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NAVIGATION

Summary of Key Updates

The House Democrats' current draft of the Build Back Better Act delays the implementation of the $35 billion Medicare hearing benefit by one year to 2023 (Inside Health Policy, November 6).

More than 150 members of Congress penned a letter to the Departments of Health and Human Services, Labor, and Treasury recommending the Biden administration revise the independent dispute resolution process established in the recent interim final rule on surprise billing (Inside Health Policy, November 5).

On November 9, CMS released a final rule updating home health and home infusion therapy payment rates and requirements, survey and enforcement requirements for hospice programs, Medicare provider enrollment requirements, and COVID-19 reporting requirements for long-term care facilities (Federal Register, November 9).

From November 4 to November 10, CMS approved four 1915(c) Appendix K waivers and 13 SPAs, five of which are COVID-19 disaster relief SPAs.

Our team works with an array of clients to tackle financing, policy, and operational issues. With our deep expertise in Medicaid, we have advised managed care organizations, private equity firms, vendors, provider groups, health information technology companies, and others interested in expanding or deepening their presence in the Medicaid market. Learn more about ways our Medicaid Market Advisory Services have helped companies advance critical priorities in Medicaid.

Federal Updates

News

- On November 8, the Department of Health and Human Services (HHS) Office on Women's Health released the list of more than 200 hospitals from all 50 states that participate in the HHS Perinatal Improvement Collaborative, under a contract with Premier, Inc. This new collaborative is focused on improving maternal and infant health outcomes that will inform program planning and policy development to ensure the U.S. is one of the safest countries in the world to give birth. The collaborative was designed as a part of the HHS Maternal Morbidity and Mortality Data and Analysis Initiative and involves a two-part approach that includes obtaining and incorporating patient and clinical care data from both mother and child to understand potential causes of harm and death, while improving measurements and comparison techniques. Each hospital will be looking at more than 150 measures, including hypertension, COVID-19, and infection, to understand clinical and non-clinical factors that impact maternal and infant health. Additionally, the collaborative plans to develop and implement methods to reduce racial, ethnic, and geographic disparities in care to advance health equity (HHS, November 8).
- On November 8, the Medicare Payment Advisory Commission (MedPAC) discussed the implementation of an administratively set trend factor to forecast cost trends for accountable care organizations (ACOs). ACO benchmarks are currently reset each performance period based on each ACO's past performance, creating challenges for top performing ACOs to meet benchmarks that grow year after year. MedPAC claims this effect, known as ratcheting, may put long-term ACO participation at risk by reducing incentives for ACOs to continuously create savings. To combat the ratcheting effect, MedPAC commissioners suggested an administratively set trend factor based on metrics such as a discounted projection of Medicare fee-for-service spending growth or projected gross domestic product (GDP) growth. However, MedPAC commissioners questioned the feasibility of the proposed benchmark system in a voluntary ACO environment. The commissioners claimed ACOs, especially smaller ones, could be negatively impacted by one-time changes in spending practice patterns and leave the program due to undesirable benchmarks. Despite potential drawbacks, MedPAC commissioners overwhelmingly agreed to investigate administratively setting the trend factor as a remedy for the ratcheting effect and discussed the possibility of mandating ACO program participation (Modern Healthcare, November 8).

Federal Legislation

- Under the House Democrats' recent draft of the Build Back Better Act, implementation of the new $35 billion Medicare hearing benefit would be delayed by one year to 2023. The plan would also cover hearing aids under Medicare Part B for beneficiaries with hearing loss in one or both ears once every five years. House Democrats also shifted money among several other programs in the draft, including funding for technical assistance in setting up state HCBS programs from $15 million to $40 million, reducing palliative care and training funding from $30 million to $25 million, and allocating $50 million to improve skilled nursing facility data. The current bill draft also delays the permanent extension of the Money Follows the Person Rebalancing demonstration until after fiscal year 2022 and provides $50 million in grants to states to apply for an Affordable Care Act section 1332 innovation waiver (Inside Health Policy, November 6).
- The House version of the Build Back Better Act establishes 4,000 new Medicare-funded Graduate Medical Education (GME) residency slots. The most recent draft of the Act calls for 20% of the new GME slots to be distributed to hospitals in rural areas or sole community hospitals, 30% to hospitals training above their Medicare caps, 20% to hospitals in states with new medical schools or campuses, 20% to hospitals serving health professional shortage areas, and 10% to hospitals in states with the lowest ratios of medical residents to population. For the first two distribution cycles, 25% of the new slots must be

awarded to primary care residencies, and 15% must be awarded to psychiatry residencies. The proposed legislation also creates a new "Pathway to Practice" program that funds 1,000 annual medical scholarships for students from underserved, rural or health professional shortage areas starting in 2023. The House passed a procedural vote on the Build Back Better Act early on November 6, but members were not able to come together to pass a final vote until a small group of members receive a fiscal impact analysis from the Congressional Budget Office (Modern Healthcare, November 5, CNBC, November 6).

- In a November 5 letter to the Departments of Health and Human Services, Labor, and Treasury, more than 150 members of Congress recommended the Biden administration revise the independent dispute resolution process established in the recent interim final rule on surprise billing. The No Surprises Act, passed in December 2020, creates a new independent dispute resolution process in which providers and insurers each submit a payment proposal, and an arbitrator chooses which party's submission to accept based on the qualifying payment amount (QPA) or the median in-network rate and information provided on training, patient acuity, teaching status, market share, and past attempts to negotiate contracts in good faith. The QPA is the primary factor for proposal selection under the law, and other factors are only to be considered in rare cases. The lawmakers opposing the final rule contend that the hierarchical influence of the QPA establishes an imbalanced process for settling payment disputes, and it does not reflect the intent of Congress in writing and passing the No Surprises Act. The lawmakers urged the Biden administration to revise the law to consider all factors outlined in the statute without disproportionately weighting QPA in dispute resolution (Inside Health Policy, November 5).

Federal Regulation

- On November 9, CMS released a final rule updating home health and home infusion therapy payment rates and requirements, survey and enforcement requirements for hospice programs, Medicare provider enrollment requirements, and COVID-19 reporting requirements for long-term care facilities. The final rule, effective January 1, 2022, includes the following provisions:
    - Updates home health and home infusion therapy services payment rates in accordance with existing statutory and regulatory requirements.
    - Finalizes recalibration of the case-mix weights and updates functional impairment levels and comorbidity adjustment subgroups while maintaining the current low utilization payment adjustment (LUPA) thresholds.
    - Establishes the occupational therapy add-on factor for LUPA add-on payment amounts and makes conforming regulations text changes to reflect that select practitioners may establish and review the plan of care.
    - Finalizes proposed changes to the Home Health Quality Reporting Program (QRP), including finalizing proposed measure removals and adoptions, public reporting, and modification of effective dates.
    - Finalizes proposed modifications to the effective date for the reporting of measures and certain standardized patient assessment data in the Inpatient Rehabilitation Facility (IRF) QRP and Long-Term Care Hospital (LTCH) QRP.
    - Codifies certain Medicare provider and supplier enrollment policies.
    - Makes permanent selected regulatory blanket waivers related to home health aide supervision issued during the COVID-19 public health emergency (PHE)
    - Updates the home health conditions of participation for occupational therapists to implement provisions of the Consolidated Appropriations Act of 2021 (CAA 2021).
    - Finalizes proposals to expand the Home Health Value-Based Purchasing Model and ends the original model one year early.

  - Establishes survey and enforcement requirements for hospice programs as set forth in the CAA 2021.
  - Extends the mandatory COVID-19 infection control reporting requirements for long-term care facilities until December 31, 2024 (Federal Register, November 9).

- CMS has opened a public comment period on the development of the All-Cause Emergency Department (ED) Utilization for Medicaid Beneficiaries measure. The measure is defined as the number of all-cause ED visits per 1,000 beneficiary months among Medicaid beneficiaries ages 18 and older. The measure is intended to be a baseline measure on ED utilization monitoring trends in all-cause ED visits within the Medicaid population over time and potentially identify disparities among vulnerable Medicaid populations. The public comment period is open from November 8, 2021, to December 8, 2021 (CMS, November 8).
- On November 5, the U.S. District Court of New Jersey ruled that drug makers cannot impose restrictions on 340B discounts to pharmacies that contract with hospitals in the 340B program, arguing that the 340B statute did not authorize the drug makers' restriction limits and that barring enforcement action would "dramatically size-down" the discount program created by Congress. Meanwhile, the U.S. District Court of the District of Columbia presided over a similar case. The Court sided with drug makers in this case, ruling they are not required to provide 340B discounts to contract pharmacies. The judge in the case argued that HHS was not permitted to require unconditional discounts to contract pharmacies, but noted that a more limited regulation might be permissible. Both of these lawsuits come after a separate ruling by the U.S. District Court of Southern Indiana that found drug makers are not required to provide 340B discounts to contract pharmacies. The mixed series of federal rulings centers around an advisory opinion issued by HHS in December 2020 that mandated drug makers to give 340B discounts to all pharmacies that contract with hospitals in the 340B program. The lawsuit in the NJ District Court was filed by Sanofi and Novo Nordisk against HHS, whereas the lawsuit in the D.C. District Court was filed by Novartis and United Therapeutics against Health Resources and Services Administration (Reuters, November 8; Fierce Healthcare, November 8).

COVID-19

- In September, the Biden administration announced that employees of federal contractors must be vaccinated against COVID-19 by December 8, which has since been pushed to January 4, 2022. The mandate applies to employees who work in the office and remotely unless they have a religious or medical exemption. Since the announcement, many health insurers with federal contracts have required their employees to receive the COVID-19 vaccine. Most recently, Blue Shield of California and Cambia Health Solutions have joined in requiring employee vaccinations. Since Blue Shield of California has received some push back from employees who claim the January deadline does not allow for sufficient time, the insurer has decided that employees who require more time will be placed on unpaid leave starting January 5 and will have 30 days to be fully vaccinated (Health Payer Specialist, November 8).
- After the approval and rollout of Pfizer's pediatric COVID-19 vaccine on November 2, early data from the Centers for Disease Control and Prevention (CDC) has shown more than 360,000 children from 5 to 11 years old have received at least one dose of the COVID-19 vaccine. The CDC further plans to update the vaccination data for this age group later this week. The Biden administration has stated they have enough doses for every US child between ages 5 and 11 (The Washington Post, November 9).
- The Biden administration announced firms can require unvaccinated employees to pay for their own required weekly COVID-19 testing. However, some labor law experts argue that existing laws likely require companies to cover most of the costs for workers who claim religious or medical exemptions to the vaccines, and which could cost companies hundreds of dollars per unvaccinated employee per month. If this analysis is correct, hitting businesses with new testing costs as many struggle to retain staff

could create more opposition to Biden's plan. The Equal Employment Opportunity Commission has clarified that employers can mandate vaccinations in their workplace if they provide accommodations for exemptions, but some attorneys are skeptical that the cost of testing qualifies as an accommodation. If employers require workers to be tested during the workday, they will likely have to cover the cost, and it is also unclear whether insurance companies will cover workplace testing (Politico Pro, November 8).

- Pfizer has found its experimental COVID-19 treatment pill, when used in combination with a common HIV treatment drug, can reduce the risk of hospitalization or death from COVID-19 by 89% in high-risk adults exposed to the virus. Pfizer's COVID-19 antiviral pill is the second COVID-19 treatment drug after Merck's to show high efficacy. The drug maker is expected to submit its data and application on its antiviral pill to the FDA for emergency use authorization before Thanksgiving (CNBC, November 5).

Waivers

- Section 1915(c) Appendix K
    - Colorado
        - Temporarily provides a 25% rate increase for respite services from the period of Aprl 1, 2021 through March 31, 2022 and a base wage requirement of $15 per hour through a rate increase for direct care workers from the period of January 1, 2022 through July 1, 2022 using American Rescue Plan Act (ARP) funds.
    - Illinois
        - Temporarily authorizes a one-time payment to address the state's delay in implementing a rate increase for in-home and homemaker service providers from $21.84 to $23.40 with the payment effective September 5, 2021.
    - Montana
        - Effective July 1, 2021, temporarily allows the Severe and Disabling Mental Illness Waiver case management entity to provide residential direct services if serving as the only willing and qualified entity to provide case management or develop person-centered service plans.
    - Pennsylvania
        - Temporarily extends supplemental payments to cover COVID-19 related staffing expenses for direct support professionals or supports coordinators using ARP funds.

SPAs

- COVID-19 SPAs
    - Louisiana (LA-21-0013, effective December 23, 2020): Enables federally qualified health centers (FQHCs) and rural health clinics (RHCs) to be reimbursed outside of the established, all-inclusive prospective payment system (PPS) rate for administration of the COVID-19 vaccine. This time-limited COVID-19 SPA terminates at the end of the PHE.
    - Massachusetts (MA-21-0020, effective March 1, 2021): Allows flexibility to use FY2019 time study results when calculating FY2020 final cost reimbursement rates for the Department of Children and Families and the Department of Mental Health rehabilitation. This time-limited COVID-19 SPA terminates at the end of the PHE.
    - Michigan (MI-21-0011, effective December 1, 2020): Provides authority for an alternative payment methodology to FQHCs, tribal FQHCs, and RHCs for COVID-19 vaccine administration to allow payment outside the PPS rate. This time-limited COVID-19 SPA terminates at the end of the PHE.

  - New Mexico (NM-21-0007, effective March 15, 2021): Adds vaccine administration for homebound beneficiaries under the preventive services benefit, including a brief health screening, in addition to administration of the COVID-19 vaccine, and adds a reimbursement methodology for those services. This time-limited COVID-19 SPA terminates at the end of the PHE.
  - Washington (WA-21-0036, effective March 1, 2020): Enables the state to receive federal Medicaid matching funds for fee-for-service COVID-19-related supplemental payments to hospitals in the following categories: prospective payment hospitals other than psychiatric or rehabilitation hospitals; psychiatric hospitals; rehabilitation hospitals, and border hospitals. This time-limited COVID-19 SPA terminates at the end of the PHE.

- Payment SPAs
  - Colorado (CO-21-0017, effective April 1, 2022): Updates the outpatient pharmacy rate methodology for blood clotting factor drugs by incorporating Average Acquisition Cost and Clotting Factor Maximum Allowable Cost rates, along with a $0.03/unit enhanced professional dispensing fee for those drugs.
  - Michigan (MI-21-0010, effective September 1, 2021): Provides reimbursement for medically necessary Rapid Whole Genome Sequencing testing, separate from the Diagnosis Related Group payment in the inpatient hospital setting.
  - Nevada (NV-21-0007, effective July 1, 2021): Continues supplemental payments to qualifying private and public inpatient hospitals to preserve access to inpatient hospital services, through state fiscal year 2022.
  - Pennsylvania (PA-21-0022, effective September 12, 2021): Authorizes an additional class of disproportionate share hospital payments to qualifying Medical Assistance (MA) enrolled acute care general hospitals that provide inpatient services to MA beneficiaries. These payments are to provide financial relief to hospitals and promote access to acute care services for MA beneficiaries during the coronavirus pandemic.
  - South Carolina (SC-21-0013, effective October 1, 2021): Updates the non-state-owned governmental Medicaid nursing facility rates to reflect the most recent pre-COVID reimbursement methodology in effect on October 1, 2019. Updates the state-owned governmental Medicaid nursing facility rates based upon the most recent cost report information and updated trend factor available.
  - Texas (TX-21-0040, effective September 1, 2021): Updates the home health fee schedule.
  - Texas (TX-21-0041, effective September 1, 2021): Updates physicians' and other practitioners' fee schedules.

- Service SPAs
  - Arizona (AZ-21-0008, effective October 1, 2021): Adds Emergency Triage, Treat, and Transport to the state plan.

State Updates

- Louisiana Medicaid has delayed awarding new managed care contracts. The Louisiana State Department of Health informed *Health Payer Specialist* that bids were still being assessed and declined to comment further. As reported last week, the awards were to be announced on November 5 (Health Payer Specialist, November 8).

Private Sector Updates

Providers

- Tenet Healthcare will acquire SurgCenter Development in a $1.2 billion deal that will add 92 ambulatory surgical centers to the for-profit health system. The 92 centers Tenet will acquire includes 65 mature centers and 27 that either opened in the last year or will begin in 2022. The centers are located in 21 states. Additionally, Tenet plans to open at least 50 new facilities over the next five years as a part of the deal with SurgCare Development and the owners who retain stakes in existing facilities (Modern Healthcare, November 8).
- A recent Lown Institute report estimates Medicare could save $8 billion annually if all hospitals included in the report increased their cost and outcome metrics to match those of the high performing hospitals. The report ranks more the 3,000 hospitals based on cost efficiency and shows a broad range of variation in cost, ranging from $9,000 to $27,000 per patient, despite some hospitals being of similar size, type, region, and having comparable mortality rates (Modern Healthcare, November 9).

Insurers

- Cole County Circuit Court of Missouri has ruled in favor of Centene being granted the state's $1.4 billion seven-year contract to provide health care to the state's prison population. The case was filed against Centene by Corizon Health, which held the contract since 1992. Corizon Health will appeal the court's decision once the written judgement is release (Health Payer Specialist, November 8).

Sellers Dorsey Updates

- Janice Fagen, Senior Strategic Advisor, spoke at Texas Association of Health Plans' (TAHP) annual conference, Texas Covered, on the new Provider Directory Verification Mandate of the No Surprises Act. Sellers Dorsey is a proud sponsor of the conference and is also a proud affiliate member of TAHP. Check out our Q&A with Janice to learn more about her and her colleagues!
- Our team works with an array of clients to tackle financing, policy, and operational issues. With our deep expertise in Medicaid, we have advised managed care organizations, private equity firms, vendors, provider groups, health information technology companies, and others interested in expanding or deepening their presence in the Medicaid market. Learn more about ways our Medicaid Market Advisory Services have helped companies advance critical priorities in Medicaid.
- We are excited to attend and sponsor the annual NAMD Fall Conference on November 14-16. With several former Medicaid directors on staff, this conference is a great way for our experts to connect with industry leaders. Contact us here if you would like to connect with one of our team members at the event.

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