Highmark's Weekly Capitol Hill Report

Issues for the week ending February 24, 2023

Federal Issues

Regulatory

AHIP Details How Risk Model Changes Result in Major Cuts to Medicare Advantage

AHIP developed a new resource detailing how the proposed risk adjustment model changes in the Centers for Medicare & Medicaid Services' (CMS) 2024 Advance Notice would lead to major cuts for MA.

Why this matters: As a part of the Advance Notice, the Biden Administration is proposing a new risk adjustment model for 2024 with major revisions to the **data years used to calibrate the model**, moving from ICD-9 to ICD-10 **diagnoses codes**, and **changes to diagnoses and condition categories included in the model**. While AHIP has supported the use of more recent data years and the move to ICD-10 diagnosis codes in the risk model, AHIP has also urged CMS to be transparent and provide stakeholders enough time to provide meaningful feedback on the changes.

The new resource explains in detail the complex changes to the MA risk model CMS is proposing and its extremely short time frame. Click here to read more in AHIP's new resource on how CMS' proposed risk model changes would result in major cuts to MA.

In this Issue:

- **Survey Shows Seniors Overwhelmingly Want the Government to Protect Medicare Advantage Funding**

Departments Issue FAQs on Gag Clause Provision

The Department of Labor's Employee Benefits Security Administration, along with the Departments of HHS and the Treasury (Departments), issued FAQs part 57, which provides guidance related to the gag clause prohibition and attestation requirement under the Consolidated Appropriations Act of 2021 (sec. 201).

Why this matters: This provision prohibits health plans from entering into contracts with providers and other entities that would prohibit sharing with members provider-specific cost or quality of care information. The gag clause prohibition requirement applies to group health plans and health insurance issuers offering group health insurance coverage and health insurance issuers offering individual health insurance coverage (see Q8 for application to specific LOB and exclusions). The FAQs address attestations for self-funded group health plans (see Q9, Q10 for details), who may designate a TPA or other service providers to attest on their behalf, but the legal requirement to provide a timely attestation remains with the group health plan.

As described in the FAQs, the Departments have released a web system and new gag clause landing webpage with instructions for making an attestation, as well as a user manual and template. The first attestation is due by December 31, 2023, covering the period beginning December 27, 2020, or the effective date of the applicable group health plan or health insurance coverage (if later), through the date of attestation. Subsequent attestations are due by December 31 of each year.

CMS Requests Comments on QRS and QHP Enrollee Survey

CMS requests comment on proposed changes to the QRS and QHP Enrollee Survey included in the Draft 2023 Call Letter for the Quality Rating System and the Qualified Health Plan Enrollee Experience Survey. The Draft Call Letter for the Quality Rating System (QRS) and the Qualified Health Plan (QHP) Enrollee Experience Survey communicates proposed changes to the QRS and QHP Enrollee Survey and request comments on these proposed refinements.

CMS is requesting feedback on topics such as CMS' newly developed Adult and Pediatric "Universal Foundation" measure sets, refinements to the QRS measure set, advancing health equity, Electronic Clinical Data System reporting, and QHP Enrollee Survey updates. The survey can be found here.

State Issues

New York

Legislative

Joint Health Budget Hearing This Week

There is a joint hearing on the Governor's health budget provisions hosted by the Assembly Ways & Means and Senate Finance committees on Tuesday, February 28. The NY Health Plan Association will testify in opposition to the "pay and pursue" proposal, Medicaid pharmacy carve-out, and establishment of a health insurer guaranty fund provisions, among other proposals.

State Issues

West Virginia

Legislative

Senate Committee Advances Prior Authorization Legislation

On Wednesday, February 22, the Senate Finance 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 full Senate.

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.

Senate Advances Insulin Cap Legislation

On Thursday, February 23, the Senate advanced Senate Bill 577 (Maroney, R-Marshall) to the House Health and Human Resources Committee. Senate Bill 577 proposes $35 copay cap on insulin per 30-day supply and further seeks to impose a $100 copay cap on diabetic devices per 30-day supply.

Senate Committee Modifies Legislation to Expand Number of Medicaid MCOs

Background: The original version of this legislation (SB 476) instructed DHHR to select up to four MCOs (there are currently three with Medicaid contracts) in its upcoming competitive bidding cycle.

Why this matters: On Thursday afternoon, the Senate Health Committee dramatically modified the bill to eliminate the requirement that the MCO selection process follow competitive bidding rules through the Department of Administration—leaving the scope and details of the MCO selection process completely in the hands of DHHR with no direction in the law other than each prospective MCO could submit an "application" for entry into the Medicaid market based on as of yet unknown factors of quality performance metrics and network adequacy.

Next Steps: It is not yet known what the disposition of the House of Delegates may be on this issue.

Industry Trends

Policy / Market Trends

CMS Hosts Sixth Continuous Enrollment Unwinding Webinar

CMS hosted the sixth webinar in its series "Medicaid and Children's Health Insurance Program (CHIP) Continuous Enrollment Unwinding: What to Know and How to Prepare."

Why this matters: In the webinar, CMS shared its approach to consumer communications leading up to and during the unwinding of the Medicaid continuous enrollment requirement. CMS will conduct a two-phased outreach campaign to help ensure individuals retain healthcare coverage. During the first phase, CMS will promote general awareness of Medicaid redeterminations and encourage enrollees to update their contact information. During the second phase, CMS will focus on enrolling individuals who have lost Medicaid coverage in Marketplace coverage. Materials from the webinar will be available on the CMS Stakeholder Calls page in the coming days.

CMS Releases Updated COVID-19 Medicaid and CHIP Service Utilization Data

The Centers for Medicare & Medicaid Services (CMS) released an updated data snapshot providing information on COVID-19 service utilization.

Why this matters: The snapshot includes data on testing, treatment, and acute care use, service use among beneficiaries 18 years of age and younger, services delivered via telehealth, services for mental health and substance use disorders, and reproductive health services for female beneficiaries. Read More

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Survey Shows Seniors Overwhelmingly Want the Government to Protect Medicare Advantage Funding

The Coalition for Medicare Choices (CMC) released the results of a new survey that shows American seniors want the government to fully fund the Medicare Advantage (MA) program. The survey, conducted by Seven Letter Insight on behalf of CMC, shows near-unanimous satisfaction with MA and that funding it is extremely important for senior voters. Further, 85% of voters in key 2024 Senate battleground states believe that President Biden would be breaking his promise to protect Medicare if cuts are made to Medicare Advantage.

The survey found:

- **Senior voters with MA are nearly unanimously satisfied** with their current plan's affordability (93%), convenience (96%), value (95%), and the choices that their plans provide them (95%).

- **Funding MA is an extremely important issue for senior voters.** Voters with Medicare Advantage believe that the government (95%) and President Biden (83%) should fully fund Medicare Advantage to cover increasing health care costs.

- **A strong, bipartisan majority believe that the Biden Administration's proposed cuts to MA are simply unacceptable.** Fully 83% of senior voters (including 88% of Republicans, 83% of Independents, and 77% of Democrats) say the cuts are unacceptable.

- **The consequences of cutting funding to MA are dire.** Many senior voters (72%) believe that cuts would impact their ability to afford health care; 70% of senior voters with Medicare Advantage believe increased premiums would negatively impact their ability to afford other necessities.

- **Cutting MA could be politically disastrous.** 85% of voters, (including 95% of Republicans, 84% of Independents, 72% of Democrats, and 87% of senior voters in key battleground states) believe that President Biden would be breaking his promise to protect Medicare if cuts are made to MA.

Click here to read the survey results. CMC will continue to strongly advocate against the proposed cuts in the 2024 Advance Rate Notice for MA and show policymakers the impact the cuts would have on the 30 million seniors and people with disabilities.

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/.**