HEALTHCARE ON THE HILL

AMERICA'S PHYSICIAN GROUPS

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Welcome to "Healthcare on the Hill," APG's weekly e-newsletter on the latest healthcare happenings in our nation's capital, with a special focus on the value-based care movement.

APG is working to ensure you have the very latest information on the legislative and policy developments impacting the healthcare landscape and your practice.

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Garrett Eberhardt
Director of Federal Affairs
America's Physician Groups

House Energy and Commerce Oversight Subcommittee Holds Hearing on Medicare Advantage

Earlier this week, the House Energy and Commerce Subcommittee on Oversight and Investigations held a hearing to evaluate the role of the private sector within the Medicare Advantage (MA) program and the value that these plans offer beneficiaries. Witnesses included Erin Bliss, Assistant Inspector General for the Department of Health and Human Services' Office of Inspector General (OIG); Leslie Gordon, Acting Director for Health Care for the Government Accountability Office; and James E. Mathews, Ph.D., Executive Director of the Medicare Payment Advisory Commission. While Republicans on the subcommittee stopped short of showing interest in completely overhauling the program, both members and witnesses were largely critical of the practices of MA plans in comparison to traditional Medicare fee-for-service (FFS) plans, noting that MA plans are allowed to use internal clinical coverage criteria that goes beyond the scope of Medicare coverage rules in certain circumstances. Members cited barriers to access to services that they attributed to utilization management techniques such as prior authorization and step therapy. Both Democrats and Republicans expressed support for the implementation of electronic prior authorization. She also asked the witnesses if Congress must take additional steps to "course correct" on MA and all agreed that it must.

In her opening statement, Subcommittee Chair Diana DeGette (D-CO) cited a recent OIG report that suggested that beneficiaries enrolled in certain MA plans face impediments to care, including

payment denials and “improper” utilization management techniques. Chairwoman DeGette called for additional data on the program to provide better oversight and accountability and stated the Subcommittee’s intentions to continue to conduct oversight of MA to ensure that beneficiaries are receiving proper care and that funding for the program is used appropriately.

Subcommittee Ranking Member Morgan Griffin (R-VA) discussed the differentiations between the MA program and FFS, speaking favorably of the use of prior authorization in MA to use benchmarks to control costs. He asked the panel of witnesses if they believed that eliminating the MA program entirely was the proper course of action, with all witnesses agreeing that it is not.

Erin Bliss stated that OIG recommends that the Centers for Medicare and Medicaid Services (CMS) issue new guidance on the appropriate use of clinical criteria and that CMS assess the use of these criteria in its audits of MA plans. Leslie Gordon discussed CMS’ status in addressing GAO findings, concluding that while CMS has adhered to the implementation of certain recommendations, the agency has largely failed to incorporate process improvements suggested by GAO. Dr. Mathews advocated for both Congressional and federal agency action to rectify issues within the MA program, offering recommendations that correct “improper” coding practices, among other items.

You can reach a summary of the hearing here. APG will continue to be proactive in policy development around MA in the interests of preserving and strengthening the program along lines that will benefit both beneficiaries and our member groups. We will continue to keep you updated on developments on Capitol Hill regarding the program.

Biden Administration Releases Spring 2022 Unified Agenda

Earlier this month, the Office of Management and Budget (OMB) published the Spring 2022 Unified Agenda which outlines the Biden administrations future regulatory priorities. Included in the agenda are proposed rules to implement changes to the Medicare Advantage (MA) (Part C) and prescription drug (Part D) programs for contract year (CY) 2024 and the HHS Notice of Benefit and Payment Parameters for 2024, which would set forth payment parameters and provisions related to the risk adjustment programs, cost-sharing parameters, and user fees for issuers offering plans on federally-facilitated Exchanges and State-based Exchanges using the federal platform. The agenda also includes a rule proposing changes to the Medicaid managed care regulations, which would add parameters on states’ use of In Lieu of Services or Settings (ILOS) and state-directed payments under Medicaid managed care contracts, among other policy and reporting changes. Additionally, the Unified Agenda proposes to implement requirements set forth by section 203 of the Consolidated Appropriations Act, 2021 (CAA) related to Medicaid shortfall and third-party payments, as well as making technical changes to the disproportionate share hospital (DSH) program.

HHS Releases Request for Information on Strengthening Primary Care

On Tuesday, the U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Health (OASH) officially released a Request for Information (RFI) regarding ideas on how the federal government can strengthen primary health care in the United States. The OASH is requesting input from health care providers, purchasers and payers, educators, researchers, and other members of the public about what the federal government could do to Improve access to health care, advance health equity, and improve the health of the nation.

The Biden administration cites high-quality primary health care as having been shown to improve health equity and health outcomes and considers primary care to be essential for addressing its key priorities including the COVID-19 pandemic; mental and substance use disorder prevention and care, suicide and overdose prevention; prevention and management of chronic conditions; and maternal and child health and well-being. The HHS Initiative to Strengthen Primary Health Care (Initiative) aims to establish a federal foundation for the provision of primary health care for all that supports improved health outcomes and advanced health equity, with the first task to develop an

initial HHS plan for strengthening primary health care that will delineate specific actions that HHS agencies and offices may take to achieve the aims, within the current legislation and funding environment. HHS states that the purpose of the RFI is to provide OASH with diverse perspectives, experiences, and knowledge that may inform the development of the initial plan for HHS, as well as future steps for the Initiative. OASH is seeking information about successful approaches and innovations that improve primary health care payment, delivery models, service integration, access, workforce education, training and well-being, digital health and primary care measurement and research. OASH also seeks information about barriers to implementation of such innovations and how they could be overcome, including specific ideas for possible HHS action. OASH encourages respondents to address health equity, and is particularly interested in information from community-based settings, such as public housing, personal homes, group homes, and assisted living facilities where older adults and people with disabilities may live, and about populations traditionally underserved by current primary health care.

CMS Releases CY2023 End-State Renal Disease (ESRD) Prospective Payment System Proposed Rule

Last week, the Centers for Medicare and Medicaid Services (CMS) released its Calendar Year (CY) End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) proposed rule. The rule sets payment rates for next year (CY) 2023 and proposes changes to the ESRD Quality Incentive Program (QIP). The agency says it expects to pay $8.2 billion for dialysis services in CY 2023 and is proposing to increase the PPS base rate to $264.09, an increase of $6.19 over CY 2022 rates. CMS estimates that ESRD facilities would see an increase of approximately $320 million in payments in CY 2023.

CMS is proposing to establish a permanent mitigation policy that would impose a five percent cap on decreases in the ESRD PPS wage index for CY 2023 and subsequent years, in order to “smooth” the impact of year-to-year changes in ESRD payments. Additionally, beginning in CY 2023, the agency is proposing to increase the wage index floor from 0.5 to 0.6.

For the ESRD QIP performance year 2023, CMS is proposing to pause the use of specified measures data for both scoring and payment adjustment purposes while continuing to collect and publicly report all ESRD QIP measures. The agency states that this proposal stems from the effects of the COVID-19 public health emergency (PHE) on the validity of the measures and performance scores. CMS is additionally proposing to utilize data from CY 2019 as the baseline period for the PY 2023 ESRD QIP as this data was collected prior to the PHE.

The proposed rule also includes requests for information (RFI) on ways that CMS can:

- Work to close the health equity gap in the ESRD program
- Support the use of home dialysis for ESRD patients
- Possibly include a pair of two screening measures in a future ESRD PPS as a means to “smooth” the impact of year-to-year changes in ESRD payments

You can read a fact sheet on the proposed rule here**.** CMS will accept public comment on the proposed rule through August 29, 2022.