS published a proposal to repeal two Trump-era final rules relating to HHS sub-regulatory guidance and civil enforcement actions. These rules worked in concert to lessen HHS' flexibility, both in issuing guidance on regulations and enforcing such regulations through civil monetary penalties. Specifically, the sub-regulatory guidance rule (or "good guidance") diluted the impact of sub-regulatory guidance by declaring it as non-binding both in law and in practice, unless incorporated into a contract. The Biden administration asserts rescinding these two rules will forward several points in their health care agenda including advancing racial equity and strengthening Medicaid and the ACA. The administration notes the increased regulatory burden associated with more limited options for binding regulatory guidance and enforcement of such guidance has a disproportionate impact on health care agencies and the vulnerable populations they serve. HHS has chosen to repeal the two rules through the formal rulemaking process and will be accepting comments on the proposal through November 19, 2021 (Federal Register, October 20; Modern Healthcare, October 19).
- In public comments to the Department of Homeland Security (DHS), America's Health Insurance Plans (AHIP) and the American Medical Association (AMA) pressed DHS to protect immigrants' access to Medicaid and other public benefits as the administration works to put out new public charge guidance. The Trump-era 2019 public charge rule, which denied green cards to immigrants based on their likely use of public benefits including Medicaid, was vacated in March 2021 after the Biden administration said it would not defend the policy in a lawsuit before the Seventh Circuit appellate court. DHS, which is currently operating under the 1999 public charge guidance that excludes Medicaid or Children's Health Insurance Program (CHIP) enrollment in public charge determinations, announced its plans to promulgate a proposed rule to change the public charge regulation and requested public feedback in August. AHIP's comment on the advance notice of proposed rulemaking applauds DHS' stated intention to make sure new rules do not interfere with access to public benefits, specifically with regards to Medicaid, and says that any final rule needs to protect that access. AMA's comment emphasizes its opposition to any policy that discourages immigrants or anyone else from applying for benefits including Medicaid and CHIP, and AMA maintains that DHS must explicitly state in its new policy that Medicaid and other health benefits and services will not be considered for public charge determinations. Additionally, AMA says DHS should use a very narrow definition of health conditions that could constitute someone with a public charge, and communicable but treatable diseases like HIV should not count towards a public charge decision. The public comment period closed on October 22, and updated public charge guidance from DHS is still pending (Inside Health Policy, October 25).

COVID-19

- On October 22, CMS published a State Health Official letter providing guidance on further COVID-19-related coverage and beneficiary protections under ARP. The guidance mandates:
    - State Medicaid and CHIP programs cover, without cost sharing, pharmacological and non-pharmacological products or services used to treat COVID-19. The guidance lays out the ARP requirements that states cover COVID-19 treatments and preventions without cost sharing and submit state plan amendments attesting to that coverage. CMS permitted states to apply utilization management controls specifically when the product or service is covered as a COVID-19 related treatment unless those controls are unreasonable or unnecessary barriers to accessing coverage. Furthermore, states can only limit coverage on the amount, duration or scope of such products or services if they are used to treat a condition other than COVID-19.
    - State Medicaid and CHIP programs provide coverage without cost sharing for any treatment of a comorbid condition for a beneficiary diagnosed with or presumed to have COVID-19. This guidance comes as CMS has noted that there are certain comorbidities, such as diabetes, cancer, obesity, Down Syndrome, cardiovascular and chronic lung diseases, that can put a patient with COVID-19 at higher risk of complications. While the comorbidity requirement is broad and encompasses a wide array of possible treatments and therapies, CMS has allowed states to provide coverage without cost sharing only for services that are covered under the state plan as of March 11 unless states choose to expand coverage areas (CMS, October 22; Inside Health Policy, October 25).
- To increase access to COVID-19 testing, HHS is taking several actions to expand availability of over the counter (OTC) COVID-19 tests. Under HHS orders, the National Institutes of Health will invest $70 million from ARP into the Independent Test Assessment Program (ITAP). ITAP will establish an accelerated pathway to support FDA evaluation of OTC tests with potential for large-scale manufacturing. Additionally, the FDA will further streamline the regulatory pathway for manufacturers developing OTC at-home tests and will provide recommendations for labeling updates to facilitate OTC single-use testing for symptomatic individuals for tests currently authorized only for serial testing. Finally, the FDA has authorized an additional OTC COVID-19 test granting emergency use authorization to Celltrion Diatrust for its COVID-19 Home Ag Test for OTC single-use testing for symptomatic adults and OTC serial testing for all adults (HHS, October 25).
- A study published on October 22 by JAMA Health Forum showed more money flowed to hospitals that were in a strong financial position prior to the pandemic than went to hospitals with weaker finances. In the analysis of 952 hospitals, 24% received less than $5 million, 8% received more than $50 million, and small, rural hospitals received 40% less funding than their larger counterparts. The researchers did not take the $24 billion that was targeted to rural and safety-net hospitals in underserved areas into account. Some of the larger hospitals that received hundreds of millions of dollars in federal funding purchased smaller and less lucrative hospitals and physician groups during the COVID-19 pandemic. Additionally, a September report commissioned by the American Hospital Association found that a third of hospitals will have operating losses in 2021 due to treating sicker patients and paying more for staff, supplies, and drugs (New York Times, October 22).
- The American Telehealth Association (ATA) sent a letter to the HHS Secretary, urging HHS to extend the COVID-19 public health emergency (PHE) until the end of 2022 to avoid a "telehealth cliff" or a sudden end to virtual care coverage flexibilities after the end of the PHE. ATA's request cites an extended PHE would give Congress more time to enact permanent telehealth policies "without creating a temporary and frustrating gap in access for Medicare beneficiaries" once the PHE expires. Currently HHS has extended the PHE through January 16, 2022 (Fierce Healthcare, October 25).

Waivers

- Section 1115
    - On October 21, CMS approved Alabama's request for a new Section 1115(a) demonstration titled, "Community Waiver Program." Approval of this demonstration, concurrently with a new 1915(c) waiver, will enable the state to create a new HCBS program and expand coverage to beneficiaries who are currently on the waiting list for the Intellectual Disability and Living at Home 1915(c) HCBS waivers. The demonstration will overlay specific waiver authorities over a new 1915(c) waiver and establish an expenditure authority to allow the state flexibility to operate the new program and expand coverage for targeted populations. The demonstration is in effect through September 30, 2026.
- Section 1915(c) Appendix K
    - Colorado
        - Temporarily allows the provision of limited residential services in out-of-state settings for the HCBS for the Developmentally Disabled waiver when service providers within Colorado are not able to meet the waiver participant's needs.
        - Temporarily provides a 2.11% rate increase for the provision of select HCBS.
    - Pennsylvania
        - Temporarily allows one-time supplemental payments for providers to cover recruitment, retention, and COVID-19 related staffing expenses for direct support professionals or supports coordinators to include funding for hazard pay, costs of recruitment efforts, sign-on bonuses, retention bonuses, and other incentive payments.

SPAs

- Administrative SPAs
    - Washington (WA-21-0025, effective July 1, 2021): Updates the reference to the location of air ambulance transportation rates. The website was no longer valid, and the state replaced the citation with a cross-reference to the State Plan section that contains the correct website.
- Payment SPAs
    - Arizona (AZ-21-0006, effective October 1, 2021): Updates the methods and standards used for reimbursing Arizona's School-Based Services Program.
    - Hawaii (HI-21-0015, effective October 1, 2021): Updates the reimbursement methodology for Medicaid Hospice Services consistent with Sections 1814(i)(1)(C)(ii) and 1902(a)(13)(b) of the Social Security Act.
    - Illinois (IL-21-0011, effective July 1, 2021): Increases reimbursement rates for facilities licensed by the Department of Public Health under the intellectual disabilities and developmental disabilities (ID/DD) Community Care Act or the medically complex for the developmentally disabled (MC/DD) Act to provide per hour wage increases for aides working in those facilities.

State Updates

- State Medicaid programs continue to reshape policy in response to the PHE while advancing other initiatives, including addressing social determinants of health and health equity, according to results of a new Kaiser Family Foundation (KFF) survey. This year's survey highlights policies in place and changes implemented or planned for fiscal year 2022, and reviews policies adopted during the COVID-19 pandemic. A companion survey provides a look at state Medicaid spending and enrollment. Half of responding states reported expanding of programs related to social determinants of health, and three-

quarters of responding states reported initiatives in place or planned to address racial and ethnic disparities in health, with many focusing on maternal and infant health, behavioral health, and COVID-19 outcomes and vaccination rates. A large majority of states also cited the value of telehealth in maintaining and expanding access to care during the pandemic, particularly for behavioral health. Post-pandemic telehealth coverage and reimbursement policies are being evaluated in most states, with states weighing expanded access against quality concerns. While the companion survey data anticipates Medicaid enrollment growth to slow overall, the recent extension of the PHE may impact these projections (KFF, October 27).

- Massachusetts, New Jersey, and New York have set minimum requirements for how much nursing homes must spend on residents' direct care and imposed limits on what can be spent on administrative expenses, executive salaries, advertising, and how much companies can earn as net profit. Facilities that exceed the limits must refund the difference to the state. All three states promise a boost in Medicaid payments to facilities that comply with the laws. Advocates believe these requirements will allow residents to receive better care and decrease violations of federal quality standards, while those in opposition believe the spending mandate comes at a challenging time for an industry still recovering from the pandemic and facing staffing shortages and low occupancy (KFF, October 25).
- On October 18, New Mexico's state health officials advised hospitals to ration care if necessary due to continued nursing staff shortages and the filling of hospital beds by those who delayed care due to the COVID-19 pandemic. Officials indicated that individual providers have the authority to suspend procedures they deem medically unnecessary if the hospital in which they operate does not have the capacity to accept patients. State officials also pushed for more people to either get vaccinated or get their booster shots against COVID-19, as the state's vaccination rate continues to hover just below 72% (Modern Healthcare, October 19).

Private Sector Updates

- On September 21, the National Association of Accountable Care Organizations (NAACOS) released a white paper outlining key recommendations for CMS to collaborate with ACOs to help close health equity gaps. NAACOS recommended updating a required ACO patient survey to incorporate equity-focused questions inquiring whether patients receive timely access to culturally appropriate care. The group urged CMS to work with ACOs on developing quality measures to judge population health equity and creating a standardized health equity screening tool. NAACOS also called on CMS to create new incentives for ACOs to improve quality scores for certain populations, suggesting that the agency award initial bonus points to ACOs based on reporting race and ethnicity alongside other quality data. CMMI called on ACOs to gather more data on race and ethnicity of their patients, but it has not laid out detailed requirements for ACOs and other providers to tackle equity in value-based care (Fierce Healthcare, October 25).

Sellers Dorsey Updates

- Medicaid managed care is a critical focus area for nearly every health care organization working with Medicaid. Our experts at Sellers Dorsey partner with managed care organizations, hospitals, states, and others to connect funding, programming, and outcomes. To learn more about our expertise in Medicaid managed care and connect with our subject matter experts, visit here.
- Sellers Dorsey is proud to be an ACAP preferred vendor and we are looking forward to seeing you in person at the CEO Summit in Washington, DC on October 28-29. This conference will be a great opportunity to network, connect, and share ideas for creating opportunities from the challenges we have all faced this past year.

- In case you missed it, we released an updated state budget summary analysis that includes highlights on key Medicaid spending for the following states: Alabama, Arkansas, Idaho, and Michigan. Check out the summary here.
- Sellers Dorsey was recently honored by the American Ambulance Association as its 2021 Affiliate of the Year. We are grateful to be recognized for our efforts to bring critical funding to EMS providers to better serve their Medicaid populations.

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