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DIGEST

ISSUE #89

Key Updates

On June 17, the Centers for Medicare and Medicaid Service (CMS) released a proposed rule that would reduce Medicare home health agency payment rates resulting in $810 million in lost Medicare revenues in 2023 (Modern Healthcare, June 17; Becker's Hospital Review, June 21).

A congressional deal for $10 billion in COVID-19 pandemic funding has reached an impasse (Becker's Hospital Review, June 17).

CMS announced additional expanded postpartum coverage approvals in the District of Columbia, Maine, Minnesota, and New Mexico, which now marks 14 states and the District of Columbia to have expanded coverage to improve maternal child health and maternal mortality outcomes (Fierce Healthcare, June 16; CMS, June 16).

From June 14 to June 22, CMS approved two Appendix K waivers and 13 SPAs, four of which are COVID-19 disaster relief SPAs.

Sellers Dorsey is pleased to announce an invaluable new addition to our team, Director Matt Hicks. His extensive experience in health care includes improving access and outcomes for Medicaid members as former Senior Vice President and Chief Policy Officer at Grady Health System. Welcome, Matt!

Federal Updates

The Federal Trade Commission released an enforcement policy statement announcing an increase of enforcement and examination for drug rebates that would prevent access to less expensive prescription pharmaceuticals.

State Updates

CMS announced additional expanded postpartum coverage approvals in the District of Columbia, Maine, Minnesota, and New Mexico.

Private Sector Updates

Walgreens executives announced plans to launch clinical trials through partnerships with drug manufacturers.

Sellers Dorsey Updates

We're excited to be attending the America's Essential Hospitals VITAL2022 conference!

FEDERAL UPDATES

News

- Shortly after the announcement of an investigation into pharmacy benefit managers (PBMs), the Federal Trade Commission released an enforcement policy statement announcing an increase of enforcement and examination for drug rebates that would prevent access to less expensive prescription pharmaceuticals. The statement defined what rebates or fees could lead to potential fines or penalties against PBMs or other intermediaries and indicated that rebates are believed to be a key factor in the increasing prices of vital prescriptions, like insulin, by more than 300% in recent years (Fierce Healthcare, June 17).
- In its biennial report to Congress, the Medicare Payment Advisory Commission (MedPAC) has recommended changes to the risk adjustment process in the monthly capitation payments to Medicare Advantage (MA) plans. MedPAC proposes modifying the risk adjustment model, known as the hierarchical condition category (HCC), to include reinsurance which would give MA plans with sicker patients' higher payments. HCC relies on beneficiaries' demographics and medical conditions to predict how costly it is to treat them. HCC is used to determine a beneficiary's risk score which is incorporated to determine the benchmark rate for the MA plan. The model is updated frequently to reflect new treatment costs. The recommendation focuses on modifying outliers (very high-cost and low-cost beneficiaries) in MA payments to resolve the issue of over- or underpayments from Medicare (Fierce Healthcare, June 17).

Federal Litigation

- On June 15, the Supreme Court ruled unanimously in favor of the American Hospital Association (AHA), the Association of American Medical Colleges (AAMC), America's Essential Hospitals, and three hospital members in the 340B case. The ruling reversed a 2020 decision that allowed the Department of Health and Human Services (HHS) to significantly decrease payments to hospitals that participated in the 340B Drug Pricing Program. The ruling concluded that "HHS acted unlawfully by reducing reimbursement rates for 340B hospital," hospitals that perform essential and valuable services for low-income and rural communities (AHA News, June 15).

Federal Regulation

- On June 17, CMS released a proposed rule that would reduce Medicare home health agency payment rates resulting in $810 million in lost Medicare revenues in 2023. The cut represents a 4.2% reimbursement decrease in funding from 2022, which is due to negative pay adjustments to account for increased expenditures CMS says resulted from a recently implemented payment system known as the Patient-Driven Groupings Model. The model is not allowed to cause higher Medicare spending, so CMS reduced home health agency pay starting in 2020 in anticipation of how home health agencies would respond to the model. Starting in 2023, CMS proposes a 7.69% cut ($1.33 billion) to maintain budget neutrality. The proposed rule solicits comments on collecting data on telecommunications technology use in Medicare home health claims, including information about access barriers (Modern Healthcare, June 17; Becker's Hospital Review, June 21).

COVID-19

- A congressional deal for $10 billion in COVID-19 pandemic funding has reached an impasse. Senate Republicans have criticized the Biden administration of providing "patently false" information on the use and availability of funds from previous COVID-19 aid legislation. The White House, in the meantime, has said it must shortchange some of its supplies by reallocating funds to replenish funds for other items, primarily vaccines, since the $10 billion aid legislation have been stuck in Congress for months (Becker's Hospital Review, June 17).
- U.S. regulators have authorized the first COVID-19 shots for infants and preschoolers, with vaccinations beginning this week. The Food and Drug Administration's advisory panel had a unanimous recommendation for the shots from Moderna and Pfizer. This means American children under the age of five are now eligible for COVID-19 vaccinations. The Centers for Disease Control and Prevention (CDC)

subsequently recommended use of the new vaccines, kicking off the rollout of millions of vaccine doses that have already been preordered by states, tribes, community health centers, and pharmacies (Modern Healthcare, June 17; CDC, June 18).

Studies and Reports

- On June 17, the Department of Health and Human Services' Office of Inspector General (OIG) released a report revealing inaccuracies and limitations on Medicare's enrollment data on race and ethnicity. CMS has been collecting race and ethnicity data from providers and payers but may need access to new data. Medicare collects race and ethnicity data from the Social Security Administration and then applies an algorithm to the data and collects self-reported data from nursing homes. OIG found Medicare enrollment data will sometimes identify a beneficiary as a race or ethnicity that they do not identify themselves in the self-reported data. Additionally, Medicare's collection of enrollment data was not consistent with federal data standards. OIG recommends CMS create its own source of race and ethnicity data and not rely on the Social Security Administration. CMS should also create a new process for ensuring the data is standardized (Fierce Healthcare, June 17).
- A Kaiser Health News and NPR joint investigation revealed that over 100 million Americans, 41% of all American adults, have debt stemming from medical or dental care. The figure is higher than previously estimated, as the investigation found that much of the debt takes the form of credit card balances, provider payment plans, and loans from family. The investigation revealed that women and people of color are disproportionately likely to be burdened with medical debt. It also revealed that two-thirds of those with medical debt have delayed seeking health care due to cost (Kaiser Health News, June 16).

STATE UPDATES

Waivers

- Section 1915(c) Appendix K
  - Iowa
    - Provides one-time recruitment and retention payments to qualifying Individual Consumer Directed Attendant Care providers and home- and community-based services (HCBS) Waiver Consumer Choices Option Employees in accordance with the state's Section 9817 ARP Spending Plan.
  - Mississippi
    - Provides a one-time supplemental payment to 1915(c) direct care providers, estimated at 5% of total expenditures paid from April 1, 2020 to March 31, 2021, using enhanced Federal Medical Assistance Percentages (FMAP) funding authorized under the ARP.

SPAs

- Administrative SPAs
  - Nebraska (NE-22-0003, effective January 1, 2022): Adds an assurance of coverage of routine patient services and costs associated with participation in qualifying clinical trials, as required by section 210 of the Consolidated Appropriations Act.
- COVID-19 SPAs
  - Georgia (GA-22-0001, effective July 1, 2021): Updates nursing home rate components for general liability, property insurance, and property tax pass-through to the 2021 cost report. This time-limited COVID-19 SPA terminates at the end of the public health emergency (PHE).
  - Minnesota (MN-22-0019, effective March 1, 2020): Waives signature requirements for the dispensing of drugs during the COVID-19 pandemic. This time-limited COVID-19 SPA terminates at the end of the PHE.

  - Ohio (OH-22-0011, effective April 1, 2022): Implements one-time supplemental payments to hospitals for COVID-19 disaster relief. This time-limited COVID-19 SPA terminates at the end of the PHE.
  - Ohio (OH-22-0012, effective November 2, 2020): Disregards certain accumulated resources that are normally subject to the post-eligibility treatment of income rules for long-term care beneficiaries. This time-limited COVID-19 SPA terminates at the end of the PHE.
  - Wisconsin (WI-22-0011, effective April 1, 2022): Provides attestation for coverage and reimbursement of COVID-19 vaccines, testing, and treatment without cost-sharing.

- Eligibility SPAs
  - Montana (MT-22-0002, effective January 1, 2022): Increases the general income disregard for medically needy individuals from $100 to $269 per month and further modifies the disregard consistent with Social Security Administration cost-of-living adjustments beginning in 2023 and in subsequent years.

- Payment SPAs
  - Colorado (CO-22-0001, effective January 1, 2022): Applies a prudent layperson standard for cost-sharing imposed for non-emergency use of a hospital's emergency department. For cost-sharing to be imposed for non-emergency services in a hospital emergency department, the hospital must first provide the appropriate medical screening examination required by the Emergency Medical Treatment & Labor Act.
  - North Dakota (ND-22-0006, effective April 1, 2022): Includes the Medicare fee Schedule in the overall lesser of logic calculation for physician-administered drugs.

- Service SPAs
  - District of Columbia (DC-22-0001, effective April 1, 2022): Adopts the statutory option to provide 12 months of extended postpartum coverage to individuals who were eligible and enrolled under the Medicaid state plan during their pregnancy (including during a period of retroactive eligibility).
  - Maine (ME-22-0016, effective August 1, 2022): Adopts the statutory option to provide 12 months of extended postpartum coverage to individuals who were eligible and enrolled under the Medicaid state plan during their pregnancy (including during a period of retroactive eligibility).
  - Minnesota (MN-22-0008, effective July 1, 2022): Adopts the statutory option to provide 12 months of extended postpartum coverage to individuals who were eligible and enrolled under the Medicaid state plan during their pregnancy (including during a period of retroactive eligibility).
  - New Mexico (NM-22-0013, effective April 1, 2022): Adopts the statutory option to provide 12 months of extended postpartum coverage to individuals who were eligible and enrolled under the Medicaid state plan during their pregnancy (including during a period of retroactive eligibility).

News

- CMS announced additional expanded postpartum coverage approvals in the District of Columbia, Maine, Minnesota, and New Mexico. There are now 14 states and the District of Columbia that have expanded coverage to improve maternal child health and maternal mortality outcomes. During the Biden administration, an additional 235,000 parents have gained access to postpartum care because of the American Rescue Plan (ARP) and the administration's commitment to maternal mortality and morbidity (Fierce Healthcare, June 16; CMS, June 16).

PRIVATE SECTOR UPDATES

- AHA criticized CMS on its proposed rules for the inpatient and long-term care hospital (LTHC) prospective payment systems (PPS) for fiscal year 2023 as it does not adjust the market basket to account for the

record inflation presently faced by hospitals and health systems. AHA has urged CMS to adjust the market basket in both PPS provisions to account for the inflationary environment (AHA, June 17).

- Walgreens executives announced plans to launch clinical trials through partnerships with drug manufacturers. Walgreens intends to leverage its access to patient data, technology assets, and retail locations to increase enrollment and racial and ethnic diversity in the drug development process. Walgreens also plans to offer clinical trials from home through its home health subsidiary CareCentrix. Walgreens is currently in active engagement with potential pharmaceutical partners and has not yet announced a launch date for the clinical trial program (Fierce Healthcare, June 16).
- On June 17, Centene increased its profit forecast for the year, citing higher insurance premiums from federal marketplace health plans as the main driver. Initially, the company projected $5.40 to $5.55 per share, with the profit now expected to be between $5.55 and $5.70 per share (Reuters, June 17).
- Senior executives at Centene, the largest Medicaid managed care provider, have said the company can lose up to 1.7 million of its members during the Medicaid redetermination process once the COVID-19 PHE ends. It will be a 58% reduction in enrollees and a $7.5 billion reduction in its revenue. Approximately 88% of Centene's Medicaid enrollees are in states that are allowing 10 months to complete redeterminations. Centene contracts with 29 states to run their Medicaid programs (Health Payer Specialist, June 17).
- On June 28, Anthem will officially become Elevance Health and will launch new brands for two of its subsidiaries. The insurer will consolidate all health care services businesses under one umbrella called Carelon. Carelon will include Anthem's in-house pharmacy benefit manager Ingenio RX, as well as recent acquisitions such as Beacon Health Options and myNEXUS. Additionally, Anthem will unify its Medicare, Medicaid, and commercial plans in certain markets under the new Wellpoint brand (Fierce Healthcare, June 15).

SELLERS DORSEY UPDATES

- We're excited to be attending the America's Essential Hospitals VITAL2022 conference! Stop by our booth to learn more our work supporting safety-net hospitals through Medicaid to improve lives and health care outcomes.
- Interested in learning more about promoting health equity through value-based payments in Medicaid? Our colleague Scott Allocco will be speaking about this topic at the upcoming HFMA Conference. Check out this post on our website to learn more.
- Sellers Dorsey is pleased to announce an invaluable new addition to our team, Director Matt Hicks. His extensive experience in health care includes improving access and outcomes for Medicaid members as former Senior Vice President and Chief Policy Officer at Grady Health System. Welcome, Matt!