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DIGEST

ISSUE #69

Welcome to the all-new Sellers Dorsey Digest! With a fresh new look and improved content navigation, you can quickly access the sections and content most relevant to you. Explore both current and archived editions on the site or download full pdfs to access later. Keep an eye out for feature articles offered on a monthly basis. We hope you continue to find this content relevant and useful!

Feature Article

How Equity-Driven Medicaid Financing Programs Improve Population Health

Health care entities are increasingly adopting Medicaid value-based payment approaches and are beginning to incorporate equity-focused Medicaid supplemental funding to reduce health disparities. These Medicaid supplemental payment programs are designed to improve outcomes and align with specific population health goals. Leading providers are rethinking how they set goals for the use of supplemental funding.

Learn more about the impacts of equity-driven financing solutions in our latest article.

Summary of Key Updates

Senators Brian Schatz and Roger Wicker led a bipartisan and bicameral group of 45 lawmakers in a letter requesting congressional leaders to extend the pandemic-related telehealth waivers by two years as part of February's must-pass omnibus legislation (Inside Health Policy, January 28).

Insurers and provider groups are pushing back on three key provisions in the Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters proposal for the 2023 plan year (Modern Healthcare, January 28; Fierce Healthcare, January 28).

From January 26 to February 2, CMS approved one Section 1915(c) Appendix K waiver and 10 SPAs, six of which are COVID-19 disaster relief SPAs.

Federal Updates

The Food and Drug Administration has granted full approval to Moderna's COVID-19 vaccine, now known as Spikevax, for people ages 18 and older.

State Updates

The Florida House of Representatives is currently considering legislation that would reincorporate dental care into the state's Medicaid managed care program.

Private Sector Updates

CEOs of three of the top ten private health care insurers in the U.S. have signaled plans to implement and expand value-based care into commercial and pharmacy markets.

Sellers Dorsey Updates

In case you missed it, check out the key takeaways from the January 18 CMS Stakeholder Meeting.

FEDERAL UPDATES

News

- On January 20, HHS Administration for Children and Families and the Centers for Medicare and Medicaid Services (CMS) jointly released a toolkit to support the development of automated, two-way data exchanges between Medicaid agencies and child welfare agencies. The toolkit highlights the benefits to data exchange between child welfare and Medicaid agency systems, which include administrative simplification, improved care coordination, and improved program integrity. It also underscores the historical challenges to meaningful data exchange, which include a lack of clarity on data sharing authority, insufficient interagency planning and agreement, and barriers to designing and developing exchanges. To overcome these challenges, the toolkit recommends that both Medicaid and child welfare agencies agree upon "trigger" events, such as a change in placement or new service authorization, that automatically provides for the exchange of data between agencies. It also recommends that leadership from both agencies enter into a written agreement, such as a Memorandum of Understanding (MOU) or an Interagency Agreement (IAA), to formally establish two-way data exchange protocols. The toolkit offers sample trigger events, suggested MOU and IAA content, and funding resources for data exchange implementation (HHS, January 20).

Federal Legislation

- Senators Brian Schatz (D-HI) and Roger Wicker (R-MS) led a bipartisan and bicameral group of 45 lawmakers in a letter requesting congressional leaders to extend the pandemic-related telehealth waivers by two years as part of February's must-pass omnibus legislation. More than 200 stakeholders signed the letter. In the letter, the lawmakers stress that telehealth has been a critical tool in ensuring patients across the country receive the health care they need throughout the pandemic while keeping both providers and patients safe (Inside Health Policy, January 28).

COVID-19

- The Food and Drug Administration (FDA) has granted full approval to Moderna's COVID-19 vaccine, now known as Spikevax, for people ages 18 and older. Spikevax is the second vaccine to be fully licensed in the country. Moderna's vaccine will still be available for emergency use authorization (EUA) providing the company with blanket liability protection. The company's vaccine for teenagers is still pending full approval from the FDA (Politico, January 31; Inside Health Policy, January 31).
- Novavax has submitted an EUA application to the FDA for its COVID-19 vaccine for individuals age 18 and older. Trial data shows the Novavax vaccine has a 90% efficacy rate and is administered via two doses 21 days apart. The protein-based vaccine offers an alternative to the mRNA vaccines from Pfizer and Moderna and the adenovirus vector vaccine offered by Johnson & Johnson (Inside Health Policy, January 31).
- Pfizer-BioNTech are expected to submit an EUA application to the FDA by the week of February 7 for its COVID-19 vaccine for children under five years of age. The FDA encouraged the companies to submit the EUA application for potential approval in February based on the two-dose data, even though current trial data has shown that the two-dose regimen does not induce a strong immune response. The FDA supports EUA submission for the two-dose regimen, reasoning it could approve a third dose once that data is available (The Washington Post, January 31; Associated Press, February 1).

STATE UPDATES

Waivers

- Section 1915(c) Appendix K
  - California
    - Temporarily extends the effective period of previously approved time-limited rate increases for Independent Living Program providers.

- Temporarily implements rate increases for Community Living Arrangement Services providers utilizing the Alternative Residential Model (ARM) rate methodology due to an increase to the state minimum wage.

SPAs

- COVID-19 SPAs
  - Connecticut (CT-21-0016, effective March 1, 2020): Authorizes the following: (1) temporary five percent nursing home rate, effective April 1, 2021 – June 30, 2021; (2) additional rate add-ons for pediatric inpatient psych services effective June 1, 2021 – June 30, 2022; (3) rate add-on for hospitals that increase pediatric inpatient psychiatric bed days by at least 10% or two beds compared with the same quarter in 2019, whichever is greater; and (4) rate add-on for pediatric inpatient psychiatric bed days provided to each child whose behavior demonstrates acuity that requires additional support on the inpatient unit and is sufficiently acute that it interferes with therapeutic participation, effective July 1, 2021 – November 30, 2021. This time-limited COVID-19 SPA terminates at the end of the public health emergency (PHE).
  - Connecticut (CT-21-0020, effective March 1, 2020): Provides payments to outpatient hospitals for providing specimen collection for COVID-19 tests when no other service is provided to that beneficiary on the same date by that hospital at 100% of the Medicare rate on Addendum B. This time-limited COVID-19 SPA terminates at the end of the PHE.
  - Iowa (IA-21-0018, effective March 13, 2020): Implement the provider retainer payments identified in Section E from April 1, 2020 through April 30, 2020. This time-limited COVID-19 SPA terminates at the end of the PHE.
  - Minnesota (MN-21-0014, effective March 1, 2020): Authorizes a new payment method for Federally Qualified Health Centers and Rural Health Clinics, adjusts the resource-based relative value scale conversion factor used to set payment rates for professional services, and modifies requirements for private duty nursing services. This time-limited COVID-19 SPA terminates at the end of the PHE.
  - Montana (MT-21-0025, effective April 1, 2021): Adds single case agreement language to inpatient hospital out-of-state provider payment methodology. It also adds reimbursement for Crisis Assessment services conducted after hours, effective July 1, 2021. This time-limited COVID-19 SPA terminates at the end of the PHE.
  - Washington (WA-21-0038, effective March 1, 2020): Enables the State to receive federal Medicaid matching funds for fee-for-service COVID-19-related supplemental payments to Small Rural Disproportionate Share Hospitals. This time-limited COVID-19 SPA terminates at the end of the PHE.
- Payment SPAs
  - California (CA-21-0006, effective January 1, 2022): Continues the supplemental payment for intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs).
  - Colorado (CO-21-0016, effective May 14, 2021): Adjusts the payment methodology for In-State (public or private) hospital providers to allow the Department to pay up to, but no more than 100% of the hospital's anticipated costs in consideration of: the level of patient acuity, exhaustion of all other placement options, and prior authorization from the Department's medical consultant for the service.
  - South Carolina (SC-21-0006, effective April 1, 2021): Approves the annual update to the state's supplemental teaching physician payment program using the average commercial rate.
- Service SPAs
  - Texas (TX-21-0002, effective February 1, 2022): Amends the Other Practitioners' Services pages of the state plan to clarify that, to the extent required by EPSDT, a licensed behavior analyst (LBA) operating within the LBA's state scope of practice and licensure requirements may provide applied

behavior analysis (ABA) evaluation and treatment services to children under 21 who have a diagnosis of autism spectrum disorder. This SPA implements ABA as a Medicaid benefit in Texas.

News

- On January 31, a former Molina Healthcare executive, Jennifer Strohecker, was named the Utah Medicaid Director. Prior to her new role, Strohecker was Utah's Director of the Bureau of Healthcare Policy and Authorization. Strohecker is expected to play a significant role in the Utah Sustainable Health Collaborative announced in November 2021. The initiative is still in the initial planning stages but aims to cut the cost of delivering health care to Utah residents (Health Payer Specialist, January 31).
- The Florida House of Representatives is currently considering legislation that would reintegrate dental care into the state's traditional Medicaid managed care program. The sponsor of the bill, Rep. Sam Garrison (R), argues that the separate dental care services managed care plans have failed to meet performance standards the State established two years ago. However, legislators from both parties disagree, contending it is too early to determine the success of the separate dental care managed care program. The Florida Legislature first approved carving dental benefits out of the traditional managed care program in 2016, and the state Medicaid agency implemented the separate dental managed care program in 2019. The current dental managed care contracts expire in 2023 with a one-year contract extension option. In addition to carving dental care back into the traditional managed care program, the bill adds provisions that would mandate specialty providers, like acute neonatal care specialists, to contract with regional health care plans that offer a broad spectrum of services. Under the current law, the Medicaid agency is responsible for handling differences between specialty providers and health care plans. According to the bill, a specialty provider would risk losing millions in revenue, particularly in charity care funding, if it fails to contract with a health plan. The proposed bill received a 14-3 vote from the House Finance and Facilities Subcommittee (Politico, January 27).
- New York Governor Kathy Hochul (D) included an under-the-radar Medicaid managed care procurement process in her released proposed executive budget. The budget language allows the Department of Health to competitively procure managed care organizations that participate in certain Medicaid managed care programs. The Hochul administration believes this proposal would reduce costs (by approximately $100 million in FY 2024 and $200 million in FY 2025 according to the Division of Budget) and promote community investment. The Department of Health agrees with the proposal and adds that it would bring New York in alignment with most other states while addressing the overabundance of plans that are currently contracted. However, health plans have raised concerns that the overhaul could reduce coverage options and disrupt current services and networks. Lawmakers are expected to consider the health- and Medicaid-related proposals in Hochul's budget during a February 8 joint legislative hearing (Politico, January 27).

PRIVATE SECTOR UPDATES

Providers

- Results from a poll conducted by 340B Health, an industry group representing hospitals participating in the 340B drug pricing program, indicate the recently imposed restrictions on 340B discounts are costing safety-net hospitals millions of dollars in savings. The poll collected responses from 510 hospitals participating in the 340B program in late 2021, a point at which eight major drug manufacturers had announced policy changes limiting 340B pricing. Critical Access Hospital (CAH) respondents reported losing an average of 39% ($220,000 per CAH) of 340B contract pharmacy savings, with 10% of CAH respondents reporting losses of at least $700,000. Disproportionate share hospitals, sole community hospitals, and rural referral centers reported average community pharmacy savings losses of 23%, with a median reported loss of $1 million and the top 10% of such respondents tallying losses of $9 million or more. Four additional drug manufacturers have announced 340B policy changes since the survey closed, but HHS is currently pursuing litigation to fine drugmakers for restricting the sale of 340B discounted drugs (Fierce Healthcare, January 31).

- According to a paper published in JAMA Network Open on January 27, between May and September 2021, clinicians used stigmatizing language in medical records more often when patients were Black. The paper analyzed 49,000 medical records of patients who had chronic pain, substance use disorder, or diabetes at a single medical center. The study's findings reinforce the need for cultural competency training and a commitment to detail when describing patients and any barriers to their care in electronic health records (EHRs). Using stigmatizing language can serve to jeopardize the overall quality of patient care. (Modern Healthcare, January 31).
- The JAMA Health Forum journal published a study that found volume-based compensation was the most common type of base pay for over 80% of primary care physicians and over 90% of physician specialists. This finding demonstrates how health systems continue to pay physicians based on volume of services provided despite the push towards value-based payment arrangements. While financial incentives for quality and cost performance were commonly used by health systems, only nine percent of primary care providers and five percent of specialists were compensated based on quality and cost. In the study, performance-based financial incentives for value-oriented goals were commonly included in compensation, but since those payments represented a small fraction of total compensation, the incentives likely have little effect on overall physician behavior (Fierce Healthcare, January 28).
- The Kaufman Hall January 2022 report found that hospital financials fared better in the second calendar year of the COVID-19 pandemic than the first, although the industry is still performing well below pre-pandemic data. Hospitals' median change in operating margin for the full year of 2021 (without CARES Act relief) rose by 44.8% compared to 2020. Patients also required longer hospital stays during the past year, with full-year adjusted discharges up by 6.9%, adjusted patient days up 11.8%, average lengths of stay up 3.5%, operating room minutes up 8.3%, and emergency department visits up 10.9% over 2020. As 2021 came to an end, hospitals saw volumes, revenues, and expenses all on the upswing due to the Omicron wave. Hospital and health systems continue to face increasing workforce shortages and supply costs as they enter the third year of the pandemic (Fierce Healthcare, January 31).

Insurers and Vendors

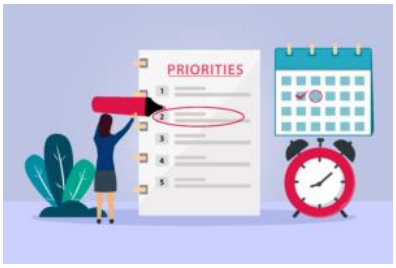
- Insurers and provider groups are pushing back on the following three key provisions in the HHS Notice of Benefit and Payment Parameters proposal for the 2023 plan year:
    - The requirement that insurers offer standardized plan options for every non-standardized plan they run, though CMS is considering resuming meaningful difference standards to help consumers better understand differences between plans under the new requirement.
    - The requirement to conduct network adequacy reviews for qualifying health plans in states that use the federal exchanges based on time and distance standards and appointment wait time standards, and would ultimately require plans that divide providers into tiers associated with different cost-sharing to contract with providers on the lowest cost-sharing tier to meet network adequacy requirements.
    - The requirement that essential health benefits be designated based on clinical evidence via the essential benefits nondiscrimination policy.

  Payer and provider groups claim the three provisions in question would overburden consumers with choices, stifle innovation among plans, and threaten the growing stability of the Affordable Care Act (ACA) marketplace, but opinions diverge on the appropriate solutions to address these concerns. America's Health Insurance Plans urged CMS to extend the comment period on the proposed rule to allow more time for feedback on its proposals (Modern Healthcare, January 28; Fierce Healthcare, January 28).
- According to a report from the National Opinion Resource Center (NORC), a University of Chicago think tank, Medicare Advantage (MA) plans are positioned to help address social determinants of health (SDoH) among their enrollees because of their flexibility based on benefits offered. Some MA plans have already started to focus on age-related health problems along with issues such as poverty, isolation, housing, education, and literacy. Enrollment in MA dual-eligible plans increased by approximately 125% between 2013 and 2019. This trend further demonstrates the need for innovative approaches to address all social

risk factors of a diverse beneficiary population (Health Payer Specialist, January 31; Fierce Healthcare, January 28).

- CEOs of three of the top 10 private health care insurers in the U.S. have signaled plans to implement and expand value-based care (VBC) into commercial and pharmacy markets. Anthem is considering expanding its current VBC models in its government contracts for Medicaid and Medicare to commercial plans and affiliates. UnitedHealth Group is experimenting with VBC in its pharmacy business, particularly in its pharmacy benefit management division called Optum Health. CVS Health has proposed changes to CVS Caremark to expand it into pharmacy value-based care (Health Payer Specialist, January 31).

SELLERS DORSEY UPDATES



- In case you missed it, Sellers Dorsey summarized the key takeaways from the January 18 CMS Stakeholder Meeting.

  Click here to learn what goals have been set for the year and how they may impact conversations, funding, and programs for all entities in health care. If you are a health care professional, stakeholder, or Sellers Dorsey client, you can't afford to miss this update.

- States are looking to managed care organizations for a commitment to innovations that move the needle on health equity and health-related social issues. Our team of managed care experts is well-equipped to help with your needs in this critical area. Many of our experts are former state Medicaid and human services officials who bring years of experience, innovations, and best practices with a strong focus on better ways to provide services to Medicaid beneficiaries. Learn more about how we can help.