Highmark's Weekly Capitol Hill Report

Issues for the week ending February 3, 2023

Federal Issues

Legislative

Senators Send Bipartisan Letter to CMS Supporting Medicare Advantage

A strong bipartisan group of more than 60 Senators – led by Sens. Catherine Cortez Masto (D-NV), Tim Scott (R-SC), Gary Peters (D-MI), and Shelley Moore Capito (R-WV) – sent a letter to Centers for Medicare & Medicaid Services (CMS) with a clear message: Protect and strengthen Medicare Advantage (MA) for the more than 30 million seniors and people with disabilities who depend on it for their health and financial well-being.

Why this matters: The letter was sent just ahead of the MA Advance Rate Notice for 2024, which proposes payment rates and policies that will affect the benefits and solutions available for the next benefit year. Significantly, the letter was signed by virtually every newly elected Senator.

The signatories reaffirmed their strong commitment to MA and the high-quality care it provides:

- "We ask that the Administration provide a stable rate and policy environment for Medicare Advantage that will strengthen and ensure the long-term sustainability of the program—

In this Issue:

protecting access to its important benefits on which our constituents have come to rely," they write.

They also note how MA is an affordable choice, with average MA premiums falling to a 16-year low of $18 per month for 2023. In addition, the letter highlights how MA enables plans to address health-related social needs like food insecurity or lack of transportation.

Upon release of the Senate letter, AHIP President and CEO Matt Eyles commented:

- "Today's letter is another example of the strong bipartisan support Medicare Advantage receives. Across the country—from Pennsylvania to California—millions of Americans depend on the affordable, high-quality care they receive through their MA plans. We'll continue to work with Congress to improve MA and help more Americans live their fullest, healthiest lives."

State Issues

West Virginia

Legislative

- **Senate Committee Advances Prior Authorization Legislation**

Federal Issues

Regulatory

Biden Administration to End COVID-19 National and Public Health Emergencies on May 11

The Biden Administration announced that it plans to end both the COVID-19 national emergency and COVID-19 public health emergency (PHE) on **May 11, 2023**. The national emergency is currently set to expire on March 1, 2023 and the PHE is currently set to expire on April 11, 2023. The Administration previously stated that it would give states and stakeholders 60 days' notice prior to termination of the PHE.

- **White House signals timeframe for COVID-19 product commercialization.** Dr. Ashish Jha, the White House's COVID-19 response coordinator, stated that commercialization for COVID-19 vaccines and treatments will occur sometime in the summer to early fall. This timeframe is later than some commercialization dates released by HHS in 2022, and we expect transition dates for commercialization to vary by product. *HHS is likely to resume stakeholder calls on this topic.*

Why this matters: This announcement will spark a wave of action by the Administration to address and clarify how to transition temporary policy changes that were put in place for the duration of the PHE.

CMS Releases 2024 Advance Medicare Advantage and Part D Rate Notice

On Feb. 1, CMS released the Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies. The Advance Notice must be released 60 days prior to the issuance of the final MA/Part D rates for the upcoming contract year in order to provide preliminary information related to the rates and notice of any methodological changes for the upcoming contract year. CMS also released the corresponding fact sheet and press release.

The final 2024 Rate Announcement is expected for publication no later than Monday, April 3, 2023.

Key highlights include:

- CMS projects that county benchmarks will increase by 2.09%, but they estimate the overall payment impact for plans on average will be -2.27% before accounting for potential changes in risk scores.
    - In the fact sheet, CMS suggests the expected change in revenue for 2024 is 1.03% if an expected MA risk score trend of 3.3% is included.
    - CMS does not provide information on how they determined the MA risk score trend.
    - Risk adjustment model revisions using restructured condition categories under ICD-10, updated underlying FFS data years, as well as revisions focused on conditions that are subject to more coding variation.
- A coding intensity adjustment at the statutory minimum, -5.90% (no change year-over-year).
- Star ratings updates to several measure specifications, of which CMS is soliciting feedback, particularly towards its "Universal Foundation" of quality measures, designed to align with other CMS programs.
- Implementation of Inflation Reduction Act policies, including elimination of cost-sharing for recommended, preventive vaccines and Part D prescription drugs in the catastrophic phase, expansion of eligibility for full cost-sharing and premium subsidies under the Low-Income Subsidy (LIS) program, and the growth cap in the Base Beneficiary Premium at 6%.

Comments are due to CMS by **March 3, 2023.**

AHIP President and CEO Matt Eyles issued a statement following the release of the CY2024 MA Rate Notice:

"We are concerned with the potential adverse impact of the rate notice on seniors and people with disabilities, especially when taken together with the final risk adjustment data validation (RADV) rule and other policy changes proposed for next year. We will carefully review and analyze the details of the proposed notice and provide comprehensive, constructive feedback to CMS during the comment period to reinforce that CMS should not finalize payment policies that increase costs and/or reduce benefits for MA enrollees, especially when health care cost and inflationary pressures remain high.

More than 30 million of America's seniors and people with disabilities choose MA because it delivers better services, better access to care, and better value. MA also covers more racially diverse populations than original Medicare. As demonstrated by a letter signed by over 60 Senators, MA enjoys strong bipartisan support and is a prime example of the government and free market working together successfully."

CMS Releases Long-Delayed Final Rule on the Risk Adjustment Data Validation (RADV) Program

The Centers for Medicare & Medicaid Services (CMS) issued a pre-publication version of a final rule regarding Risk Adjustment Data Validation (RADV) for Medicare Advantage (MA) plans. CMS also released a fact sheet on the rule.

Background: The RADV rule took five years to complete after its proposed version attracted vehement opposition from the health insurance industry in 2018.

Why this matters: CMS uses RADV to recover improper risk adjustment payments made to MA plans. Under the final rule, CMS will recover payments made to MA plans following made in diagnostic coding reaching back to 2018. CMS expects to recover $479 million from plan year 2018, and projects it will recoup $4.7 billion from 2023 to 2032. In addition to the clawbacks of money CMS determines shouldn't have been paid, the agency will stop applying a fee-for-service adjuster to its audit findings, which had been used to ensure payments under fee-for-service Medicare and Medicare Advantage were actuarially equivalent.

A preliminary summary of key provisions in the rule is provided below:

- **No Fee-for-Service adjuster:** CMS is finalizing its proposal to not apply a fee-for-service (FFS) adjuster to audit findings when calculating overpayment amounts. CMS provides several justifications, including the argument that its conclusion is supported by the reasoning in the D.C. Circuit's decision in UnitedHealthcare v. Becerra on the Part C Overpayment Rule.

- **Extrapolation starting 2018:** CMS will extrapolate findings from CMS RADV audits and RADV audits conducted by the Office of Inspector General (OIG) from sampled records, beginning with audits of payment year 2018. CMS states it will not extrapolate findings from payment years prior to 2018. CMS also indicates it may, in certain circumstances, decide not to extrapolate findings from an audit sample.

- **Treatment of prior years:** For payment years 2011-2017, CMS will move to collect non-extrapolated overpayments identified in CMS RADV audits and OIG audits for those years.

- **Risk-based audits:** CMS states that "Any sampling and extrapolation methodologies adopted by CMS for RADV audits will be focused on MAO contracts and enrollees' HCCs that, through statistical modeling and/or data analytics, are identified as being at highest risk for improper payments."

- **Repayments of amounts identified in prior audits:** CMS states that after the effective date of this final regulation (April 3, 2023), on a rolling basis (over a period of months, which will be communicated to MAOs by CMS), the agency will begin issuing the enrollee-level audit findings from the CMS RADV audits that have been completed, as well as recovering the enrollee-level improper payments identified in HHS-OIG audits.

- **Audit methods:** Rather than finalizing any particular sampling method such as contract-level sampling and extrapolation technique described in the 2012 methodology or a specific extrapolated audit methodology based on sub-cohorts of enrollees, CMS will "rely on any statistically valid method for sampling and extrapolation that it determines to be well-suited to a particular audit."

Insurers Respond:

- **AHIP President and CEO Matt Eyles issued a statement following the release of the final rule:** "Our view remains unchanged*:* This rule is unlawful and fatally flawed, and it should have been withdrawn instead of finalized. The rule will hurt seniors, reduce health equity, and discriminate against those who need care the most. Further, the rule would raise prices for seniors and taxpayers, reduce benefits for those who choose MA, and yield fewer plan options in the future."

- **BCBSA** believes these changes will raise costs, reduce choice and make it harder for seniors and those with disabilities to manage their health. BCBSA provided a statement , saying, "…While we all can agree that improvements can be made, the failure to adjust for the legitimate differences between Medicare Advantage and original Medicare will have a detrimental effect on the seniors and people with disabilities who rely on the Medicare Advantage program…"

CMS Releases Guidance on Medicaid Redeterminations & Exceptional Circumstances SEPs

CMS released the following guidance related to Medicaid Redeterminations when the Medicaid continuous enrollment condition ends and eligibility redeterminations begin.

Why this matters: In December 2022, Congress decoupled the continuous enrollment requirement from the COVID-19 public health emergency (PHE), allowing states to begin the redeterminations process as early as this month to verify all Medicaid enrollees who are still eligible for the program. Medicaid enrollment has grown to over 86 million Americans – and a recent analysis concluded that, as a result of redeterminations, **18 million people could lose access to Medicaid coverage**.

Marketplace Guidance on "Unwinding SEP"

CMS released guidance on a temporary Exceptional Circumstances Special Enrollment Period (SEP) for consumers losing Medicaid and CHIP coverage due to the unwinding of the continuous enrollment condition. The "Unwinding SEP" permits individuals who are redetermined from Medicaid, CHIP, or BHP coverage and eligible to enroll in Federally-facilitated Marketplace coverage. Specifically, this SEP will be available to consumers who:

- Are eligible for Marketplace coverage;

- Submit an application between March 31, 2023 and July 31, 2024 and answer "Yes" to the application question asking if their Medicaid or CHIP coverage ended recently or will end soon; and,

- Attest to a last date of Medicaid or CHIP coverage between March 31, 2023 and July 31, 2024.

Per regulation, consumers losing minimum essential coverage (MEC) may report that loss of coverage up to 60 days before their last day of Medicaid or CHIP coverage and submit an application for Marketplace

coverage prior to losing MEC. Consumers then have 60 days from the date on which they submit a HealthCare.gov application to make a plan selection. Marketplace coverage will start the first day of the month following plan selection under this Unwinding SEP, unless a consumer is eligible for multiple SEPs and qualifies for an earlier coverage effective date.

Medicaid Guidance

With respect to the Medicaid program, CMS released a State Health Official Letter on Medicaid continuous enrollment condition changes. In the latest guidance, CMS again encourages states to distribute renewals in a reasonable manner and recommends states initiate no more than 1/9 of their total caseload in a given month.

- **Conditions for enhanced FMAP**: The temporary 6.2 percentage point FMAP ends on March 31, 2023, but enhanced FMAP continues through 2023, gradually phasing down until December 31, 2023.The new guidance details the conditions states must follow for continuing to receive the enhanced FMAP.

- **Medicaid eligibility redetermination requirements**: The guidance provides reminders of the federal renewal requirements that states must adhere to and provides details of the requirements to attempt to ensure the state is using up-to-date contact information and to contact beneficiaries using more than one modality prior to terminating coverage on the basis of returned mail.

- **Reporting**: States must submit to CMS certain monthly data about activities related to eligibility determinations and redeterminations conducted during the period beginning April 1, 2023, and ending June 30, 2024.

- **Enforcement**: The guidance indicates CMS has been granted additional enforcement mechanisms, including a reduction to the state's standard FMAP for any fiscal quarter between July 1, 2023, and June 30, 2024, when the state does not satisfy the reporting requirements.

- **Other COVID-19 Flexibilities**: Includes additional implications noted for other PHE-related flexibilities that could be implicated by the CAA, including the optional COVID-19 group and waivers already approved under section 1902(e)(14)(A).

Trades Submit Comments on Essential Health Benefits, 2024 Notice of Benefit and Payment Parameters & Confidentiality of SUD Patient Records

Essential Health Benefits

- On January 25, AHIP submitted comments in response to CMS' Request for Information on the Essential Health Benefits (EHB) under the Affordable Care Act (ACA). CMS requested comment on a variety of topics related to the coverage of benefits in health plans subject to the EHB requirements of the ACA, including EHB benefit descriptions, the scope of benefits covered in typical employer plans, coverage of prescription drugs, and substitution of EHB..

Why this matters: AHIP's comments highlighted the preference to maintain the current EHB structure, which effectively balances state flexibility while ensuring there is a consistent federal standard of guaranteed benefits for health insurance coverage.

Notice of Benefit and Payment Parameters for 2024

AHIP & BCBSA submitted comments in response to the Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters for 2024 ("Payment Notice"), which was published in the Federal Register on December 21, 2022. BCBSA's comments focused on the proposed limit on the number of standardized plan options, network adequacy rules, risk adjustment recalibration, appointment wait time standards, reenrollment hierarchy, and special enrollment periods.

AHIP's comment letter focuses on recommendations that promote affordability, competition, and consumer choice while minimizing disruption for Americans. **Specifically, AHIP's comments address:**

- **Non-Standardized Plan Option Limits:** AHIP strongly recommended HHS not limit non-standardized plan options, and instead adopt the alternative proposal to implement a meaningful difference standard to make it simpler and easier for consumers to compare coverage.

- **Network Adequacy**: The letter outlines several potential improvements to the network adequacy review process for plan years 2024 and beyond and requests additional time for implementation of appointment wait time standards.

- **Standardized Plans**: Urges HHS continue deferring to issuers to establish prescription drug tiers for standardized plans that effectively balance cost, access, and quality for enrollees.

- **Consumer Choice**: AHIP emphasizes the importance of active consumer choice in several places, and recommends HHS improve consumer decision support tools and education to empower consumers throughout the plan selection process.

Confidentiality of SUD Patient Records

AHIP sent a letter to the U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) in response to proposed regulations addressing substance use disorder (SUD) treatment records and information protected by federal confidentiality regulations.

Why this matters: The proposed changes would generally align the regulations for SUD treatment records (commonly referred to as the "Part 2" rules) with the privacy rules under the Health Insurance Portability and Accountability Act (HIPAA). In the letter, **AHIP expresses support for the alignment of Part 2 with HIPAA** "to offer providers a more complete picture of an individual's past, present, and future health care experience to improve patient safety, care coordination, and patient engagement and to eliminate unnecessary administrative complexities."

Click here to read the full letter and detailed information.

Biden Administration Releases Proposed Rule on Contraception Coverage

On January 30, the Departments of Health and Human Services (HHS), Labor (DOL), and Treasury released a proposed rule regarding contraception coverage, part of the preventive services requirement

under Section 2713 of the Public Health Service Act, added by the Affordable Care Act (ACA). Comments on the proposed rule are 60 days from the date of publication. A press release and fact sheet are also available.

Why this matters: The proposed rules seeks to ensure broader access to contraceptive services by creating an independent pathway for individuals enrolled in plans arranged or offered by objecting entities to make their own choice to access contraceptive services directly through a willing contraceptive provider without any cost. This would allow women and covered dependents to navigate their own care and still obtain birth control at no cost in the event their plan or insurer has a religious exemption and, if eligible, has not elected the optional accommodation.

The proposed rule:

- **Retains existing religious exemption**: The proposed rule leaves the existing exemption for entities and individuals with religious objections in place. It also preserves the optional accommodation for contraception.

- **Rescinds moral exemption**: The proposed rule rescinds the existing exemption for entities and individuals with sincerely held non-religious moral objections.

- **Establishes new pathway for individual contraceptive arrangements**: The proposed rule establishes a new pathway called an individual contraceptive arrangement, for individuals enrolled in plans or coverage that is sponsored, arranged, or provided by objecting entities that are not eligible or have not opted to use the existing optional contraception accommodation. Under this pathway, individuals may obtain contraceptive services at no cost directly from a willing provider or facility.

- **Preserves current coverage standards**: The proposed rule does not propose changes to current contraceptive coverage standards as outlined in existing HHS guidance.

Departments Release Updated Tools for Determining Federal Independent Dispute Resolution Applicability

On Jan. 13, the Departments of Health and Human Services, Labor, and Treasury (Departments) released two revised charts to assist in use of the Federal Independent Dispute Resolution (IDR) process.

- The revised **Chart for Determining the Applicability for the Federal Independent Dispute Resolution (IDR) Process** clarifies by state whether the Federal IDR process or a specified state law (SSL) or All-Payer Model Agreement (APMA) applies for determining the out-of-network rate. If the state in which the qualified IDR items or services are furnished is in the “Bifurcated Process” column, the Departments recommend parties review the SSL or APMA and, if necessary, consult with the proper state authorities on whether the state or the Federal IDR process applies to the particular payment dispute at issue.

- In some ‘bifurcated states’, some items or services provided by out-of-network providers, facilities or providers of air ambulance services may be subject to the Federal IDR process, while other items and services are subject to an SSL or APMA. The revised **Chart Regarding Applicability of the Federal Independent Dispute Resolution (IDR) Process in Bifurcated States** is a tool to assist

certified IDR entities in determining whether a given payment dispute is subject to the Federal IDR process in bifurcated states.

MACPAC Votes to Recommend Congress Let States Restrict Drug Coverage

The Medicaid and CHIP Payment and Access Commission (MACPAC) voted to recommend Congress grant states the ability to impose Medicaid coverage limitations on certain drugs.

Background: Under the terms of the Medicaid Drug Rebate Program, unlike Medicare, state Medicaid programs are currently required to cover nearly all FDA-approved drugs and have limited flexibility to put coverage limitations on drugs, regardless of their cost or how much real-world evidence exists on the drug's effectiveness.

The commission voted 15-1 to advance two recommendations to Congress: one to amend the Social Security Act to allow states to exclude or otherwise restrict coverage for outpatient drugs based on the terms Medicare includes in Coverage with Evidence Development (CED) decisions; and a second to require Medicaid managed care contracts include those coverage restrictions.

State Issues

West Virginia

Legislative

Senate Committee Advances Prior Authorization Legislation

On Thursday, February 2, the Senate Health Committee advanced Senate Bill 267 (Takubo, R-Kanawha). Senate Bill 267 proposes significant changes to prior authorization request timelines, appeal timelines and gold carding standards. Senate Bill 267 now awaits consideration from the Senate Finance Committee due to costs outlined for OIC, BMS and PEIA.

Major provisions of the revised Senate Bill 267 are as follows:

- **No change in the "episode of care" definition found in current Code**. The original proposed bill language included a revised definition of "episode of care," that sought to enable more types of treatment to be undertaken on the basis of one initial health plan decision—followed by multiple other courses of treatment as determined by a provider.

- Continuance of incentive for providers to submit prior authorization requests electronically—if they are not, then none of the PA processes outlined in the bill can be utilized.

- Health plans are only required to communicate with providers electronically regarding PA requests—no communication directly with patients is required as in the original bill.

- The timeline for answering PA requests changes from the current 7 business days to 5 business days for regular requests and from 3 business days to 2 business days for emergent requests.

- Removes the limitations in the original bill that only peer providers licensed in-state can answer PA requests and address appeals.

- PA appeals must be answered within 10 business days.

- The so-called “Gold Card” program for easing prior authorization requirements will be modified to apply to specific providers—regardless of the treatment being sought—rather than in connection with specific treatment modalities. To be eligible for this status, a provider must have had their PA requests approved at a 90% level over a 6-month period.

- PEIA comes under the Office of the Insurance Commissioner with regard to PA enforcement and supervision.

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/.**