TxSCO Update

May 9, 2024

ADVI & HillCo

Agenda

Federal

- FTC Noncompete Final Rule
- Change Healthcare Cyberattack
- CMMI Faces Continued Scrutiny Over Lack of Demo Savings
- In-office Dispensing: Awaiting Final Medicaid Rule

State

- Upcoming Elections
- Texas House Runoff Races
- Texas HHS Medicaid Re-procurement
- Senate Interim Charges

Federal Updates

FTC Releases Noncompete Final Rule

April 23, 2024: FTC voted to finalize a new rule to prohibit employers from enforcing noncompetes against workers.

Summary

- The rule states that noncompetes are an unfair method of competition. As a result, the rule prohibits employers from entering into new noncompetes with workers.
- The rule prohibits employers from enforcing noncompetes with workers other than senior executives.
  - Less than 1% of workers are estimated to be senior executives under the final rule.
  - Specifically, the final rule defines the term "senior executive" as **workers earning >$151,164** who are in a "**policy-making position**."
- The rule requires employers to notify workers whose noncompetes are no longer enforceable that their noncompetes are no longer in effect and will not be enforced. The FTC provides model language that employers can use to notify employees.
- The rule includes an exception that allows noncompetes between the seller and buyer of a business.
- **Tax-exempt hospitals will be exempt** from the final rule, so long as:
  - The entity "is organized for and actually engaged in business for only charitable purposes," and
  - "Its net proceeds be properly devoted to recognized public, rather than private, interests."

Impact of Noncompetes on Oncology Care

- "Due to mistreatment and to escape workplace toxicity, one of my colleagues left our practice in compliance to our non-compete conditions, even though they caused great hardship. I, too, wanted to leave, but could not because doing so would have harmed my family's well being. What I witnessed in the aftermath was unconscionable. There was a void in patient care and months later, there still is a void. Not only was this physician required to move quite a distance from the practice, he was forbidden to even inform his patients that he was leaving. The practice in turn, did not inform the patients, and when asked, just informed them that he was no longer with the practice. **Consequently, wait times to treat cancers doubled and now have tripled**" (pg. 205, final rule).

Notable Stakeholder Reactions

- "The ban makes it more difficult to recruit and retain caregivers to care for patients, while at the same time creating an anticompetitive, unlevel playing field between taxpaying and tax-exempt hospitals." – **Federation of American Hospitals**
- "We applaud FTC's final rule banning physician noncompete clauses which often harm patients and break continuity of care. This rule will bolster competition and create healthy work environments for physicians while improving access for patients." – **American Academy of Family Physicians**
- Health systems "have a voracious appetite for acquiring independent medical practices or putting those practices out of business by luring their physicians away with above-market employment contracts. As such, if the FTC eliminates existing and future non-compete clauses for physician partners/owners in independent medical practices it will decrease competition, not increase it as may be the case in other industries." – **COA, Proposed Rule comments**
- **Four business groups filed a lawsuit** in the Eastern District of Texas on April 24, stating that the FTC doesn't have the authority to issue such a broad rule.

Source: FTC final rule (link); FAH press release (4/23/24, link); AAFP response (4/23/24, link); COA comment letter (3/6/23, link); Stat News (4/24/24, link)

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FTC Releases Noncompete Final Rule: “Policy-Making Position”

§ 910.1 Definitions.

- *Policy-making authority* means final authority to make policy decisions that control significant aspects of a business entity or common enterprise and does not include authority limited to advising or exerting influence over such policy decisions or having final authority to make policy decisions for only a subsidiary of or affiliate of a common enterprise.
- *Policy-making position* means a business entity’s president, chief executive officer or the equivalent, any other officer of a business entity who has policy-making authority, or any other natural person who has policy-making authority for the business entity similar to an officer with policy-making authority. An officer of a subsidiary or affiliate of a business entity that is part of a common enterprise who has policy-making authority for the common enterprise may be deemed to have a policy-making position for purposes of this paragraph. A natural person who does not have policy-making authority over a common enterprise may not be deemed to have a policy-making position even if the person has policy-making authority over a subsidiary or affiliate of a business entity that is part of the common enterprise.

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Change Healthcare Cyberattack: Timeline and Implications

Since February 21, Change Healthcare has been shut down due to a cyberattack. As of April 29, around 80% of Change's services are online. This attack was described by Becker's Healthcare as “the most significant and consequential cyberattack in American history.”

Change Healthcare Overview

- Change Healthcare serves as a middleman among insurers, other clearinghouses, and providers, transferring claims data.
- Data transmitted by Change include medical claims, prior authorization requests, medical attachments (including physician notes), eligibility inquiries and responses, and electronic remittance advice transactions.
- In the U.S., Change handles data from 1 in 4 patient records, 6,000 hospitals and health systems, 1M physicians, and 39,000 pharmacies, totaling 15B healthcare transactions and $1.5T in healthcare claims.

Feb. 21

- Optum reported Change was experiencing a network disruption due to a cybersecurity threat.

Feb. 27

- In a public statement, Aetna stated it was aware that some providers may not be receiving timely payments.

Feb. 29

- Change confirmed that ransomware group ALPHV/ BlackCat had conducted a cyberattack on the system.
- According to the ransomware group, 6 terabytes of data, including patient medical records and Social Security numbers, were stolen.

Early March

- At least five lawsuits have been filed against UnitedHealth Group (UHG), which purchased Change in October 2022.

March 5

- Elevance Health said they are seeing a 10% reduction in the daily volume of data received from providers.
- Humana said that 20% of their medical claims go through Change’s system, making it difficult to gauge the impact on total medical expenses.

March 7

- UHG released a timeline for restoring Change systems:
  - March 7: Pharmacy electronic prescribing expected to be fully functional
    - Note: As of March 19, 99% of pharmacy network services are functional.
  - March 15: Electronic payment platform restored, with payer implementation still continuing.

March 18

- Week of March 18: Medical claims network began testing for reconnection.

May 1

- UHG CEO Andrew Witty testifies before the Senate Finance Committee, confirming that the cyberattack occurred through a lack of two-factor authentication, and that the company paid the ransom to the attackers.

- The cyberattack has had a significant impact on providers and patients, with an AHA survey reporting that 74% of hospitals are facing a direct impact on patient care.
- According to Kodiak Solutions, the total estimated cash flow impact for hospitals through March 9 is $6.3B in delayed payments.
- News stories have reported instances of patients paying out-of-pocket for prescription drugs and of hospital discharges being delayed.

Source: Becker’s Health IT (3/15/24, link); Stat News (3/4/24, link); Court presentation from *United States of America, et al. v. UnitedHealth Group Inc. & Change Healthcare Inc.* (accessed 3/19/24, link); Politico (4/29/24, link)

CMMI: Continued Scrutiny over Lack of Demo Savings

April 26, 2024: House Budget Committee Chairman Jodey Arrington (R-TX) and Budget Committee Health Care Task Force Chair Michael C. Burgess (R-TX) wrote to the GAO asking for an investigation into spending by CMMI.

Background

- The Affordable Care Act (ACA) established the Centers for Medicare and Medicaid Innovation (CMMI) in 2010. CMMI is mandated with developing and implementing new payment models in order to address increased costs. The purpose of the initiative was to reduce federal spending on health care.
- CMMI receives $10 billion in mandatory funding each decade.
- On April 26, 2024, the House Budget Committee released a statement accusing CMMI of doing the opposite of saving money.
- The report cited a Congressional Budget Office Report released in September 2023, in which the CBO found CMMI increased spending by $5.4B over the past decade and is projected to increase spending by $1.3B over the next decade.

Representatives Ask GAO to Examine CMMI Spending

- On April 26, 2024, Representatives Arrington and Burgess asked the Government Accountability Office (GAO) to investigate CMMI's use of funding and provide an assessment of its performance.
- The letter requested ten specific directives aimed at how CMMI has used its funding to create models and carry out agency functions; its use of the mandatory appropriation; status of models; and CMMI's method for determining which providers to include in its models.

Table 3.

Estimated Budgetary Effects of CMMI's Activities, 2021 to 2030

Billions of Dollars

	Previous Projection[a]	Current Projection
CMMI's Outlays	10.9	8.3
Change in Spending on Benefits	-88.4	-7.0
Net Increase or Decrease (-) in Outlays	**-77.5**	**1.3**
Percentage of Net Spending on Medicare	-0.80	0.01

Data source: Congressional Budget Office. See www.cbo.gov/publication/59274#data.

CMMI = Center for Medicare & Medicaid Innovation.

Takeaway: with increased pressure to find savings, expect CMMI to pursue *more mandatory*, and/or *more punitive*, models

Sources: Letter to GAO (4/26 link); Press Release (4/26 link); Information Sheet (4/26 link)

In-office Dispensing: Awaiting Final Medicaid Rule

Takeaway: if finalized, creates new incentive for manufacturers to *not* provide discounts on in-office dispensed drugs (since those discounts would count toward the stacked Best Price)

Rebate "Stacking" Proposal to Determine Best Price

CMS provided example*:

"If a manufacturer provides a discount to a **wholesaler**, → then a rebate to the dispensing **provider**, → and an additional rebate to the **insurer**, → the best price must include (or "stack") all discounts and rebates associated with the final price [for a single drug transaction], even if the entity did not buy the drug directly from the manufacturer."

*Dollar amounts not included in CMS example

Note: This proposal does not alter the MDRP rebate formula, which is:
The greater of: minimum rebate (23% of AMP) or AMP minus Best Price

State Updates

Elections

May 4th Local Elections

- Local political subdivisions, such as cities, school districts, and water districts, held their regular general elections for members of their governing bodies or special elections to fill vacancies.
- A new elected position was created for Appraisal District Boards

May 28, Primary Runoff Election

- Texas will hold its 2024 runoff elections May 28 to finalize which Democratic and Republican primary candidates will be on the ballot in the November general election.

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Texas House Race Runoffs

On May 28th, 19 runoffs will be held to determine the candidate that will advance to the general election in November. Of those, two are of significant interest to TXO:

House District 121 – Beaumont (Jasper, Orange, and Jefferson counties)

- Currently represented by Dade Phelan, Speaker of the House
- Outcome of this runoff will determine future House leadership

House District 91 – North Richland Hills (Tarrant County)

- Currently represented by Stephanie Klick, Chair of the House Committee on Public Health

Other incumbents facing runoffs

- Republican: VanDeaver, Holland, Kuempel, Burns, Frazier, Stucky
- Democrat: Thierry

Texas HHS Announces Procurement Awards for Medicaid Managed Care Organizations

- On March 7th, Texas HHS announced preliminary awards for its re-procurement of managed care contracts for Texas Medicaid and CHIP programs.
- The announcement included drastic changes to current coverage in the state's 13 managed care service areas; in a lot of cases, the incumbent plans lost their current service areas and won others.
- At least 8 MCOs have filed protests with the state, which adds uncertainty to the procurement process.
- Additionally, members of the Legislature are weighing in on HHS' decision, calling for reform of the procurement process including Dr. Tom Oliverson and a group of 19 South Texas Democrat lawmakers
- Legislative opinion seems to be in favor of considering moving toward an "application state" procurement system
- If overturned this would be the third procurement effort over the course of 6 years that has been scrapped because of process deficiencies

Senate Interim Charges

Senate Health & Human Services – Meeting May 14th to consider:

- **Health Insurance:** Examine the Texas health insurance market and alternatives to employer-based insurance. Identify barriers Texans face navigating a complex health insurance market. Make recommendations that help individuals obtain health care coverage.

- **Cancer Prevention:** Identify and recommend ways to address the growing impact of cancer on Texans by evaluating sate investments in cancer prevention and screenings including, but not limited to, “CT,” “MRI,” and “PET” scans. Study and make recommendations on funding adequacy for prevention efforts at the Cancer Prevention and Research Institute of Texas (CPRIT.)

Senate Interim Charges

Other issue areas of focus for Senate interim charges include many recurring themes: Energy/Grid, Border Security, Property Tax Relief, Water, Elections, Artificial Intelligence, DEI, ESG, and Mental Health

Additional charges of interest from the HHS Committee include:

Access to Health Care: Evaluate current access to primary and mental health care. Examine whether regulatory and licensing flexibilities could improve access to care, particularly in medically underserved areas of Texas. Make recommendations, if any, to improve access to care while maintaining patient safety.

Monitor: relevant agencies and programs under the committee's jurisdiction. Specifically, make recommendations for any legislation needed to improve, or enhance, the following:

- Initiatives to reduce Medicaid fraud, waste, and abuse, as well as other cost containment strategies; and
- Medicaid managed care oversight and accountability

Appendix

White Bagging: BCBS of Tenn “Saved More than $81M for TN Businesses”

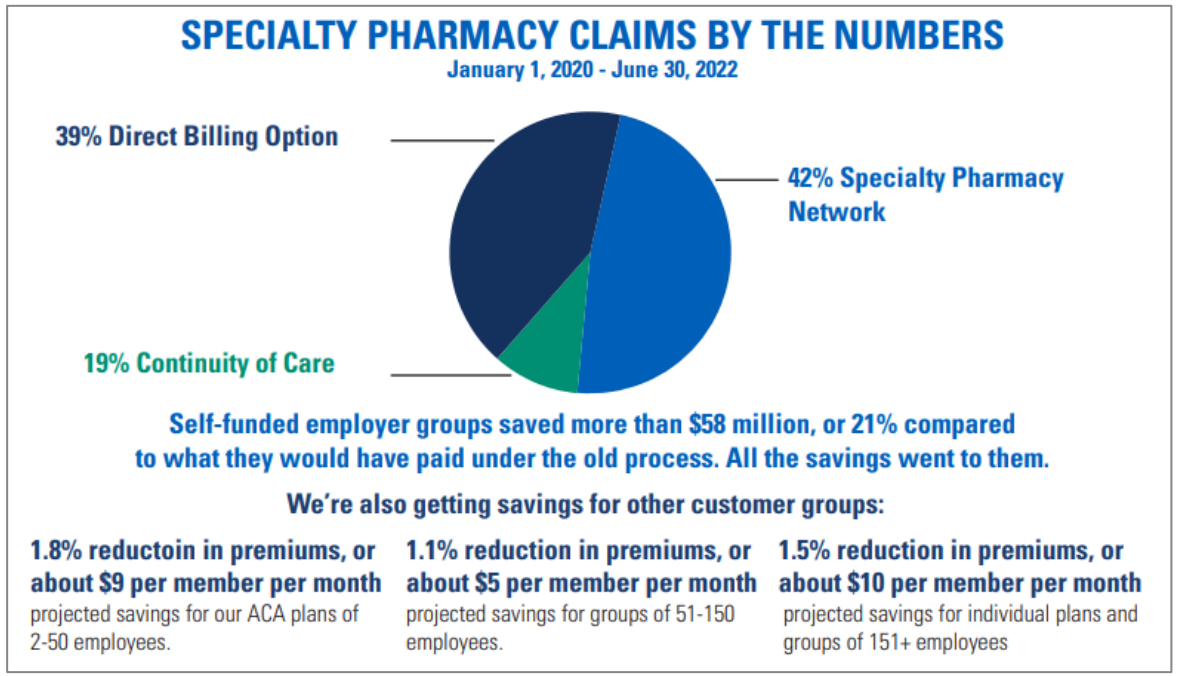
Drug Channels: White Bagging “Savings” (April 30, 2024)

Last September, I pondered whether white bagging by specialty pharmacies saves money or merely shifts costs.

As you can see below, BlueCross BlueShield of Tennessee has answered the first half of this conundrum. According to its recently released figures, eliminating buy-and-bill saved $58M (21%) on provider-administered drugs due to (1) white bagging by specialty pharmacies, and/or (2) providers matching SP network prices.

Alas, a health plan’s savings from white bagging often come from the lost profits and incremental costs incurred by providers, patients, and manufacturers. In general, patient out-of-pocket costs are generally higher when products are white bagged compared with buy-and bill.

Perhaps that’s why the BCBS of TN analysis mentioned premiums, but omitted any consideration of white bagging’s economic impact on everyone else.



BCBST: How our specialty pharmacy program saved more than $81 million for Tennessee businesses

DRUG CHANNELS
Expert Insights on Pharmaceutical Economics and the Drug Distribution System

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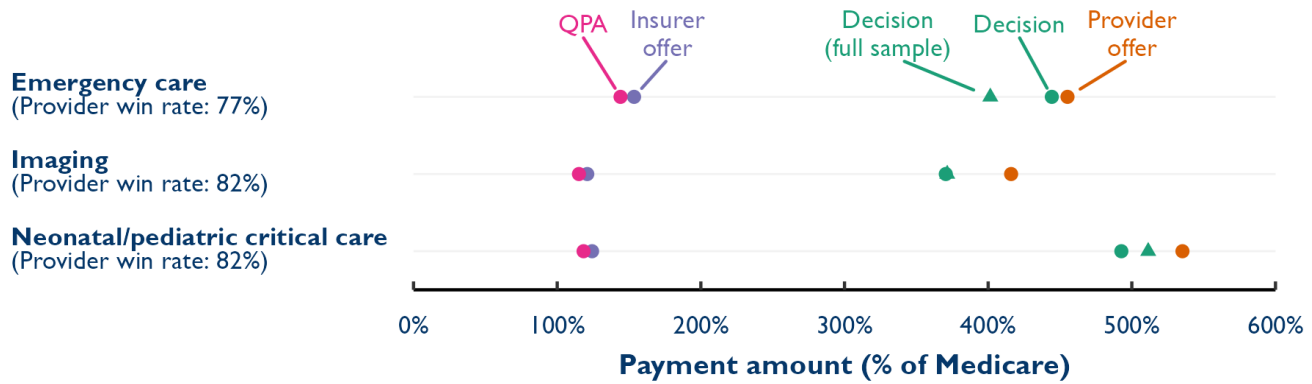
Private Equity Groups Disproportionately Benefit from No Surprises Act, Brookings Study Finds

An analysis released in March 2024 by the Brookings Institute found that the No Surprises Act's independent dispute resolution (IDR) process was primarily used by private equity groups, with decisions falling closer to provider offers than insurer offers.

Key Findings	Four PE-backed staffing firms (Envision Healthcare, TeamHealth, SCP Health, and Radiology Partners) initiated 74% of disputes.
	The median IDR decision is at least 3.7 times what Medicare would pay.
	On average, arbitrators awarded providers amounts 50% higher than what insurers in the area paid doctors and hospitals in their network.
Impact	The high usage of the IDR process by large provider groups indicates these providers can better financially withstand the cost and timeline associated with the IDR process.
	The NSA may place upward pressure on in-network prices, resulting in higher premiums.
	In-network prices are unlikely to align with the Qualifying Payment Amount (QPA), as predicted by the CBO.

Figure 2. Median Decisions, Offers, and QPAs by Type of Service



Source: Authors' analysis of IDR public use file for 2023Q1 and 2023Q2.

Members of Congress, including Reps. Brett Guthrie (R-KY-2), Cathy McMorris Rodgers (R-WA-5), and Frank Pallone (D-NJ-6) have shared with Politico that they want to further examine the impact of the No Surprises Act, with Rep. Guthrie stating, "It's not working the way we want it to work."

Source: Brookings Institute (3/27/24, link); Politico (4/17/24, link); CBO Score (link)

The State of Telehealth: Permanent vs. Temporary Extensions

On April 10, 2024, Representatives from the House Committee on Energy and Commerce discussed multiple bills relating to telehealth. Lawmakers debated options to avoid a "telehealth cliff," as Pandemic-era flexibilities end on December 31, 2024.

At the April 10th House E&C hearing titled "Legislative Proposals to Support Patient Access to Telehealth Services," lawmakers discussed various options for either permanent or temporary extensions of telehealth policies.

Lawmakers discussed waiving originating site requirements, expanding which providers are eligible to use telehealth, audio-only calls, and more. These provisions will most likely be part of a large health care package during the lame duck session.

House E&C members are largely undecided on whether a permanent or temporary approach is best. Witnesses discussed how telehealth is already embedded within the healthcare system and many investments have been made.

Lawmakers cited it will be key to understand CMS' ability to capture telehealth data, best practices on digital billing codes, and ways to limit fraud and prevent overuse of telehealth before deciding on permanent or temporary provisions.

Legislative proposals discussed:

- **H.R. 134**, *To amend title XVIII of the Social Security Act to remove geographic requirements and expand originating sites for telehealth services*
- **H.R. 1110**, *KEEP Telehealth Options Act of 2023*
- **H.R. 3432**, *Telemental Health Care Access Act* (Rep. Doris Matsui)
- **H.R. 3875**, *Expanded Telehealth Access Act*
- **H.R. 4189**, *CONNECT for Health Act of 2023*
- **H.R. 5541**, *Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act*
- **H.R. 5611**, *Helping Ensure Access to Local TeleHealth (HEALTH) Act of 2023*
- **H.R. 6033**, *Supporting Patient Education And Knowledge (SPEAK) Act of 2023*
- **H.R. 7149**, *Equal Access to Specialty Care Everywhere (EASE) Act of 2024*
- **H.R. 7623**, *The Telehealth Modernization Act of 2024*
- **H.R. 7711**, *To amend title XVIII of the Social Security Act to make permanent certain telehealth flexibilities under the Medicare program*
- **H.R. 7858**, *Telehealth Enhancement for Mental Health Act of 2024*
- **H.R. 7856**, *The PREVENT DIABETES Act*
- **H.R. 7863**, *To require the Secretary of Health and Human Services to issue guidance on furnishing behavioral health services via telehealth to individuals with limited English proficiency under Medicare program*
- **H.R. ____**, *Hospital Inpatient Services Modernization Act*

Sources: House E&C Committee Hearing (4/10, link), Fierce Healthcare (4/11, link), KFF (4/10, link), InsideHealthPolicy (4/10, link)

Senate Finance Committee Discusses Physician Payment Reform

On April 11, 2024, the Senate Finance committee held a hearing to discuss Medicare physician payment reforms entitled "Bolstering Chronic Care through Medicare Physician Payment."

Overview

- The hearing was scheduled after lawmakers passed a skinny health package in March which included a 1.68% partial fix for the 3.37% physician pay cut.
- Earlier this year, a bipartisan Medicare Payment Reform Working Group of six senators was formed with a primary goal of proposing long-term reforms to Medicare Payments.
  - Working group members are Sens. Catherine Cortez Masto (D-NV), Marsha Blackburn (R-TN), John Thune (R-SD), John Barrasso (R-WY), Debbie Stabenow (D-MI), and Mark Warner (D-VA)
- Hearing witnesses included leaders from the American College of Surgeons, American Academy of Family Physicians, Physicians of Southwest Washington, and a Professor from the University of Pennsylvania.

Notable Comments

- **Committee Chair Ron Wyden (D-OR) noted that he wanted to avoid another temporary pay fix but was not able to give a timeline on a larger overhaul.**
- Sen. Warner (D-VA) expressed general concerns about physicians' low adoption rate for Medicare reimbursements related to advance care planning.
  - Warner also called for concise payment rates from CMS so that they are easier for physicians to understand and implement.
- **Sen. Blackburn (R-TN) claimed that reimbursements are not keeping pace with operational costs and suggested the possibility of eliminating MIPS**, which determines Medicare payment adjustments based on physicians' reported data.
- Sen. Stabenow (D-MI) commented on the discrepancy in payments between MA and Medicare.
  - Chair Wyden noted that this money should be "spent on patients" and that he would be collaborating with the working group to formulate a solution.

While no legislation was specifically discussed in the hearing, **committee leaders and working group members signaled an overhaul of the Medicare Access and CHIP Reauthorization Act that may involve changes to the MIPS program and prior authorization**. Leaders also hinted that these changes could be partly paid for by controlling overpayments to Medicare Advantage.

Sources: Hearing Transcript (4/11/24, link), IHP (4/11/24, link)