Highmark's Weekly Capitol Hill Report

Issues for the week ending July 22, 2022

Federal Issues

Legislative

Senate Readies Health Care Reconciliation Bill
On Thursday, the Senate parliamentarian reviewed the health-only reconciliation package – prescription drug reforms coupled with a two-year extension of the enhanced Affordable Care Act (ACA) subsidies passed as part of the American Rescue Plan Act (ARPA). Last week, the Congressional Budget Office (CBO) released its cost estimate, noting that permanently extending the ACA subsidies would cost the federal government $247.9B over a 10-year period. If made permanent, the scoring agency believes 4.8 million new enrollees would join the marketplace annually. A ruling by the parliamentarian is expected this week.

Why this matters: The parliamentarian's ruling will determine if any elements of the proposal must be removed for not qualifying with the parameters of budget reconciliation. Once the ruling is in, Democrats can begin to prepare the legislation for floor activity and eventual passage next week.

Senator Joe Manchin (D-WV), the swing vote on the package, has only agreed to support the drug pricing and ACA provisions coupled with deficit reduction to

In this Issue:

address his longstanding concern with rising inflation rates.

- **State's COVID Disaster Emergency Extended**
- **Governor Unveils COVID "Fall Action Plan"**

Industry Trends

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- **New HHS Report: ACA, ARPA Led to Marketplace Access and Affordability**
- **CMS, MedPAC & MACPAC Findings Released**

Federal Issues

Regulatory

CMS Releases OPPS Proposed Rule

On July 15, 2022, the Centers for Medicare & Medicaid Services (CMS) released the (CY) 2023 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Proposed Rule and fact sheet outlining planned updates to the Medicare payment rates, quality reporting requirements, and other policies.

Why this matters: CMS proposes to update the OPPS and ASC payment rates for hospitals that meet applicable quality reporting requirements by 2.7%. CMS is also creating a new provider type, the Rural Emergency Hospital (REH) as required by the Consolidated Appropriations Act of 2021. CMS outlines eligibility requirements, how payments would change for REHs, and conditions of participation requirements. In addition, a request for information is included soliciting feedback on how the agency can drive competition in health care marketplaces through the release of additional data, such as enrollment data, or information on changes in ownership of provider entities.

CMS notes that they plan to rescind the cuts to the OPPS 340B policy per the Supreme Court's decision in in *American Hospital Association v. Becerra*. However, given the timing of the decision, CMS was unable to adjust the proposed payment rates and budget neutrality calculations to account for that decision before issuing this proposed rule. CMS fully anticipates applying a rate of average sales price (ASP) plus 6% to drugs and biologicals covered by this policy in the final rule for CY 2023.

Initial key takeaways:

- **Mental Health via Telehealth flexibilities beyond PHE.** CMS outlines policy proposals to ensure continued access to mental health services via telehealth by hospital clinical staff to a beneficiary at home as a covered outpatient service following the conclusion of the COVID-19 PHE. The policy proposal aligns with changes to Medicare payment for mental health services via telehealth under PFS and for rural health clinics and federally qualified health centers. Consistent with other related Medicare payment policies a beneficiary must undergo an in-person visit within 6 months of starting telehealth visits under OPPS and within 12 months of

each mental health visit furnished and clinical staff must be able to provide two-way, audio/visual services but may use audio-only to accommodate a beneficiary's technological limitations, abilities, and preferences.

- **Other Post-PHE proposals.** CMS is further cementing recent flexibilities allowing certain non-physician practitioners to supervise select diagnostic services. CMS is proposing to compensate hospitals for the increased cost of acquiring certain personal protective equipment during the COVID-19 pandemic.

- **Rural Emergency Hospitals.** CMS is proposing to pay Rural Emergency Hospitals 105% of OPPS payments for services furnished to program beneficiaries, and to make a substantial supplemental monthly facility payment. Additionally, CMS proposes to maintain its site neutrality process but to for the first time exempt rural sole community hospitals from the existing site neutral policy.

- **Organ Acquisition.** As a follow-up to the FY 2022 IPPS rulemaking cycle, CMS proposes a methodology for calculating the Medicare share of organ acquisition costs. It also seeks additional information from stakeholders on an alternative approach for counting organs.

- **OPPS Payment for Software as a Service.** Algorithm-driven services that assist practitioners in making clinical assessments can include clinical decision support software, clinical risk modeling, and computer aided detection (CAD). CMS refers to these technologies as software as a service (SaaS). For CY 2023, CMS is seeking comments on the specific payment approach they might use for these services under the OPPS as SaaS-type technology becomes more widespread.

- **Changes to the Inpatient Only (IPO) List**. CMS identifies services for which Medicare will only make payment when the services are furnished in the inpatient hospital setting because of the invasive nature of the procedure, the underlying physical condition of the patient, or the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged. For CY 2023, CMS proposes 10 services (see page 441 and 412 of the display version of the NPRM for the details) to remove from the IPO list.

- **340B Purchased Drugs** - Beginning in CY 2018, CMS adjusted the 340B drug payment rate to ASP minus 22.5%. This policy has been the subject of significant litigation, recently culminating in the Supreme Court's decision in AHA v. Becerra, holding that CMS may not vary payment rates without having conducted a survey of hospitals' acquisition costs. While the Supreme Court's decision concerned payment rates for 2018 and 2019, it obviously has implications for CY 2023 payment rates. However, given the timing of the Supreme Court's decision, CMS lacked the necessary time to incorporate the adjustments to the proposed payment rates and budget neutrality calculations to account for that decision before issuing this proposed rule. Thus, the payment rates, tables, and addenda in this Proposed Rule reflect a payment rate of ASP minus 22.5 percent for drugs and biologicals acquired through the 340B program for CY 2023, but CMS fully anticipates applying a rate of ASP+6 percent to such drugs and biologicals in the final rule. CMS seeks comment on how to deal with updating 2018 and 2019 payments.

- **Additionally, CMS has two RFIs** on Software as a Service payments and Driving Competition in the Healthcare Marketplace, focused on if CMS should consider releasing data on mergers, acquisitions, consolidations, and changes in ownership for other provider types.

Comments are due September 13.

HHS Invests $49 Million to Reduce Uninsured Rates

On Tuesday, the U.S. Department of Health and Human Services (HHS) announced that, through the Centers for Medicare & Medicaid Services (CMS), it had awarded $49 million to organizations involved in expanding health care coverage. This is the largest sum ever awarded by CMS to the Connecting Kids to Coverage program to increase outreach and enrollment. The recipients of these funds will provide health care enrollment and renewal assistance to children, their families, and expectant parents to improve maternal health. Grantees will receive up to $1.5 million over three years to support the Medicaid and Children's Health Insurance Program (CHIP) and these grantees include: state and local governments, tribal organizations, federal health safety net organizations, non-profits, and schools. Grantees have the option to work on several of the following projects on their own:

- Engage schools and other programs serving young people.
- Bridge demographic health disparities by targeting communities with low coverage.
- Establish and develop application assistance resources to provide high-quality, reliable Medicaid/CHIP enrollment and renewal services in local communities.
- Use social media to conduct virtual outreach and enrollment assistance.
- Use parent mentors and community health workers to assist families with enrolling in Medicaid and CHIP, retaining coverage, and addressing social determinants of health.

CMS Issues Guidance on Failure to File and Reconcile (FTR) Operations Flexibilities for Plan Year 2023

Due to the ongoing impacts of the COVID-19 pandemic on federal tax return processing, CMS is extending last year's guidance giving additional flexibilities to all exchanges for plan year 2023. Specifically, for plan year 2023, CMS will continue to not act on data from the IRS for consumers who have failed to file tax returns and reconcile a previous year's advance payments of the premium tax credit (APTC) with the premium tax credit allowed for the year. The new guidance can be found here.

CMS Publishes Updated Risk Adjustment Report

On July 19, 2022, CMS published an updated Summary Report on Permanent Risk Adjustment Transfers for the 2021 Benefit Year. This revised version includes updates to Alabama small group risk adjustment transfers that reflect the approved Alabama state flexibility request for 2021 benefit year small group market transfers. Appendix C has also been updated to include updated transfer amounts in the Alabama small group market.

CMS Issues Beneficiary Protections and Medicaid Drug Coverage, Particularly Under Value Based Purchasing (VBP) Arrangements Bulletin

The Center for Medicaid and CHIP Services (CMCS) released an informational bulletin on Beneficiary Protections and Medicaid Drug Coverage, Particularly Under Value Based Purchasing (VBP) Arrangements.

Why this matters: The bulletin reminds states and stakeholders of regulatory and statutory beneficiary protections that must be followed when states enter novel payment arrangements, including VBP arrangements, with drug manufacturers. Read More

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CMS Releases First-Ever HCBS Quality Measure Set

CMS released the first-ever home- and community-based services (HCBS) quality measure set.

Why this matters: The measure set is intended to promote consistent quality measurement within and across state Medicaid HCBS programs, provide insight into the quality of HCBS programs and enable states to measure and improve health outcomes for people relying on HCBS. While use of this measure set will be voluntary, CMS plans to incorporate the measure set into the reporting requirements for specific authorities and programs, including the Money Follows the Person (MFP) program and future HCBS-related section 1115 demonstrations. Within the release, CMS also noted it is developing and will release additional guidance on how states can use the measure set as part of their HCBS quality measurement, reporting, and improvement activities. Read More

State Issues

New York

Regulatory

The Department of Financial Services (DFS) Finalizes Circular Letters on Record Retention, UR

- **Books and Record Storage** — This Circular Letter is related to storage of books and records electronically, including in the cloud. The CL notes that materials stored off-site must be fully and easily accessible from an insurer's New York principal office and that the insurer meet certain other requirements, including compliance with all applicable state and federal laws and regulations.

- **UR Circular Letter** — This Circular Letter addresses implementation of recommendations of the Administrative Simplification Workgroup in relation to utilization review best practices.

DFS Issues Climate Risk Disclosure Report

Last week DFS also issued the 2021 Update on New York Domestic Insurers' Management of the Financial Risks from Climate Change - An Analysis of NAIC Climate Risk Disclosure Survey Reponses and Other Reporting. The report is part of DFS's ongoing efforts to evaluate insurers' management of climate-related financial risks and provide resources that will accelerate the industry's progress. Related to this, the Department is hosting a webinar on August 2, 2022 from 10-11am to provide an overview of the report. Interested parties can register here.

State's COVID Disaster Emergency Extended
Governor Hochul pointed to hospital admissions that continue to exceed 100 statewide each day as she extended Executive Order 11, renewing the state's disaster emergency and extending it through August 13.

Governor Unveils COVID "Fall Action Plan"
The Governor unveiled the plan to prepare for back-to-school and seasonal COVID surges, aimed at protecting the public health and supporting New York's ongoing response to the pandemic. The fall plan includes stockpiling 60 days' worth of personal protective equipment heading into the fall, when surges are common around the holiday season, and distributing three million COVID tests to schools. The Governor also announced plans to create what she described as a first in the nation "pandemic after-action review," with an independent review board to be tasked with examining the state's response to the crisis and issuing a report that will analyze what went well during the pandemic and what didn't. The board will also make recommendations and develop a planning guide for the state to use in future emergencies.

Industry Trends
Policy / Market Trends

New HHS Report: ACA, ARPA Led to Increased Marketplace Access and Affordability
The Health and Human Services (HHS) Office of the Assistant Secretary for Planning and Evaluation (ASPE) released a report on Marketplace coverage. The report found "the Affordable Care Act (ACA) Marketplace has led to substantial coverage gains among small business owners and self-employed individuals, and the American Rescue Plan has bolstered the Marketplace's positive effects on household finances."

ASPE found that, in 2021, 2.6 million Marketplace enrollees ages 21-64 were small business owners or self-employed, accounting for 25 percent of working-age individuals with Marketplace coverage. The report also details how the self-employed uninsured has fallen dramatically since the implementation of the ACA in 2014.

In the report, ASPE also reviews evidence that shows access to health insurance coverage provides substantial benefits in terms of improved household finances. They detail how greater subsidies through the premium tax credits have had substantial impacts on addressing socioeconomic disparities in access to care and health outcomes. They also highlight how affordable coverage has helped rural residents as well as slow the rate of rural hospital closures.

In related news, The National Academy for State Health Policy (NASHP) sent a letter to congressional leadership on behalf of 19 state-based health insurance marketplaces (SBM) calling for the permanent extension of the enhanced Affordable Care Act (ACA) tax credits enacted under the American Rescue Plan (ARPA).

Why this matters: ARPA's tax credit affordability measures are scheduled to expire at the end of this year. The letter describes the importance of ARPA's premium relief measures and notes that 3.1 million Americans may drop their health insurance without the enhanced subsidies. NASHP resources include an ARPA hub with state specific analyses of the impact of ARPA's affordability measures.

The Congressional Budget Office (CBO) released a score that showed permanently extending the ACA plan subsidies would lead to fewer Americans without health insurance coverage and cost the government $25 billion per year.

CMS, MedPAC & MACPAC Findings Released

- The Medicaid and CHIP Payment Access Commission (MACPAC) released an issue brief showing only about 3% of individuals who were disenrolled from Medicaid or CHIP were enrolled in an Exchange plan within 12 months, according to a study of 2017-2019 enrollment data. Furthermore, most of that 3% experienced a gap in coverage, with the gap lasting longer for minorities. Read More

- The Centers for Medicare & Medicaid Services (CMS) released the 2022 Medicaid and Children's Health Insurance Program (CHIP) Beneficiary Profile and Infographic. The Beneficiary Profile and associated Infographic provide an overview of the enrollment, expenditures, characteristics, health status and experience of the beneficiaries served by Medicaid and CHIP. The profile also includes an in-depth look at dually-eligible beneficiaries and children with special health care needs. Read More

- The Medicare Payment Advisory Commission (MedPAC) announced the release of its 2022 data book on health care spending and the Medicare program. The publication provides data on Medicare spending, demographics of the Medicare population, beneficiaries' access to care, and quality of care in the program, among other information. MedPAC is now reporting MA plans are paid 104% of traditional Fee-for-service (FFS) when they account for both bids relative to benchmarks and coding. They are also reporting the average MA (A/B) rebate for all non-employer, non–Special Needs Plans has risen to a high of $164 per month per beneficiary for 2022.

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/.**