January 27, 2023

Discussion of Potential Responses to HHS Rulemaking

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MACPAC

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Proposed Notice on Benefit and Payment Parameters for 2024

Summary and areas for potential comment

Overview

- Background
- Effective date of coverage for individuals losing Medicaid or State Children's Health Insurance Program (CHIP) coverage
- Special enrollment period (SEP) for individuals losing Medicaid or CHIP coverage
- Data transparency
- Areas for Commissioner Discussion

Background on the Proposed Rule

- The Centers for Medicare & Medicaid Services (CMS) released its annual proposed rule on benefit and payment parameters for health insurance exchanges on December 21, 2022
  - Comments are due January 30, 2023
  - Most of these changes would be effective January 1, 2024
- Although the Commission does not usually comment on exchange rules, the rule includes a couple provisions related to coverage transitions for individuals losing Medicaid and CHIP coverage
  - MACPAC's prior work has highlighted the difficulty that Medicaid and CHIP beneficiaries face when transitioning to exchange coverage

Effective Date of Coverage

- Provides exchanges an option to move the effective date of coverage for individuals transitioning to the exchange to the first day of the month that Medicaid or CHIP coverage is terminated
  - This only applies to individuals who notify the exchange of the terminated coverage during the month prior to Medicaid or CHIP coverage termination
- Current policy starts exchange coverage the month following loss of Medicaid or CHIP coverage, which results in gaps for individuals terminated mid-month
  - According to MACPAC's prior analyses, about 7.9 percent of adults who transitioned from Medicaid to exchange coverage in 2018 had a gap in coverage of less than one month

Extended Special Enrollment Period

- Provides the exchanges an option to extend the SEP for individuals who lose Medicaid or CHIP coverage from 60 to 90 days
  - This would align the SEP with the 90 day reasonable opportunity period to submit a renewal form after losing coverage for procedural reasons
- In most states, individuals using the reasonable opportunity period must first submit a renewal form to Medicaid or CHIP before submitting an exchange application
  - There are challenges with this process (e.g. Medicaid and CHIP sending incomplete account transfers to the exchange) that could make it difficult to complete both the renewal and exchange application within 90 days
- The 2022 CMS proposed eligibility rule included new requirements for account transfers between Medicaid and separate CHIP, and similar changes could be considered to improve transitions to the exchange

Data Transparency

- In December, the Commission highlighted the need for publicly available data about the transition process to better understand beneficiary challenges with transitioning to exchange coverage
- The Consolidated Appropriations Act, 2023 (P.L. 117-73) added new reporting requirements on transfers between Medicaid and CHIP and the exchange that will be effective through June 2024

Areas for Commissioner Discussion

- Would the Commission like to comment on this proposed rule?
- If so, do you have any substantive changes to the proposed comments?
  - Support for the effective date and SEP changes
  - Encouragement for additional actions to smooth coverage transitions
  - Importance of data transparency and evaluation of coverage transitions during the unwinding of the Medicaid continuous coverage requirements

Proposed Medicare Advantage Rule: Changes Affecting Dually Eligible Beneficiaries

Summary and areas for potential comment

Overview

- Background on the proposed rule
- Summary of selected provisions affecting dually eligible beneficiaries
- Areas for Commissioner discussion

Background on the Proposed Rule

- The Centers for Medicare & Medicaid Services (CMS) published the proposed rule on December 27, 2022
- Would make changes to Medicare Advantage and Medicare Part D
  - Including changes to dual eligible special needs plans (D-SNPs) designed to provide coverage to dually eligible beneficiaries
    - Because of their widespread availability and the number of dually eligible beneficiaries enrolled, D-SNPs have become an area of focus for MACPAC
- Implements sections of several laws including:
  - the Inflation Reduction Act of 2022 (IRA, P.L. 117-169)
  - the Consolidated Appropriations Act, 2021 (P.L. 116-260)

Summary of Selected Provisions Affecting Dually Eligible Beneficiaries

- Language access
  - Would require that MA plans provide materials to enrollees upon request in any non-English language that is the primary language spoken by at least 5 percent of individuals in the service area
- Marketing
  - Proposes changes to marketing rules for Medicare Advantage and Medicare Part D programs designed to protect beneficiaries from confusing or misleading marketing

Summary of Selected Provisions Affecting Dually Eligible Beneficiaries, cont.

- Proposed changes to D-SNP look-alike plan requirements
  - Closes loopholes by allowing contract limitations on D-SNP look-alike plans to be written at the plan level and the plan segments level; also, applies restrictions on contracting with these types of plans to new plans and plans renewing their contracts
  - MACPAC has supported changes in past rulemaking designed to restrict growth of D-SNP look-alike plans
- Codifies sub-regulatory guidance on D-SNP models of care, related to scoring protocols and processes for amending models of care

Summary of Selected Provisions Affecting Dually Eligible Beneficiaries, cont.

- Medicare Part D Low-Income Subsidy (LIS) Program
  - Expands eligibility for the full subsidy to beneficiaries with incomes at or below 150 percent of the federal poverty level, up from 135 percent
  - There is an automatic link between eligibility for the Medicare Savings Programs (MSPs) and for LIS; in prior work MACPAC has supported greater alignment between the two programs
- Limited-Income Newly Eligible Transition (LI NET) Program
  - Makes the LI NET demonstration permanent
  - LI NET provides transitional, point-of-sale Part D coverage for beneficiaries who demonstrate a need; covers potential gaps in drug coverage that may occur when a Medicaid beneficiary becomes eligible for Medicare and transitions from Medicaid drug coverage to a Medicare Part D plan

Areas for Commissioner Discussion

- Would the Commission like to comment on this proposed rule?
- Staff is looking for feedback on potential areas for comment
  - Expanded language access
  - Protecting beneficiaries through changes to Medicare Advantage and Medicare Part D marketing practices
  - Closing loopholes that have allowed D-SNP look-alike plans to persist
  - Increasing affordability of coverage for low-income beneficiaries in the LIS program
  - Avoiding gaps in prescription drug coverage for Medicaid beneficiaries transitioning to Medicare
- Comments are due February 13, 2023

Proposed Rule on Substance Use Disorder Confidentiality of Patient Records

Summary and areas for potential comment

Overview

- Background on proposed rule
- Summary of 42 CFR Part 2 (Part 2)
- Prior MACPAC work
- Coronavirus Aid, Relief, and Economic Security Act (CARES) Act Updates to Part 2

Background

- Part 2 governs disclosure of substance use disorder (SUD) treatment records
- Part 2 regulations predate Health Insurance Portability and Accountability Act (HIPAA) protections by over 20 years
  - Part 2 regulations were first promulgated in 1975; last updated in 2020
- Part 2 requirements are stricter than those imposed by HIPAA, which governs use and disclosure of other treatment records
- Part 2 intent is to encourage individuals to seek treatment without fear of negative consequences

Part 2 Requirements

- Part 2 applies to federally-assisted entities that hold themselves out as providing SUD treatment
- Providers must obtain written patient consent to use, disclose, and redisclose SUD treatment records
- Prohibits law enforcement access to SUD treatment information, absent court order
- Allows disclosures without prior written consent in certain circumstances (e.g., medical emergencies and scientific research)
- Part 2 records must be separated or segmented from other health information

Prior MACPAC Work

- The Commission expressed concern that Part 2 limits care coordination for beneficiaries with SUD
- In 2018, MACPAC recommended that HHS issue clarifying guidance and provide education and technical assistance on Part 2
- In 2019, MACPAC supported proposed changes that allowed Part 2 records to be shared with a larger group of entities, including those that do not have a treating relationship with the patient
- In 2022, MACPAC recommended that HHS should develop a voluntary certification for information technology (IT), which permits the segmentation and sharing of Part 2 information

Concerns Related to Part 2 and HIPAA

- The Commission noted that misalignment between Part 2 and HIPAA contributes to confusion around SUD record sharing
- Patient advocates argue creating more avenues for sensitive health information to be disclosed without patient consent could cause harm and discourage individuals from seeking care
- The CARES Act sought to align elements of Part 2 and HIPAA, while strengthening enforcement and adding new protections
  - Proposed rule implements CARES Act provisions

CARES Act Updates to Part 2

Consent and redisclosure

- Permits patients to provide a single, written consent for all future uses or disclosures of their Part 2 records for treatment, payment, and health care operations (TPO) purposes, similar to HIPAA
  - Patient can consent to sharing records with their "treating providers, health plans, third-party payers, and people helping to operate this [Part 2] program"
  - However, when records are shared with an intermediary (e.g., health information exchange (HIE) or accountable care organization (ACO)), the consent form must name the specific intermediary
- Allows for general HIPAA-compliant redisclosures, as long as records are not used for civil, criminal, administrative, or legislative proceedings

CARES Act Updates to Part 2

Right to request restrictions

- Gives patients the right to request restrictions on the use of their Part 2 records
- However, a Part 2 program is generally not required to agree to those requests, consistent with HIPAA

Accounting of disclosures

- Requires a Part 2 program to provide a patient, upon written request, an accounting of disclosures of their Part 2 records

CARES Act Updates to Part 2

Restrictions on use of records in certain proceedings

- Prohibits the use of Part 2 records in criminal, civil, administrative, or legislative proceedings, absent a court order or patient consent

Notice requirements

- Aligns Part 2 notice requirements with HIPAA notice requirements

CARES Act Updates to Part 2

Breach notifications

- Applies HIPAA breach notification rules to Part 2
- Requires Part 2 programs to report breaches to individuals, HHS, and—in certain circumstances—media outlets

Complaints

- Implements a Part 2 complaint process similar to HIPAA
- Prohibits Part 2 programs from taking retaliatory action against any patient who files a complaint regarding Part 2 compliance

CARES Act Updates to Part 2

Enforcement

- Aligns Part 2 enforcement with HIPAA rules by allowing HHS to seek civil monetary and criminal penalties for Part 2 violations

Areas for Commissioner Discussion

- Would the Commission like to comment on this proposed rule?
- If so, do you have any substantive changes to the proposed comments?
  - Reinforce need for clarifying guidance, technical assistance, and education on Part 2
  - Emphasize continued importance of a voluntary certification for IT used in behavioral health and integrated care settings, that can segment Part 2 records
  - Express concern and seek clarification regarding the stricter standard for sharing Part 2 records with intermediaries (e.g., HIEs, ACOs)
- Comments are due on Tuesday (January 31)

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