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Welcome to "Washington Update," the weekly e-newsletter on the latest health care happenings in the nation's capital that affect APG's members.

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Biden Administration Announces Intention to End Public Health Emergency

The Biden administration announced that it intends to end the federal Public Health Emergency (PHE) on May 11, 2023, more than three years after it was instituted at the onset of the COVID-19 pandemic in 2020. The PHE's end signals the termination of multiple coverage protections and operational flexibilities for health care providers that Congress has not already acted to extend.

Patients are likely to see some impact. For example, beneficiaries in traditional Medicare and Medicare Advantage, as well as people covered by private insurance, have not had to pay cost-sharing, or undergo prior authorization, for COVID-19 at-home testing and testing-related services, and that will change when the PHE

ends. On the other hand, oral antiviral drugs (such as Paxlovid) will still be covered by payers at no cost to patients under provisions of the year-end spending package that Congress adopted, and President Biden signed into law, in December 2022.

Other protections and flexibilities have either been extended – for example, for provision and payment of telehealth under Medicare, or the Acute Hospital at Home Medicare waiver – or set on an "unwinding" track that is separate from the PHE. Medicaid provisions in the year-end spending package extended the COVID-era increase in federal contributions to state Medicaid programs; starting in April, states must meet new criteria for obtaining these enhanced federal matching funds, which will phase out by the end of 2023. States will also be able to terminate Medicaid enrollment for individuals no longer eligible for coverage beginning in April. Uncertainties about how many Americans could lose coverage as a result may refocus attention in some states on renewed efforts to expand Medicaid.

The administration's announcement about the looming end of the PHE came as Republicans in the House of Representatives introduced legislation that sought to end the federal designation immediately. With no support for that measure from the majority in the Democratically-controlled Senate, May will now in effect mark the official "legal" end of the pandemic – regardless of what more SARS-CoV-2 actually has in store.

Physician Groups Left Wondering What's Next After CMS Finalizes MA Audit Rule

Five years after proposing an updated method for auditing Medicare Advantage (MA) plans, CMS has finalized an approach to the Risk Adjustment Data Validation (RADV) program that the agency uses to recover improper risk adjustment payments made to MA plans. CMS risk adjusts payments to MA plans to account for the relative health status of enrollees. To capture information about enrollees' health status, CMS collects diagnoses for each enrollee submitted by MA plans – and the federal government has charged certain MA plans with submitting diagnoses allegedly unsupported by enrollees' medical records.

Following a twelve-year pause, CMS will resume collecting overpayments to MA plans that resulted from unsupported diagnoses. Under the new RADV approach, CMS will limit the collection of overpayments to the sample of cases included in the RADV and Office of Inspector General (OIG) audits between 2011 and 2017. Beginning with 2018, CMS will extrapolate on sampled cases to expand the scope of overpayment collection. CMS has also declined to employ a "Fee-for-Service Adjuster," which would account for the fact that Medicare fee-for-service claims, unlike Medicare Advantage, are not audited to determine if diagnoses are supported by the medical record. Without the adjuster, MA plans argue, the actuarial equivalence required by law between fee-for-service Medicare and Medicare Advantage cannot be achieved.

APG is now evaluating the implications of the RADV rule for member groups. Key questions include the following: Will MA plans sue to block CMS' plans as some of them have threatened? Will MA plans subject to government repayments attempt to claw back money from all contracted providers, or only from those who were responsible for submitting unsupported diagnoses? APG will continue to monitor developments and work with members to track the answers to these questions.

CMS Previews Draft 2024 Payment Rate Update for MA Plans

The old adage “what goes up must come down” appeared to ring true this week, as CMS released the agency’s early estimate of what changes MA plans can expect in 2024 in payments from Medicare. CMS’s Advance Rate Notice suggested that plans will received a 1% average growth in payments – a number sharply lower than last year, when CMS announced an 8.5% increase in average revenue. The final update for 2024, which typically constitutes an increase over the agency’s earlier estimate, will be announced this spring.

The Advance Notice includes several other proposed changes to the MA program, including switching the risk adjustment model from the use of codes related to ICD-9 to ICD-10 and revising for some conditions, which will likely have a significant financial impact on plans. CMS also sought stakeholder feedback on a new core set of quality measures that would be applied to the Stars program, and aligned across other Medicare programs as well.

Comments on the Advance Notice are due to CMS by March 3, 2023. APG will convene two workgroup calls to collect member feedback that we will include in a response to the agency. Please watch your email for an opportunity to sign up for either workgroup call.

Majority of Senate Express MA Support, But Numbers Dip

Amid the mixed-bag of news for Medicare Advantage over the past week, 60 U.S. Senators signaled support for the program, urging CMS “to ensure that any proposed payment and policy changes enable Medicare Advantage to continue providing affordable, high-quality care our constituents rely on every day.”

The annual letter, which is spearheaded by the trade group AHIP but led on the Hill by Sen. Catherine Cortez Masto (D-Nev.) and Sen. Tim Scott (R-S.C.), provides a layer of comfort for those concerned that Congress might target the programs for cuts during a legislative year focused on lifting the debt ceiling and reducing federal spending.

Although the letter’s release is welcome news for advocates of the program, the names of some past MA proponents were missing. Noticeably absent was Senate Finance Committee Chairman Ron Wyden (D-Ore.), whose committee oversees Medicare. The total number of Senate signatories was three below last year’s letter. The House has yet to send its annual letter to CMS. Last year, 346 members signed on.

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