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NAVIGATION

Summary of Key Updates

On November 29, the Supreme Court heard oral arguments on the *Becerra v. Empire Health Foundation* case, which questioned whether CMS can exclude patients who have exhausted their Medicare Part A benefits for the purpose of calculating hospitals' disproportionate share (DSH) payments (Modern Healthcare, November 29; Inside Health Policy, November 29).

A stopgap measure that funds federal government operations is set to expire on December 3, pressuring both chambers of Congress to pass a new spending agreement to prevent a federal government shutdown. Both chambers have yet to agree upon the duration of the next spending agreement and must also address the nation's borrowing cap this month (Washington Post, November 28).

The Department of Health and Human Services (HHS) announced it will distribute $7.5 billion in COVID-19 relief funds to more than 40,000 providers serving rural Medicaid, CHIP, and Medicare beneficiaries for services provided from January 1, 2019 through September 30, 2020 (Inside Health Policy, November 23).

From November 18 to November 30, the Centers for Medicare & Medicaid Services (CMS) approved one Section 1115 waiver, nine 1915(c) Appendix K waivers, and four SPAs, none of which are COVID-19 disaster relief SPAs.

In case you missed it last week, Sellers Dorsey released a summary analysis of the Build Back Better Act that was passed by the House on November 19. The bill appropriates $1.75 trillion for investments in various components of the social safety net infrastructure and also includes significant investments in new and existing federal, state, and local health and human services programs and initiatives. Check out our analysis here.

Federal Updates

News

- HHS announced it will distribute $7.5 billion in COVID-19 relief funds to more than 40,000 providers serving rural Medicaid, CHIP, and Medicare beneficiaries for services provided from January 1, 2019 through September 30, 2020. The money comes from the $8.5 billion in rural provider relief funds that Congress allocated under the American Rescue Plan Act (ARP) in March 2021. The remaining $1 billion will go to the 4% of applications that are currently in the process of being manually approved. Payments to providers average about $170,700, and $500 is the minimum (Inside Health Policy, November 23).
- On November 23, the Biden administration announced Title X awardees can apply for $35 million in ARP funds to expand telehealth services and increase community access to family planning services. HHS rolled back the gag rule that prohibited Title X grantees from referring patients for abortions on October 4 and announced $256 million in Title X grants on October 27. The $35 million in ARP funds will be distributed to approximately 60 Title X family planning providers, with grant applications open until February 3, 2022 and awards to be announced before the May 1, 2022 start date (Inside Health Policy, November 24).
- CMS released a Medicaid and CHIP Learning Collaborative brief addressing strategies states and U.S. territories can adopt to maintain coverage of eligible individuals once the continuous enrollment requirement ends. The end of the continuous enrollment requirement represents one of the largest health coverage transitions since the enactment of the Affordable Care Act (ACA), the first Marketplace Open Enrollment. When the continuous enrollment requirement ends, states and territories will have up to 12 months to return to normal eligibility and enrollment operations, which includes conducting full renewal for all Medicaid and CHIP enrollees as well as processing pending applications on time and processing changes in circumstances. CMS has developed policies and operational strategies to support states as they implement their transitions. The agency focuses on seven topic areas that detail steps and protocols states can use to maintain continuous coverage for eligible individuals enrolled in Medicaid and CHIP as well as return to normal operations:
    - Strengthen Renewal Processes
    - Update Mailing Address to Minimize Returned Mail and Maintain Continuous Coverage
    - Improve Consumer Outreach, Communication, and Assistance
    - Promote Seamless Coverage Transitions
    - Improve Coverage Retention
    - Address Potential Strains on Eligibility and Enrollment Workforce
    - Enhance Oversight of Eligibility and Enrollment Operations (CMS, November 2021)
- CMS published a brief that provides effective strategies that states can utilize to improve Medicaid/CHIP outreach and enrollment to help eligible children retain health coverage during the COVID-19 Public Health Emergency (PHE) and beyond. In the brief, CMS identified the following six strategies to improve state outreach, enrollment, and renewal activities:
    - Form strategic partnerships: State Medicaid and CHIP agencies can expand capacity and consumer assistance by partnering with (1) state agencies that provide other public benefit services, (2) community organizations (including schools), (3) providers and health plans, and (4) federally sponsored Connecting Kids to Coverage National Campaign.
    - Provide enrollment assistance: In addition to direct one-on-one enrollment assistance, states can utilize virtual assistance and other innovative technological strategies to expand and enhance the enrollment experience of eligible beneficiaries.

- Use smart messaging and layered communication approaches: State Medicaid and CHIP agencies can expand enrollment through investments in communications and messaging that encourage enrollment and renewal as well as expand marketing in multiple modes of communication.
- Use technology to make enrollment and renewal easier: State Medicaid and CHIP agencies can leverage technology to reduce administrative and time burdens of enrollment for both applicants and states. Agencies can use mobile apps for enrollment and document verification and/or enhance digital communications with text or email reminders for renewal and other notices.
- Collect and analyze data: State Medicaid and CHIP agencies can monitor and analyze their enrollment and outreach data to identify effective strategies and target underserved regions/populations lacking outreach efforts.
- Actively look for opportunities to improve policy and operations: States can use beneficiary and stakeholder input to inform changes to policies and operations that will enhance enrollment and renewals, improve procedures to streamline the processes, and expand beneficiary notices and communications (CMS, November 2021).

- According to a recent CMS Snapshot, more than 810,000 people have enrolled in plans selected through Healthcare.gov in the third week of its open enrollment (November 14–20), bringing total enrollment since November 1 to 2.43 million people. The enrollees are comprised of an estimated 447,711 new consumers and 1.9 million returning consumers across 33 states. CMS also noted that three states—Kentucky, Maine, and New Mexico—have switched from Healthcare.gov to state-based exchanges, thus their enrollment numbers are not included in the snapshots (Inside Health Policy, November 24).

Federal Legislation

- A stopgap measure that funds federal government operations is set to expire on December 3, pressuring both chambers of Congress to pass a new spending agreement before the week's end to prevent a federal government shutdown. Both chambers have yet to agree upon the duration of the next spending agreement, as the proposed expiration dates for the new agreement yield politically unfavorable outcomes for both parties. Both chambers of Congress must also address the nation's borrowing cap this month, the point at which the U.S. government is projected to default on its debt obligations unless lawmakers raise or suspend the debt ceiling. The Senate is also tasked with finalizing a $768 billion annual measure to authorize key defense spending programs this week. Once this work is complete, the Senate will turn its attention to finalizing the $1.75 trillion Build Back Better Act (BBBA), which passed in the House on November 19. Despite competing priorities in Congress and unresolved policy negotiations within the bill, Senate Majority Leader Chuck Schumer (D-NY) reaffirmed his commitment to passing the BBBA through budget reconciliation before Christmas (Washington Post, November 28).

Federal Litigation

- On November 29, the Supreme Court heard oral arguments on the *Becerra v. Empire Health Foundation* case, which questioned whether CMS can exclude patients who have exhausted their Medicare Part A benefits for the purpose of calculating hospitals' DSH payments. During the oral arguments, the justices asked about the interpretation of language HHS used to create its DSH formula, specifically the difference between beneficiaries who are entitled to Medicare benefits versus individuals who are eligible for them. Hospitals involved in the case claim HHS made Medicare DSH payments a disincentive in 2005 by changing a 20-year-old policy to no longer pay providers to care for patients entitled to benefits under Medicare if they have used all their Part A benefits. The Supreme Court accepted the case in July after the 9th Circuit Court ruled that the words "entitled" and "eligible" cannot be interchangeable if the statute includes both terms (Modern Healthcare, November 29; Inside Health Policy, November 29).

- The Supreme Court will hear arguments in a case that seeks to reverse a nearly 30%, or $1.6 billion, cut to reimbursements in the 340B Program. The cuts were introduced by the Trump administration and have continued under the Biden administration. The plaintiffs, including the American Hospitals Association and other provider associations, argue that CMS exceeded its authority under Medicare statute by revising reimbursement rates without collecting hospital acquisition cost survey data. The Justice Department counters that HHS has sufficient legal authority and that the cost data cited by the plaintiffs was unavailable when the regulation was written. If the Supreme Court rules for the hospitals, they may be retroactively reimbursed to make up for the lower payments they received during the two years the cuts were in force (Modern Healthcare, November 24).
- On November 30, a U.S. District Court judge for the Western District of Louisiana issued a preliminary injunction to halt enforcement of the Biden administration's nationwide vaccine mandate for health care workers. The CMS final rule in question requires medical facilities receiving Medicaid and Medicare funding to impose COVID-19 vaccine requirements as a mandatory condition of employment for all employees by January 4, 2022, or risk losing federal funding. The injunction comes in response to a legal challenge filed by state officials in Alabama, Arizona, Georgia, Idaho, Indiana, Kentucky, Louisiana, Mississippi, Montana, Ohio, Oklahoma, South Carolina, Utah, and West Virginia. Florida's Attorney General filed a separate request to halt the mandate, which was denied by a federal court and sent to the Circuit appeals court for reconsideration. The final ruling on the nationwide vaccine mandate will likely be decided in a higher court, pending further litigation (Politico, November 24; Modern Healthcare, November 30).

COVID-19

- Given the recent identification and classification of the new COVID-19 variant as a highly transmissible virus of concern, the Biden administration announced a travel ban to South Africa and seven other nations in Southern Africa effective November 29. The World Health Organization has named the new variant "omicron," and early evidence has suggested it has an increased risk of infection (Politico, November 26).
- On November 22, Pfizer and BioNTech announced plans to seek full Food and Drug Administration (FDA) approval of their COVID-19 vaccine for adolescents aged 12 to 15. The companies reported 100% vaccine effectiveness in a phase 3 clinical trial comprising 2,228 adolescents over the course of ten months, which produced no serious safety concerns and an adverse event profile similar to other clinical safety data for the vaccine. The vaccine for patients aged 12 to 15 is currently available under emergency use authorization only (Inside Health Policy, November 22).
- The Department of Veterans Affairs (VA) reports 1,498 veterans and 54 staff members from special State Veterans Homes died from COVID-19 since late May 2020. The numbers are likely to rise because data from some homes in hard-hit states are missing or under VA review. The VA is now requiring that state homes report COVID-19-related information to the VA and the CDC, which the VA will then make publicly available weekly on their website (Politico, November 19).

Waivers

- Section 1115
    - On November 18, CMS approved Virginia's 1115 Demonstration Waiver which extends Medicaid coverage to 12 months postpartum since the passage of the ARP, easing the administrative burden on states that wish to extend the duration of postpartum Medicaid coverage for up to one year beginning April 1, 2022. The House version of the BBBA, currently pending Senate approval, furthers the policy by mandating 12-month postpartum coverage in Medicaid programs nationwide. The House-passed BBBA also includes investments in the perinatal

workforce and creation of an option for states to open a maternal health home for pregnant and postpartum women (Inside Health Policy, November 23).

- Section 1915(c) Appendix K
  - Arkansas
    - Temporarily increases the waiver year 5 Factor C from 11,350 to 11,650 and increases the point-in-time number of beneficiaries served from 9,434 to 9,683 under the ARChoices in Home Care waiver.
  - Minnesota
    - Retroactively implements a temporary automatic inflationary adjustment for component values within service rates that are determined using the Disability Waiver Rate System.
  - Missouri
    - Temporarily increases service provider rates under the Aged and Disability, Adult Day Care, and Independent Living waivers through the temporary Federal Medical Assistance Percentages (FMAP) increase under the ARP.
  - Missouri
    - Temporarily increases funding for Individual Supported Living and Group Home service rates and the Division of Developmental Disabilities Personal Assistant provider rates through the temporary FMAP increase under the ARP.
  - Missouri
    - Temporarily increases service provider rates under the AIDS waiver through the temporary FMAP increase under the ARP.
  - Missouri
    - Temporarily increases service provider rates under the Medically Fragile Adult waiver through the temporary FMAP increase under the ARP.
  - New York
    - Provides a retroactive one-time performance payment for Direct Support Professionals and Family Care Providers who delivered services between March 2020 and September 2021 and are still employed by the agency.
    - Provides a one-time bonus to providers who are fully vaccinated against COVID-19 and a one-time workforce longevity and retention bonus.
    - Temporarily enhances current rates for Intensive Behavioral Support Services to increase clinician wages and expand the availability of services.
  - New York
    - Temporarily implements three supplemental payments, including a COVID-19 vaccine incentive payment, for Day Habilitation, Prevocational Services, Residential Habilitation, Respite, Supported Employment, Community Habilitation, Pathway to Employment, Intensive Behavioral Services and Fiscal Intermediary (for staff serving individuals in the self-direction program) service providers.
  - West Virginia
    - Temporarily allows master's level, non-licensed clinicians to provide select Child Support Enforcement Division services under clinical supervision as is required for Licensed Behavioral Health Centers.
    - Temporarily increases Intellectual or Developmental Disabilities, Aged and Disabled, and Traumatic Brain Injury provider payment rates.

- Provides temporary eligibility for Intellectual/Developmental Disabilities Waiver agencies that provide day services that contain personal care or components of personal care (Facility-Based Day Habilitation, Job Development, Pre-Vocational Training, and Supported Employment) to receive retainer payments.

SPAs

- Payment SPAs
  - Idaho (ID-21-0011, effective July 1, 2021): Transitions the current cost-based reimbursement methodology for acute care hospitals to a Prospective Payment System (PPS) All Patient Refined Diagnosis Related Group (DRG) methodology.
  - Iowa (IA-21-0016, effective July 1, 2021): Reduces the Iowa state-owned hospital disproportionate share fund to $0.00 due to the implementation of the managed care state-directed payment to the Iowa state-owned hospital.
  - Pennsylvania (PA-21-0020, effective September 5, 2021): Establishes the annual aggregate limit and continues funding for inpatient disproportionate share, outpatient supplemental, and direct medical education payments.
- Service SPAs
  - Montana (MT-21-0024, effective November 1, 2021): Adds an Intensive Outpatient benefit for youth with serious emotional disturbance. This time-limited COVID-19 SPA terminates at the end of the PHE.

State Updates

- CMS continues to reevaluate Georgia's 1332 waiver that allows the state to rely on private vendors for ACA outreach and enrollment instead of using Healthcare.gov. On November 9, the agency opened a 60-day public comment period seeking stakeholder comments on whether the waiver still meets statutory guardrails since the enactment of the ARP, which includes funding for outreach, the special enrollment program, and enhanced subsidies. Additionally, CMS is evaluating whether the state can still guarantee the waiver will not result in fewer insured individuals than without the waiver. Georgia has expressed that the state's proposal meets current guardrails, and questions CMS' authority to reevaluate an approved waiver (Inside Health Policy, November 30).
- Fourteen states, led by Ohio and Utah, submitted an amicus brief for a case involving tort recoveries, urging the U.S. Supreme Court to allow Medicaid agencies access to larger civil lawsuit payouts when enrollees have been injured. Federal law allows state Medicaid programs to only take portions of civil settlements for services already rendered. In the brief, states argue that Medicaid should be able to collect from any portion of a tort settlement, regardless of whether the medical services relate to future expenses or past treatments. The Court is scheduled to hear arguments in the case, *Gallardo v. Marstiller*, in January 2022 (Health Payer Specialist, November 29; Modern Healthcare, November 24).
- On November 30, North Carolina Governor Roy Cooper (D) announced that Department of Health and Human Services (DHHS) Secretary Dr. Mandy Cohen will be stepping down at the end of the year. Kody Kinsley, Chief Deputy Secretary for Health at DHHS, will succeed Dr. Cohen as Secretary beginning January 1, 2022. Kinsley was a former policy analyst with the White House and the U.S. Department of Treasury before beginning work at DHHS in March 2018. He served as a Deputy Secretary for Behavioral Health and Intellectual and Developmental Disabilities for his first three years at the agency before leading operations for the agency's response to the pandemic in March 2020. Kinsley will begin serving once appointed as Secretary but will still face a confirmation vote in the North Carolina Senate (The News & Observer, November 30).

- The Oregon Health Authority is offering to pay pharmacies $35 for each dose of COVID-19 vaccine administered. The goal is to boost vaccination rates in the state, with 79% of residents 18 years or older reported to have received at least one dose of the vaccine. Additionally, the program addresses staffing shortages at pharmacies by offering to pay temporary pharmacists to bolster the workforce. While all pharmacies can receive vaccine payments from the state, temporary pharmacy staffing is only available to independent pharmacies (Modern Healthcare, November 29).

Private Sector Updates

Providers

- In an op-ed released by *Modern Healthcare* on November 29, Dr. Bruce Siegel, President and CEO of America's Essential Hospitals, urged members of Congress to remove the DSH payment cuts proposed in the House version of the BBBA. The version of the bill currently pending Senate approval would restrict federal contributions to pools that fund hospitals' uncompensated care costs in states that have not adopted Medicaid expansion, based on the assumption that the financial gains stemming from more insured patients covered through proposed ACA marketplace coverage expansions would negate the financial losses incurred by the cuts. Dr. Siegel contends these cuts would punish safety net hospitals for state policy decisions outside of their control, jeopardize care for communities that rely on safety net hospitals, and negate efforts to improve health equity by punishing hospitals with the fewest resources and the poorest patients. Dr. Siegel also claims that the policy fails to account for fluctuations in the Medicaid population or the costs of uncompensated care, yielding an unfavorable financial outlook compounded by the notion that safety net hospitals may not see the promised increase in commercially insured patients (Modern Healthcare, November 29).

Insurers

- UPMC Health Plan saw its Medicaid enrollment grow nearly 10% year over year, covering 557,000 Pennsylvania Medicaid beneficiaries, which is nearly 50,000 more than the year before. Additionally, commercial enrollment fell 4% to 649,000 members, the Medicare base grew by 2.5% to 200,738, and the total health plan membership was slightly over four million. The plan's operating income fell by $206 million, and its operating margin was 1.6% during the first nine months of 2021, down from 4% compared to the same period in 2020 (Modern Healthcare, November 24).
- Insurers are increasingly offering plans that push patients toward virtual visits before in-person care, signifying the potential for a semi-permanent shift to telemedicine in the aftermath of the COVID-19 pandemic. Proponents of the telehealth-first approach contend that virtual visits will effectively serve as a triage before presenting in-person care options, which could yield substantial cost savings for payers. Proponents also argue that the virtual care push among private insurers could shape Medicare telehealth payment policy, as members of Congress continue to deliberate whether providers of virtual visits should receive the same level of reimbursement as in-person care providers. However, uncertainty remains as to whether telehealth visits result in a net substitution effect or add to a patient's total number of visits, casting doubt on the perceived cost savings associated with telehealth-first plans. Additionally, despite the trend toward telehealth-first visits, industry-wide adoption remains relatively low as in-person care options become more readily available (Politico, November 22).
- Sutter Health Plus, a health maintenance organization in Northern California, has dropped Cigna for CVS Caremark as its pharmacy benefits manager starting January 1, 2022. The new contract includes retail, mail-order and specialty prescription drugs, claims processing, and prior authorization requests for drugs (Health Payer Specialist, November 29).

- Kaiser, Anthem, and Blue Shield of California have increased agent rates for Covered California, which oversees the marketplace exchange related to ACA plans. The overall compensation will increase by $22 million a year to over $125 million in total (Health Payer Specialist, November 29).
- UnitedHealthcare Community Plan of Massachusetts announced it will start offering coverage to dual-eligible Medicare/Medicaid beneficiaries under the age of 65 in the state. The health plan announced that OneCare, the coverage program for under-65-year-old dual-eligible beneficiaries, will launch in nine counties mainly around the greater Boston area (Health Payer Specialist, November 29).

Sellers Dorsey Updates

- Sellers Dorsey proudly supports the California Association of Public Hospitals and Safety Net Institute's Annual Conference, Meeting the Moment, on December 2–3. We are excited to hear from health care executives, advisors, and state leadership discuss topics such as health equity, the future of public health care systems, and health policies.
- In case you missed it last week, Sellers Dorsey released a summary analysis of the BBBA that was passed by the House on November 19. The bill appropriates $1.75 trillion for investments in various components of the social safety net infrastructure and also includes significant investments in new and existing federal, state, and local health and human services programs and initiatives. Check out our analysis here.
- The annual four-day long Home and Community-Based Services Conference by ADvancing States is right around the corner. We look forward to spending the week with policymakers and health care experts, learning more about long-term services and supports. If you are attending, connect with us and don't forget to visit our booth!

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