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NAVIGATION

Summary of Key Updates

On January 14, the Department of Health and Human Services (HHS) Secretary Xavier Becerra renewed the public health emergency (PHE) declaration for another 90 days (Inside Health Policy, January 14; HHS, January 14).

On January 14, the Centers for Medicare and Medicaid Services (CMS) released guidance for health care facilities in 24 states that are newly subject to the federal COVID-19 vaccine mandate. Health care workers employed by federally funded facilities in the 24 states have until February 14 to receive their first COVID-19 vaccine dose and March 15 to receive their final dose (Modern Healthcare, January 14).

On January 13, the Medicare Payment Advisory Commission (MedPAC) unanimously voted on a series of recommendations that would lower or freeze Medicare pay rates for 2023 and mandate some cost reporting and telehealth-use data reporting (Inside Health Policy, January 14).

From January 13 to January 19, CMS approved four Section 1915(c) Appendix K waivers and four SPAs, three of which are COVID-19 disaster relief SPAs.

Sellers Dorsey is positioned at the intersection of industry and government and can help translate health care policy trends into sound business decisions for private equity and companies who serve them. We use our expertise to help clients address challenges in Medicaid by delivering highly specialized research and advisory capabilities related to all things Medicaid. Learn more about our expertise and the services we offer to health care investors and private equity firms.

Federal Updates

News

- MedPAC unanimously voted on a series of recommendations that would lower or freeze Medicare payment rates for 2023 and mandate some cost reporting and telehealth-use data reporting. The recommendations include:
    - Freeze physician fee schedule pay rates in FY 2023.
    - Reduce base payment rates by 5% for nursing home and inpatient rehabilitation in FY 2023.
    - Eliminate the update to the 2022 conversion factor for ambulatory surgical centers and require cost data reporting. MedPAC estimates this recommendation results in $50-$250 million in savings for one year.
    - Eliminate the update to 2022 base payment rates, and wage adjust and reduce hospice aggregate cap by 20%. MedPAC estimates this recommendation results in decreased spending relative to the current law of $250 million to $750 million in one year.
    - Maintain the pay increase in the end-stage renal disease prospective payment system planned for 2023.
    - Require clinicians, hospices, and home health agencies to report telehealth claims data using a claims modifier to identify audio-only telehealth services.

  While the votes were unanimous, many commissioners expressed concern that freezing or reducing pay rates could demoralize the workforce. In addition, the American Medical Association strongly opposed the MedPAC recommendations (Inside Health Policy, January 14).

- MedPAC continues to have discussions on how a new model with risk tracks and administratively set benchmarks could be the way forward for population-based alternative payment models (APM). MedPAC has developed a blueprint for a three-track APM model. In November 2021, MedPAC began developing administratively set benchmarks for accountable care organizations (ACOs) based on spending for beneficiaries who would have been eligible for the ACO in the baseline years, along with the growth in ACO spending between baseline and performance years. ACO benchmarks are reset each performance period, so an ACO that improves savings each year will have benchmarks that are increasingly harder to exceed. The MedPAC three-track APM model is based on a division of providers by size and categories as follows: (1) independent physician practices/small safety net (or rural) providers, who could be in a track that involves no financial risk and the providers could keep 50% of savings generated relative to their benchmark; (2) mid-sized organizations, such as multi-specialty physician practices or small community hospitals, who could be in a track that includes financial risk using a 75% shared savings or loss rate; and, (3) large health systems, who would be in a track that includes full financial risk using a 100% shared savings or loss rate. Some stakeholders are questioning whether organizational size should determine risk readiness. Additionally, how quickly providers should be pushed to accept financial risk is still up for debate (Modern Healthcare, January 14).

- The National Association of Accountable Care Organizations is backing provider-led direct contract entities. Under the Biden administration, CMS put the Geographic Direct Contracting model on hold in March 2021, since ACOs and advocates raised concerns. Last year, CMS announced that 53 direct contracting entities would be participating in the global and professional tracks that started in April 2021. Some entities postponed participation until the 2022 performance year. Those participants will continue in the model this year, and except for Next Generation ACOs, CMS has not accepted new applications for 2022. There is much debate as to whether direct contracting will lead to increased privatization, with some opposing stakeholders believing this will threaten the future of Medicare (Inside Health Policy, January 12).

COVID-19

- On January 14, HHS Secretary Xavier Becerra renewed the PHE declaration for another 90 days. Health care providers are pleased with the decision since it allows COVID-19 waivers that loosen restrictions around telehealth services, nursing home staff training, three-day hospital stays, and Medicaid eligibility to continue in place to help combat the Omicron variant (Inside Health Policy, January 14; HHS, January 14).
- On January 14, CMS released guidance for health care facilities in the 24 states that are newly subject to the federal COVID-19 vaccine mandate: Alabama, Alaska, Arizona, Arkansas, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Mississippi, Missouri, Montana, Nebraska, New Hampshire, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Utah, West Virginia, and Wyoming. Health care workers employed by federally funded facilities in these states have until February 14 to receive their first COVID-19 vaccine dose and March 15 to receive their final dose. Health care facilities in these states will be required to present evidence of policies and procedures, ensuring that all staff members are vaccinated against COVID-19 by February 14. The new guidance does not apply to providers in the 25 states, plus the District of Columbia and the U.S. territories, where the vaccine mandate was in effect prior to the catalyzing Supreme Court ruling (see Supreme Court ruling directly below). The guidance also does not apply to Texas, where the vaccine mandate was stayed due to litigation unaffected by the Supreme Court decision. On January 18, Texas moved to dismiss their case setting the stage for CMS to enforce the mandate in all 50 states (Modern Healthcare, January 14; Modern Healthcare, January 19).
- The Supreme Court voted in a 5-4 ruling to keep CMS' vaccine mandate for health care workers at Medicare and Medicaid-certified health care facilities. The Court's decision overturns the lower court's mandate block that affected 25 states. In anticipation of the ruling, CMS updated its guidance and mandated that health care workers must get their first vaccine dose by January 27 and be fully vaccinated or have exemptions by February 28. In a separate 6-3 ruling, the Supreme Court rejected the Occupational Safety and Health Administration's mandate that required vaccinations or regular testing of workers at businesses with at least 100 employees (Modern Healthcare, January 13; Fierce Healthcare, January 13).
- On January 15, new federal rules require private insurers to cover the at-home COVID-19 tests for Americans across the country. Some insurers say it will take weeks to set up systems to meet this requirement, and that the tests do not have the type of billing codes insurers use to process claims. Health plans rarely process retail receipts, and because of this some insurers are planning to first manage the rapid test claims manually (New York Times, January 14).

Waivers

- Section 1115
    - On December 30, New Mexico submitted an addendum to its amendment to the Centennial Care 2.0 section 1115(a) demonstration. The amendment, originally submitted in March 2021, provides for federal financial participation for beneficiaries with a diagnosis of serious mental illness residing in Institutions for Mental Diseases, a High-Fidelity Wraparound service model which provides intensive care for children and youth with Severe Emotional Disorder, additional graduate medical education funding, and funding for COVID-19 vaccine administration. The addendum allows for three increases to existing programs outlined in the demonstration's Special Terms and Conditions: (1) Additional Community Benefit Waiver Slots; (2) an increase in Transitional Service Limits; and (3) an increase in Environmental Modification Service Limits. CMS will accept public comments through February 13.
    - On December 27, Utah requested an amendment to the section 1115(a) demonstration titled, "Primary Care Network" (PCN). The amendment seeks to provide temporary medical respite

services to beneficiaries in the Adult Expansion Medicaid eligibility group who are experiencing homelessness. Utah requested a second amendment to the PCN demonstration to provide fertility preservation services for Medicaid eligible beneficiaries diagnosed with cancer. CMS will accept public comments on both amendments through February 12.

- Section 1915(c) Appendix K
  - Arkansas
    - Temporarily increases the rate for the Attendant Care service provided under the ARChoices Waiver from $4.53 to $5.12 per 15-minute unit.
  - Illinois
    - Temporarily increases rates for Adult Day Care, Adult Day Service, and homemaker services provided under the Persons who are Elderly, Persons with Disabilities, Persons with HIV/AIDS, and Persons with Brain Injury waivers using American Rescue Plan (ARP) funds.
  - New Hampshire
    - Temporarily provides add-on payments to fund recruitment, retention, and training for direct support workers operating under home and community-based (HCBS) waivers using ARP funds.
  - Tennessee
    - Temporarily increases rates for select HCBS delivered through the Statewide, Comprehensive Aggregate Cap, and Self-Determination waivers as authorized in the FY 2021-22 Appropriations Act by the Tennessee General Assembly.
    - Temporarily increases the Individual Cost Limit in the Self-Determination waiver to accommodate targeted rate increases for Direct Support Professionals as authorized in the FY 2021-22 Appropriations Act by the Tennessee General Assembly.
    - Temporarily provides an exception to the Individual Cost Limit in the Self-Determination and Statewide waivers and authority to exceed certain benefit limits to allow a one-time increase of up to $3,000 for family caregivers as provided in the State's conditionally approved Enhanced HCBS Federal Medical Assistance Percentage (FMAP) Spending Plan.

SPAs

- COVID-19 SPAs
  - Connecticut (CT-21-0004-A, effective April 19, 2021): Rescinds the flexibilities previously approved in CT-20-0015 in which the state authorized a 90-day supply of medication other than controlled substance medications and allowed prescription refills when 80% or more of the prescription was used.
  - Maine (ME-21-0015, effective March 1, 2020): Makes Hospital Ambulatory Payment Classifications payments for vaccine administration equal to 100% of Maine Medicare rate; adds reimbursement for medication management by behavioral health providers; implements a one-time supplemental payment of $23 million (inpatient $12.5 million/outpatient $10.5 million) to non state-owned Acute Care Non-Critical Access hospitals and critical access hospitals; implements a supplemental payment of $2,079,376 to Adult Family Care Services providers; adds crisis services under behavioral health professionals; and allows several providers to provide crisis services. This time-limited COVID-19 SPA terminates at the end of the PHE.

  - Michigan (MI-21-0015, effective October 1, 2021): Allows for a temporary 2.5% increase to the nursing facility rate setting methodology. This time-limited COVID-19 SPA terminates at the end of the PHE.

- Payment SPAs
  - New Mexico (NM-21-0006, effective the day after the PHE ends): Implements targeted access payments for Safety-Net Care Pool hospitals.

State Updates

- California's Assembly Health Committee voted 11-3 to advance the Guaranteed Health for All Act, AB 1400 to the Assembly Appropriations Committee. For the bill to become law, it must pass the full assembly by the end of January. Californians would then have to vote on and endorse an income tax increase, which is likely not to happen until 2024, similar to ACA 11. Governor Newsom (CA-D) released his budget blueprint on January 11, including universal health care as a key focus. At this time, it is unclear if AB 1400 and the Governor's budget proposal will overlap (Times-Standard, January 12).

Private Sector Updates

Providers

- The American Telehealth Association (ATA) applauded HHS Secretary Becerra's decision to extend the PHE for another 90 days, keeping telehealth waivers in place through the extension. The ATA is now urging the administration to make these telehealth policies permanent. Under these extended telehealth waivers, HIPAA-covered health care providers are permitted to provide telehealth services to patients using remote communication technologies. The waivers also lift certain originating site and geographic requirements for telehealth services, provide payment for telehealth appointments as if they were provided in person, and allow federally qualified health centers and rural health centers to serve as distant telehealth sites to provide services to patients in their homes (Inside Health Policy, January 18).
- According to a Johns Hopkins study published by JAMA on January 14, approximately 11% of U.S. health systems are overutilizers of low-value services, such as MRIs for patients with traumatic brain injury and pap smears for women over 65. The study analyzes Medicare claims data from 2016-2018 at 3,745 hospitals for 17 services labeled as unnecessary. This type of study can help to support health systems to de-implement practices that are no longer necessary, allowing them to reduce the burden on their already strained workforce (Modern Healthcare, January 14).

Insurers

- In a panel discussion during J.P. Morgan's Annual Health Care Conference on January 10-13, Dr. Sandhya Rao, Chief Medical Officer of Blue Cross Blue Shield of Massachusetts, expanded on the payer's previously announced plan to advance health equity among its patient population. The payer plans to: (1) encourage patients to voluntarily disclose their race and ethnicity through its app; (2) incorporate incentives into physician payment plans and value-based contracts that reward providers for demonstrating improvement in health outcomes stratified by race; and, (3) provide a $25 million grant to the Institute for Healthcare Improvement to support provider groups working to reduce race-based disparities in health outcomes (MedCity News, January 13).

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