Highmark's Weekly Capitol Hill Report

Issues for the week ending January 19, 2024

Federal Issues

Legislative

Congress Passes CR to Fund Government Into March

As reported last week, Congressional leaders reached agreement on a continuing resolution (CR) that would extend federal government funding through early March. On Thursday evening, the House and Senate both passed the CR ahead of a Friday snowstorm in DC and President Biden promptly signed it into law. The "laddered" CR would extend the two deadlines for funding the government to March 1, 2024, and March 8, 2024.

Meanwhile, negotiators continue to work on health policy proposals that could be included with the legislation, including potential extenders and transparency provisions such as those included in the House-passed Lower Costs, More Transparency Act.

As previously reported, the Lower Costs, More Transparency Act contains provisions that:

In this Issue:

- Expand existing transparency in coverage requirements;
- Require additional PBM transparency; increase drug competition;
- Expand site neutral payments; and
- Address fair billing.

West Virginia

Legislative

- **Biomarker Testing Mandate on House Insurance Committee Agenda**

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- **OIC Issues Prior Authorization Bulletin**

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- **HHS Releases New Medicaid Renewals Resource Hub**

Federal Issues

Regulatory

CMS Releases Interoperability & Prior Authorization Final Rule

CMS released the Advancing Interoperability and Improving Prior Authorization Processes final rule.

Why this matters: This rule builds on the CMS Interoperability and Patient Access final rule which required plans in federal programs to build and maintain application programming interfaces (APIs) to support the exchange of clinical, claims, and directory information to improve patient access to health information.

The details: The final rule laid out new requirements and guidelines on a broad range of topics, including:

- **Implementing** and updating APIs for patients and providers as well as payer-to-payer and prior authorization requests and responses
- **Setting** PA decision timelines and requiring payers to give specific reasons for PA denials
- **Adding** a new electronic prior authorization attestation measure for clinicians, hospitals and critical access hospitals using the Merit-Based Incentive Payment System

The rule applies to Medicare Advantage organizations, state Medicaid and CHIP FFS programs, Medicaid managed care plans, CHIP managed care entities, and issuers

on the federal exchanges. Although CMS encourages commercial plans to also adopt the technologies and policies and notes that Medicare fee-for-service will implement the provisions.

Specifically, the new regulations require plans in federal programs to expand or build by January 1, 2027:

- **Patient Access API**—Expand the information available to consumers to include the outcome of prior authorization decisions and report metrics on use of the Patient Access API to CMS.
- **Prior Authorization API**— Develop a FHIR-based API that automates the process for providers to determine if prior authorization is necessary, what information is required, and electronically exchange the request and response.
- **Provider Access API**—Develop a FHIR-enabled API for payers to share clinical, claims, encounter data (excluding cost information), and prior authorization requests/decisions with in-network providers to support value-based care and payments.
- **Payer-to-Payer API**—Develop a FHIR-enabled API for insurers to share clinical and claims data (excluding cost information) with each other as consumers change insurers and at their request for up to five years of data.

The rule would also make procedural changes to prior authorization requests— whether via paper, fax, or API— starting January 1, 2026.

- CMS finalized the proposal to require impacted payers (not including QHP issuers on the FFEs) to send prior authorization decisions for standard (i.e., non-urgent) requests within 7 calendar days down from 14 days.
- CMS also finalizes the proposal to require impacted payers to post certain aggregated metrics about prior authorization on the payer's website on this timeline.

CMS also finalized the proposal to add a new electronic prior authorization measure to the Merit-Based Incentive Payment System (MIPS) and Medicare Promoting Interoperability programs requiring clinicians and hospitals to attest to the use of the Prior Authorization API. However, we note that the Office of the Coordinator for Health Information Technology (ONC) did not issue the necessary companion regulation that would require vendors to build electronic prior authorization into the electronic health record. We are hopeful that this will be a component of an upcoming ONC rule that is under development.

Departments Post Updated 2024 No Surprises Act Fees

The Departments of Health and Human Services, Labor and Treasury (Departments) updated the No Surprises Act website to reflect upcoming changes to the Independent Dispute Resolution (IDR) certified IDR entity (IDRE) fee ranges, including the new fees being set by each IDRE for 2024. This update is in accordance with the recent IDR Fees Final Rule, which becomes effective Jan. 22.

Departments Issue Updated Compliance Resources on CAA 2021 Gag Clause Provision

Towards the end of 2023, CMS posted revised instructions and user manual for providing a Gag Clause Prohibition Compliance Attestation (GCPCA) to federal agencies. These are dated December 2023 and listed as Version 5. In response to a BCBSA inquiry to CMS, staff reported that for the next release, CMS will add a section on changes that have been made to the instructions and user manual (i.e., what has changed from the last version) and will send out a REGTAP notice when new versions are released.

Why this matters: The gag clause provision prohibits health plans from entering into contracts with providers and other entities that would prohibit sharing with members provider-specific cost or quality of care information. The gag clause prohibition requirement applies to group health plans and health insurance issuers offering group health insurance coverage and health insurance issuers offering individual health insurance coverage. The first attestation demonstrating compliance with this provision was due by December 31, 2023.

CMS Announces New Integrated Behavioral Health Model

The Centers for Medicare & Medicaid Services (CMS) announced the Innovation in Behavioral Health (IBH) model, which will be tested under its Center for Medicare and Medicaid Innovation (CMMI).

Why this matters: IBH's goal is to improve the quality of care and outcomes for Medicaid and Medicare populations with moderate to severe mental health conditions and/or substance use disorder (SUD) by integrating primary care into behavioral health settings.

IBH is a state-based model focused on community-based behavioral health organizations and providers, including Community Mental Health Centers, public or private practices, opioid treatment programs, and safety net providers.

What's next? CMS will select up to 8 states to participate in IBH through a Notice of Funding Opportunity (NOFO). The model will launch in Fall 2024 and is anticipated to operate for eight years. In concert with state-led Medicaid IBH implementation, CMS will concurrently launch a parallel Medicare version of IBH in the states it selects to participate.

See the model homepage, fact sheet, and FAQ.

State Issues

New York

Legislative

Governor Releases Executive Budget

Governor Hochul last week unveiled her Executive Budget for the 2024-25 Fiscal Year. The proposal totals $233 billion — the largest in state history — and would increase state spending by 4.5 percent. Governor Hochul said her spending plan seeks to rein in New York's spending on education and Medicaid, and she pledged not to impose new taxes on New York consumers and businesses.

Of interest to health plans, the Governor's plan contains a number of provisions to expand coverage, such as ensuring continuous coverage for children aged 0-6, increasing subsidies for individuals purchasing coverage on the NY State of Health exchange and allowing New York to join interstate provider compacts to help address provider shortages. However, it also includes proposals that impose more than $600 million in cuts to health plans. This includes:

- **Eliminating the 1% Rate Increase to Medicaid plans** – The budget proposal eliminates the 1% across the board administrative rate increase provided to Medicaid managed care organizations in the current year, resulting in a cut to plan rates of more than $400 million in FY25. While the previous rate increase brought Medicaid plans above the bottom of the allowable rate range for the first time in several years, the proposed rate cut would make it more difficult for health plans to make the investments necessary to fulfill the goals of advancing health equity, reducing health disparities, and enhancing care coordination envisioned in the State's recently approved 1115 Medicaid Waiver.

- **Elimination of the Quality Pools** – The Executive Budget would completely eliminate funding for the Medicaid Quality Incentive (QI) Program, totaling more than $223 million. Elimination of this funding would undercut the ability of the State to address and eliminate long-standing racial and ethnic disparities and build a more equitable health care system in New York. In recent years, the Executive Budget has eliminated or reduced the QI funding, with the Legislature restoring the funding.

- **Medicaid Managed Care Procurement** – The Governor's proposed budget reintroduces a proposal to procure the Medicaid managed care program. The impact of this would be taking away options from the state's most vulnerable residents by eliminating health plans from the program and disrupting their care. Two years ago, the Legislature rejected a similar proposal, in part, because of the impact it would have on more than 5 million New Yorkers who rely on Medicaid managed care plans for their coverage.

The Health Plan Association (HPA) issued a statement on the on the Governor's budget, voicing disappointment with these proposals and calling on the Legislature to reject them. The Senate Finance and Assembly Ways and Means Committees will hold joint hearings on the Governor's budget plan starting this week. First up is the health budget on Tuesday.

Healthcare Bills in Committee

There are several bills of interest to health plans on committee agendas this week:

- S. 1965A/A.3865 — Requires insurance coverage for prenatal vitamins. Most plans currently provide this benefit.
- S. 4435 — Requires actuarially appropriate reductions in health insurance premiums in return for an enrollee's or insured's participation in a qualified wellness program.
- S.3282/A.1777 – Creates a new process for health plan terminations of health care professionals.
- S.4790/A.7244 – Require all Medicaid health insurance plans to cover medically tailored meals and medical nutrition therapies for individuals limited in activities of daily living by one or more chronic condition.
- S.3282/A.1777– Prohibits health insurers from requiring prior authorization for pre-exposure prophylaxis (PrEP) used to prevent HIV infection.
- S.1197-B/A.8592– Requires all health insurers to report to the State the percentage of overall annual health care spending on primary care services and mandates that at least 12.5% of all total annual expenditures are directed to primary care services.
- S.4889 – Requires insurance coverage for the treatment of asthma. Health plans already cover asthma treatments and services.
- S.1366-B – The bill seeks to protect New Yorkers from unfair medical bills and aggressive debt collection practices by providers by requiring providers to implement a uniform financial assistance policy and utilize a simplified standard form.

Regulatory

DOH Issues Proposed Network Adequacy Regulation for MCOs

The New York Department of Health (DOH) has issued a proposed regulation that would implement sections of Chapter 57 of the Laws of 2023, which requires the commissioner, in consultation with various state agencies, to set forth network adequacy standards for mental health and substance use disorder (MH/SUD) treatments for managed care organizations (MCOs), with the goal of improving access to behavioral health services for New Yorkers.

The proposal does the following:

- Requires MCOs to have an adequate network of MH/SUD providers including mobile crisis intervention services providers as well as residential facilities that provide:
    - Sub-acute care;
    - Assertive community treatment providers; and
    - Critical time intervention services providers
- Sets forth appointment wait time standards for MH/SUD services (7-10 business days depending on service).
- Requires MCOs to provide assistance to an enrollee in finding an in-network provider if they cannot access MH/SUD services.
- Requires MCOs to allow an enrollee to access an out-of-network provider at the in-network cost-sharing if no in-network provider can meet the wait time standards and the out-of-network provider can.
- Requires MCOs to verify information in their provider directories and to include information in the directories on any restrictions concerning the conditions or ages treated by network providers.
- Requires MCOs to:
    - Develop a method for enrollees and providers to report directory errors;
    - Develop an access plan to monitor the utilization of MH/SUD services; and
    - Submit an annual certification of compliance to the Commissioner.

The proposed rule would apply to MCOs policies and contracts issued, renewed, modified, or amended on or after January 1, 2025. MCOs will also need to submit annual compliance certifications by December 31, 2025. The DOH is currently accepting comments on the proposal, which are due March 10.

Artificial Intelligence Systems and External Consumer Data Use

The Department of Financial Services (DFS) last week posted a proposed Circular Letter on its website related to using artificial intelligence systems and external consumer data and information sources in insurance underwriting and pricing. This is relevant to health insurance generally and certainly for the large group market. It is not clear whether it applies to HMOs, PHSPs and/or MLTC plans.

State Issues

West Virginia

Legislative

Biomarker Testing Mandate on House Insurance Committee Agenda

The 2024 Regular Session of the West Virginia Legislature made it through its first full working week in a fairly routine manner with some health care activity.

Recent Activity:

- **Biomarker Testing Mandate:** The House Insurance Committee is expected to consider HB 4753, regarding cancer biomarker testing, at its meeting Tuesday. Committee Chairman Delegate Steve Westfall has been working with health plan representatives and the American Cancer Society to develop legislation using the new New York law as the basis for a West Virginia bill.

- **SB 228:** The Senate Health Committee this past week advanced SB 228 requiring medically necessary treatment for cleft palates on to the Senate Finance Committee for further consideration. This bill is very likely to move forward and eventually become law since no opposition has been expressed to the proposal.

There has been no activity to date in the legislative session on key health insurance bills of importance, including:

- SB 178—Creating a dental plan required medical loss ratio standard.
- SB 250—Mandating that health plans cover infertility services.
- SB 443—Oral Health and Cancer Rights
- SB 444—Clarifying health plan coverage for emergency ambulance transport.
- HB 4174—Prohibiting the practice of “white bagging.”
- HB 4617—Mandating coverage for advanced breast cancer screening.

Finally, the House of Delegates has created a Select Committee on Artificial Intelligence to study the various and complex issues surrounding this topic and is soliciting presentations from experts in wide-ranging fields, including healthcare.

Regulatory

OIC Issues Prior Authorization Bulletin

The West Virginia Office of the Insurance Commissioner (OIC) has issued Bulletin No. 24-01 regarding prior authorization for prescription drugs at inpatient discharge. While the requirement is not new, an additional enforcement section was included in SB 267, legislation enacted during the 2023 legislative session that makes a number of changes to the prior authorization process. The change, allowing OIC to assess a civil penalty, became effective on January 1, 2024.

According to the bulletin:

- The state's prior authorization law exempts prescriptions written for inpatients at the time of discharge from health insurer prior authorization requirements.
- Such prescriptions are immediately approved for a minimum of three days, provided the medication cost does not exceed $5,000 per day.

- Physicians or healthcare practitioners must note on the prescription or inform the pharmacy that it is for a patient at discharge. After three days, prior authorization is required.
- To comply with the relevant provisions of West Virginia's prior authorization law, an electronic portal should include an option to bypass or forego the usual prior authorization requirement for a three[1]day supply of a prescription drug at the time of an inpatient discharge so long as the cost of the prescription drug does not exceed $5,000 per day.
- A new enforcement section effective January 1, 2024, allows the OIC to assess civil penalties for violations of the prior authorization law.
- Penalties may include fines up to $10,000.
- The OIC emphasizes the importance of prior authorizations in drug utilization management but will enforce penalties for violations.
- The bulletin encourages the availability of "real-time" electronic prior authorization approvals for efficiency in healthcare procedures.

Industry Trends

Policy / Market Trends

HHS Releases New Medicaid Renewals Resource Hub

The U.S. Department of Health and Human Services (HHS) launched a new resource hub for partners to access Medicaid and CHIP renewal and transition resources.

Why this matters: The outreach and engagement resource hub includes information from across the federal government, as part of the Administration's all-hands-on-deck effort to support individuals through the renewal process, and transitions to other coverage if appropriate.

Highlights include:

- Communications toolkit to help people renew Medicaid and CHIP coverage, available in English, Spanish, Chinese, Hindi, Korean, Tagalog, and Vietnamese;
- Agent/ Broker toolkit with information on how to assist consumers in transitioning coverage;
- Outreach materials by population category, such as kids and families, clinicians, people with disabilities and older adults, faith-based populations, and rural populations; and
- Key government actions taken to support Medicaid renewals and transitions, including federal nutrition program and housing authorities.

More information is available in the HHS Press Release.

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/.** .