Highmark's Weekly Capitol Hill Report

Issues for the week ending March 29, 2024

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Federal Issues

Legislative

Senator Casey Introduces Bill to Support Care in Rural Areas

U.S. Senator Bob Casey (D-PA) introduced a bill last week that would support training opportunities for medical students in rural, underserved communities.

The Community Training, Education, and Access for Medical Students (TEAMS) Act would create a nationwide grant program for medical schools and community-based clinics to fund training opportunities in these areas.

The TEAMS Act would:

- Provide eligible medical institutions with the opportunity to apply for grants under the Health Resources and Service Administration (HRSA).
- Prepare more students for the unique challenges of serving high-risk communities after graduation.
- Increase the number of medical training sites in our rural communities.

In this Issue:

Additional information about the bill is available **online**.

- **CMS Issues Quarterly Update to List of Part B Drugs Subject to the Inflation Rebate Program**

State Issues

New York

Legislative

- **Late Budget**

Regulatory

- **Updated PBM Regulation Issued**

Pennsylvania

Legislative

- **State House Advance Several Health-Related Bills**
- **Governor Signs Legislation to Establish Associate Licensure for Professional Counselors & Therapists**

Regulatory

- **Governor Announces Guidance for Health Insurers to Improve Coverage for Over-the-Counter Contraception**
- **Updated Guidance on Hospital Attestation Process for New Services and New or Updated Pieces of Equipment**

Industry Trends

Policy / Market Trends

- **HHS Releases Enrollment Reports Making 10 Years of ACA Marketplaces**
- **Coalition Fact Sheet Spotlights Home and Community-Based Services**
- **CMS Releases 2024 Value-Based Care Strategy Blog**

Federal Issues

Regulatory

CMS Releases Final Rule on Streamlining Medicaid, CHIP, and BHP Eligibility, Enrollment, and Renewal

The Centers for Medicare & Medicaid Services (CMS) released the *Streamlining Medicaid and Children's Health Insurance Program (CHIP), and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes* final rule. Effective June 3, the new rule finalizes many of the provisions introduced in the September 2022 proposed rule while making some changes to compliance timelines, allowing states additional time needed to meet new requirements.

Why this matters: CHIP provides low-cost health coverage to children in families that earn too much to qualify for Medicaid but not enough to buy private insurance.

- Combined, Medicaid and CHIP cover more than 85 million Americans.
- Streamlining enrollment and renewal processes for these critical programs will ensure millions will continue to have access to the quality, affordable health care on which they depend.

With respect to CHIP, the final rule:

- **Eliminates** annual, lifetime or other aggregate dollar limitations on medical or dental services covered under the state plan**;**
- **Ends** the practice of locking children out of CHIP coverage if a family is unable to pay premiums;
- **Eliminates** waiting periods for CHIP coverage so children can access health care immediately; and
- **Improves** the transfer of children from Medicaid to CHIP when a family's income rises.

Medicaid provisions include requiring states to provide all individuals with at least 15 days to provide any additional information when applying for the first time and 30 days to return documentation when renewing coverage; and prohibiting states from 1) conducting renewals more frequently than every 12 months; or 2) requiring in-person interviews for older adults and people with disabilities.

The final rule is scheduled for publication in the Federal Register on April 2, 2024.

New Proposed Rule for Critical Infrastructure Sector Cyber Incident Reporting

The Department of Homeland Security (DHS) Cybersecurity and Infrastructure Security Agency (CISA) released a notice of proposed rulemaking (NPRM) to implement the Cyber Incident Reporting for Critical Infrastructure Act (CIRCIA) of 2022. Comments are due 60 days after publication in the Federal Register.

Why this matters: The NPRM contains cyber incident and ransom payment reporting requirements by covered entities, including health plans, and implements other aspects of the CIRCIA regulatory program. Key proposals include:

- Defining a "covered entity" based on size (per the Small Business Administration standard) and sector-specific criteria.
- Requiring covered entities to report any covered cyber incidents to CISA no later than 72 hours from the time the entity reasonably believes the incident occurred.
- Requiring covered entities to report to CISA within 24 hours of making any ransom payments due to a ransomware attack.
- Establishing exceptions to CISA reporting requirements when a covered entity reports "substantially similar" information in a "substantially similar" timeframe to another federal agency.

AHIP commented on CISA's request for information in November 2022, which informed the NPRM. Read AHIP's comments here.

Federal Tri-Departments Finalize STLDI/Fixed Indemnity Rules

The Departments of Health and Human Services (HHS), Labor, and Treasury (the "Tri-Departments") released a final rule affecting short-term, limited duration insurance (STLDI) plans and supplemental health insurance benefits, including fixed and hospital indemnity insurance.

AHIP and BCBSA submitted comments on the proposed rules to the Tri-Departments in September 2023. Their comments supported the Tri-Departments' proposal to limit the duration of STLDI, but cautioned that proposed changes to the tax treatment of fixed indemnity and hospital indemnity insurance would limit consumer choices for supplemental coverages that millions of Americans value.

The final rules:

- Limit STLDI to a coverage expiration date not more than 3 months after the effective date of the final rule and no longer than 4 months in total, including renewals or extensions.
- Require STLDI and fixed indemnity insurance policies "that provide a fixed, cash payment for a health care event," to include a clear, easy-to-understand consumer notice on marketing, application, enrollment, and reenrollment materials, so that consumers can make informed coverage purchasing decisions, according to a CMS press release.

Tax Treatment of Fixed Indemnity Plans: The Tri-Departments opted not to finalize any changes to the definition or tax treatment of fixed indemnity benefits as outlined in the proposed rule, but indicated they would continue to consider those proposals.

Go Deeper: Read the 2023 AHIP-ACLI-BCBSA survey highlighting the value of the additional protection offered by fixed indemnity and specified disease plans.

CMS Extends Medicaid Unwinding Special Enrollment Period & Issues New Guidance

HHS and the Centers for Medicare & Medicaid Services (CMS) made several announcements related to the Medicaid unwinding and helping people maintain coverage:

Extension of the Marketplace SEP to November 30

CMS issued guidance announcing the Unwinding Special Enrollment Period (SEP) end date will be extended from July 31 to November 30, 2024. The guidance is applicable to all Marketplaces.

Additional CMS Unwinding Guidance

- CMCS Informational Bulletin (CIB) released March 15, covering "essential reminders" to states on conducting renewals during the unwinding period and beyond.
- A new slide deck for states with illustrative examples of processes not permitted under Medicaid and CHIP renewals.
- March 2024 updates to the slide deck on strategies for engaging MCOs during renewals.
- New resources for navigating Medicaid fair hearings and a new case study from the U.S. Digital Service detailing their partnership with CMS.

December 2023 Renewal Data

According to CMS' latest batch of Medicaid Redeterminations data from December 2023:

- Of the 7.1 million people due for renewal in December, 62.3% had their coverage renewed in Medicaid and CHIP. Of those renewals, 75.9% were done through an *ex parte*
- 9% lost their Medicaid and/or CHIP coverage. Within that cohort, 68.9% of terminations in December were for procedural reasons.
- Another 18.8% of people due for renewal in December were still pending with their state at the end of the month.

OMB Finalizes Revised Race and Ethnicity Data Standards

The Office of Management and Budget (OMB) released final revisions for collecting and reporting race and ethnicity data across federal agencies. These revisions replace and supersede previous OMB race and ethnicity data standards in place since 1997.

The final revisions include several changes, with the most notable being:

- Combining race and ethnicity into a single question.
- Creating a separate Middle Eastern or North African (MENA) response category.
- Requiring detailed data collection beyond the minimum categories as a default.
- Updating the terminology, definitions, and question wording of the Statistical Policy Directive No. 15.
- Requiring an action plan for each agency within 18 months and a deadline to implement the collection of these revised data standards within five years.

The final data standards largely align with AHIP's recommended revised data standards that were developed by AHIP's Health Equity Workgroup and presented to OMB and other federal agencies in Fall 2022 as well as comments submitted by AHIP in April 2023. AHIP is continuing efforts to build consensus around demographic data standards beyond race and ethnicity based on standards developed by AHIP's Health Equity Workgroup.

OMB Issues Guidance on Federal Government Use of AI

OMB issued its first government-wide policy related to artificial intelligence (AI).

Why this matters: The OMB policy is a component of President Biden's October 2023 Executive Order (EO) on AI, which directed federal agencies to act to strengthen AI safety and security. According to the White House, federal agencies have reported that they have now completed all of the 150-day actions tasked under the EO.

The guidance directs federal agencies to:

- **Address risks from the use of AI.** By December 1, 2024, federal agencies will be required to implement safeguards when using AI in a way that could impact Americans' rights or safety.
- **Expand transparency of AI use** by requiring agencies to improve public transparency in their use of AI such as reporting, notifications, and release of code.
- **Advance responsible AI innovation** with particular emphasis on addressing the climate crisis and responding to natural disasters, advancing public health, and protecting public safety.
- **Grow the AI workforce.** OMB's guidance directs agencies to expand and upskill their AI talent. The Administration has committed to hiring 100 AI professionals to "promote the trustworthy and safe use of AI" by summer 2024.
- **Strengthen AI governance** by requiring federal agencies to designate Chief AI Officers and establish AI Governance Boards.

Go Deeper: Read the White House Fact Sheet for additional information on the OMB policy.

CMMI Launches ACO PC Flex Model

On March 19, CMS announced a new voluntary model that empowers primary care providers in Accountable Care Organizations (ACOs) in the Shared Savings Program.

Why this matters: Beginning on Jan. 1, 2025, the ACO Primary Care Flex Model (ACO PC Flex Model) – see FAQ and model factsheet – and will provide a one-time advanced shared savings payment and monthly prospective primary care payments (PPCPs) to ACOs. The advanced shared savings payments provide ACOs with needed resources and flexibility to cover costs associated with forming an ACO (where relevant) and administrative costs for required model activities. PPCPs will be distributed by ACOs to primary care practices, giving them improved resources and flexibility to provide care that best suits individuals' needs.

CMS Announces Changes to National Producer Number (NPN) Information and Fraud and Abusive Conduct Notifications

Due to ongoing issues with inadvertent changes and inconsistent Agent/Broker Data in enrollment reconciliation, CMS has announced that starting with June's Run 7, CMS will no longer update Agent/Broker Information through the enrollment reconciliation process.

Why this matters: This data includes Agent/Broker NPN and Agent/Broker Name. If Issuers have a business need to change or remove the Agent/Broker on record with the FFE, a dispute will be necessary once this change has been implemented.

Additionally, CMS' Center for Program Integrity (CPI) will begin sending issuer notifications when an agent's/broker's (A/B's) Marketplace agreements have been terminated due to fraud and/or abusive conduct. Notifications will only be sent after an A/B's appeal opportunities (i.e., rebuttal and reconsideration) have been exhausted and will identify the terminated A/B and an Excel file that identifies any policies submitted to an issuer by that A/B (i.e., via the A/B's FFM User ID) and/or that indicate the A/B is the assister (i.e., include the A/B's National Producer Number). CMS continues to expect issuers to conduct data analysis and consumer outreach to identify any additional fraud or impacted enrollees.

CMS Issues Quarterly Update to List of Part B Drugs Subject to the Inflation Rebate Program

The U.S. Department of Health and Human Services (HHS) issued a press release updating the list of Part B drugs that will be subject to the Medicare Prescription Drug Inflation Rebate Program under the Inflation Reduction Act. For the 41 Part B drugs beneficiary coinsurance may be lower from April 1 through June 30.

The impacted prescription drug list is available in the quarterly ASP public file.

State Issues

New York

Legislative

Late Budget
The state's fiscal year started Monday without a new budget, as the Governor and Legislature are still negotiating major issues including housing, education and health care. Last week the Legislature approved and Governor Hochul signed a budget extension until April 4 to keep state government operating through the weekend.

Regulatory

Updated PBM Regulation Issued
The Department of Financial Services last week issued a new proposed regulation to govern pharmacy benefit managers operating in New York.

The regulation covers definitions and licensing of PBMs, contracting with network pharmacies, acquisition of PBMs, consumer protections, and audits. It is a follow up to the PBM regulation that was ultimately withdrawn last fall, and this version revises or removes a number of provisions that health plans had identified as being particularly problematic for plans including requirements related to pricing, network adequacy and use of specialty networks.

The new proposed regulation does add a new section on disclosure of costs associated with compliance with the regulation. Comments on the new proposal are due in 60 days.

State Issues

Pennsylvania
Legislative

State House Advance Several Health-Related Bills
State lawmakers last week advanced several pieces of legislation affecting the hospital community, including a proposal that would ban non-compete agreements between healthcare practitioners and the primary health care facilities and offices that employ them.

During Wednesday, the state House Health Committee advanced legislation that would ban new, and nullify upon license renewal, any existing restrictive covenants ("non-compete agreements") between health care practitioners and the primary health care facilities and offices that employ them.

The bill passed 21–4, with no votes from Representatives Tim Bonner (R-Mercer, Butler), Leslie Rossi (R-Westmoreland), Paul Schemel (R-Franklin), and Tim Twardzik (R-Schuylkill). The legislation heads to the full House for consideration.

The Hospital & Healthsystem Association of Pennsylvania (HAP) and the PA Chamber of Business and Industry have opposed the legislation. In a **letter** to lawmakers, HAP outlined the ways the bill could jeopardize access to care and exacerbate workforce shortages, particularly in rural areas.

The committee passed an amendment that would allow employers in smaller counties (classes 6, 7, and 8) to enforce these agreements under certain circumstances.

The House Health committee also advanced Senate Bill 668, which allows Certified Nursing Assistants (CNA) who work in skilled nursing settings to become Certified Medication Aides.
Under the proposal, CNAs who complete training would be able to perform some medication administration duties in long-term care settings, allowing licensed nurses to focus more on tasks that require their specific expertise.

During Monday, House lawmakers passed **House Bill 1956**, which clarifies hospital requirements for patient test result reporting and removes language related to significant abnormalities. The legislation, which was amended and unanimously voted favorably from the House Health Committee on February 6, 2024, amends Act 112 of 2018, which considers diagnostic imaging services.

The primary benefit of the law is clarifying communication with patients. **House Bill 1956 will achieve better outcomes by:**

- Removing the ambiguous “significant abnormality” language.
- Providing patients notice at the time of service that they will be receiving their test results in their electronic health record or that they can ask the provider to mail the results to them.
- Allowing providers to hold some potentially life-altering test results for one full business day prior to posting to a patient’s electronic health record.

Governor Signs Legislation to Establish Associate Licensure for Professional Counselors & Therapists

Governor Josh Shapiro signed House Bill 1564 on March 28.

Why this matters: The legislation establishes a Pennsylvania professional license for an Associate Marriage and Family Therapist and Professional License for an Associate Professional Counselor.

Highmark Inc. supported the legislation, as it creates a pathway for the Commonwealth to license additional health care professionals, specifically behavioral health care providers. Licensure will provide accountability and standards patients deserve and expect while creating opportunity for more professionals to deliver needed care.

Regulatory

Governor Announces Guidance for Health Insurers to Improve Coverage for Over-the-Counter Contraception

Governor Josh Shapiro urged health insurers in Pennsylvania to make contraception more accessible and affordable, announcing new guidance will be issued on insurance coverage for over-the-counter (OTC) contraception.

With the launch of the first ever FDA approved OTC daily birth control pill, Opill, Pennsylvania insurers are strongly encouraged to cover OTC contraceptives with or without a prescription, and are being asked to exempt this medication from the lengthy drug exceptions process as a best practice.

If an insurer chooses not to cover OTC contraception options, the **Pennsylvania Insurance Department (PID)** will require them to provide additional information to verify compliance with federal law and regulations, assessing why OTC contraception is not covered by the health care plan.

“PID will be pushing companies to make sure exception processes aren’t preventing women from obtaining reproductive healthcare” said **Pennsylvania Insurance Commissioner Michael Humphreys**. “The U.S. Congress has identified opportunities for insurers to improve access to contraceptive care. PID, too, has identified that such opportunities exist among Pennsylvania’s health insurance plans. We can do better. The Shapiro Administration is committed to protecting Pennsylvanians’ freedom and ensuring they are empowered with choices in their reproductive health care, and covering OTC contraception as a best practice, as a few of our insurers do today, is a nation-leading step forward.”

Updated Guidance on Hospital Attestation Process for New Services and New or Updated Pieces of Equipment

Last week, the Pennsylvania Department of Health Division of Acute and Ambulatory Care (DAAC) released **updated guidance** on the regulatory processes required when new hospital services are added or new and/or replacement equipment is needed (commonly referred to as the attestation process).

DAAC indicates in the guidance that it is narrowing the scope of equipment that requires an attestation and hopes to clarify how to meet regulatory requirements when multiple pieces of equipment are needed and when emergency situations arise.

The attestation process was put into place in 2020 to help hospitals comply with Chapter 51 of the Health Care Facility Regulations. These regulations indicate that a hospital must provide 60-day notice prior to initiating a new service or using a new or updated piece of equipment. Through this process, hospitals are asked to submit a “notification and attestation” that provides the department with the required information about the service or equipment and provides assurances that the hospital is operating in ways that are compliant with the regulations in place.

Effective immediately, DAAC surveyors will be advised to use the World Health Organization's definition of equipment to determine when notification and attestation is required. Several other issues are addressed in this guidance including when an attestation must be made for replacement equipment, and the number of attestations that need to be made for several pieces of identical equipment.

Why this matters: Hospitals have long complained that the notification and attestation requirements were being applied too broadly, resulting in a significant amount of work for hospital regulatory teams and delays impacting the ability to operationalize the desired changes efficiently.

These changes are intended to drastically reduce the instances when hospitals must use the attestation process.

Industry Trends

Policy / Market Trends

HHS Releases Enrollment Reports Marking 10 Years of ACA Marketplaces

The U.S. Department of Health and Human Services (HHS) issued 4 new reports showing the Affordable Care Act (ACA) has made historic gains in Americans' health insurance coverage.

Key points include:

- Total Marketplace Plan Selections During 2024 Open Enrollment Period: During the 2024 Open Enrollment Period (OEP), **over 21.4 million consumers** selected or were automatically re-enrolled in health insurance coverage through HealthCare.gov Marketplaces and State-Based Marketplaces (SBMs). 5.1 million more consumers signed up for coverage during the 2024 OEP compared to the 2023 OEP, a 31% increase. Nearly 7 million more consumers signed up compared to the 2022 OEP and 9.4 million more consumers signed up compared to the 2021 OEP, reflecting a 48% and 79% increase respectively.
- Coverage Under the Affordable Care Act: 2024 Enrollment Trends and State Estimates: **6 million people** have coverage thanks to the ACA's Medicaid expansion.
- ASPE Marketplace Enrollment by Race and Ethnicity Issue Brief (2015-2023): An estimated **7 million Black people** and **3.4 million Latino people** enrolled in Marketplace plans in HealthCare.gov states during the 2023 Open Enrollment Period, representing enrollment **increases of 95% and 103%** respectively since 2020.
- How the ACA Marketplaces have evolved in 10 years (2014-2024): Between 2013 and the third quarter of 2023, the uninsured rate for all ages fell from **4% to 7.7%.** Since 2013, the uninsured rate for children has decreased from **6.5% to 3.4%** in 2023.

Read the highlights here.

Coalition Fact Sheet Spotlights Home and Community-Based Services

The Modern Medicaid Alliance (MMA) published a new resource spotlighting key facts about home and community-based services (HCBS).

Why It matters: Medicaid is the primary source of coverage for HCBS, which millions of Americans living with disabilities rely on for essential supports.

Excerpts include:

- More than half of all states deliver some or all HCBS through Medicaid managed care.
- HCBS serve a diverse population, including individuals with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.
- Without the critical services HCBS provide, patients' family members often have to fill in the gaps to provide care. More than 53 million people across the country serve as family caregivers who provide vital assistance to family members, including children or adults with disabilities and aging parents.

Go Deeper: Check out MMA's Medicaid HCBS Toolkit.

CMS Releases 2024 Value-Based Care Strategy Blog

CMS published a blog in Health Affairs titled "Update on the Medicare Value-Based Care Strategy: Alignment, Growth, Equity" provides a progress report on accomplishments and a look toward the future for CMS' Value-Based Care Strategy.

Why this matters: It also covers CMS' strategy to move toward value-based payment, a focus on alignment across payers, growth in accountable care, and promoting equity. Among other topics, CMS aims to scale model learnings, support primary care providers in value-based care, improve quality measurement, and improve the flexibility of practitioners to work with community-based organizations to address social needs, while also emphasizing the importance of value-based data transparency and fostering competition within Medicare Advantage.

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/.**