Highmark's Weekly Capitol Hill Report

Issues for the week ending January 6, 2023

Federal Issues

Legislative

McCarthy Elected Speaker After Contentious Debate

Rep. Kevin McCarthy (R-CA) was elected Speaker of the House late Friday after a days-long holdout from a group of Republicans opposed to his election finally ended after McCarthy made several concessions in House rules.

Why it matters: The concessions may make it more difficult for McCarthy to govern the House given the slim GOP majority, enabling a small number of members to potentially derail the legislative process, especially on contentious issues such as the debt ceiling and government funding.

This week the House will pass its rules package and work on organizing committees. The Senate returns to Washington to begin its legislative session on January 23.

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Federal Issues

Regulatory

CMS Issues Guidance on Key Dates Related to the Medicaid Continuous Enrollment Condition Provisions

The Centers for Medicare & Medicaid Services (CMS) released three new resources on Medicaid redeterminations. The first is an informational bulletin for states on key dates related to the Medicaid continuous enrollment condition provisions included in the Consolidated Appropriations Act of 2023 (CAA). The CAA decouples the end of the COVID PHE and the continuous enrollment condition for receiving enhanced Medicaid FMAP. The key dates are as follows:

- **February 1, 2023**: States may initiate renewals (i.e., do a data match on eligibility, the first step of a renewal; letters to members could follow within days). States that choose to initiate renewals at this earliest allowable date will be required to submit a Renewal Redistribution Plan and Systems Readiness Artifacts to CMS on February 1. All other states are required to submit these reports to CMS by February 15.

- **March 31, 2023**: The continuous enrollment requirement ends.

- **April 1, 2023**: Medicaid eligibility terminations can be effective.

CMS notes that states that do not choose the earliest start date must *initiate* renewals by March 31, 2023 and *complete* renewals within 14 months, i.e., by May 31, 2024.

The associated FMAP increases under the CAA are phased down as follows:

- 6.2% until March 31, 2023,

- 5.0% from April 1 through June 30, 2023,

- 2.5% from July 1 through September 30, 2023, and

- 1.5% from October 1 through December 31, 2023.

For comparison's sake only, note that under the MOE rules established by the Families First Coronavirus Response Act, if the PHE had ended on April 11, 2023, states could have initiated renewals on March 1 and started terminating coverage on May 1. The impact of the CAA is to move renewals up by one month compared to the previously anticipated unwinding date.

CMS also updated a slide deck titled Strategic Approaches to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations. The updated deck provides new examples of ways health plans can engage with states and beneficiaries to support continuity of coverage during unwinding, including providing information about Qualified Health Plans (QHP) affiliated with the Medicaid managed care organization to an individual who will lose Medicaid coverage, or allowing an associated QHP to encourage the member to apply for Marketplace coverage. The guidance notes these activities may be subject to additional state and federal regulations and contractual agreements.

CMS also released a document that provides detailed description of the configuration/implementation plan, testing plan, and testing results that states will need to submit when continuous enrollment condition ends. The intent of the document is to help states understand systems readiness artifacts that are routinely submitted to CMS' State Systems team during IT project and certification reviews.

CMS indicated it will issue additional guidance soon, including about the reporting requirements for states during the unwinding period.

CMS Guidance on State Flexibility to Better Address Social Needs & Coverage and Payment of Interprofessional Consultation in Medicaid and CHIP

CMS issued new guidance outlining how state Medicaid programs can address health-related social needs (HRSNs) for Medicaid beneficiaries through the use of "in lieu of services and settings" (ILOS) authority in Medicaid managed care.

Background: This authority, originally authorized in the 2016 Medicaid managed care regulation, allows Medicaid managed care organizations (MCOs) to pay for nonmedical services instead of standard Medicaid benefits when itis medically appropriate and cost effective to do so.

Why this matters: The January 4 guidance clarifies how states and MCOs can use the authority to pay for services such as housing, nutrition and transportation that would reduce health costs by preventing adverse health events. It also establishes the requirements and guardrails states must meet in order to receive CMS approval for such programs. **CMS outlines six principles that CMS will consider when reviewing contracts:**

- ILOS must advance the objectives of the Medicaid program
- ILOS must be cost effective
- ILOS must be medically appropriate
- ILOS must be approved in a manner that preserves enrollment protections
- ILOS must be subject to appropriate monitoring and oversight
- ILOS must be subject to retrospective evaluation, when applicable

Moving forward, states just justify their use of ILOS in a manner consistent with this guidance. States using existing ILOS in managed care contracts will have until the contract period beginning on or after Jan. 1, 2024 to confirm with this guidance.

On Thursday, CMS also released guidance to states on policy for Medicaid and CHIP to allow one provider to discuss a Medicaid or CHIP beneficiary's case with a specialist and pay the specialist for their service directly. Both the treating and consulting practitioner must be enrolled in Medicaid or CHIP, and the discussion between the two providers may occur with or without the beneficiary present. CMS notes that some states may need to submit a state plan amendment to enact coverage for interprofessional

consultation, and all states will need to submit a state plan amendment to enact payment directly between providers as outlined in the guidance. Read More

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CMS Releases Guidance on Provider Good Faith Estimate (GFE) Requirements

CMS released additional frequently asked questions (FAQs) on implementation of Sec. 112 of the No Surprises Act related to provider-issued GFEs for uninsured and self-pay individuals. The guidance includes information for providers and facilities who offer sliding fee discounts or know in advance that they do not expect to bill an individual.

FDA Releases Guidance on Mifepristone Distribution in Pharmacies

The Food and Drug Administration (FDA) released guidance on the distribution of Mifepristone, the abortion pill, in retail pharmacies. The FDA stipulates that retail pharmacies can now offer Mifepristone to patients in states where abortion is legal under the supervision of a certified prescriber. Pharmacies can only offer the drug if they complete a Pharmacy Agreement Form and it is unclear how stringent this process will be. Pharmacies in states that currently have abortion bans will be unable to stock and dispense the drug. The guidance can be found here.

Industry Trends

Policy / Market Trends

Synergie Medication Collective to Drive Rx Affordability

BCBSA and BCBS companies are banding together to support the launch of the Synergie Medication Collective.

Why it matters: Synergie is focused on improving affordability and access to costly medical benefit drugs—ones that are injected or infused by a health care professional in a clinical setting—for nearly 100 million Americans.

- **These high-cost treatments include** multi-million-dollar gene therapies and infusible cancer drugs and represent a substantial portion of overall drug spend, with significant growth in future spend anticipated.

“We’re proud to help launch Synergie Medication Collective to tackle medication affordability and access,” said Kim Keck, BCBSA CEO. “We believe there is a better way to do business—and this first-of-its-kind approach will have a positive impact for millions of people across the United States.”

The big picture: BCBS companies’ support of Synergie is part of our larger shared goal to address high drug prices.

Other efforts to lower Rx costs include:

- BCBS companies’ support of CivicaScript and Civica’s insulin initiative

- BCBSA's partnership with the Aspen Institute to develop a white paper advocating for the modernization of current policies and payment models for advanced therapies

The bottom line: "The costs of medications continue to rise and are unsustainable, especially when it comes to medicines that treat rare and complex diseases," says Keck.

Go deeper: See Synergie's press release for the full list of BCBS companies investing in the collective.

CMS Releases Latest Medicaid and CHIP Enrollment Figures

The Centers for Medicare & Medicaid Services (CMS) released the latest enrollment figures for Medicaid and the Children's Health Insurance Program (CHIP). As of September 2022, over 83.9 million people were enrolled in Medicaid and over 7 million people were enrolled in CHIP. Since February 2020, enrollment in Medicaid and CHIP has increased by 28.6%. Read More

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SAMHSA Announces National Survey Results Detailing Stark Mental Illness and Substance Use Levels in 2021

On Wednesday, the U.S. Department of Health and Human Services' (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) released the results of its annual National Survey on Drug Use and Health (NSDUH), which shows how people living in America reported about their experience with mental health conditions, substance use, and pursuit of treatment in 2021. The research topics covered in the report are: Drug Use and Substance Use Disorder, Major Depressive Episodes (MDE) Among Adolescents, Mental Illness among Adults, Co-Occurring Substance Use Disorder with Any Mental Illness, Serious Thoughts of Suicide, Suicide Plans, and Suicide Attempts, and Recovery. The NSDUH measures:

- Use of illegal drugs, prescription drugs, alcohol, and tobacco,
- Substance use disorder and substance use treatment,
- Major depressive episodes, mental illness, and mental health care, and
- Perceived recovery from substance use and mental health issues.

HHS emphasizes methodological issues with the survey results that impair comparing the data to past years' surveys, due to the impact of COVID-19 pandemic which necessitated data collection changes. Still, the report reveals troubling trends. Nearly 1 in 4 adults 18 and older, and 1 in 3 among adults aged 18 to 25, had a mental illness in the past year. 46.3 million people aged 12 or older (or 16.5 percent of the population) met the applicable DSM-5 criteria for having a substance use disorder in the past year, including 29.5 million people who were classified as having an alcohol use disorder and 24 million people who were classified as having a drug use disorder.

Interested in reviewing a copy of a bill(s)? Access the following web sites:

Delaware State Legislation: **http://legis.delaware.gov/.**
New York Legislation: **https://nyassembly.gov/leg/**
Pennsylvania Legislation: **www.legis.state.pa.us.**
West Virginia Legislation: **http://www.legis.state.wv.us/**
For copies of congressional bills, access the Thomas website – **http://thomas.loc.gov/.**

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