WASHINGTON UPDATE

April 7, 2023

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

Know people who may enjoy receiving it? Forward this email and have them email communications@apg.org to be added to the subscription list. And remember to visit APG's website for more news and resources, or contact a member of APG's Washington, DC, policy and communications team below.

Matt DoBias
Vice President, Congressional Affairs
mdobias@apg.org

Jennifer Podulka
Vice President, Federal Policy
jpodulka@apg.org

Garrett Eberhardt
Executive Director, Medicaid Policy
geberhardt@apg.org

Greg Phillips
Director of Communications
gphillips@apg.org

Table of Contents

- **CMS Opts to Phase in Overhaul of Medicare Advantage Risk Adjustment Model**
- **Biden Administration to Appeal Federal Court Ruling Axing Preventive Care Services in the Affordable Care Act**
- **Medicare Trustees Extend Part A Trust Fund Insolvency Date to 2031**
- **CMS Tightens Prior Authorization, Expands Equity Measures in Final MA Rule**

CMS Opts to Phase in Overhaul of Medicare Advantage Risk Adjustment Model

Controversial changes to the Medicare Advantage (MA) risk adjustment model will be phased in over two years, the Centers for Medicare & Medicaid Services (CMS) announced last week. The changes involve removing more than 2,000 diagnostic codes and medical education costs from the calculation of fee-for-service costs for Medicare Advantage (MA) benchmarks. Both sets of changes will be phased in, with

the agency applying the new risk adjustment and education cost calculations at 33 percent in 2024 and 67 percent in 2025. The changes will be fully in effect in 2026.

APG released a statement welcoming CMS's decision to phase in the changes, but noted that additional analysis will be needed to discern the full effect on MA beneficiaries and APG member groups. Further policy development on risk adjustment is also needed. As APG explained in a Deep Dive Webinar on the MA changes this week, CMS is expected to continue to compare MA diagnosis coding to fee-for-service Medicare coding and conclude that the difference indicates that MA coding is always excessive. APG plans to continue to address this unfounded approach through ongoing research and advocacy.

Please join the APG Medicare Advantage Coalition on Tuesday, April 11, from 2:00 PM to 3:00 PM ET to learn more about CMS's decision and discuss next steps. APG members are welcome, and guests are invited to join up to three meetings before they are required to join APG to continue participation. Register for the meeting here.

Biden Administration to Appeal Federal Court Ruling Axing Preventive Care Services in the Affordable Care Act

The Biden administration will appeal the quixotic ruling by a U.S. District Court judge in Texas invalidating certain preventive services coverage provisions of the Affordable Care Act (ACA), according to a notice filed with the court last week. The move came one day after U.S. District Court Judge Reed O'Connor ruled that the ACA provision requiring health plans to cover care and treatments recommended by the U.S. Preventive Services Task Force (USPSTF) is unconstitutional. The administration is also deemed likely to ask an appeals court to stay the decision pending the appeal.

The ruling by O'Connor applies specifically to services recommended by the USPSTF, which the judge determined violates the Constitution because the task force's members are not appointed by the president and approved by the Senate, but rather by HHS. As such, the ruling does not invalidate coverage requirements for other preventive measures, including vaccines recommended by the Advisory Committee on Immunization Practices, women's preventive health services recommended by the Health Resources and Services Administration's (HRSA), or services for children and young adults recommended by Bright Futures, the national health promotion and prevention initiative led by the American Academy of Pediatrics and supported by HHS, HRSA, and HRSA's Maternal and Child Health Bureau (MCHB).

Although the ruling is effective immediately, health insurers have said there will be no immediate disruption in care or coverage, since health plan contracts typically run for a full calendar year. Many insurers, provider, and health care groups have also condemned or expressed disappointment in the ruling, noting that O'Connor has a long history of antagonism against the ACA—presiding over the last major legal case that ultimately went to the Supreme Court, where his ruling was overturned in 2018.

Medicare Trustees Extend Part A Trust Fund Insolvency Date to 2031

Medicare's Part A Trust Fund will have sufficient income to cover expenses through 2031, according to the 2023 Medicare Trustees Report released last week. The projection extends the solvency of the Trust Fund by three years compared to last year's report. The report cited as a major cause lower Medicare spending in the pandemic, in part because Medicare enrollees who survived COVID-19 were less sick than those who died. Other contributing factors were the enrollment of more dual-eligible beneficiaries in Medicare Advantage (MA) plans, and the movement of joint replacement procedures from inpatient to outpatient settings.

The Trustees estimated that, as of today, the Trust Fund in 2031 will have only 89 percent of the revenue needed to cover costs for hospital, post-acute care, and other Part A services. In the past, Congress has thwarted insolvency by addressing Trust Fund income and expenses, or improved projections have pushed back the insolvency date, as occurred this year.

Notwithstanding the improved projections, Congress is likely to focus on the insolvency projection as additional motivation to seek savings in the Medicare program. APG will continue to advocate with Congress to recognize the demonstrated quality and savings record of value-based care providers, including many participants in MA.

CMS Tightens Prior Authorization, Expands Equity Measures in Final MA Rule

New clinical criteria guidelines governing prior authorization will help to ensure that Medicare Advantage (MA) enrollees receive access to the same medically necessary care that they would receive in Traditional Medicare, according to new policies finalized last week by the Centers for Medicare & Medicaid Services (CMS). The new rule allows prior authorization policies between health plans and contracted providers in HMO and PPO arrangements to be used only to confirm the presence of a diagnosis and ensure that an item or service is medically necessary. Additionally, MA health plans will be required to comply with national, local, and general coverage determinations when they develop their benefit packages. When coverage criteria are not fully established, CMS says, MA organizations may create internal coverage criteria based on current evidence in widely used treatment guidelines or clinical literature made publicly available to CMS, enrollees, and providers.

The steps are the latest in years-long effort by the federal agency to provide safeguards for utilization management in general, and prior authorizations policies specifically, to protect beneficiary access to care. Last year, a study by the HHS Office of the Inspector General found that among prior authorization denials by MA organizations, 13 percent of them would have been covered automatically under traditional Medicare. Under the final rule, MA coordinated care plans will be barred from deploying prior authorization requirements for at least 90 days if a patient undergoing treatment is new to MA or switches from one health plan to another.

In comments provided to the agency in February, APG cautioned against finalizing both of those proposals, calling for a shorter, 30-day transition period for new MA enrollees and exceptions that allow for the use of prior authorization when the

approach improves the quality of care. APG also called for guidance around patient handoffs between MA plans.

Shifting to another CMS priority, the agency finalized a health equity index reward beginning with the 2027 Star Ratings period, a move that APG conditionally approved of in its comments to the agency. APG also called for greater flexibility in benefits design for providers in delegated arrangements with MA plans.

Finally, the final rule moves to strengthen network adequacy requirements by adding clinical psychologist and licensed clinical social workers as specialty types under network standards. Those types of providers will also be eligible for the 10-percentage point telehealth credit.

# # #