Highmark's Weekly Capitol Hill Report

Issues for the week ending May 5, 2023

Federal Issues

Legislative

Senate Committee Examines Medicare Advantage Mental Health Networks

On Wednesday, the Senate Finance Committee held a hearing to discuss ways to improve the accuracy of Medicare Advantage provider directories. The focus was on what Committee Chairman Ron Wyden (D-OR) refers to as "ghost networks" in the mental health space, where health plans appear to have robust networks in their directories but those seeking care hit roadblocks in contacting providers and scheduling appointments.

Why this matters: The issue has become a priority for Wyden, who believes provider directory accuracy is significantly worse in the mental health space compared to physical health.

- He is calling for a three-legged bipartisan approach to address concerns, including more oversight, increased transparency and stronger penalties for insurance companies.

The hearing: Wyden raised a recent release of a secret shopping study conducted by committee staff as evidence of ghost networks in MA. Investigators contacted 120 providers from 12 different Medicare Advantage plans in six states – Ohio, Pennsylvania,

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Oregon, Massachusetts, Colorado and Washington. The report found that 33 percent of listings contacted were inaccurate, non-working numbers, or unreturned calls. In addition, callers were only able to make a covered appointment 18% of the time.

Next steps: Specific next steps the committee might take are unclear but there has been bipartisan interest in improving access to mental health services across the health care landscape.

- Chairman Wyden and his colleagues focused on the need for additional plan requirements, transparency and penalties for insurance companies to improve accuracy.
- **Republicans stated** that provider reporting requirements should be part of the solution and expressed caution over creating additional burdens for providers and plans.
- **Dig deeper:** Read Sen. Wyden's letter to CMS supporting provider directory requirements included in the recent 2024 Medicare Advantage policy and technical rule.

Insurer perspective: The Blue Cross Blue Shield Association (BCBSA) provided a statement to the committee highlighting the work that the Blues are doing to maintain accurate provider directories, while also underscoring the challenges such as lack of provider responsiveness and engagement that Plans face in providing timely updates.

- BCBSA also acknowledged that improving provider directories alone will not expand access to quality mental health care.

As long-term solutions are developed, BCBSA recommended that lawmakers:

- **Invest** in providers and payment models that promote care integration
- **Expand** the use of telehealth to help increase access to care

- **House Advances Cyber Security Legislation**
- **Health and Human Services Committee Advances Testing and Coverage for Lyme Disease**
- **House Health Committee Holds Hearing to Address Legislation Mandating Nurse Staffing Ratios**

Industry Trends

Policy / Market Trends

- **New Resource Highlights the Importance of Eliminating Low-Value Care**
- **Government Requests Partial Stay from Circuit Court in ACA Preventive Services Ruling**

- **Increase** the number of residency slots and expand incentives for students to enter the behavioral health workforce

Federal Issues

Regulatory

CMS Issues FAQs & Publishes New Guidance on End of COVID-19 Public Health Emergency

The Centers for Medicare & Medicaid Services (CMS) recently issued a frequently asked questions (FAQ) document on the various waivers and flexibilities tied to the COVID-19 Public Health Emergency (PHE), which is set to expire on May 11, 2023. The document addresses Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and private insurance program specific FAQs regarding the PHE wind down.

Why this matters: The FAQ document clarifies the distinction between the PHE and the end of the COVID-19 national emergency, answers specific questions about coverage of vaccines and treatment, and addresses issues pertaining to telehealth. The full FAQ document can be found here.

CMS also published an informational bulletin on the end of the COVID-19 PHE and implications of the end of the PHE for Medicaid and CHIP.

- The CMS Informational Bulletin reviews the status of continuous enrollment requirements, coverage of vaccines, testing and treatments, telehealth, Section 1135 waivers, and other flexibilities implemented during the PHE. An Appendix contains a useful chart of the expiration dates of the main categories of flexibilities.

CMS Releases 2024 Final Letter to Issuers in the Federally-Facilitated Exchanges & Form Filing FAQ

CMS released the 2024 Final Letter to Issuers in the Federally-facilitated Exchanges.

Why this matters: The 2024 Letter to Issuers provides updates on operational and technical guidance for the 2024 plan year for issuers seeking to offer qualified health plans (QHPs), including stand-alone dental plans (SADPs), in the Federally-facilitated Exchanges (FFEs) or the Federally-facilitated Small Business Health Options Programs (FF-SHOPs). The Letter to Issuers also describes how parts of the Letter apply to issuers in State-based Exchanges on the Federal Platform (SBE-FPs). Issuers should refer to these updates to help them successfully participate in any such Exchange in 2024. You can access the finalized Letter to Issuers here.

CMS also released the form filing frequently asked questions for Plan Year 2024 form filing submissions from issuers in states where CMS directly enforces the No Surprises Act or Transparency Provisions of the Consolidated Appropriations Act, 2021 (CAA).

CMS Extends Medicare Diabetes Prevention Program Flexibilities through 2023

The Centers for Medicare & Medicaid Services (CMS) recently issued a notice in the Federal Register extending the effective date of current Medicare Diabetes Prevention Program (MDPP) flexibilities put into place during the COVID-19 Public Health Emergency (PHE). The agency states that although the PHE is scheduled to expire on May 11, the ability of MDPP suppliers to suspend in-person delivery of MDPP services will be extended through December 31. The flexibilities permit suppliers to provide MDPP services virtually, as long as those virtual services are furnished in a manner consistent with requirements described in the notice. More details are provided in the notice.

DEA Delays Restrictions on Prescribing of Controlled Medicines via Telemedicine

On Wednesday, the Drug Enforcement Administration (DEA) announced that it will extend the current telemedicine flexibilities for prescription of controlled medications after the COVID-19 Public Health Emergency (PHE) expires. **The extensions include:**

- The full set of telemedicine flexibilities regarding prescription of controlled medications as were in place during the COVID-19 PHE will remain in place through November 11, 2023.
- For any practitioner-patient telemedicine relationships that have been established on or before November 11, 2023, the full set of telemedicine flexibilities regarding prescription of controlled medications as were in place during the COVID-19 PHE will continue to be permitted through November 11, 2024.

This rule extension applies to the prescribing of certain controlled substances without the need for an in-person evaluation, including buprenorphine for the treatment of opioid use disorder.

Background: This announcement is in response to comments regarding the Telemedicine Buprenorphine Proposed Rule and the Telemedicine Controlled Substance Proposed Rule. These Proposed Rules would have implemented limits for telemedicine prescribing of controlled substances without a prior in-person exam.
Why this matters: The goal of this temporary rule is to ensure a smooth transition for patients and practitioners that have come to rely on the availability of telemedicine, as well as allowing adequate time for providers to come into compliance with any new standards or safeguards that DEA and/or SAMHSA promulgate in final rules. The timeline for a final rule is not yet clear.

State Issues

New York

Regulatory

DFS to Issue COVID Testing and Immunization Guidance

With the public health emergency ending May 11, the Department of Financial Services is drafting a circular letter (CL) to provide guidance related to coverage of COVID-19 testing and immunizations. The letter, expected to be issued this week, notes that plans are allowed to institute normal processes for COVID testing (permits cost-sharing, prior authorization and does not require plans to cover OON testing unless the policy covers OON services). It reminds plans that cost-sharing is not permitted for COVID vaccines and administration, but reiterates that plans are not required to cover OON immunizations unless the policy covers OON services.

The CL will indicate that plans should notify members when they will begin to impose cost-sharing, PA or other medical management requirements for COVID tests. DFS said although there is no specific time requirement for notices, it strongly encourages plans to post information on their websites before making any changes to cost-sharing and medical management requirements, and also encourages that notice be provided as soon as possible and ideally before the end of the PHE.

State Issues

Pennsylvania

Legislative

Governor Signs Prohibition on Cost Sharing for Breast MRI and BRCA Gene Testing Legislation

On Monday, May 1, Governor Shapiro signed Senate Bill 8 (K. Ward, R-Westmoreland) and is now Act 1 of 2023. Act 1 of 2023 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.

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.

- Highmark also expressed concerns that this legislation may require health insurers to provide coverage outside of the clinical and scientific standards and undermines insurer's ability to design different plans to meet customers' needs, while potentially leading to increased premium costs.

House Advances Cyber Security Legislation

On Monday, May 1, the House of Representatives unanimously advanced House Bill 739 (Boyle, D-Philadelphia). House Bill 739 would require licensed insurance entities to develop cybersecurity policies and report cybersecurity events to the Insurance Commissioner.

House Bill 739 now awaits consideration from Senate committee.

Health and Human Services Committee Advances Testing and Coverage for Lyme Disease

On Tuesday, May 2, the Senate Health and Human Services Committee unanimously advanced Senate Bill 100 (Brooks, R-Crawford). Senate Bill 100 would require health insurers to cover treatment plans for Lyme disease or related tick-borne illnesses as prescribed by a patient's health care practitioner, regardless if the treatment plan includes short-term or long-term antibiotic treatment.

Senate Bill 100 now awaits consideration from the full Senate.

Why this matters:

- Highmark and AHN opposed advancing Senate Bill 100.
- Long-term antibiotic therapy does not align with the current clinical practices for the treatment of Lyme Disease and in some cases poses significant harm to patients.

House Health Committee Holds Hearing to Address Legislation Mandating Nurse Staffing Ratios

On May 2, the House Health Committee hosted a hearing about House Bill 106, which would mandate nurse staffing ratios for Pennsylvania hospitals.

The Hospital and Healthsystem Association of Pennsylvania's (HAP) President and CEO Andy Carter testified—along with Michele Szkolnicki, RN, FACHE, CMPE, senior vice president and chief nursing officer, Penn State Health Milton S. Hershey Medical Center, and Stephanie Pollock, BSN, RN, CCRN, pediatric intensive care unit, patient care manager, St. Luke's University Health Network—about the extraordinary efforts hospitals are making to recruit and retain nurses and how government-mandated ratios would affect patient care.

There are very real concerns that statewide ratio mandates will diminish Pennsylvanians' access to care. If hospitals are unable to meet mandated ratios due to the scarcity of available RNs, they will have no choice but to close beds and reduce other health care services in order to comply with state law.

Among the key takeaways:

- **Core issue:** Mandated ratios do not address the state's shortage of registered nurses, which is projected to be worst in the nation, with a shortfall of more than 20,000 nurses within the next three years.
- **Rural challenges:** Mandated hospital staffing ratios will especially challenge rural facilities that already struggle to recruit staff, subjecting them to penalties and risking the closure of some hospital service lines.
- **Weaknesses:** This legislation does not consider the certifications nurses need to work in certain hospital units and care settings. It also does not account for real-time adjustments that hospitals need to make in response to crises that can happen at any time.
- **Workforce solutions:** HAP and the hospital community are focused on comprehensive solutions to address the health care workforce crisis and relieve strain on health care teams. This includes growing the number of nurse educators and preceptors; supporting nurses through scholarships,

tuition discounts, loan relief, and other incentives; implementing interstate licensing compacts; reforming the state's licensing and enrollment processes; and promoting health care worker wellness and safety.

The Allegheny Health Network provided written comments for the record.

Why this matters: The staffing challenges we face today are reflective of a supply issue, not the absence of mandated staffing ratios. Pennsylvania needs comprehensive policy solutions that bring more nurses to the bedside, not government-mandated staffing ratios that won't produce more nurses.

- Pennsylvania hospitals need the flexibility to react quickly to changing needs within their communities, such as mass casualty incidents. Ratios do not address several important factors in health care, such as patient acuity, comorbidities, experience and training across staff, and the high-risk nature of work.

- There is no single solution that will solve Pennsylvania's health care workforce crisis. Hospitals are urging lawmakers to very carefully scrutinize potentially overly simplistic or ineffective proposals. Alternative—and more promising—policy efforts could include investing in nurse educators, expanding nursing education programs and apprenticeships, supporting nursing students, and forgiving the educational debt of currently practicing bedside nurses.

Industry Trends

Policy / Market Trends

New Resource Highlights the Importance of Eliminating Low-Value Care

AHIP released a new resource highlighting several independent studies demonstrating that low-value care – services that have little or no clinical benefit or where the risk of harm from the service outweighs the potential benefit – contributes to $75.7 billion to $101.2 billion of waste in health care.

For instance, VBID Health's Task Force on Low-Value Care estimates that 5 low-value health care services account for more than $25 billion in avoidable annual expenditures, including:

- $44 million in avoidable Medicare spending for non-recommended PSA testing.
- $9.5 billion in avoidable spending for unneeded pre-surgery tests and imaging services.
- $500 million in avoidable spending for unnecessary imaging for low pack pain.
- $14.7 billion in unnecessary spending on branded drugs.
- $800 million in unnecessary spending on non-clinically indicated vitamin D tests.

This resource also reinforces the value of medical management as a critical tool to promote effective, appropriate, and affordable care. Read the full AHIP resource here.

Government Requests Partial Stay from Circuit Court in ACA Preventive Services Ruling

Following the District Court for the Northern District of Texas' decision to defer a request for a partial stay in *Braidwood Management, Inc. v Becerra*, the Department of Justice requested a partial stay of final judgement from the Fifth Circuit Court of Appeals, asking for a decision by May 18.

Why this matters: If granted, the stay will prevent changes in the coverage requirements from going into effect until after the appeal ruling. This will require plans and issuers to continue to cover items and services recommended with an “A” or “B” rating by the USPSTF on or after March 23, 2010 without cost sharing.

Multiple groups, including the American Medical Association, American Lung Association and others have filed amicus briefs in support of the government’s request for a stay.

Background: In March, Judge O’Connor of the United States District Court for the Northern District of Texas granted Braidwood Management Inc.'s request for a “universal” remedy in the *Braidwood Management, Inc. v. Becerra* court case.

- This decision blocks the Affordable Care Act (ACA) mandate that insurers must cover services recommended by the United States Preventive Services Task Force (USPSTF) with an “A” or “B” rating without cost-sharing.
- The decision also finds that requiring coverage of pre-exposure prophylactic drugs for HIV prevention without cost-sharing violates plaintiffs’ rights guaranteeing religious freedom.
- This decision does not affect coverage recommendations made by the Health Resources and Services Administration (HRSA) or the Advisory Committee on Immunization Practices (ACIP), including contraceptive care and vaccine recommendations.

If this ruling is upheld, insurers and employers can choose whether to cover preventive care, and if so, whether to do so without cost-sharing.

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/.**