Highmark's Weekly Capitol Hill Report

Issues for the week ending April 5, 2024

Federal Issues

Regulatory

CMS Finalizes Lower Than Expected 2025 Rates for Medicare Advantage, Part D

The Centers for Medicare & Medicaid Services (CMS) released the Announcement of Calendar Year (CY) 2025 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (Rate Notice). The agency has released a related press release and fact sheet.

CMS also released the final Part D Redesign Program Instructions and a related fact sheet.

Why this matters: According to CMS, county benchmarks will increase by 2.33% for 2025, with a **net payment impact of all payment policies of -0.16%, on average**. This compares with projected benchmark growth of 2.44% and net payment change of -0.16% in the Advance Notice, published in late January. In the fact sheet released in conjunction with the Rate Notice, CMS suggests the expected change in revenue for 2025 will be 3.70% by taking into account an expected MA risk score trend of 3.86% for 2025.

The final payment policies reflect updated estimates for MA and FFS costs for 2025. CMS also modified the

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phase in of a technical correction to cost estimates related to graduate medical education payments. For 2025 CMS will apply 52% of the technical correction instead of 67%, as proposed.

CMS finalized other payment policies, including the continued phase in of a new Part C risk model, implementation of a revised Part C normalization methodology, a revised Part D risk model reflecting changes to the Part D benefit resulting from the Inflation Reduction Act, and separate Part D normalization factors for MA plans that include Part D coverage and stand-alone Part D plans. For MA Star Ratings, CMS uses the Rate Notice to provide routine updates and reminders for the upcoming Star Ratings year and also announces potential changes to Star Ratings that may be proposed through future rulemaking.

Insurer Perspective: Following the release of the final MA and Part D Rate Notice from CMS, AHIP President and CEO Mike Tuffin issued the following statement:

- "These policies will put even more pressure on the benefits and premiums of 33 million Medicare Advantage beneficiaries who will be renewing their coverage this fall. It is important to note that the Medicare Advantage and Part D programs are already undergoing a number of significant regulatory and legislative changes. Moreover, the cost of caring for Medicare Advantage beneficiaries is steadily rising.
- "Over the past several weeks, scores of bipartisan members of Congress and a diverse array of stakeholders have reinforced their strong support for Medicare Advantage. We appreciate these policymakers and organizations who stood up for the high-quality, affordable coverage and care seniors and people with disabilities count on in Medicare Advantage."

- **The Alliance to Fight for Health Care Highlights Site-Neutral Payment Proposals in 2025 Budget Proposal**
- **HHS Report Points Out Gaps in Mental Health Care Access**
- **HHS Announces $39.4M in Grants to Address SUD & Behavioral Health**
- **Coalition Spotlights Growth of Private Equity-Acquired Physician Practices**

CMS Releases 2025 Medicare Advantage and Part D Final Rule

The Centers for Medicare & Medicaid Services (CMS), finalized the Contract Year (CY) 2025 Medicare Advantage (MA) and Part D final rule. They also released a press release and fact sheet outlining the major policies.

Key provisions include:

- **Mid-Year Enrollee Notification of Available Supplemental Benefits.** MA plans will be required to provide a personalized notification to each enrollee annually, between June 30 and July 31, of any supplemental benefits not accessed by the individual during the first six months of the year.

- **Revisions to Agent and Broker Compensation.** The definition of "compensation" for purposes of current law limits on agent/broker commissions will be expanded, while the national agent/broker fixed compensation amount for initial enrollments into an MA or Part D plan will be increased by $100 (this amount was $31 in the proposed rule).

- **Annual Health Equity Analysis of Utilization Management (UM) Policies and Procedures.** MA plans will need to conduct and publish an annual analysis of certain prior authorization metrics for enrollees with specified social risk factors—those receiving the low-income subsidy, those who are dually eligible for Medicare and Medicaid, and those with a disability.

- **Additional Changes to an Approved Formulary—Substituting Biosimilar Biological Products.** Part D sponsors will have more flexibility to make mid-year substitutions of biosimilars for their reference products on their formularies.

- **Changes to Part D Medication Therapy Management (MTM) Eligibility Criteria.** Part D MTM eligibility will be expanded, including a requirement that plans include all specified chronic diseases in their MTM targeting criteria.

- **Changes to Enrollment Options for Medicare-Medicaid Dually Eligible Enrollees.** Several changes will be made to Part D special enrollment period (SEP) rules for Medicare/Medicaid dual eligibles and people with Part D low-income subsidies. In addition, starting in 2027, new rules will limit enrollment in certain D–SNPs to individuals enrolled in an affiliated Medicaid managed care plan and limit the number of D–SNP plan benefit packages that an MA organization or related company can offer in the same service area as an affiliated Medicaid plan.

- **Contracting Standards for Dual Eligible Special Needs Plan "Look-Alikes."** The MA D SNP look-alike threshold will be reduced from 80% to 70% in 2025 and to 60% in 2026.

HHS Releases 2025 Notice of Benefit and Payment Parameters

The U.S. Department of Health and Human Services (HHS) released a pre-publication version of the 2025 Notice and Benefit Payment Parameters (NBPP) final rule.

Why this matters: The rule finalizes standards for issuers of qualified health plans and the Affordable Care Act (ACA) Marketplaces, including the federally facilitated marketplace and state-based marketplaces as well as requirements for agents and brokers. The NBPP specifies payments under the HHS-operated risk adjustment and risk adjustment data validation programs, as well as 2025 user fee rates for QHP issuers.

Major topics addressed in the NBPP include:

- **Non-Standardized Plan Option Limits:** Finalizes a proposal to establish an exceptions process for plans offered beyond the limit of two non-standardized plans if they provide 25 percent reduced cost-sharing for chronic and high-cost condition benefits.

- **Network Adequacy:** Extends network adequacy requirements to State-based Exchanges and State-based Exchanges on the Federal Platform (SBE-FPs) for plan years beginning on or after January 1, 2026.

- **Essential Health Benefits (EHB):** Finalizes that state-mandated benefits are not considered "in addition to EHB" under CMS' defrayal policy if the mandated benefit is an EHB in the state's EHB-benchmark plan.

- **Prescription Drug Benefits:** Revised the minimum membership standards for Pharmacy & Therapeutics (P&T) Committees to require at a minimum one patient representative, including specific requirements related to the patient representative. CMS also codified a requirement that, for Marketplace plans, non-EHB prescription drug coverage will be subject to EHB cost sharing limits. In a separate FAQ, the Tri-Agencies expressed an intent to propose rulemaking to extend this standard to large group and self-insured group plans.

- **User Fees**: Reduced user fee rates of 1.5% of total monthly premiums for the Federal Exchange and 1.2% of total monthly premiums for State Exchanges on the Federal Platform due to increased enrollment numbers.

- **Open Enrollment & SEP Dates:** Aligns annual open enrollment dates and special enrollment period (SEP) effective dates across all Marketplaces, including establishing an open enrollment start date of November 1 and end date no earlier than January 15 for most Marketplaces.

Additional Materials: The final rule takes effect 60 days following publication in the Federal Register. The Biden-Harris Administration released this fact sheet and press release to accompany the 2024 NBPP. The 2025 Final Actuarial Value (AV) Calculator and Methodology was published.

HHS Releases 5 Year Health IT Strategic Plan

HHS has released its draft 5 year strategic plan to increase access for patients and providers to electronic health information without compromising safety and privacy. The 2024-2030 draft released by HHS' Office of the National Coordinator for Health IT outlines its plans to help patients and providers access health records more easily.

The draft specifically:

- Outlines federal health IT goals and objectives that are focused on improving access to health data, delivering a better, more equitable health care experience, and modernizing our nation's public health data infrastructure.

- Places an emphasis on the policy and technology components necessary to support the diverse data needs of all health IT users.

The plan supports the Department's recent Health Data, Technology, and Interoperability: Certification Program Updates, Algorithm Transparency, and Information Sharing (HTI-1) final rule to advance the access, exchange, and use of electronic health information (EHI), and deliver more transparent and equitable care for individuals. It also aligns with the HHS Health Care Sector Cybersecurity concept paper and voluntary health care specific Cybersecurity Performance Goals (CPGs) to help health care organizations prioritize implementation of high-impact cybersecurity practices.

Comments on the draft are open through May 28.

State Issues

New York

Legislative

Still No Budget

One week into the 2025 Fiscal Year, New York is still without a budget. However, late last week the Governor and legislative leaders indicated agreement on a final spending plan was "close." After approving another budget extension late last week to keep state government operating until April 8, the Legislature passed another extension to April 11, to allow members to be in their districts for solar eclipse activities.

Although there still is no final budget agreement, reports from the Capitol over the weekend were that negotiations on major issues are picking up and there is a desire to try to wrap up "soon."

Regulatory

Essential Plan Expansion Kicks Off

Last week started the long-planned eligibility expansion of New York's Essential Plan, opening enrollment in the program aimed at lower-income residents who do not qualify for Medicaid to people earning up to 250% of the federal poverty level - or annual incomes of $37,650. Previously, eligibility was limited to New Yorkers earning up to 200% of the federal poverty level. It is expected that the expansion will enable nearly 100,000 more New Yorkers to enroll in the EP, the vast majority in the downstate area.

State Issues

Pennsylvania

Regulatory

Pennsylvania Insurance Department Issues Guidance Related to the Use of AI

The Insurance Department issued guidance in the *Pa Bulletin* via Notice 2024-04 related to the use of Artificial Intelligence (AI).

Why this matters: The Department reminds all insurers authorized to do business in Pennsylvania "that decisions or actions impacting consumers that are made or supported by advanced analytical and computational technologies, including Artificial Intelligence (AI) systems, must comply with all applicable insurance laws and regulations. This includes those laws that address unfair trade practices and unfair discrimination."

- The notice sets forth the Department's expectations for insurers with how insurers will govern the development/acquisition and use of certain AI technologies.
- It also outlines the types of information and documentation that the Department may request during an investigation or examination relating to the use of AI technologies and systems.
- The Department's guidance is based upon a National Association of Insurance Commissioners (NAIC) Model Bulletin, which the NAIC adopted during its 2023 Fall National Meeting.

Industry Trends

Policy / Market Trends

New Surprise Billing Analysis Finds High Payments Awarded to Providers

Brookings published a new analysis of No Surprises Act Independent Dispute Resolution (IDR) data from CMS that compared qualifying payment amounts (QPAs) and arbitration payment determinations to Medicare payment rates as a benchmark.

Why this matters: The report found that providers benefit greatly from the IDR process, with median IDR determinations paying at least 3.7 times what Medicare would pay. Payment determinations appear closer to the amounts insurers historically paid for out-of-network care.

The analysis highlights the role of large private investor-backed provider groups in driving up the number of IDR cases and suggests that the payment trends could cause in-network prices and premiums to increase. That's the opposite of what the Congressional Budget Office predicted would happen.

- The prevailing assumption before the law took effect was that removing financial incentives to be out of network would encourage in-network care and ultimately lower prices.
- The Brookings analysis "suggests that the amount of money providers can collect when out of network might not change dramatically," and being out of network may even be more attractive now because patients are no longer the ones being hit with big bills.

The Alliance to Fight for Health Care Highlights Site-Neutral Payment Proposals in 2025 Budget Proposal

The Alliance to Fight for Health Care (the Alliance) published a new article spotlighting a key proposal in the Administration's proposed FY2025 budget. The proposal, which would save **$2.3 billion over 10 years**, would "ban facility fees for telehealth and certain outpatient services in commercial insurance."

The Alliance goes on to explain that charging patients a hospital 'facility fee' for telehealth services that occur in the patient's home is particularly egregious but is unfortunately happening. The Alliance supports site-neutral payment reform and policies to tamp down or eliminate hospital facility fees for care received outside of the hospital setting.

Additional information on site-neutral payment reform: Check out the December letter from the Alliance to Fight for Health Care to House Leadership in support of Sections 203 & 204 in H.R. 5378, the *Lower Costs, More Transparency Act* (LCMT).

HHS Report Points Out Gaps in Mental Health Care Access

Access to mental health services is limited for many Americans, including people in vulnerable populations and many enrolled in Medicare or Medicaid, according to a report from the HHS Office of Inspector General.

There are less than five active mental health service providers for every 1,000 people on Medicare, and some US counties have no clinicians. The findings are especially concerning in light of the growing need for services, said lead author Meredith Seife.

HHS Announces $39.4M in Grants to Address SUD & Behavioral Health

Recently, the U.S. Department of Health and Human Services (HHS), through the Substance Abuse and Mental Health Services Administration (SAMHSA), announced $39.4 million in grant opportunities to address the overdose epidemic and tackle the mental health crisis.

Why this matters: The awards facilitate ongoing efforts to advance HHS' Overdose Prevention Strategy, support the Administration's mental health strategy, as well as the National Drug Control Strategy. Several grant funding opportunities being announced are:

- Promoting the Integration of Primary and Behavioral Health Care: States ($6 million) – This program promotes integration and collaboration between behavioral health and primary physical health care providers. It also supports bi-directional integrated care models that improve wellness and better manage illness across physical and behavioral health.

- Promoting the Integration of Primary and Behavioral Health Care: Collaborative Care Model ($5.2 million) – The Collaborative Care Model seeks to improve care for mental and substance use conditions in primary care settings.

- Assisted Outpatient Treatment Program for Individuals with Serious Mental Illness ($15.2 million) – This program helps implement new Assisted Outpatient Treatment (AOT) programs in communities to support adults with serious mental illness (SMI) who meet state-specific criteria for AOT.

Read more about the grant opportunities here.

Coalition Spotlights Growth of Private Equity-Acquired Physician Practices

The Coalition Against Surprise Medical Billing (CASMB) published a new blog spotlighting a recent report in *Health Affairs* on the increase in the number of private equity (PE) acquired physician practices and the potential impact on the quality and cost of health care for patients.

Highlights:

- "The PE business model of 'rolling up' additional practices through acquisitions can exacerbate market concentration in the physician practice industry. When PE firms acquire multiple providers in the same specialty within a local or regional market, those firms can gain significant market power, which can lead to higher prices or lower quality, or both, as a result of reduced competitive pressure."

- "Of the 1,094 acquisitions in these ten specialties for the entire study period, dermatology practices were most commonly acquired by PE firms (34 percent of all acquisitions), followed by ophthalmology (25 percent) and gastroenterology (11 percent)."

- "This trend raises concerns about its potential impact on competition, patient care, and prices in those local markets. PE acquisitions in health care often result in higher prices for services, such as in dermatology practices, where prices can increase by 3–5 percent."

PE Role in Surprise Billing: Further, new federal data paints a clear picture how these private equity-backed out-of-network providers are now using the Independent Dispute Resolution (IDR) established under the *No Surprises Act* to drive up reimbursements, ultimately costing consumers and taxpayers.

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/.**