Highmark's Weekly Capitol Hill Report

Issues for the week ending December 9, 2022

Federal Issues

Legislative

Congress Wrestles with Government Funding as Deadline Looms

Congressional negotiators reported some progress in negotiations on an omnibus spending package over the weekend as Friday's government funding deadline looms. Senate Appropriations Chair Patrick Leahy (D-VT) announced that Democrats would hold off on plans to advance a Democrat-only omnibus package in the hopes that a deal will come together in the coming days.

Even if an agreement is reached, Congress will have to pass another short-term continuing resolution (CR) by Friday as several days will be required to develop the text of the legislation once an agreement is reached on topline spending numbers. **As previously reported, if a deal come together, several health-related items could be addressed in the spending package, including:**

- Traditional "extenders" of payment policies for providers in Medicare and Medicaid
- Extension of telehealth flexibilities
- Medicare physician payment relief
- Mental health initiatives
- Prior authorization in Medicare Advantage

In this Issue:

- Maternal health initiatives

If negotiators are unable to reach agreement on a spending package before the end of the year, alternatives would include a short-term CR that would allow them to continue negotiations into January or a long-term CR that would cover the remainder of fiscal year 2023.

Federal Issues

Regulatory

CMS Proposes Electronic Prior Authorization by 2026 for Publicly Sponsored Plans

CMS recently released a Proposed Rule with a Request for Information (RFI) and an accompanying fact sheet on ways to advance interoperability and tackle process challenges around prior authorization (PA).

Why this matters: This proposed rule, which builds on the FHIR-based application programming interface (API) requirements from the CMS Interoperability and Patient Access Rule, provides stakeholders with an opportunity to help shape regulations around the implementation of electronic PA processes**.**

The details: The proposed changes, which would be effective Jan. 1, 2026, with reporting requirements starting on March 31, 2026, would require Medicare Advantage, Medicaid, CHIP and federal exchange payers to:

- Implement an electronic PA process using FHIR-based APIs for access by patients, providers and other payers
- Provide reasons for PA denials
- Seek input on delivery PA decisions within 72 or 48 hours for expedited cases
- Publicly report certain PA metrics on an annual basis

CMS also is seeking information on:

- Accelerating adoption of social risk factor data standards
- Advancing electronic exchange of behavioral health information
- Improving the electronic exchange of information in Medicare Fee-for-Service

- Leveraging interoperability and prior authorization processes to improve maternal health
- Incentivizing use of the Trusted Exchange Framework and Common Agreement

What's next: The proposed rule will publish in the Federal Register on Dec. 13 with a 90-day comment period.

The release of this regulation and revision of the CBO score could reinvigorate interest in passing the ePA legislation, H.R. 3173 / S. 3018, which has bipartisan, bicameral support. Capitol Hill is waiting for an updated Congressional Budget Office score detailing how the proposed rule and legislation will interact.

Matt Eyles, President and CEO of AHIP, issued this statement in response to the proposed rule: "This proposed rule would require clinicians and hospitals to adopt electronic prior authorization to meet certain quality measures, ensuring that we are all incentivized to work together for a better patient and clinician experience that improves satisfaction, efficiency, and affordability for everyone."

HHS Announces Nearly 5.5 Million Have Enrolled in Health Coverage in ACA Marketplace Since Start of Open Enrollment Period

On Wednesday, the Department of Health and Human Services announced continued strong enrollment numbers for Marketplace coverage, as nearly 5.5 million people have selected a Marketplace health plan nationwide since the start of the 2023 Marketplace Open Enrollment Period (OEP) on November 1.

This represents activity through December 3, 2022 (Week 5) for the 33 states using HealthCare.gov and through November 26, 2022 (Week 4) for 17 states and the District of Columbia with State-based Marketplaces (SBMs). Total plan selections include 1.2 million people (22% of total) who are new to the Marketplaces for 2023, and 4.3 million people (78% of total) who have active 2022 coverage and returned to their respective Marketplaces to renew or select a new plan for 2023. The 5.5 million total plan selections represent an 18% increase from 4.6 million this time last year.

The 2023 Marketplace OEP runs from November 1, 2022 to January 15, 2023 for states using the HealthCare.gov platform.

HHS Releases Medicaid, CHIP FMAPs for Fiscal Year 2024

The U.S. Department of Health and Human Services published fiscal year 2024 Medicaid and CHIP FMAPs to the Federal Register. The FMAPs will be effective Oct.1, 2023 through Sept.30, 2024.

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/.**