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Center for Medicaid, CHIP, and Survey & Certification

CMCS Informational Bulletin

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FROM: Cindy Mann, Director
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SUBJECT: Updates on Medicaid/CHIP

This Informational Bulletin covers several important topics of interest to States:

- New Initiative for Medicare-Medicaid Enrollees;
- Proposed Regulations Regarding Affordable Insurance Exchanges
- Home Health Services NPRM;
- PRA Package for Medicaid and CHIP State Plan, Waiver, and Program Submissions;
- CMS Second National Background Check Program Conference;
- Inclusion of Training Costs in Rate Development:
- Pharmacy Pricing Survey

New Initiative for Medicare-Medicaid Enrollees

CMCS and the Office of Medicare-Medicaid Coordination is pleased to announce the release of a State Medicaid Director's letter providing guidance on opportunities to test new financial models designed to help States improve quality and share in the lower costs that result from better coordinating care for individuals enrolled in both Medicare and Medicaid (Medicare-Medicaid enrollees). A longstanding barrier to coordinating care for Medicare-Medicaid enrollees has been the financial misalignment between Medicare and Medicaid. To address this, and in response to State requests CMS is eager to collaborate with States to test two models to better align the financing of these two programs and integrate primary, acute, behavioral health and long term services and supports for their Medicare-Medicaid enrollees. We will be setting up calls with States to review these opportunities.

For more information, please visit:
https://www.cms.gov/smdl/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf

Proposed Regulations Regarding Affordable Insurance Exchanges

On July 11, 2011, CMS issued the a proposed rule setting forth a framework to assist States in building Affordable Insurance Exchanges, state-based competitive marketplaces where individuals and small businesses will be able to purchase affordable private health insurance. Starting in 2014, Exchanges will make it easy for individuals and small businesses to compare health plans, get answers to questions, find out if they are eligible for tax credits for private

insurance or health programs like Medicaid and the Children's Health Insurance Program (CHIP), and enroll in a health plan that meets their needs.

The proposed rules offer States guidance and options on how to structure their Exchanges in two key areas:

- Setting standards for establishing Exchanges, setting up a Small Business Health Options Program (SHOP), performing the basic functions of an Exchange, and certifying health plans for participation in the Exchange, and;
- Ensuring premium stability for plans and enrollees in the Exchange, especially in the early years as new people come in to Exchanges to shop for health insurance.

These proposed rules set minimum standards for Exchanges, give States the flexibility they need to design Exchanges that best fit their unique insurance markets, and are consistent with steps States have already taken to move forward with Exchanges. The proposed rules build on over a year's worth of work with States, small businesses, consumers and health insurance plans and offer States substantial flexibility. For example, it allows States to decide whether their Exchanges should be local, regional, or operated by a non-profit organization, how to select plans to participate, and whether to partner with the Department of Health and Human Services (HHS) to split up the work.

To reduce duplication of effort and the administrative burden on the states, HHS also announced that the federal government will partner with States to make Exchange development and operations more efficient. States can choose to develop an Exchange in partnership with the federal government or develop these systems themselves. This provides States more flexibility to focus their resources on designing the right Exchanges for their local insurance markets.

To review the proposed rule visit: http://www.ofr.gov/OFRUpload/OFRData/2011-17610_PI.pdf . The comment period closes on September 28, 2011. HHS will also convene a series of regional listening sessions and meetings to facilitate pubic comments. Additional guidance—including proposed rules related to eligibility and enrollment procedures for Exchanges and Medicaid—will be issued in the future.

For more information on Exchanges, including fact sheets, visit http://www.healthcare.gov/exchanges.

Home Health Services; Policy Changes and Clarifications Related to Home Health

On Tuesday, July 5, 2011, CMS released a Notice of Proposed Rule Making (NPRM) providing additional guidance to States on the implementation of section 6407 of the Affordable Care Act which adds a requirement that in the course of authorizing home health services, physicians must document the existence of a face-to-face encounter (including through the use of telehealth) with the Medicaid eligible individual within specified timeframes. This proposed rule aligns Medicaid implementation of face-to-face encounters with Medicare's regulatory guidance. This will improve facilitation of services for individuals dually eligible for both programs, and make it easier for providers participating in both programs to understand the rules. This provision was effective on January 1, 2010, but this is a proposed rule and comments are welcome.

In addition, this proposed rule clarifies that home health services, including medical supplies, equipment and appliances may not be restricted to the home, and if medically necessary, should be provided in any non-institutional setting in which normal life activities take place. It includes in regulation the definition of medical supplies, equipment and appliances.

For more information and instructions on how to submit comments on this rule, please visit: http://www.gpo.gov/fdsys/pkg/FR-2011-07-12/pdf/2011-16937.pdf. All comments are due by September 12, 2011.

PRA Package for Medicaid and CHIP State Plan, Waiver, and Program Submissions

On Friday, July 1, 2011, CMS published a generic Paperwork Reduction Act (PRA) package in the Federal Register that includes forms necessary for CMCS to conduct ongoing business with our State partners to continue the implementation of the Affordable Care Act provisions related to Medicaid and the CHIP. These forms include State plan amendments, waiver, demonstration and reporting templates that will be developed over the 3-year approval period.

This PRA package provides support to both States and CMS by:

- Developing streamlined submissions for States to implement health reform initiatives in Medicaid and CHIP;
- Enhancing collaboration and partnerships by documenting CMS policy for States to use as they are developing program changes; and
- Improving the efficiency of administration by creating a common and user friendly understanding of the information needed by CMS to process requests for State plan amendments, waiver, demonstrations and reporting.

For more information and instructions on how to submit comments on this rule, please visit: http://www.gpo.gov/fdsys/pkg/FR-2011-07-01/pdf/2011-16600.pdf. Comments and recommendations must be submitted by August 30, 2011.

Encouraging States to Attend the CMS Second National Background Check Program Conference

We are pleased to announce that the second CMS National Background Check Program (NBCP) Conference is scheduled for 2.5 days, September 13-15, 2011 at the Crowne Plaza Hotel, St. Louis-Downtown located at 200 N. Fourth Street, St. Louis, Missouri. This conference will provide education to NBCP grantee States as well as non-grantee States interested in establishing or improving their background check programs for long term care providers and facilities. Although grantee States are required to use grant funds to send at least three attendees to each of the NBCP conferences, we also hope States who have not yet received a grant will attend.

The NBCP conference is part of the technical assistance efforts CMS is providing to States in support of section 6201 of the Affordable Care Act of 2010, which directs the Secretary of the Department of Health and Human Services to establish a nationwide program to identify efficient,

effective, and economical procedures for long term care facilities and providers to conduct background checks on a statewide basis on all prospective direct patient access employees. The NBCP will enhance the safety of residents and clients of long term care providers by disqualifying certain offenders from positions that would bring them into contact with vulnerable populations served in long term care settings.

Non-grantee States interested in attending the second CMS NBCP Conference at their own expense, should contact Lisa Byrd, CMS Training Coordinator, via email at lisa.byrd@cms.hhs.gov by **Monday, August 1, 2011** for registration assistance**.** If you are a non-grantee State with travel funding issues that may prohibit attendance at this conference, please contact the Background Check Team at Background_Checks@cms.hhs.gov to discuss the potential for CMS assistance. For all other questions related to conference registration, please contact lisa.byrd@cms.hhs.gov.

Inclusion of Training Costs in Rate Development

In light of questions we have received, CMCS is providing this information regarding the mechanism by which provider-related training costs may be considered in the development of the rate of payment for medical services. Questions have come up particularly in the area of home health services.

Medicaid statute and regulations (section 1902 of the Social Security Act and 42 Code of Federal Regulations 430 and 447) allow reimbursement for covered services delivered by a qualified provider to an eligible beneficiary. Costs associated with requirements that are prerequisite to being a qualified Medicaid provider are not reimbursable by Medicaid. However, costs associated with maintaining status as a qualified provider may be included in determining the rate for services. Specifically, if as part of its provider qualification requirements, a State requires a provider to acquire a certain minimum number of hours of specified types of continuing education (CE) each period (annually or quarterly, for example), the State may recognize such CE expenses as a cost to the provider of doing business and may consider such costs in developing the rate paid for the service. The cost of CE may only be included as part of the rate paid for the service and may not be claimed separately by the Medicaid agency as an administrative expense.

For example, a State's provider qualification standards could require the direct service provider to: 1) have a high school diploma (or its equivalent) and be at least 18 years of age, and 2) complete a certain number of specified CE hours or credits during the calendar or fiscal year (or quarter) in order to maintain eligible provider status. The State could not pay, or include in its rates, costs for individuals to obtain a high school diploma or its equivalent. However, the State may include the estimated costs of meeting ongoing CE requirements in determining the rate paid for the service. If the provider fails to acquire the minimum required number of CE hours or credits, the provider would no longer be qualified, and no Medicaid payment could be made either for services or for the CE that would be needed as a prerequisite to regaining status as a qualified provider.

Similarly, should a State wish to promote advanced provider skills training to increase the availability of providers qualified to serve beneficiaries with more complicated or difficult medical needs, costs associated with that advanced training could also be included in the development of rates paid for services requiring more complex levels of care. The State could set provider qualification requirements at a separate and distinct level for those advanced level providers, and pay rates commensurate with their higher skill levels. The qualifications and rates could be higher than those for services furnished by less skilled individuals such as family members.

If you have additional questions, please contact Dianne Heffron, Director, Financial Management Group, who may be reached at (410) 786-3247.

Pharmacy Pricing Survey

CMS is pleased to announce that Myers and Stauffer, LC has been awarded a contract to conduct a Survey of Pharmacy Retail Prices. The survey, which was initially requested by States and which Secretary Sebelius committed to in her February 3, 2011 letter to Governors, is part of CMS' commitment to working with States to ensure that they have accurate information about drug costs in order to make prudent purchasing decisions.

The contractor will develop a monthly survey of retail community pharmacy prescription drug prices and generate of publicly available pricing files to help States. We anticipate that these files will afford State Medicaid agencies with a valid array of covered outpatient drug information, regarding retail prices for the ingredient costs of prescription drugs and consumer purchase prices for such drugs. We expect that State Medicaid agencies will be able to use this information to compare their own pricing methodologies and payments to those derived from this survey.

Additionally, on an annual basis, CMS will obtain from State Medicaid agencies information on their prescription drug payment and utilization rates and prepare a comparative report regarding the performance of the States' reimbursement prices and the national retail price data collected in the survey.

I hope that this information will be helpful to you.