# Highmark's Weekly Capitol Hill Report

**Issues for the week ending February 23, 2024**

## Federal Issues

Regulatory

### CMS Finalizes Rule on DSH Payments

The Centers for Medicare & Medicaid Services (CMS) released the final Disproportionate Share Hospital (DSH) Third-Party Payer Rule.

**Why this matters:** The rule addresses changes to the hospital-specific limit on Medicaid DSH payments under the Consolidated Appropriations Act, 2021 and clarifies how that limit will be calculated. Under the new DSH payment methodology, the calculation of a hospital's Medicaid shortfall (the difference between Medicaid costs and Medicaid payments) will only include services furnished to beneficiaries for whom Medicaid is the primary payer. Additionally, under the new final rule, any DSH overpayments identified through audits must be returned to the federal government or, if permitted under a state plan, redistributed to other qualifying hospitals in the state. Provisions of the final rule will go into effect on April 20, 2024. Read More

## In this Issue:

- **AHIP Resource Reviews Impact of Federal Prior Authorization Requirements on States**

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**CMS Issues 2025 Part C Bid and Operational Instructions for Comment**
On February 21, the Centers for Medicare & Medicaid Services (CMS) released Contract Year (CY) 2025 Part C bid and operational instructions for comment. Comments on the Part C instructions are due to CMS by March 13 at 6:00 p.m.

## State Issues

**New York**
Legislative

**Bills in Committee**
Several bills of interest will be considered in committees this week:

- **Essential Plan coverage for immigrants (S.2237B/A.3020-B** – would allow coverage in New York's Essential Plan for individuals who would otherwise meet the criteria to enroll in the program but are currently precluded from participating based on their immigration status.
- **Medicaid DME reimbursement (S.3468/A.3408)** -- requires Medicaid managed care organizations to reimburse durable medical equipment (DME) providers at no less than one hundred percent of the Medicaid DME fee schedule.
- **Payment parity for FQHC telehealth (S6733/A.7316** – requires telehealth payment parity for Federally Qualified Health Centers for care delivered where neither the provider nor the patient were located in a clinic.

Regulatory

**Proposed Behavioral Health Regulation Issued**

The Department of Financial Services formally issued its proposed regulation on standards for network adequacy for mental health and substance use disorder treatment services. The proposal, published in the State Register and announced in press releases from the Governor and the Superintendent of DFS, impose maximum wait times for visits – including requiring health plans to help patients secure a behavioral health visit within 10 days of their initial request for an appointment and within seven days for patients being discharged from hospital settings.

Additionally, if a patient is unable to secure an in-network visit within the standard wait time, health plans would need to cover treatment by an out-of-network provider at no additional cost to the patient. The proposal also requires health plan directories to list contact information and descriptions for each provider, including the specific age groups and mental health conditions that each provider treats.

The proposed DFS regulation applies to commercial health plans, however, the Department of Health proposed an identical regulation for health plans providing coverage under Medicaid managed care, Child Health Plus, and the Essential Plan.

**Why this matters**: As the Health Plan Association has stated in responding to media inquiries, a major issue in getting quick behavioral health appointments is the ongoing shortage of providers.

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### Medicaid Waiver Recording Available

The Department of Health last week posted its pre-recorded webinar that outlines key initiatives included within the 1115 Waiver amendment.

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## State Issues

### West Virginia

Legislative

### Legislative Update

The 2024 Regular Session of the West Virginia Legislature has now passed the 75% point of completion as Friday marked the 45th day of the 60-day term. The pace of activity will be very fast last week as any bill that is to have a chance of making it all of the way through the legislative process has to be reported out from all committees and pass at least one house—either the Senate or House of Delegates—by Friday, March 1.

After that point, the respective houses can only consider bills that have been passed by the other, so the roster of prospective bills will be greatly narrowed over the final 10 days of the session.

**Bills of interest:**

- **HB 4753—Cancer Biomarker Testing**
  The House Judiciary Committee reported a committee substitute version of the bill out late Thursday evening after a contentious and lengthy debate prompted by the opposition to the bill generated by the American Cancer Society, the Alzheimer's Foundation and the Parkinson's Foundation. Those groups wanted to eliminate prior authorization, the limitation to post-diagnosis testing and the limitation for only FDA approved or cleared testing and therapies. All of the health plans were united with PEIA and Medicaid in support of the bill, which passed on a close voice vote in the committee—estimated to be 14-8 unofficially. It is clear that ACS and the others will be promoting their amended version of the bill when it reaches the House floor and in the Senate, if it passes the House. However, if ACS achieves its goal of gaining an amendment to the bill, it is very likely that both PEIA and Medicaid will develop significant cost estimates for the bill that will cause the Senate to view the proposal with disfavor.

- **HB 5417—NCOIL model bill on dental plan expenditure reporting.**
  The House Health Committee chair has acceded to the wishes of the West Virginia Dental Association in killing this bill by not placing it on her agenda for consideration, so it will advance no further in 2024—despite being a delicately negotiated work product between plans and the ADA at the national level—with the direct involvement of House Insurance Chairman Steve Westfall.

- **HB 4956--Oral Health and Cancer Rights.**
  The House Health Committee moved this bill to the full House at its meeting late Thursday but had questions about the potential costs to PEIA and Medicaid. Chair Summers promised that the agencies would produce a cost estimate prior to the final vote on the bill in the House. This bill has not moved from the first of two committees to which it was assigned in the Senate. This legislation seems likely to pass with the only potential impediment to this bill being if the public health programs project major costs that will affect the state's budget.

- **HB 5340—Requiring coverage of non-opioid medications as a priority.**
  This bill is being pushed by Vertex Pharmaceuticals because of a new non-opioid pain medication that has not yet been approved by the FDA. The House Health Committee endorsed this bill to the full House at its late Thursday meeting and modified its provisions to only mandate this new medication for patients who have been diagnosed with substance abuse disorder only. PEIA and Medicaid are both included in the coverage mandate and like HB 4956 described above, are going to develop cost projections for its implementation that may affect the House's course on this bill.

- **HB 5379/SB 831—Relating to financial assistance for prescription drugs.**
  The House Finance Committee unexpectedly placed HB 5379 on its late Friday agenda—a bill proposing to refine and somewhat expand the original 2018 legislation legitimizing the use of pharmaceutical manufacturers' discount coupons to pay down plan member deductibles. The Finance Committee considered the bill

at its late evening session on Friday in a slightly modified form to ensure that current law in this area stays in place until these new provisions become effective for plan years beginning on or after January 1, 2025. The bill now goes to the full House where it will pass prior to the crossover deadline on March 1.

The Senate Health Committee has one more meeting left before the crossover deadline and committee counsel indicated that this bill is not currently on the list to be considered.

- **SB 444—Mandatory coverage of emergency care. SB 533—Reimbursement for treatment without transport.**
  Both bills are moving with language inserted to remove air ambulances from the reimbursement requirements. Both of these bills will pass through the full legislative process before the end of the session.

- **HB 5103—Relating to EMS payment without transport.**
  This bill proposes to put a burden on health plans for the non-payment of local ambulance fees and taxes by plan members. The House Finance Committee will not be considering this bill.

- **HB 5310—Remote Outcome Improvement Act.**
  This bill appears to be in a position to advance no further this year but will be an issue in years going forward because of the aggressive interest in the topic by House Technology & Infrastructure Committee Chairman, Delegate Daniel Linville of the Huntington area. The bill speaks to the permissibility/desirability of health plans and broadband providers teaming to bring service to citizens for purposes of medical treatment and monitoring.

- **HB 5338—Data Privacy Protection Act.**
  This is a major bill affecting a broad range of economic interests and is pending in the House Finance Committee—and could be considered in the committee as early as Monday. There is support for the inclusion of clarifying language protecting plans and TPAs covered under HIPAA.

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Regulatory

### Mental Health Data Call

The West Virginia Office of the Insurance Commissioner (OIC) has published a 2024 Mental Health Parity Data Call. The data call stems from *W.VA. Code §§33-15-4u, 33-16-3ff, 33-24-7u, 33-25-8r, 33-25A-8u, and W.Va. Rule 114-64-7.3 and 8* which charges the OIC to annually issue a mandatory data call and provide a detailed report to the Joint Committee on Government and Finance on the status of mental health and substance use disorder (MH/SUD) parity.

Carriers are familiar with this data call and provided information in April 2022 for 2021 plan year data (published in May 2022); and again in April 2023 for 2022 plan year data (published in May 2023). Information from carriers for the 2024 data call is due March 15. This is approximately a month earlier than in the previous two years.

**Why this matters:** Based on a review of the carrier responses to the data call, the OIC may determine that a carrier is not in compliance with federal or state laws and regulations. If the OIC decides that a carrier is out of compliance, they will notify the carrier of the determination and any intended enforcement action and/or any corrective action for non-compliance.

## Industry Trends

Policy / Market Trends

### Coalition Urges Congressional Leaders to Uphold *No Surprises Act*

The Coalition Against Surprise Medical Billing (CASMB) sent a letter to Congressional leaders stressing the importance of the *No Surprises Act* in safeguarding patients from more than 25 million surprise medical bills since 2022.

**Key Quote:** "Extrapolating the latest data from AHIP and the Blue Cross Blue Shield Association, the law has prevented more than 25 million surprise medical bills from health care facilities, providers, and air ambulances from reaching patients since implementation in January 2022. Further, data shows health plan provider networks have grown – a testament to the law's impact in achieving one of Congress' priorities of expanding access to affordable, in-network care."

**Bottom Line:** The data show that certain out-of-network providers continue to overutilize the federal independent dispute resolution (IDR) process at a rate 14 times greater than initial estimates. This trend underscores the need for Congress and the Administration to ensure that the arbitration process is not exploited, but rather, provides a predictable, consistent and uniform process as a last resort for dispute resolution.

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### AHIP Resource Reviews Impact of Federal Prior Authorization Requirements on States

AHIP published a new resource that reviews the impact of new prior authorization rules and how they create opportunities for states to align with federal requirements, promote transparency, and improve care.

**Background:** New federal rules finalized in 2024 require Medicare Advantage, Medicaid, and Qualified Health Plans in the Federally Facilitated Exchanges to build electronic prior authorization systems to communicate prior authorization information and efficiently process prior authorization requests.

**Essential Requirements of the Rules:**

- **Prior Authorization Response Timeframes:** The rule requires impacted payers to send a prior authorization decision within 72 hours for expedited or urgent requests and reduces the time frame from 14 to 7 calendar days for standard or non-urgent requests.
- **Prior Authorization Reason for Denial:** Impacted payers must specify a reason in a standard, interoperable format when they deny a prior authorization request.
- **Electronic Process for Requests and Decisions:** Impacted payers are required to build standardized electronic prior authorization systems to communicate when prior authorization is needed, what documentation is necessary, and communicate both requests and decisions including the reason for denial, if applicable.
- **Prior Authorization Public Reporting:** Impacted payers are also required to annually report specific prior authorization metrics on the payer's website.

**Requests to States:**

- **Defer any legislative or regulatory action** on prior authorization while new federal rules are being implemented to avoid conflicting requirements, and
- Align state efforts with federal rules by **encouraging provider adoption of electronic prior authorization systems** that payers are required to offer.

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**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/.**