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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Following Court Verdicts, CMS Recalculates Medicare Advantage Star Ratings And Accepts New Plan Bids

Following a second legal victory for Medicare Advantage (MA) plans, the Centers for Medicare & Medicaid Services (CMS) has recalculated Star Ratings for all MA plans and will allow affected MA plans to resubmit bids for the 2025 plan year. These affected MA plans, health care providers, and even MA beneficiaries will now benefit broadly as payments to plans will rise – although whether adjusted payments or any benefit increases will be retroactive isn't yet clear.

New ratings: All MA plans can view their new 2024 Star Ratings in the standard CMS online portal. MA plans with Star Ratings increases of 3 to 3.5 stars, 3.5 to 4.0 stars, or 4.0 to 4.5 stars have until June 28, 2024, to resubmit their bids, including changes to price, plan benefit packages,

and formularies. CMS also plans to update MA plans Star Ratings on the online Medicare Plan Finder website in the coming weeks.

CMS's moves stem from two recent court cases. Within days of its earlier ruling that CMS improperly calculated SCAN Health Plan's 2024 Star Rating, the same court ordered CMS to recalculate the rating for Blue Cross Blue Shield (BCBS) of Georgia's MA plan on the same grounds. With other MA plans also suing to force adjustments in their Star Ratings, and the 2025 open enrollment season approaching, CMS clearly decided to move forward and recalculate all the plans' ratings and allow resubmission of bids.

Bipartisan House Effort Resurfaces To Streamline Prior Authorization In Medicare Advantage

A bipartisan bill making multiple changes in the use of prior authorization (PA) in Medicare Advantage (MA) that passed the House unanimously in 2022, but was sidelined due to hefty cost estimates, has now been resurrected and faces strong prospects for enactment in both houses of Congress. Among other measures, the newly introduced legislation would compel plans as of 2026 to report to the federal government annually on items and services subject to PA requirements, and by 2027, institute secure electronic transmission of PA requests and responses between providers and MA plans.

Since the House overwhelmingly approved the precursor bill two years ago, the Centers for Medicare & Medicaid Services has already instituted multiple changes in PA. As a result, the Congressional Budget Office (CBO) now says the legislation's additional measures would have no impact on federal costs, an assessment that drastically improves its odds of enactment. Previously, CBO's analysis had said that placing greater requirements on MA plans' use of PA would result in greater use of health care services, adding $16 billion in federal costs over ten years.

PA in Context: Separately, a new report from the Medicare Payment Advisory Commission (MedPAC) places new context around the PA controversy. MedPAC's analysis found that, in 2021, 95 percent of the nearly 38 million PA determinations made that year ended in services being fully approved, and that "only a small share of prior authorization requests have been denied." Independent reviews of plans' decisions to turn down PA requests upheld the plans' decisions most of the time. The report also noted that major MA plans have taken steps to reduce the administrative burden on health care providers, which is expected to improve when more efficient and timely electronic transmission of PA requests becomes the norm.

Lawsuits Brought By Sales Middlemen Challenge New Medicare Advantage Marketing Rules

Insurance brokers and other sales "middlemen" have mounted legal challenges to new compensation limits adopted earlier this year on how Medicare Advantage (MA) plans can pay insurance agents and brokers. Multiple lawsuits have been filed in the U.S. District Courts for the Northern District of Texas and the Middle District of Florida to bar CMS from imposing the new limits ahead of MA open enrollment season, which begins October 15, 2024.

The compensation limits, aimed at deterring brokers and agents from steering beneficiaries into plans that aren't appropriate for them, were adopted by CMS in April. In comments to CMS on the new broker restrictions before they were finalized, APG agreed with the agency's concerns and recommended that CMS follow through with the proposed changes. The raft of lawsuits challenging the rules make various arguments, including that the compensation limits shouldn't apply to payments from MA plans that go to so-called field marketing organizations and are not passed along to agents and brokers. Other lawsuits argue that CMS lacks the statutory authority to compel fixed fees and that its rule is "arbitrary and capricious." Decisions, possibly followed by appeals, are expected soon.

Track Record Of CMS Innovation Center Gets House GOP Scrutiny Once More

House Republicans this week again voiced longstanding frustration about the CMS Innovation Center and its ongoing efforts to test new payment models to cut costs and improve quality, largely in Medicare.

At a House Energy and Commerce committee hearing, members pressed the center's director, Liz Fowler, to commit to new goals for saving taxpayer money, following a recent Congressional Budget Office projection that the center's activities would marginally increase net Medicare spending between 2021-2030. Fowler demurred, pointing out that any savings would depend on which models could be launched and which providers would enter them, since most of the models are voluntary. But she reiterated that the center has learned multiple lessons from the models that have also spread throughout U.S. health care.

Complaints: Committee members also complained once more about the lack of models emanating from the center that specifically engage specialists and other subsets of physician care. U.S. Representative

Michael Burgess (R-TX), a physician-lawmaker who is retiring this year, told Fowler that he is developing legislation to ensure the utility of the Physician-Focused Payment Model Technical Advisory Committee (PTAC), an entity that he helped to create under the 2015 MACRA law. To date, and for various reasons, no proposed model recommended by PTAC has been adopted into Medicare by the Secretary of Health and Human Services, to Burgess's and others' frustration. Burgess told Fowler he hoped that she would support his forthcoming bill.

In Case You Missed It

- CMS's new National Health Expenditures projections show health care's share of the gross domestic product growing from 17.3 percent in 2022 to 19.7 percent by 2032.
- The **Supreme Court** rejected a lawsuit aimed at blocking access to the abortion drug mifepristone, contending that the plaintiffs lacked legal standing – but said that the plaintiffs had other avenues, such as regulatory and legislative processes, to make their case.
- The **Ascension** health system disclosed that patient health information was breached during the recent cyberattack, which occurred when "an individual working in one of our facilities downloaded a malicious file that they thought was legitimate." Ascension said it has now mostly restored access to electronic information systems in its care settings.
- **States** need to do a better job analyzing Medicare Advantage (MA) encounter data to improve care coordination for dual-eligible beneficiaries and states' oversight of their contracts with MA Dual Eligible Special Needs Plans (D-SNPs), a new report from the Medicaid and CHIP Payment and Access Commission says.

APG Announcements And Offerings

- APG joined other value-based care associations in a letter to the House Energy and Commerce Committee with recommendation to improve the CMS Innovation Center.
- The next **APG Medicare Advantage Coalition** meeting is June 27, 2:00 – 3:00 pm ET. Register here.
- Want to get more involved in APG's Federal advocacy efforts? Join APG Advocates today.
- The submission deadline for **APG Case Studies in Excellence 2024** is June 17. Click here for details.

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