# Highmark's Weekly Capitol Hill Report

**Issues for the week ending April 7, 2023**

## Federal Issues

Legislative

### Senators Introduce Bill on Medicare Advantage Coding

On Mar. 27, Senators Bill Cassidy, M.D. (R-LA) and Jeff Merkley (D-OR) introduced the No Unreasonable Payments, Coding, or Diagnoses for the Elderly (No UPCODE) Act, designed to revise the way that Medicare Advantage (MA) plans assess patients' health risks and reduce overpayments for care.

**Why this matters**: The Senators tout that the bill will save taxpayers billions by eliminating incentives to overcharge Medicare for care. Introduction of the legislation comes after much scrutiny of the coding practices of MA plans in recent years.

Specifically, the legislation would:

- require the HHS Secretary to use two years of diagnostic data, rather than one
- exclude diagnoses collected from chart reviews and health risk assessments in risk adjustment
- require the Secretary to evaluate and publicly report the coding patterns of plans, providing adjustments to fully account for differences

## In this Issue:

While short-term action is not expected on this legislation, interest in the subject of plans coding practices is likely to continue on Capitol Hill.

## Federal Issues

Regulatory

### CMS Makes Significant Changes to MA and Part D Marketing, Utilization Management, Quality, and VBID Model

On Wednesday, CMS released the first of what may be a two-rule series finalizing proposals to the Medicare Advantage (MA) and Part D programs. CMS stated it will address other proposals, whose applicability would begin no earlier than January 1, 2025, in future rulemaking.

- In December, CMS proposed to place restrictions on marketing of MA and Part D benefits, building on an effort that began in last year when CMS defined what a “third party marketing organization” (TPMO) is and how plan sponsors are expected to oversee their activities, no matter how far downline these entities are. All told, CMS finalized 21 provisions designed to ensure beneficiaries are not subject to unsolicited or unwanted contact and are aware of the effect of their enrollment decisions and the potential limited plan choices presented to them by agents and brokers.
- CMS also overhauled the Star Ratings program (providing quality bonus payments to higher-starred plans) by downgrading the quadruple-rated enrollee experience and access measures in favor of a methodology that aligns more with other CMS quality rating systems and emphasizes plans’ ability to improve care for enrollees with certain social risk factors via a Health Equity Index reward starting in 2027.
- CMS also addressed prior authorization practices, reinforcing that plans must apply Traditional Medicare’s medical necessity criteria, publish and follow internal guidelines based on widely used clinical guidelines or literature where Traditional Medicare criteria do not apply, and finalized various provisions to ensure greater transparency and continuity of care for services subject to utilization management practices.

Alongside the final rule, CMS announced changes to the Center for Medicare and Medicaid Innovation’s only Medicare Advantage and Part D-focused demonstration model, called the Value-Based Insurance Design (VBID) model, for the years 2025-2030. Today, the only mandatory VBID feature is wellness and health care planning. In 2025, VBID plans must offer supplemental benefits to address health-related social needs in at least two of three health-related social needs areas: food, transportation and housing insecurity and/or living environment. Further, demonstration plans can target interventions like enhanced non-medical

transportation benefits using the Area Deprivation Index (ADI) to target certain geographic "deserts" rather than only targeting these benefits to enrollees based on their chronic condition, eligibility for the low-income subsidy, or disability status.

- Link to CMS Fact Sheet and Final Rule

- Link to VBID Extension Fact Sheet

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## Biden Administration Releases 2023 Medicare Trustees Report

On March 31, the Department of the Treasury released the annual Social Security and Medicare Trustees Reports. The Trustees Report is an annual report that details information on the past and estimated future financial operations of the Hospital Insurance and Supplementary Medical Insurance Trust Funds.

**Why this matters:** The Board of Trustees project that for 2023, **the Hospital Insurance (HI) Trust Fund will be able to pay 100% of total scheduled benefits until 2031, 3 years later than reported last year**. At that point, that fund's reserves will become depleted and continuing program income will be sufficient to pay 89% of total scheduled benefits.

Read the full Medicare Trustees Report and corresponding fact sheet for more information.

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## CMS Updates List of Part B Drugs Subject to the Inflation Rebate Program

On March 30, CMS updated a press release announcing the Part B drugs, whose price increases exceeded the CPI-U with respect to the reference quarter, that will be subject to the Medicare Prescription Drug Inflation Rebate Program under the Inflation Reduction Act, including the requirement for potentially adjusting beneficiary coinsurance for the quarter running from April 1 through June 30.

The impacted prescription drug list, which is available in the quarterly Average Sales Price (ASP), reflects a list of 20 Part B drugs. CMS had previously released a list of 27 drugs subject to the program.

**Why this matters:** Notably, CMS states that it expects that some Medicare beneficiaries, depending on factors such as their individual coverage, could save between $1 and $372 per average dose of their prescriptions starting April 1. Additional information is available through an updated press release and the Part B Drug ASP website.

- The development highlights the speed at which CMS must implement the Inflation Reduction Act's complex inflationary rebate provisions. CMS is expected to refine its backend processes as it gains experience with these calculations each quarter and will not invoice manufacturers for the rebate owed until 2025.

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## Medicaid Continuous Coverage Requirement Ends

The Medicaid continuous enrollment requirement was enacted by the Families First Coronavirus Response Act (FFCRA) and in effect since March 2020. On April 1, five states (Arizona, Arkansas, Idaho, New Hampshire and South Dakota) planned to begin terminating coverage for some of the tens of millions of

people who have remained covered by Medicaid during the pandemic. Fourteen more states will start terminating enrollees in May, followed by 20 in June and 10 in July. Oregon will be the last to start, in October.

**Why this matters:** CMS estimates more than 15 million of the 92 million people enrolled in Medicaid will lose coverage throughout the process. Of the former, 7 million are expected to be eligible for the program but still lose their coverage because of what's known as "administrative churn," or bureaucratic hurdles that lead to lost coverage because of missed notices, incorrect paperwork or other reasons. Another 8.6 million are projected to be ineligible and may need help connecting with employer-sponsored coverage or a plan on their state's health insurance exchange.

**The HHS Office for Civil Rights (OCR) reminded states of their obligations** under federal civil rights laws as the continuous Medicaid coverage requirement unwinds and states resume Medicaid redeterminations.

The letter underscores states' independent obligations under federal civil rights laws to ensure eligible individuals and families continue to have access to Medicaid and CHIP coverage, and highlights the need to prioritize language access and effective communication to prevent individuals with disabilities, people with limited English proficiency and people of color from becoming disenrolled as a result of inaccessible communications.

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## End of COVID-Era Flexibilities in Medicaid Home & Community-based Services

A new resource provides staff of Medicaid agencies, aging and disability agencies, and Medicaid HCBS plans with information to prepare for the end of federal flexibilities adopted during the COVID 19 public health emergency (PHE) to support people enrolled in Medicaid home and community-based services (HCBS) programs.

Released jointly by the **National Association of Medicaid Directors (NAMD), ADvancing States,** and the **National Association of State Directors of Developmental Disabilities and Services (NASDDS),** the resource reviews the various flexibilities adopted by many state HCBS programs and the Medicaid disaster relief authorities enabling those flexibilities. Some flexibilities will end concurrent with the end of the COVID PHE planned for May 11, 2023, while others will sunset on dates specified in state or federal regulations.

Although not directly related to the resumption of Medicaid eligibility renewals, planning for the end of these flexibilities in HCBS will be another significant task that HCBS programs will need to focus on to ensure smooth transitions for people receiving HCBS.

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## TEFCA Recognized Coordinating Entity Releases Draft Standard Operating Procedures for Payments

The Trusted Exchange Framework and Common Agreement (TEFCA) outlines a common set of principles, terms, and conditions to support the nationwide exchange of electronic health information (EHI). Stakeholders will be able to use the requirements of TEFCA to send and receive EHI.

**Why this matters:** The Sequoia Project, Recognized Coordinating Entity (RCE) for TEFCA, released two draft Standard Operating Procedures (SOP) for stakeholder feedback. These SOPs outline the requirements for the following information exchanges under TEFCA:

- Draft Payment: Risk Adjustment Exchange Purpose Implementation SOP
- Draft Health Care Operations: Limited Exchange Purpose Implementation SOP

The two draft SOPs define the Exchange Purposes of Risk Adjustment and HCO Limited and identify specific requirements that Qualified Health Information Networks (QHIN), participants, and subparticipants must follow when exchanging information for these purposes. It also specifies the conditions under which the Exchange Purposes require a response.

The draft SOPs states only Health Plans and Health Care Providers may request TEFCA Information for the purpose of Risk Adjustment and HCO Limited. The SOPs also specify what information must be provided to support the request and the information that must be included in the response.

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## CMS to End COVID-19 Temporary Enforcement Discretion Policy on May 11

CMS released an HPMS memo titled COVID-19 Related Exercise of Enforcement Discretion Ending May 11, 2023, clarifying the temporary enforcement discretion policy extended through Jan. 14, 2022, guidance ("COVID-19 Permissive Actions Extended in Contract Year 2022), will end when the Public Health Emergency (PHE) and national emergency expire on May 11.

**Why this matters:** After May 11, Medicare Advantage Organizations (MAOs), Part D sponsors, and Medicare-Medicaid Plans will no longer be able to offer mid-year benefit enhancements. MAOs will not be able to provide any expanded or additional benefits that are not included in the Calendar Year 2023 benefit package.

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## HHS Releases National Cancer Plan

The Department of Health and Human Services (HHS) released the National Cancer Plan, developed by the National Institutes of Health's (NIH) National Cancer Institute (NCI). The plan provides a framework for stakeholders across the federal government and all of society to collaborate in ending cancer, as part of the President and First Lady's Cancer Moonshot vision. The plan includes an overview of 8 goals and accompanying strategies that outline what must be accomplished to prevent more cancers, reduce deaths from the disease, and improve the lives of everyone after a diagnosis with cancer. No additional funding was announced in conjunction with the Plan's release.

The National Cancer Plan's goals are:

1. Prevent Cancer
2. Detect Cancers Early
3. Develop Effective Treatments
4. Eliminate Inequities

5. Deliver Optimal Care
6. Engage Every Person
7. Maximize Data Utility
8. Optimize the Workforce

The agency intends for this plan to be a living document that will evolve over time as research continues, advances are made, and lessons are learned across the cancer care community. Read more about the National Cancer Plan here.

**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/.**