Issues for the week ending February 2, 2024

In this Issue:

Federal Issues
Legislative
- Bipartisan Majority of Senators Ask CMS to Protect Medicare Advantage

Regulatory
- CMS Releases 2025 Medicare Advantage/Part D Advance Notice & Draft Part D Redesign
- Summary of the CMS Interoperability & Prior Authorization Final Rule
- SAMHSA Finalizes Rule to Allow Telehealth Prescribing of Buprenorphine
- CMS Releases FAQs on Extending Postpartum Coverage for Medicaid
- CMS Releases Updated Prescription Drug Data Collection (RxDC) Materials

State Issues
New York
Legislative
- Advocacy to Restore Medicaid Quality Incentive Funding

Regulatory
- 2025 Rate Setting Kicks Off

.

Federal Issues

Legislative

Bipartisan Majority of Senators Ask CMS to Protect MA

A bipartisan group of 61 Senators sent a letter to the Centers for Medicare & Medicaid Services (CMS) expressing their support for Medicare Advantage (MA). The letter, led by Sens. Catherine Cortez Masto (D-NV), Tim Scott (R-SC), Gary Peters (D-MI), and Shelley Moore Capito (R-WV), urges CMS to strengthen and protect MA as a critical choice for more than 32 million seniors and people with disabilities who choose it because it delivers better services, better access to care, and better value.

Why this matters: Acknowledging that the MA program now serves a majority of Medicare eligibles, the senators asked the agency to "look at meaningful ways to continue to sustain and strengthen Medicare Advantage to protect beneficiaries' affordability and access while improving transparency and building on the unique attributes of this important program."

The support letter comes as CMS released its CY 2025 MA/Part D Advance Notice for comment last week.

Pennsylvania
Regulatory

- **State Announces Program to Help Substance Use Disorder Workers with Student Loan Dept**

West Virginia
Legislative

- **Legislative Update**

Industry Trends
Policy / Market Trends

- **AHIP Submits Comments to MedPAC Highlighting Methodology Concerns in 2024 Medicare Advantage Report**
- **CMS Releases Latest Medicaid, CHIP Enrollment Figures & Redetermination Data**
- **HCSC Reaches Deal to Acquire Cigna Medicare Advantage Plans**
- **Latest BCBSA and AHIP Report Confirms Success of No Surprises Act**

Federal Issues

Regulatory

CMS Releases 2025 Medicare Advantage/Part D Advance Notice & Draft Part D Redesign

The Centers for Medicare & Medicaid Services (CMS) released two important proposed payment updates for comment:

1. Calendar Year (CY) 2025 Advance Notice for Medicare Advantage (MA) and Medicare Part D
2. Draft CY 2025 Part D Redesign Program Instructions

Fact Sheets: CMS also released a corresponding Advance Notice Fact Sheet and Part D Redesign Program Instructions Fact Sheet.

Context: The Advance Notice must be released annually 60 days before the issuance of the final MA rates and Part D payment-related information for the upcoming contract year to provide preliminary information related to the rates and notice of any methodological changes.

Why this matters: The Centers for Medicare & Medicaid Services (CMS) released the Advance Notice in which CMS provides a preliminary estimate of changes in county benchmarks and proposes other payment policies for Medicare Advantage (MA) and Part D plans for the upcoming contract year. Proposals are subject to change in the Final Notice, which will be released by April 1, based on comments received from stakeholders.

Key proposed changes include:

- **MA Payment Policies:** According to CMS, county benchmarks will increase by 2.44%, but CMS estimates the net payment impact for plans on average will be -0.16% before accounting for potential changes in risk scores. In the Fact Sheet released in conjunction with the Advance Notice, CMS suggests the expected change in revenue for 2025 is 3.70% if an expected MA risk score trend of 3.86% is included.
- **Risk Model:** CMS proposes to continue the phase-in of the Part C risk model finalized last year in the 2024 Final Rate Notice. CMS will calculate enrollee risk scores using 67% of the 2024 Part C risk model and 33% of the 2020 Part C risk model.
- **FFS (Fee-for-Service) Normalization Factor:** For 2025 CMS is proposing to change the way the normalization factor is calculated to account for the impact of the pandemic on beneficiary scores.
- **Coding Intensity Adjustment:** CMS proposes to continue applying the statutory minimum adjustment of 5.9% in 2025. This amount is unchanged from 2024.
- **RxHCC Model:** CMS proposes numerous changes to the RxHCC model for 2025 to reflect the substantial changes the IRA made to the Part D benefit for 2025 and the resulting expected increase in plan liability. The proposed changes include model recalibration, age category model constraints, and normalization factors.
- **Benefit Parameters:** The API for CY 2025 is 8.58%. However, given the changes in Part D design enacted under the IRA, including the elimination of the coverage gap phase and the annual OOP threshold of $2,000 for CY 2025 set by statute, the only defined standard Part D prescription drug benefit parameter that is updated using the API for CY 2025 is the deductible. The Part D deductible for CY 2025 is $590 (compared to $545 for 2024). The annual OOP threshold will be updated using the API starting in CY 2026.

CMS also released the draft CY 2025 Part D Redesign Program Instructions for comments.

Why this matters: The purpose is to address the implementation of provisions of the IRA that affect the structure of the defined standard Part D drug benefit. Guidance in the draft program instructions addresses topics that include:

- **Enhanced Benefit Plan:** For CY 2025, CMS proposes to use the Part D Out-of-Pocket Costs (OOPC) model to estimate the value of enhanced alternative (EA) plans relative to the value of the defined standard benefit.
- **Meaningful Difference:** CMS is proposing to require, under the PDP meaningful difference test, that the EA plan value be at least 15% better than the basic plan offered by the same parent organization in the same region. CMS also proposes to add an additional test to ensure that formulary "robustness" and benefit design/tier placement is no worse for the EA plan compared to the basic plan.
- **TrOOP:** The draft program instructions also discuss other key policies, including costs counted toward True Out-of-Pocket Costs (TrOOP), a revised reinsurance subsidy calculation methodology, and how prospective reinsurance payments to all Part D EGWP sponsors will be calculated.

Additionally, CMS is seeking input on possible future changes to existing Part C & Part D Star Ratings measures and display measures as well as potential new measures and methodological changes. **Star Ratings issues include:**

- Status on including "Universal Foundation" measures as part of the Star Ratings measure set (this is a subset of measures that are aligned across CMS quality measurement programs).
- Potential substantive changes to Part C appeals measures that would have to be proposed through rulemaking.
- Potential changes to the existing Health Outcomes Survey (HOS) measures. CMS indicates that it plans to conduct a field test to inform potential changes to HOS content and survey procedures.
- Potential new Part D measure to evaluate the accuracy of sponsors' pricing data displayed on the Medicare Plan Finder (MPF) tool.

Next Steps: Comments for both proposals are due to CMS by **March 1, 2024, at 6:00 p.m. ET**.

Summary of the CMS Interoperability & Prior Authorization Final Rule

On January 17, 2024, CMS released the Advancing Interoperability and Improving Prior Authorization Processes (CMS-0057-F) final rule. A more detailed summary is available here.

Why this matters: As previously reported, the rule builds on the CMS Interoperability and Patient Access final rule which required plans in federal programs to build and maintain application programming interfaces (APIs) to support the exchange of clinical, claims, and directory information to improve patient access to health information. The final rule requires impacted payers to expand the information made available to consumers, enable clinicians to look up coverage requirements, deploy electronic prior authorization technology, share clinical and claims information with providers, and exchange clinical and claims data with each other as consumers change payers.

The rule applies to Medicare Advantage organizations, state Medicaid and CHIP FFS programs, Medicaid managed care plans, CHIP managed care entities, and QHP issuers

in the FFEs. However, CMS encourages commercial plans to also adopt the technologies and policies and notes that Medicare fee-for-service will implement the provisions.

The new regulations require plans in federal programs to expand or build by January 1, 2027:

- **Patient Access API**—Expand the information available to consumers to include the outcome of prior authorization decisions and report metrics on use of the Patient Access API to CMS.
- **Prior Authorization API**— Develop a FHIR-based API that automates the process for providers to determine if prior authorization is necessary, what information is required, and electronically exchange the request and response.
- **Provider Access API**—Develop a FHIR-enabled API for payers to share clinical, claims, encounter data (excluding cost information), and prior authorization requests/decisions with in-network providers to support value-based care and payments.
- **Payer-to-Payer API**—Develop a FHIR-enabled API for insurers to share clinical and claims data (excluding cost information) with each other as consumers change insurers and at their request for up to five years of data.

For additional information from CMS, see the press release and fact sheet.

SAMHSA Finalizes Rule to Allow Telehealth Prescribing of Buprenorphine

The Department of Health and Human Services, through the Substance Abuse and Mental Health Services Administration (SAMHSA), and in consultation with the Drug Enforcement Administration (DEA), has issued a final rule that permanently extends flexibilities in the prescribing of medications for opioid use disorder (MOUD).

The final rule:

- Allows practitioners in Opioid Treatment Programs (OTPs) to prescribe buprenorphine via telehealth – both audio-video and audio-only – without the need for an in-person visit.
- Allows for the use of audio-visual telehealth for any new patient treated by the OTP with methadone if an adequate evaluation can be accomplished via telehealth; however, audio-only telehealth cannot be used to conduct this examination unless the patient is in the presence of a licensed practitioner who is registered to prescribe and dispense controlled medications.
- Defers to the judgment of the practitioner regarding take-home doses of methadone, when operating as part of an OTP; the final rule now allows up to 28 days' supply for stable patients and up to 14 days' for less stable patients who can still safely handle the medication, at the discretion of the OTP provider.
- Eliminates the requirement for a patient to have a diagnosis of opioid use disorder (OUD) for at least one year prior to admittance to an OTP.
- Modifies requirements for the initial and periodic medical exams.
- Updates OTP admission criteria to reflect a patient's need for treatment using evidence-based standards, including evaluation for active moderate or severe

OUD, OUD remission status, or if someone is at high risk for recurrence or overdose.
- Eliminates the rule stating a patient cannot initiate methadone treatment more than twice per year.
- Eliminates the requirement that minors have at least two documented unsuccessful attempts to manage drug withdrawal before initiating buprenorphine or methadone.
- Makes flexibilities for mobile units permanent.
- Updates references to accreditation and certification standards to allow online and electronic forms.
- Updates language to remove outdated references, remove stigmatizing terminology, and make the rule more patient-centered.
- Promotes a patient-centered approach that does not make medication continuity or toxicology testing contingent upon involvement in OTP services, provided these do not negatively impact treatment.

Review the final rule here.

The final rule is effective April 2, 2024, and the compliance date is October 2, 2024.

Why this matters: These changes to decades-old federal rules are intended to simplify and expand access to addiction treatment. While this rule change will help anyone needing treatment, it will be particularly impactful for those in rural areas or with low income for whom reliable transportation can be a challenge.

CMS Releases FAQs on Extending Postpartum Coverage for Medicaid

The Centers for Medicare & Medicaid Services (CMS) released a set of frequently asked questions (FAQs) to supplement the 2021 State Health Official Letter informing state Medicaid and Children's Health Insurance Program (CHIP) agencies about the opportunity to extend the duration of pregnancy-related Medicaid coverage to 12 months postpartum. The FAQs address the benefits covered during the extended postpartum period and requirements related to the mandatory tobacco cessation benefit. Read More

---

CMS Releases Updated Prescription Drug Data Collection (RxDC) Materials

CMS released an Information Collection Request and Paperwork Reduction Act (PRA) package (CMS-10788) for the Prescription Drug and Health Care Spending reporting requirements (RxDC) for the 2023 reference year for use in reporting by the June 1, 2024 deadline. Comments are due in 60 days (April 1).

Why this matters: This is the third PRA issued by CMS on this reporting requirement from section 204 of the Consolidated Appropriations Act (CAA) of 2021. The most significant changes to the RxDC reporting instructions from the previous version can be found on page 3 of the attached reporting instructions. **CMS staff highlighted the following changes:**

- not extending suspension of the aggregation restriction (that is, data submitted by PBMs must be at the same or less rolled-up level as the issuer)
- added a column to D6 (enrollment in pharmacy benefits)
- simplified average premium calculation

State Issues

New York

Legislative

Advocacy to Restore Medicaid Quality Incentive Funding

The importance of the Medicaid Quality Incentive Program and the NY Health Plan Association (HPA) advocacy to support restoration of the funding for the program in the FY25 State Budget is in the spotlight.

On Monday, the NYS Black, Puerto Rican, Hispanic, and Asian Legislative Caucus hosted a panel discussion on the quality incentive program with providers, consumers and health plan leaders to share their experiences on the critical role QI funding plays in their efforts to improve the quality of care and addresses health disparities for low-income New Yorkers. Following the discussion, the Caucus, joined by the panel participants and other supporters, helld a press conference calling for the restoration of the Quality Incentive Program and to fully fund the program in the final FY25 State Budget.

To supplement the Caucus's efforts and amplify the message about the value of the program, plans and the HPA have been working with community partners to demonstrate the impact of the QI Program. Two op-eds appeared last week, sharing first hand accounts of how funding under the QI Program is making a difference in communities across the state. The Times Union published an op-ed on how the program is supporting Family Promise of the Capital Region's efforts to assist homeless and low-income families, while an op-ed in the Buffalo News highlighted how program funding is enabling two Western New York organizations, the Buffalo City Mission and Adult Health NP House Calls, to meets low-income residents where they are to provide critical services that keep people from falling through the cracks. Highmark provided funding for the Buffalo City Mission's recuperative care unit with quality inventive dollars.

Regulatory

2025 Rate Setting Kicks Off

The Department of Financial Services last week hosted a meeting of plan actuaries to begin discussions about the 2025 Individual and Small Group rate filing process. Staff reviewed changes to the 2025 Standard Plan Designs, which are necessary because existing standard plans no longer meet required actuarial values. Staff said they intend to require the use of 2023 data as the starting point for rate development as well as

requiring 2023 risk adjustment results as the starting point for purposes of developing the 2025 risk adjustment assumption.

The meeting also included discussions of how the state might handle several items related to the 1332 Waiver and provisions in the Executive's 2025 Budget proposal. 1332 Waiver issues include extending cost-sharing subsidies for more Qualified Health Plan enrollees and eliminating QHP cost-sharing for certain diabetes and prenatal care services. Budget items include requiring mental health treatment services at facilities certified by the Office of Addiction Services and Supports to be reimbursed at least at the Medicaid rate, and elimination of cost-sharing for insulin, prenatal care services and treatment of HIV. All are subject to approval in the final budget and the Department indicated it is still working on how it would calculate the potential impact on rates.

The timeline for the 2025 rate process was also reviewed, which includes the following key dates:

- May 8 – rate filings due to DFS
- May 24 – tentative date for DFS to post applications
- June 3 – tentative start of the public comment period
- July 29 – rate decisions due
- August 9 – estimated date for DFS to announce and post rate decisions

DFS intends to host at least one more actuary meeting.

State Issues

Pennsylvania

Regulatory

State Announces Program to Help Substance Use Disorder Workers with Student Loan Debt

The state Department of Drug and Alcohol Programs (DDAP) announced $18 million in funding through the substance use disorder (SUD) student loan repayment program to assist practitioners within the SUD treatment, prevention, case management, and recovery support services workforce.

Officials said the program will support employee recruitment and retention, and access to care for Pennsylvania residents seeking SUD treatment. Grant agreements will be awarded based on the availability of funding. This funding opportunity is made possible from the Opioid Settlement Fund (McKinsey) and Pennsylvania's Medical Marijuana Program Fund.

Key Provisions of the Program:

- DDAP will provide loan repayment opportunities as an incentive to retain SUD practitioners willing to continue providing services within the commonwealth for two years.
    - Practitioners can apply for up to $75,000 if they practice full-time or $37,500 if they meet half-time practice criteria.
- The SUD loan repayment program focuses on DDAP-licensed drug and alcohol treatment facilities as well as staff providing Single County Authority-funded prevention, case management, and recovery support services.
- Qualifying professions include physicians, psychiatrists, registered nurses, certified registered nurse practitioners, certified addictions registered nurses, licensed social workers, certified clinical supervisors, certified alcohol and drug counselors, case managers, prevention specialists/managers, and administrative staff, among others.
- Applications must be submitted **online** by March 1, 2024.

Questions regarding the grants and the application process should be emailed to RA-DASUDLRP@pa.gov.

Why this matters: Under a similar program in 2022, more than 270 SUD practitioners including case managers, counselors, licensed social workers, physician assistants, and registered nurses were awarded funding totaling almost $19 million to go towards repaying their student loans.

State Issues

West Virginia
Legislative

Legislative Update

EMS-Ambulance Reimbursement
Bills on emergency ambulance services and insurance reimbursement (SB 444 and HB 5255) emerged last week as active issues as a part of the EMS coalition's efforts to secure stable funding for their operations outside of state appropriations. Emergency air ambulance services have been removed from the legislation, as well as any entitlement to receive reimbursement for non-patient treatment/non-transport scenarios.

DHS testified in the Senate Health Committee that Medicaid would gain cost savings advantages from being included in SB 444 since they believe the proposal would reduce Medicaid Emergency Department visits. The bill goes to the Senate Finance Committee next where that change appears to be on track for the bill.

HB 5255 in the House of Delegates has also been rewritten to eliminate any references to air ambulance services as entitled to non-transport reimbursements from health plans.

HB 4753—Cancer Biomarker Testing
This bill, which was based on the New York statute passed in 2023, and was negotiated among interested parties by House Insurance Chairman Steve Westfall, is likely to be considered this week in the House Judiciary Committee before going before the full House of Delegates.

Other Significant Mandated Coverage Proposals
SB 443, pertaining to oral health and cancer rights, mandates coverage that would fall outside of the EHB under ACA and has remained in the Senate Banking & Insurance Committee without any activity so far in the legislative session. Similarly, the same Senate committee has control of SB 486 mandating breast cancer screening and there are no current indications of this bill moving forward for consideration at this point either.

We are also closely monitoring other mandate proposals including HB 4174 prohibiting "white bagging," SB 250 mandating coverage of infertility services and SB 383 mandating an expansion of coverage for autism treatment. None of these bills are under consideration at present.

HB 5310—Remote Outcome Improvement Act
Delegate Daniel Linville of the Huntington area, Chairman of the House Technology & Infrastructure Committee has advanced HB 5310, which proposes to establish a statutory framework for broadband providers and health plans to voluntarily partner in delivering services to plan members for purposes of improving patient access to telemedicine services and remote health monitoring.

HB 5338—Data Privacy Protection Act
This is a comprehensive privacy bill that loosely follows the Virginia statute on privacy but includes a number of other elements, including cybersecurity provisions. The privacy bill in its current form is nearly universally opposed by all elements of the business community.

It is not clear how this very significant bill will be considered in the House Finance Committee, where it is now assigned.

HB 5417—NOIL model bill on dental plan expenditure reporting.
House Insurance Committee Chairman Steve Westfall is a major part of the NCOIL governance structure and introduced the organization's model dental expenditure reporting bill last week.

Industry Trends

Policy / Market Trends

AHIP Submits Comments to MedPAC Highlighting Methodology Concerns In 2024 Medicare Advantage Report

AHIP recently submitted a letter to the Medicare Payment Advisory Commission (MedPAC) in response to its analysis of Medicare Advantage and fee-for-service Medicare 2024 projected spending.

Why this matters: The comment letter raised concerns over the validity of the conclusions drawn from the group's analysis of projected 2024 spending in the Medicare Advantage (MA) and fee-for-service (FFS) programs. AHIP found that the estimates of relative MA and FFS spending included various assumptions about differences between MA and FFS enrollees, and projections of future changes in costs.

AHIP highlights that reducing program funding could adversely affect MA enrollees, particularly the low-income, older, and diverse beneficiaries who increasingly choose MA. AHIP urged MedPAC to consider these concerns before finalizing its assessment of the MA program in its March Report to Congress. AHIP continues to engage with MedPAC and stakeholders to explore ways to build on the strengths of Medicare Advantage. Read the letter here.

CMS Releases Latest Medicaid, CHIP Enrollment Figures & Redetermination Data

CMS released the latest enrollment figures for Medicaid and CHIP. As of October 2023, there were over 80.2 million individuals enrolled in Medicaid and over 7 million enrolled in CHIP. Combined enrollment in the two programs decreased by over 1.6 million from the prior month. Read More

CMS also reported the latest batch of Medicaid Redeterminations data required under the Consolidated Appropriations Act, 2023; click here to access. CMS posted a summary of outcomes for the renewals initiated in October 2023, including:

- 7.2 million people were due for renewal in October, holding steady with September.
- Of those due for renewal, 56.8% had their coverage renewed in Medicaid and CHIP (a jump from 53.8% in September and continuing a positive trend). Of those renewals, 67% were done through an *ex parte* review, which also continues a positive trend (e.g., the rate was 63.7% in September, and 57.8% in June).
- More than one fifth (22.6%) lost their Medicaid and/or CHIP coverage, similar to September (22.9%), which also continues a slight downward trend. Within that cohort, 68.9% of terminations in October were for procedural reasons, compared with 64.8% in September. However, many procedural terminations were held in September due to the household *ex parte* mitigation.
- Another 20.7% of people due for renewal in October were still pending with their state at the end of the month (compared to the high of 25.1% in July).

The October 2023 National Summary of Renewal Outcomes (click here to access) includes additional analysis from CMS, including states that had paused some or all procedural terminations each month, month-over-month trends for the 8 months of data that are now available, and cumulative changes since the beginning of the unwinding.

HCSC Reaches Deal to Acquire Cigna Medicare Advantage Plans

Health Care Service Corporation (HCSC), parent of BCBS Plans in IL, MT, NM, OK and TX, announced it has signed a definitive agreement with Cigna to acquire its MA, Medicare Supplemental Benefits, Medicare Part D and CareAllies businesses.

Why it matters: The acquisition, if approved, would add millions of Medicare and MA members to the total number of seniors insured by BCBS companies.

The details: Cigna's Medicare plans currently serve 3.6 million Medicare members, with nearly 600,000 in MA plans, more than 450,000 on Medicare Supplement plans and 2.5 million with Medicare Part D.

- **CareAllies** — which serves approximately 450,000 patients — focuses on driving the transition to value-based care by partnering with providers to form independent physician associations and accountable care organizations.

What they're saying: "The acquisition will bring many opportunities to HCSC and its members — including a wider range of product offerings, robust clinical programs and a larger geographic reach," said Maurice Smith, president and CEO of HCSC. "It builds on our commitment to expand access to quality, affordable care for people in all phases of their lives."

What's next: HCSC anticipates completion of the acquisition, including regulatory approvals, in early 2025

Latest BCBSA and AHIP Report Confirms Success of No Surprises Act

A new survey and press release from AHIP and BCBSA were distributed this week that affirm the No Surprises Act (NSA) continues to protect millions of Americans each year.

Why it matters: The NSA prevented more than 10 million surprise bills in the first nine months of 2023, which helps limit out-of-pocket costs for consumers and supports our North Star commitment of providing affordable health care.

Yes, and: Although there was some concern that the NSA would cause doctors to leave networks, two-thirds of health insurance providers reported their provider networks have increased since the NSA became law, with none reporting an overall reduction in participating providers.

The big picture: This report follows the same framework as the previous two reports issued in 2022 with updated findings for 2023 and takeaways about the impacts to networks and how 80% of providers accept a plan's initial payment.

- **Making headlines:** The findings of the joint study were reported on by Axios, Becker's, Benefits PRO, Fierce Healthcare, Healthcare Dive, Healthpayer Intelligence and Medical Economics.

The bottom line: “Getting a bill is never fun,” said David Merritt, SVP of policy and advocacy for BCBSA. “Getting a surprise bill is awful. I'm proud to see that the No Surprises Act is doing what it’s supposed to — protecting millions of families from unexpected financial hits and the peace of mind that a surprise medical bill won’t cost them their next paycheck.”

Go deeper: Visit BCBSA’s Health of America page for more on how the NSA and the independent dispute resolutions process are protecting Americans from surprise bills.

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/.**

The content of this email is confidential and intended for the recipient specified only. It is strictly forbidden to share any part of this message with any third party, without a written consent of the sender. If you received this message by mistake, please reply to this message and follow with its deletion, so that we can ensure such a mistake does not occur in the future.