Highmark's Weekly Capitol Hill Report

Issues for the week ending April 12, 2024

Federal Issues

Legislative

Key Committee Leaders Unveil Compromise Federal Privacy Bill

On April 7, Senate Commerce Committee Chair Maria Cantwell (D-WA) and House Energy and Commerce Chair Cathy McMorris Rodgers (R-WA) released bipartisan, bicameral draft federal privacy legislation. The American Privacy Rights Act would establish national consumer data privacy rights and set standards for data security.

What's In:

- Private Right of Action: Allowing consumers to sue when companies violate their privacy rights established under the legislation and seek monetary damages.
- FTC Enforcement: Authorizing the Federal Trade Commission (FTC) to enforce the legislation's privacy requirements.
- Data Minimization: Restricting the data companies can collect, keep, and use about people to what companies need to provide products and services.

In this Issue:

- Algorithm Transparency: Requiring companies to provide "meaningful information" to consumers about how they use algorithms to make decisions.
- Cybersecurity: Mandating data security standards to prevent data from being hacked or stolen.

What's Next: The Energy and Commerce Subcommittee on Innovation Data, and Commerce has scheduled a hearing for April 17 on "Legislative Solutions to Protect Kids Online and Ensure Americans' Data Privacy Rights." Senate Commerce Committee consideration has yet to be announced.

Go Deeper: Review the draft text, and section-by-section summary.

Pennsylvania
Legislative

- **House Passes Telehealth Coverage Legislation**

Regulatory

- **DHS Issues 2023-2024 Prospective DSH Upper Payment Limit Prospective Analysis – Hospital Review due April 23**

Industry Trends

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- **AHIP, AMA, and NAACOS Release Playbook with Recommendations Toward a Sustainable Future for Value-Based Care Arrangements**

House Committee Examines Telehealth

On Wednesday, during a House Energy and Commerce Health Subcommittee hearing, the panel discussed 15 bills and heard testimony from patient advocates and health care providers. Members indicated support for maintaining expanded telehealth payment for older adults but raised several concerns including cost and trickle down impact.

Why it matters: Lawmakers are actively considering ways to extend telehealth flexibilities, which were critical to delivering care during COVID-19. **Some of these flexibilities expire at the end of the year.**

The concerns: The cost to extend the eased rules is a major concern for lawmakers. A key question is whether virtual visits would be reimbursed at the same rate as in-person care. But generally, members seemed willing to accept higher costs to expand access to virtual care. Lawmakers also want to ensure that changes to virtual care policy don't hinder access to in-person care. Chairwoman Cathy McMorris Rodgers (R-WA) said she wants to ensure patients can decide whether they get in-person care. Full committee Ranking Member Frank Pallone (D-NJ) noted he doesn't want telehealth to be used to undermine consumer protections like network adequacy standards.

BCBSA submitted a statement for the record in advance of the hearing and called on Congress to:

- **Permanently extend** certain telehealth flexibilities put in place during the pandemic
- **Prioritize** solutions that help increase access to mental health and substance use disorder services
- **Address** barriers to telehealth services for non-English speakers and pregnant and postpartum women in Medicaid

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Senate Finance Committee Examines SUD/ Medicare Physician Payments

The Senate Finance Committee held separate hearings on substance use disorder and Medicare physician payments last week.

Substance Use Disorder: On Tuesday, the Finance Health Subcommittee held a hearing titled "Closing Gaps in the Care Continuum: Opportunities to Improve Substance Use Disorder Care in the Federal Health Programs."

Witnesses included academics and a representative from a substance use disorder foundation. They discussed:

- The need for continued access to telehealth;
- The potential for delayed or denied treatment caused by prior authorization;
- The importance of coordinated, integrated care; and
- And the need for quality metrics and reporting on the part of treatment facilities.

Chairman Ben Cardin (D-MD) and Ranking Member Steve Daines (R-MT) reiterated the need for expanded access to medication assisted treatment and innovative payment models for treatment. Down dais Members talked about access to telehealth, comprehensive, coordinated care, and the important role of Certified Community Behavioral Health Clinics. During opening remarks, Senator Daines (R-MT) highlighted the need for SUD treatment and that the current opioid crisis is an epidemic.

Physician Payments: Meanwhile, on Thursday, the full Committee held a hearing titled, "Bolstering Chronic Care through Medicare Physician Payment," to explore Medicare physician payment reform. The witnesses included academics and representatives from physician specialty groups.

Chairman Ron Wyden (D-OR) spoke about improvements needed to the Medicare program to better address chronic care. He expressed concern with the fragmented health care system, noting the need for coordinated care, and telehealth flexibilities. He also expressed concerns with Medicare Advantage plans using federal funds for "marketing middlemen," and selling seniors' data.

Ranking Member Mike Crapo (R-ID) highlighted the deficits in the Medicare fee-for-service program. He expressed concern has the Medicare program has not kept up with

the cost of care, which has led to physician office practices closing or being bought by larger health systems. He advocated for structural changes to modernize Medicare payment. Chairman Wyden noted that this was the first of many Committee activities on Medicare payment reform to come.

Federal Issues

Regulatory

CMS Issues Payment Proposals for Inpatient and Long-Term Care Hospitals

CMS has released its proposal updating Medicare payments and policies for inpatient hospitals and long-term care hospitals.

- **Hospital Inpatient Prospective Payment System (IPPS)**

The Centers for Medicare & Medicaid Services last week released a proposed rule that would increase Medicare inpatient prospective payment system rates by a net 2.6% in fiscal year 2025, compared with FY 2024, for hospitals that are meaningful users of electronic health records and submit quality measure data. The official publication of the rule is expected on May 2 in the *Federal Register*.

This 2.6% payment update reflects a hospital market basket increase of 3.0% as well as a productivity cut of 0.4%. It would increase hospital payments by $2.9 billion, plus a proposed $560 million increase in disproportionate share hospital payments and proposed $94 million increase in new medical technology payments.

Among other provisions, the proposed rule would:

- ✓ Continue the low wage index hospital policy for FY 2025.
- ✓ Establish a separate IPPS payment for establishing and maintaining access to essential medicines.
- ✓ Establish a new mandatory CMS Innovation Center model that would provide bundled payment for certain surgical procedures.
- ✓ Distribute new graduate medical education slots under section 4122 of the Consolidated Appropriations Act of 2023.
- ✓ Seek public comments on the use of Medicare IPPS payments for maternity care by other payers.

In addition, CMS proposes a number of changes to its quality reporting and value programs. CMS would add seven new measures to the inpatient quality reporting program that are largely focused on hospital patient safety-related practices and outcomes and would remove four IQR measures. CMS also proposes to modify the Hospital Consumer Assessment of Healthcare Providers and Systems survey, resulting in updates to the HCAHPS sub-measures used in the IQR and the Hospital Value-based Purchasing Program. CMS proposes to increase the number of mandatory electronic clinical quality measures (eCQMs) that hospitals must report for both the IQR and the Promoting Interoperability programs.

Lastly, CMS proposes to modify and make permanent its Condition of Participation requiring hospitals and critical access hospitals to report certain data on acute respiratory illnesses. Beginning on Oct. 1, CMS would require hospitals and CAHs to report data once per week on confirmed infections of COVID-19, influenza and respiratory syntactical virus among hospitalized patients, hospital capacity and limited patient demographic information, including age.

Prelinimary Hospital Industry Take: Hospitals believe the proposed inpatient hospital payment update of 2.6% is woefully inadequate, especially following years of high inflation and rising costs for labor, drugs, and equipment. Many hospitals across the country, especially those in rural and underserved communities, continue to operate under unsustainable negative or break-even margins.

Hospitals have long supported flexible and widespread adoption of value-based and alternative payment models to deliver high quality care at lower costs. That said, hospitals are very concerned that the agency has proposed a mandatory model for five clinical episodes which expands substantially on the current Comprehensive Care for Joint Replacement model and Bundled Payment for Care Improvement model– neither of which have yielded significant net savings. Hospitals continue to encourage CMS to ensure that episode-based payment models are voluntary. Many organizations are not of an adequate size or in a financial position to support the investments necessary to transition to mandatory bundled payment models.

- **Long-term Care Hospital Prospective Payment System (LTCH PPS)**

The Centers for Medicare & Medicaid Services last week proposed increasing long-term care hospital standard rate payments by 1.2% in fiscal year 2025 relative to FY 2024. This includes a 3.2% market basket update, reduced by a 0.4% productivity adjustment. The official publication of the rule is expected on May 2 in the *Federal Register*.

In addition, CMS proposes to raise the fixed-loss amount for high-cost outlier payments to $90,921, which would reduce overall standard rate payments by 1.3%. CMS also proposes to rebase the LTCH market basket using a 2022 base year.

The proposed rule will increase net LTCH payments by 1.6 percent, or $41 million, in FY 2025, relative to FY 2024, including both standard rate payments and site-neutral payments.

While CMS does not propose to adopt or remove any quality measures from the LTCH Quality Reporting Program, the agency proposes to adopt and modify certain patient assessment items related to health-related social needs; LTCHs would be required to collect and report specific data elements related to living situation, food and utilities beginning with the FY 2028 LTCH QRP.

CMS also proposes to extend the window in which patient assessments must be done from three to four days after admission.

Finally, CMS issues two Requests for Information, one related to future measure concepts and another on a potential star rating system for LTCHs.

Initial hospital industry position: Hospitals are disappointed that CMS has proposed to increase the long-term care hospital outlier threshold, once again, by an extraordinary amount. Expecting LTCHs to absorb an additional $31,048 loss per patient would greatly exacerbate the resource challenges these hospitals face.

Long-term care hospitals care for complex patients who require extended hospitalization – a population they provide care for already at a considerable financial loss.

Any loss of access would affect not only long-term care hospitals and patients, but also would have ripple effects across the care continuum, such as placing additional burdens on short-term acute care hospitals and their intensive care units (ICUs).

CMS will accept comments on the proposed rules through June 10. A **fact sheet** and **press release** about the respective payment systems are available online.

CCIIO Issues Final 2025 Letter to Issuers

The Center for Consumer Information and Insurance Oversight (CCIIO) issued the final 2025 *Letter to Issuers in the Federally-facilitated Exchanges*.

Why this matters: The final *Letter* provides updates on operational and technical guidance for the 2025 plan year for issuers seeking to offer qualified health plans (QHPs), including stand-alone dental plans (SADPs), in the Federally-facilitated Exchanges (FFEs) or the Federally-facilitated Small Business Health Options Programs (FF-SHOPs). It also describes how parts of the final 2025 *Letter* apply to issuers in State-based Exchanges on the Federal Platform (SBE-FPs).

One significant provision that allows telehealth to count towards the appointment wait time standards, which is consistent with the recommendations made in BCBSA's comments on the proposed *Letter to Issuers*. Note however that telehealth will not count towards the time and distance standards. CMS is also implementing a "phased" approach to secret shopper surveys, which they describe in this way:

"To limit the burden on QHP issuers, we intend to only require secret shopper surveys to be conducted for a QHP issuer's primary care (routine) and behavioral health providers. We expect to require secret shopper surveys to be administered with respect to specialty care (non-urgent) providers in future plan years."

The final 2025 *Letter to Issuers* is available here.

HHS Releases White Paper on Preventing Drug Shortages

The Department of Health and Human Services (HHS), through the Assistant Secretary for Planning and Evaluation (ASPE), recently released a white paper highlighting the

steps HHS has taken to prevent and mitigate drug shortages and proposing additional solutions for policymakers to consider.

Why this matters: The white paper outlines how federal programs could operate and help address the broader market issues that lead to drug shortages.

Key highlights of the white paper include:

- How drug shortages impact patients, families, caregivers, pharmacists, hospitals, nursing homes, hospices, and other individuals and entities across the health care system.
- How market failures lead to pharmaceutical supply chains that are prone to disruption, and too slow to recover from shortages.
- How supply chain resilience involves establishing processes with the ability to withstand and mitigate disruptions, so impact is limited.
- How HHS has made significant strides in shoring up the system's ability to respond to shortages. Nevertheless, more impactful and enduring solutions require additional statutory authorities and funding to resolve underlying causes of shortages.
- Policy concepts for consideration, including collaboration with the private sector to develop and implement a Manufacturer Resiliency Assessment Program (MRAP) and a Hospital Resilient Supply Program (HRSP).

Read the white paper here.

State Issues

Delaware

Legislative

New Coverage Mandates Introduced

House Bill 362 - In 2023, the General Assembly passed House Bill 80, which required the coverage of doula services under the State's Medicaid plan beginning in 2024. This Act would require similar coverage under private health insurance plans.

- **Why this matters:** Concerns that doula's are not licensed, only certified and there is no standardization of the certification requirements which can vary widely. The bill does allow carriers to require doulas to be certified or registered in the same manner required by the Division of Medicaid and Medical Assistance.

House Bill 364 This legislation requires individual, blanket, and group health insurance carriers cover drug treatment for the associated conditions of metastatic cancer in the same way treatment for metastatic cancer is covered. Specifically, it requires insurance companies to cover any FDA approved drug prescribed to treat the side effects of metastatic cancer treatment and prohibits insurance companies from mandating that patients first fail to respond to a different drug or prove a history of failure of such drug.

- **Why this matters**: Concerns were raised with the first draft of this bill that a complete prohibition on step therapy would constrict the ability to apply evidence-based standards intended to maximize benefits for patients. HB 364 addresses some of the concerns raised by Highmark by incorporating our requested effective date as well as including the following language in relation to the step therapy prohibition: "provided, however, the use of such drug is consistent with best practices for the treatment of the associated conditions of metastatic cancer and is supported by national clinical guidelines, national standards of care, or peer reviewed medical literature".

State Issues

New York

Legislative

Budget Agreement "Close"

The Legislature approved another budget extension late last week, while Governor Hochul and legislative leaders signaled they were closing in on agreement for a final $235 billion budget – $2 billion more than the Governor originally proposed spending. Work continued over the weekend with the goal of finalizing details in order to have budget bills ready to be voted on this week.

Bills in Committees

The Senate and Assembly Insurance Committees are both scheduled to meet this week and will be considering several bills of interest to Highmark:

- **Prohibit gender-based claims denial (S.3234-A/A.1682-A)** – would prohibit health insurance claim denials based on the gender of an insured person. The bill is unnecessary because New York already protects all New Yorkers against discrimination based on sexual orientation, gender identity or expression and transgender status; health plans already adhere to the requirement.

- **Lactation consulting services (A.3980-A/S.7126-A)** – would mandate coverage of lactation consulting services. The bill is unnecessary as health plans provide comprehensive maternal care coverage.

- **Donor breast milk (A.7790-A/S.6674)** – would mandate coverage for donor breast milk for infants. The bill is unnecessary because the state already has coverage of this benefit.

- **Prohibits discrimination of individuals on PrEP (A.8834-B/S.8144-A)** – would prohibit discrimination against individuals who were prescribed pre-exposure prophylaxis medication for HIV prevention with respect to insurance coverage. The bill is unnecessary because comprehensive health policies already have protections against such discrimination.

State Issues

Pennsylvania

Legislative

House Passes Telehealth Coverage Legislation

The House of Representatives passed the following piece of legislation: House Bill 1512 (Sappey, D – Chester).

Why this matters: This legislation would amend Title 40 (Insurance) to establish the regulation of telemedicine service and to require health insurers to provide coverage for telemedicine services if coverage is provided to the same type of service offered in an in-office setting.

- **Representative Christina Sappey** stated: I'm proud to have worked on this lifesaving measure. Many people hardly have the option to see a doctor in person due to workforce shortages and other limitations in the healthcare industry. I want to emphasize that this is not a mandate. It simply requires that if an insurer covers a procedure or service in-person, it shall also cover that activity if it takes place remotely, through telehealth.

Next steps: The bill passed the House by a vote of 197/3 and now moves to the Senate for consideration.

Regulatory

DHS Issues FY 2023–2024 Prospective DSH Upper Payment Limit Prospective Analysis—Hospital Review due April 23

The Department of Human Services (DHS) March 27, 2024, sent the Medicaid FY 2023–2024 disproportionate share hospital (DSH) upper payment limit (UPL) analysis to all potentially eligible DSH hospitals.

Hospitals that are over the limit to receive payment have until April 23 to review the calculation and work with the DHS on making any necessary corrections. **Hospitals should submit requests/questions via email with the Subject: [Hospital Name] FY 2023–2024 Prospective DSH Limit Request.**

Why this matters: Under federal law, federal financial participation is not available for state DSH payments that are more than the hospital's eligible uncompensated care cost, the cost of providing hospital services to Medicaid patients and the uninsured, minus payments received by the hospital on behalf of those patients.

Each year, the department withholds DSH payments to hospitals based on the prospective DSH limit analysis for that year, so it is important for hospitals to carefully review the information to realize the maximum funding amount.

Industry Trends

Policy / Market Trends

AHIP, AMA, and NAACOS Release Playbook with Recommendations Toward a Sustainable Future for Value-Based Care Arrangements

AHIP, the American Medical Association (AMA), and the National Association of ACOs (NAACOS) released a playbook on voluntary best practices for payment structures in value-based care arrangements. These three leading industry voices formed a partnership, the Future of Value initiative, to explore how to sustain momentum for, and grow broad-based participation in, value-based care arrangements in the private sector to improve the quality, equity, and affordability of care. Last July, the initiative released its first publication that focused on data sharing.

Highlights: While the playbook recognizes there is no single, best recommendation for value-based care arrangements, its voluntary best practices were sourced from the direct experience of physicians, value-based care entities, and health plans. The insights are organized into seven domains:

1. **Payment Attribution,** determining which patients and their associated medical costs physicians or entities are accountable for.
2. **Benchmarking,** setting financial targets to compare to spending over a particular year.
3. **Risk Adjustment,** accounting for the relative sickness of patients.
4. **Quality Performance Impact on Payment,** rewarding entities for performance on quality on a set of metrics.
5. **Levels of Financial Risk,** assuming some level of financial responsibility, if and when appropriate, for improving outcomes and costs of patients.
6. **Payment Timing & Accuracy,** structuring how and when funds flow in arrangements.
7. **Incentivizing for Value-Based Care Practice Participant Performance,** considering how to educate and reward participants in achieving the goals of payment arrangements.

Go Deeper: Check out the playbook and press release here.

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/.**