sellers dorsey
DIGEST

ISSUE #82

ACCELERATING HEALTH EQUITY PROGRESS:
Four Strategies Medicaid Organizations Should Consider

Health equity has become a strategic priority for many health care organizations, particularly those who provide services to Medicaid beneficiaries. More than half (61%) of Medicaid's 73 million low-income beneficiaries identify as people of color—the populations that have been disproportionately affected by COVID-19. The COVID-19 public health emergency (PHE) has exacerbated health outcomes in certain populations and highlighted existing problems of inequity in health care.

Our latest article explores four ways to drive progress in health equity and improve quality of and access to care for all. Read our article here to see what our experts, former Medicaid director Nancy Smith-Leslie and former health executive Bill Lucia, have to say.

SUMMARY OF KEY UPDATES

On April 28, the Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) announced the 2023 Notice of Benefits and Payment Parameter Final Rule, which establishes regulatory changes in individual and small group health insurance markets and parameters and requirements issuers need to know in designing plans and setting rates for the 2023 plan year (CMS, April 28; Fierce Healthcare, April 28).

On April 8, Tennessee submitted an amendment to its Section 1115 demonstration to extend coverage under the TennCare demonstration to children adopted from state custody who do not otherwise qualify for Medicaid (Medicaid.gov).

On April 29, CMS informed Georgia that it had suspended Governor Kemp's (R-GA) plan to deviate from the Affordable Care Act's federal exchange for a state-based marketplace (11 Alive, April 30).

From April 28 to May 3, CMS approved eight SPAs, one of which is a COVID-19 disaster relief SPA.

Federal Updates

On April 29, CMS issued a final rule on oversight of Medicare Advantage (MA) plans and Medicare Part D.

State Updates

Ohio's redesigned Medicaid managed care system will roll out at the end of 2022, another delay from the rescheduled launch slated for this July.

Private Sector Updates

The American Academy of Pediatrics is reviewing all of its health care guidance, including guidelines, educational materials, textbooks, and newsletter articles, to eliminate race-based medicine and corresponding health disparities.

Sellers Dorsey Updates

Four of our Medicaid managed care experts recently discussed the effects of the ending of the PHE in a recent live webinar. Check out the recording.

FEDERAL UPDATES

Federal Regulation

- On April 29, CMS issued a final rule on oversight of Medicare Advantage (MA) plans and Medicare Part D plans aimed at strengthening access and the quality of care for individuals eligible for Medicare and Medicaid (dual eligible). CMS will increase oversight of third-party marketing organizations, require multi-language inserts regarding the availability of interpreter services in all beneficiary documents, and implement webpage interface requirements to reduce Medicare consumer confusion. CMS will also reinstate Medical Loss Ratio (MLR) reporting requirements that were in effect from 2014-2017, finalize technical changes to the Medicare Part C and Part D quality rating system, protect MA enrollees' access to services during disaster and emergency declarations, require plans applying for MA approval to demonstrate a sufficient provider network, and expand criteria for denying a new MA contract based on past performance. CMS will require enrollee advisory committee input for dual-eligible special need plans (D-SNPs), redesign MA contractual requirements and ratings systems for D-SNPs, and mandate simplified D-SNP enrollee materials. Additionally, Part D plans must pass price concessions for prescription drugs through to consumers starting in 2024. America's Health Insurance Plans contends that the rule could present challenges for plans in rural and underserved areas as well as raise costs for beneficiaries and taxpayers (Modern Healthcare, April 29; Health Payer Specialist, May 2).
- On April 28, HHS and CMS announced the 2023 Notice of Benefits and Payment Parameter Final Rule, which establishes regulatory changes in individual and small group health insurance markets and parameters and requirements issuers need in designing plans and setting rates for the 2023 plan year. The new measures set the landscape for the upcoming Open Enrollment Period beginning on November 1, 2022. The rule includes regulatory standards to assist states, marketplaces, and insurance companies to better serve consumers. The rule implements a user fee of 2.75% for federal-run marketplaces and a user fee of 2.25% for state-based marketplaces, refines essential health benefits to include equity, and updates Quality Improvement Strategy standards to mandate that plans address health care disparities as a specific topic area in the strategy. The rule also abandons an earlier proposal to create a two-stage weighted risk adjustment model for Affordable Care Act (ACA) plans. Major policies included in the rule are as follows:
    - *Advancing Standardized Plan Options*: Issuers offering Qualified Health Plans (QHPs) on Healthcare.gov are required to offer standardized plan options at every network type, at every metal level (Bronze, Silver, Gold, Platinum)F, and throughout every service area.
    - *Implementing New Network Adequacy Requirements:* Requires QHPs on the Federally Facilitated Marketplace (FFM) to ensure certain providers are available within required time and distance parameters. Sets a standard for the 2024 plan requiring QHPs on Healthcare.gov to ensure providers meet minimum appointment wait time standards and finalizes provisions requiring QHPs to report on participating providers use of telehealth
    - *Increasing Value of Coverage for Consumers:* CMS will update the allowable range in metal coverage levels for non-grandfathered individual and small group market plans.
    - *Increasing Access for Consumer and Removing Barriers to Coverage:* Refines the CMS nondiscrimination policy to protect consumers from discriminatory practices related to coverage of the essential health benefits (EHB).
    - *Expanding Access to Essential Community Providers:* CMS will increase the Essential Community Provider (ECP) threshold from 20% to 35% of available ECPs in each plan's service area to participate in the plan's provider network.
    - *Further Streamlining Healthcare.gov Operations:* Set the FFM and State-based Marketplaces on the Federal Platform user fees for 2023 at the same level as 2022 (CMS, April 28; Fierce Healthcare, April 28).

COVID-19

- On April 29, the Food and Drug Administration (FDA) set tentative dates of June 8, June 21, and June 22, to review COVID-19 vaccines for children. Both politicians and parents have become frustrated with the slow

approval process and are hopeful for eventual approval. On April 28, Moderna submitted data that allegedly proves two low-dose shots will protect children under the age of six, but it still needs to submit additional data to complete the process. Pfizer is also expected to announce whether three of its smaller-dose shots will protect children under five years of age (Modern Healthcare, April 29; Kaiser Health News, April 29).

Studies and Reports

- According to a CMS Office of Minority Health and RAND Corporation report, Black, Indigenous, and Alaska Native patients experienced the most significant disparities in clinical care among MA enrollees over the last year. Healthcare Effectiveness Data and Information Set (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) data comparing clinical data and patient satisfaction data were analyzed for the study. Among various findings, Black, American Indian, and Alaska Native enrollees ranked lowest on clinical measures, while Asian American and Pacific Islander enrollees reported the worst customer service experiences (Modern Healthcare, April 29).
- On April 28, the Office of Inspector General (OIG) released a report with findings from an examination of the 15 largest MA companies over a one-week period in June 2019. OIG found that private Medicare plans routinely rejected claims that should have been paid and denied services that were medically necessary. Medicare plans denied 18% of claims allowed under Medicare coverage rules, often the result of errors in processing claims, and turned down 13% of authorizations for services government-run Medicare would have allowed. Many denials identified were based on clinical criteria not required by Medicare, and the report cited that private Medicare plans have coverage formulas beyond what Medicare normally requires. The OIG recommends CMS update its guidance on clinical criteria for medical necessity reviews, revise audit protocols, tighten oversight, and address system errors (Kaiser Health News, April 28; USA Today, April 28; Modern Healthcare, April 28).

STATE UPDATES

Waivers

- Section 1115
  - On April 8, Tennessee submitted an amendment to its Section 1115 demonstration titled, "TennCare III." The state proposes to extend TennCare coverage to children adopted from state custody who do not qualify for Medicaid on the basis of receiving federal or state adoption assistance. CMS will accept public comments through May 28.

SPAs

- Administrative SPAs
  - Florida (FL-22-0003, effective January 1, 2022): Brings the state plan into compliance with the Consolidated Appropriations Act 2021, requiring mandatory coverage of routine patient costs for services furnished in connect with participation in qualifying clinical trials.
  - New Hampshire (NH-22-0030, effective January 1, 2022): Revises the provisions governing third party liability to clarify language around preventive pediatric services, child support enforcement, and prenatal services, as well as updates to policies and procedures.
  - Nevada (NV-22-0006, effective January 1, 2022): Provides assurances that the state complies with specific third-party liability requirements as outlined in both the Bipartisan Budget Act of 2018 and the Medicaid Services Investment and Accountability Act of 2019.
  - New Jersey (NJ-22-0010, effective January 1, 2022): Provides assurances that the state complies with third-party liability rules as authorized under both the Bipartisan Budget Act of 2018 and the Medicaid Services Investment and Accountability Act of 2019.
  - Tennessee (TN-22-0001, effective January 1, 2022): Provides assurances that the state complies with the Consolidated Appropriations Act, 2021 requiring mandatory coverage of routine patient

care and cost sharing for services furnished in connection with participation in qualifying clinical trials.

  - Utah (UT-22-0002, effective January 1, 2022): Provides assurances that the State complies with federal requirements regarding coverage of routine patient care and cost sharing associated with participation in clinical trials as required by the Consolidated Appropriations Act, 2021.

- COVID-19 SPAs
  - Florida (FL-21-0011, effective July 1, 2021): Rescinds the election at E.2., E.4., and section G of section 7.4 of the state plan, approved in FL-20-0004, to allow federally qualified health centers to request supplemental wrap-around payments on a monthly basis, instead of quarterly; allows ICF/IIDs to request a change to their current reimbursement rates based on increased costs related to COVID-19; and, eliminates sanctions on nursing facilities for the late submission of Medicaid cost reports.
- Service SPAs
  - District of Columbia (DC-21-0010, effective January 1, 2022): Allows the transition of its Section 1115 Behavioral Health Transformation Demonstration Program services to permanent state plan authority in order to retain authority to provide Medicaid reimbursement.

News

- Texas gubernatorial candidate Beto O'Rourke (D) called for the state to replicate Oklahoma's Medicaid expansion, marijuana legalization, and gambling legalization. Though both states have similar political environments, and Texas leads the nation in uninsured residents, the Republican-dominated Texas legislature has consistently rejected calls to expand Medicaid (Dallas Morning News, May 2).
- Ohio's redesigned Medicaid managed care system will roll out at the end of 2022, another delay from the rescheduled launch slated for this July. The Ohio Department of Medicaid will launch OhioRISE, a coverage program for children with behavioral and mental health needs, as scheduled this July, but the remaining program updates and the entry of new managed care organizations will not take place until October at the earliest. The state's Medicaid leadership attributes the delay to the administrative burden caused by the upcoming termination of the PHE, when many Medicaid beneficiaries will lose PHE eligibility protections and undergo the redetermination process (Insurance Newsnet, May 1).
- Oregon and Kentucky are pursuing the establishment of basic health programs. The basic health program was included in the ACA and offers federal dollars for the creation of a low-cost insurance plan for individuals who make up to twice the federal poverty level and do not qualify for Medicaid. Until now, Minnesota and New York were the only states that took advantage of the provision, and both states offer plans with little or no premiums, co-pays, or deductibles. Oregon passed a bill in March 2022 to establish a basic health program with details currently being determined by a task force. In Kentucky, $4.5 million in state funds were allocated to set up a basic health program, which was signed into law by the Governor. With the establishment of basic health programs, an estimated 85,000 Oregon and 37,000 Kentucky residents will be eligible to enroll next year (Politico, April 30).
- Senator Mary Washington (D-Baltimore City) and Delegate Anne Kaiser (D-Montgomery) have advised the Maryland Department of Health to reevaluate its Medicaid policy involving health care for transgender individuals. They reiterated that Maryland is at risk of being sued for violations of the nondiscrimination provisions under the ACA. Kaiser and Washington initially cosponsored a bill extending coverage for transgender individuals that passed in the Senate but was halted by a vote from the House Health and Government Operations committee. The Deputy Medicaid Director responded to Washington and Kaiser this week, stating the Medicaid agency will not be revising its policy at this time, but will continue to review federal requirements as necessary (WTOP News, April 30).
- On April 29, CMS informed Georgia that it had suspended Governor Kemp's (R-GA) plan to deviate from the ACA's federal exchange for a state-based marketplace. This plan was originally approved at the end of the Trump administration. However, the Biden administration had suspended parts of the original approval, including the expansion of Medicaid with a work requirement. Acumen, a research company,

reported that Georgia's plan would result in a 4.4-8.3% drop in health insurance enrollment in 2023, with a continued drop of 8.4% each year from 2024-2027. Georgia has 90 days to respond with a written challenge or submit a corrective action plan (11 Alive, April 30).

PRIVATE SECTOR UPDATES

- Rising gas prices and inflation are exacerbating staffing shortages in home health care. Industry leaders are concerned that low wages and uncompensated travel in personal vehicles, coupled with the rising cost of gas and goods, are causing workers to rethink whether they can afford to commute to their patients, threatening patients' access to home health services in remote, underserved areas (Modern Healthcare, May 2).
- The American Academy of Pediatrics (AAP) is reviewing all of its health care guidance, including guidelines, educational materials, textbooks, and newsletter articles, to eliminate race-based medicine and corresponding health disparities. These recent changes were initially driven by civil rights and social justice movements but are also backed by science showing that social determinants of health, genetics, and other biological factors affect health. AAP is encouraging other medical institutions and specialty groups to do the same to work towards eliminating racism in medicine (Associated Press, May 2).

SELLERS DORSEY UPDATES

- In case you missed our webinar with Medicaid Health Plans of America, you can watch it here to learn about the unwinding of the PHE. Our Medicaid experts, Leesa Allen, Karen Brach, Janice Fagen, and Jill Hayden, discuss strategies states are considering and impacts on states, managed care organizations, providers, beneficiaries, and other health care stakeholders.
- Sellers Dorsey is proud to sponsor Temple University Health System's 67th Annual Acres of Diamonds Gala. This event supports improving access to health care for all. We hope to see you there on May 7!