Highmark's Weekly Capitol Hill Report

Issues for the week ending April 28, 2023

Federal Issues

Legislative

House Passes Debt Limit Increase

The U.S. House on Wednesday passed Speaker McCarthy's (R-CA) proposal to raise the borrowing limit and implement spending cuts.

Why this matters: Passage of the bill puts pressure on President Biden and Majority Leader Chuck Schumer (D-NY) to come to the table with Republicans to negotiate a final deal. They have both said they want a "clean" debt ceiling increase with no conditions attached.

The Details: The House-passed legislation includes work requirements for Medicaid recipients aged 19–55, with several exceptions -- pregnant individuals, parents or caretakers of a dependent child or incapacitated person, individuals determined by a doctor to be unfit for work, or individuals participating in an education program, substance use disorder program, or alcohol treatment program. Applicable beneficiaries would need to work or participate in community service or another qualifying activity for at least 80 hours a month.

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House Panel Examines Health Care Costs

On Wednesday, the House Energy and Commerce Committee Subcommittee on Health held a hearing entitled "Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care."

Why this matters: While Democrats had some complaints about process issues, the hearing was largely bipartisan and examined 17 bills aimed at controlling costs. Prominent in the discussion were the topics of pharmacy benefit manager (PBM) reform and site-neutral payments for hospitals under Medicare.

CMS Administrator Chiquita Brooks-LaSure -- making her first appearance before Congress -- served as the witness on the first panel and discussed ways to improve price transparency in health care as well as improve competition to drive lower costs. Of particular interest to several members was the agency's controversial 2022 decision regarding coverage of new therapies for Alzheimer's disease.

The second part of the hearing focused on increasing transparency within the healthcare landscape and lowering prices. PBMs were criticized on a bipartisan basis for their roles in raising the costs of prescription drugs, suggesting that additional reforms on prescription drugs might still be possible even with divided government. Specific legislation examined at the hearing included, among others, bills addressing PBM disclosures, a ban on spread pricing, additional transparency regarding consolidation and vertical integration for entities that contract with Medicare, and site neutral payments for hospital outpatient facilities.

Insurer perspective: AHIP submitted comments for the hearing supporting legislative solutions that permit comparable payment for comparable services, regardless of setting, and encourage an efficient and competitive market that works for everyone and protect patients from unfair practices.

- In addition, AHIP expressed concern about proposals that do not advance pro-competition efforts and create unnecessary reporting requirements for Medicare Advantage, Part D plans, and certain providers, pharmacies and pharmacy benefit managers.

- BCBSA's **letter** also highlighted their site-neutral payment policy recommendations, which would create uniform payments for the same services across different care settings.

Federal Issues

Regulatory

CMS Proposes to Extend Eligibility for Marketplaces and Medicaid/CHIP to DACA Recipients

The Centers for Medicare and Medicaid Services (CMS) issued a proposed rule that would extend eligibility for Deferred Action for Childhood Arrivals (DACA) recipients to enroll in coverage through the health insurance Marketplaces, Basic Health Plan, and some Medicaid/CHIP programs.

Why this matters: If finalized, the rule would amend the current regulatory exclusion to the definition of deferred action that treats DACA recipients differently from other individuals with deferred action. It would amend the definition of "lawfully present" to include DACA recipients for purposes of Medicaid and CHIP, extending eligibility to children and pregnant women in certain states, health insurance Marketplaces, and the Basic Health Program.

According to the CMS press release, the rule could lead to 129,000 previously uninsured DACA recipients gaining health care coverage. If finalized, the rule would have an effective date of November 1, 2023, which coincides with the beginning of the Marketplace annual open enrollment period. CMS is soliciting comments by June 23.

CMS Releases Proposed Rules on Medicaid Managed Care and Medicaid Access

The Centers for Medicare & Medicaid Services (CMS) released two Notices of Proposed Rule Making (NPRM) that would, among other things, set national standards for appointment wait times and require disclosure of provider payment rates. The two rules are "Medicaid Managed Care" and "Assuring Access to Medicaid Services."

Why this matters: The rules include changes to current requirements and newly proposed requirements CMS says are designed to improve access to care, quality, and health outcomes, and promote health equity for Medicaid enrollees across fee-for-service (FFS) and managed care delivery systems, including for home and community-based services (HCBS) provided through those delivery systems, and for CHIP enrollees. CMS also set out separate compliance dates for each proposal.

The changes in the NPRMs include the following:

- **Establishing national maximum wait time standards for certain kinds of appointments for Medicaid or CHIP managed care enrollees,** and stronger state monitoring and reporting requirements related to access and network adequacy for Medicaid or CHIP managed care plans.
- **Requiring states to conduct independent secret shopper surveys** of Medicaid or CHIP managed care plans to verify compliance with appointment wait time standards and to identify inaccuracies in provider directories.
- **Requiring states to conduct annual enrollee experience surveys in Medicaid managed care for each managed care plan** to gather input directly from enrollees.
- **Establishing a framework for states to implement Medicaid and CHIP quality rating systems, a "one-stop-shop" for enrollees to compare Medicaid or CHIP managed care plans** based on quality of care, access to providers, covered benefits and drugs, cost, and other plan performance indicators.
- Modifying **rules** on a range of other issues, including **Medicaid state-directed payments (SDPs); in lieu of services; and medical loss ratio (MLR) requirements.**
- **Creating new payment reporting requirements for states** by requiring disclosure of provider payment rates in fee-for-service and requiring managed care plans to submit payment analyses of certain health services as a percentage of Medicare rates.
- **Establishing additional transparency and interested party engagement requirements for setting Medicaid payment rates for home and community-based services** (HCBS), as well as a requirement that at least 80% of Medicaid payments for personal care, homemaker, and home health aide services be spent on compensation for direct care workers (as opposed to administrative overhead or profit).
- **Creating timeliness-of-access measures for HCBS** and strengthening safeguards to ensure enrollee health and welfare and health equity.
- **Strengthening how state Medicaid agencies use Medical Care Advisory Committees to receive** guidance and advice on health and medical care services, to ensure states use these committees optimally to ensure that Medicaid is informed by the experiences of Medicaid enrollees, caretakers, and other interested parties.

CMS also released a series of fact sheets that provide additional details on key aspects of the regulatory proposals:

- The Medicaid Managed Care NPRM Fact Sheet.
- The Payment-Related Provisions Fact Sheet.
- A Fact Sheet on Medicare Care and Beneficiary Advisory Committees.
- An HCBS Provisions Fact Sheet.
- The Access-Related Notices Fact Sheet.

There is an expected **comment deadline of July 3**.

Departments Release Quarterly Report and Status Update on Surprise Billing Independent Dispute Resolution Process

The Departments of Health and Human Services, Labor and the Treasury (Departments) released an initial report on the federal Independent Dispute Resolution (IDR) process for the fourth quarter of 2022 covering data from October 1 – December 31, 2022. The Departments also released a status update on the Federal IDR process for the period from April 15, 2022 through March 31, 2023.

The Departments must publish quarterly information about the federal IDR process. This report partially fulfills that requirement for the fourth quarter of 2022 for the Federal IDR portal. The Departments previously published two status updates on the Federal IDR process: one on August 19, 2022; and one on December 23, 2022.

The report on the fourth quarter of 2022 includes the following key takeaways:

- **Dispute volume:** Disputing parties initiated 110,034 disputes, which is significantly more than the number of disputes the Departments initially estimated would be submitted for the full year, and a 53% increase in dispute volume compared to the prior quarter. Most disputes (94%) were for emergency or non-emergency items or services; the remainder were for air ambulance services.
- **Closed disputes and dispute eligibility:** Of the disputes closed during this period, 40% had payment determinations made compared to 15% in the prior quarter. Thirty percent of the closed disputes were found to be ineligible, compared to 69% in the prior quarter. Disputes that remain unresolved were most often due to delays in determining whether disputes are eligible for the federal IDR process, including determining state versus federal jurisdiction, correct batching and bundling, compliance with applicable time periods, and completion of open negotiations. Non-initiating parties challenge eligibility for approximately 40% of initiated disputes.
- The report details the top initiating and non-initiating parties, and types of CPT codes submitted, for both emergency and non-emergency services and for air ambulance services.
- The report also makes available information on expenditures and administration fees collected for the IDR process.

The status update report includes the following key takeaways:

- **High volume of disputes:** Between April 15, 2022 and March 31, 2023 disputing parties initiated 334,828 disputes through the IDR portal. This case load is nearly fourteen times greater than the Departments initially estimated the caseload would be over the course of a full calendar year. During that time, non-initiating parties challenged the eligibility of 122,781 (37%) of disputes.
- **Payment determinations:** Certified IDR entities rendered payment determinations in 42,158 disputes as of March 31, 2023. Initiating parties were the prevailing party in approximately 71% of the disputes. Non-initiating parties were the prevailing party in approximately 29% of the disputes.

MedPAC April Meeting: Site Neutral Payments

The Medicare Payment Advisory Commission (MedPAC) has been examining site neutral payment policies for over a decade and has recommended that Congress enact policy that provides for site-neutral payments for subsets of hospital outpatient services, such as services commonly performed in physicians' offices and not usually associated with an emergency department visit (see 2015 Report; 2022 Report).

MedPAC most recently met in April 2023 and reiterated prior recommendations during discussion. Furthermore, it produced an analysis that identified 66 outpatient ambulatory payment classifications (APCs) to align with the physician fee schedule and nine APCs to align with the ambulatory surgical center (ASC) rates. MedPAC also incorporated a budget neutrality adjustment to ensure aggregate spending remains the same thereby increasing payments for those APCs that are not paid on a site neutral basis. This would shift $7.5 billion from aligned APCs to non-aligned APCs, but MedPAC maintains this would also result in savings for Medicare and its beneficiaries over time.

CMS Issues FAQs on PHE Wind Down

The Centers for Medicare & Medicaid Services (CMS) recently issued a notice to announce the release of FAQs on CMS Waivers, Flexibilities, and the End of the COVID-19 Public Health Emergency (PHE). The document addresses Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and private insurance program specific FAQs regarding the end of the COVID-19 PHE.

CMS Releases 2022 Marketplace User Fee Data & Annual Renewal and Discontinuation Notices

CMS released the 2022 Marketplace User Fee Data, which includes the user fee amount totals for issuers offering qualified health plans (QHPs) through federally-facilitated Marketplaces (FFMs) and State-based Marketplaces on the Federal Platform (SBM-FP) for the 2022 plan year. The data is current as of March 15, 2023 (the Apr 2023 payment cycle). In the 2022 plan year, the FFM and SBM-FP user fees were 2.75% and 2.25% of monthly premiums, respectively. The data can be found here.

CMS also posted revised Annual Eligibility Redetermination, Product Discontinuation and Renewal Notices for comment. These revised notices will be required for coverage beginning in the 2024 plan year.

- Information Collection Request

- Notice Templates

CMS Updates Enforcement Process of Hospital Price Transparency Requirements

On Wednesday, CMS announced enforcement updates to increase compliance with the hospital price transparency requirements. The updates, listed below, will shorten the average time by which hospitals must come into compliance after a deficiency is identified to no more than 180 days, or 90 days for cases with no warning notice.

- **Requiring corrective action plan (CAP) completion deadlines**: CMS will now require hospitals to be in full compliance with the hospital price transparency regulation within 90 days from when CMS issues the CAP request, rather than allowing hospitals to propose a completion date for CMS approval which can vary.
- **Imposing civil monetary penalties (CMPs) earlier and automatically:** CMS will now automatically impose a CMP on hospitals that fail to submit a CAP at the end of the 45-day CAP submission deadline.
- **Streamlining the compliance process:** For hospitals that have not made any attempt to satisfy the requirements, CMS will no longer issue a warning notice to the hospital and will instead immediately request that the hospital submit a CAP. Currently, CMS does not issue CAP requests without first issuing a warning notice.

State Issues

New York

Legislative

Budget Agreement Reached

Last Friday, Governor Hochul announced that she and legislative leaders had reached "conceptual agreement" on the state budget, and that details would be filled in as language was developed over the weekend. **A few details have emerged:**

- **Medicaid increases**: Inpatient hospital reimbursement will increase 7.5%; hospital outpatient and nursing home reimbursement will increase 6.5%. The Governor had proposed 5% while the Legislature sought 10%.

- **Guaranty fund**: Health insurers will be brought into the existing guaranty fund; DFS is tasked with developing an offset for non-profits' assessments similar to the credit for for-profit company assessments by 1/1/24; non-profits will not be assessed until that is adopted. This was a high priority for DFS, given the expected failure of a small long-term care insurer.

- **Site of service**: Health plans will need to consider various factors when requiring services to be provided at free-standing surgical centers as opposed to hospital outpatient surgery centers. This is a compromise from a more restrictive provision sought by the hospital lobby.

Bills Moving: Drug Pricing Transparency & Biomarker Testing Mandate

- **Drug Pricing Transparency** — The Assembly Insurance Committee last week approved a proposal (A.1707/S.599) that would require pharmaceutical manufacturers to provide the Department of Financial Services (DFS) at least 60-days advance notice of their intention to raise the cost of a drug more by than 10%. Drug companies' notification would also be required to include information on the current price and proposed increase, the date of the increase, and an explanation on the need for the increase. HPA issued a statement calling it "an important step toward holding drug makers accountable for the out of control prices they charge." The bill, which has already passed the Senate, now goes to the Assembly Codes Committee.

- **Biomarker Testing Mandate** — Also last week, several lawmakers joined cancer survivors and advocates at a Cancer Action Day rally calling for action on the bill (S.1196/A.1673) to require health insurance plans to cover biomarker testing for patients. Specifically, plans would be required to cover testing that is approved or cleared by the FDA, meets CMS national coverage determinations, or nationally recognized clinical practice guidelines and consensus statements. In a media interview about the proposal, HPA voiced opposition to the legislation's overly broad criteria for biomarker tests, which may not align with the best medical practices.

Bills in Committee this Week

- **Genetic Testing (S.1193)** — requires coverage of genetic testing for ovarian cancer for patients who have a personal or family medical history of ovarian cancer.

- **DME Medicaid Reimbursement (S.3468/A.3408)** — requires Medicaid managed care organizations to reimburse durable medical equipment providers at no less than one hundred percent of the Medicaid DME fee schedule.

- **MLTC Transportation (S.4788/A.6020)** – reverses the carve out of non-emergency transportation services from managed long-term care.

- **Asthma Coverage (S.4889)** – requires Medicaid and commercial health insurers to cover asthma treatments and education.

- **Medicaid Managed Care Transparency (S.6075/A.5381)** – expands the level of detail provided to Medicaid managed care plans providing greater transparency into the MMC rate development process and allowing plans to better analyze the adequacy of the rates set by the Department of Health.

Regulatory

"Donate Life" Implementation

The Department of Health (DOH) convened a call with health plan and life insurance associations to talk about last year's law requiring that space be provided on various enrollment or renewal forms to ask applicants if they would agree to be added to the Donate Life Registry. Participants discussed implementation requirements and challenges of the new law. Understanding the complexity of this new requirement, DOH reported that the effective date for the new law has been pushed out until June 23 of 2024 (vs the 180 days after signing, as originally indicated). This was the first of what is expected to be several meetings.

State Issues

Pennsylvania

Legislative

House Committee Advances Cyber Security Legislation

On Monday, April 24, the House Insurance Committee advanced House Bill 739 (Boyle, D – Philadelphia) which would require licensed insurance entities to develop cybersecurity policies and report cybersecurity events to the Insurance Commissioner.

House Advances Prohibition on Cost Sharing for Breast MRI and BRCA Gene Testing Legislation

On Wednesday, April 26, the House unanimously advanced Senate Bill 8 (K. Ward, R-Westmoreland). Senate Bill 8 prohibits cost sharing MRIs for individuals with dense breast tissue and for genetic counseling and genetic testing for the BRCA1 and BRCA2 gene mutation for individuals believed to be at an increased risk due to personal or family history of breast or ovarian cancer.

Senate Bill 8 now awaits signature or veto consideration from the Governor.

- **Why this matters:** While Highmark provides expansive coverage of health care services for many diseases and conditions, including cancer of the breast, we expressed concerns with Senate Bill 8 regarding the inequities caused by prohibiting cost sharing for tests related to specific diseases or conditions, while those needing MRIs or tests for other conditions will continue to pay cost sharing.

Hearings Held to Reform Professional Licensure in Pennsylvania

Providers and state agency officials appeared before lawmakers in two hearings in Harrisburg to discuss ways to reform professional licensing and credentialing in Pennsylvania. The **House Professional Licensure Committee** and **Senate Consumer Protection and Professional Licensure Committee** hearings are available to watch online.

Months-long delays in the licensure review process hold back nurses and physicians from entering the workforce and hurt the commonwealth's recruitment and retention efforts.

Among the key takeaways from the two hearings:

- **Seasonal challenge:** The wait times to review practice permits and post results for clinical licensure exams significantly increase during the spring, as graduating classes of nurses and physicians look to enter the workforce.

- **Competitive burden:** States with faster processes and review times see benefits in recruiting because applicants know their materials will be reviewed quickly and that they will be able to get to work sooner.

- **Compact impact:** Advancing the nurse and physician licensure compacts will support the overall health care workforce, but the compacts alone won't alleviate the underlying credentialing and licensure delays that exist in Pennsylvania.

- **State perspectives:** Leaders with the Department of Human Services said they have been working to address backlogs in the state application system and improve the commonwealth's licensing portals. Workforce shortages have contributed to backlogs processing applications.

- **Taking action:** Increasing staffing to address the review process, improving web-based portals, and other system-wide improvements will bolster the commonwealth's licensure and credentialing process.

Why this matters: Hospitals continue to emphasize the need to improve the licensing and credentialing process to support our state's health care workforce and the hospitals delivering care across the commonwealth.

Streamlining clinician licensing is among the key policy recommendations made by the Hospital and Healthsystem Association of Pennsylvania's (HAP) Health Care Talent Task Force to grow and support the health care workforce.

Industry Trends

Policy / Market Trends

CBO Report: 600,000 Medicaid Beneficiaries Would Lose Coverage if Work Requirements Implemented

The Congressional Budget Office (CBO) reported that a House bill (HR 2811) to implement Medicaid work requirements would result in about 600,000 adult Medicaid beneficiaries losing coverage. CBO also projects about 15 million beneficiaries would be subject to work requirements per year, and the federal government would save an estimated $109 billion over 10 years. The U.S. Department of Health and Human Services released a separate report projecting about 21 million beneficiaries would be subject to the requirements.

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/.**