# Highmark's Weekly Capitol Hill Report

**Issues for the week ending March 8, 2024**

## Federal Issues

Legislative

### Congress Clears Partial Government Funding

Congress passed a six-bill fiscal year 2024 spending package late last week, which funds part of the federal government through September. President Biden signed the spending package into law on Saturday to avoid a partial government shutdown. **Funding for the remaining appropriation bills expires March 22.**

**Why this matters**: Beyond keeping the government open, the package includes several health care policies. Key health provisions include a 1.68% increase in Medicare payments for physicians in 2024 -- partially mitigating a larger reduction in reimbursements – as well as funding for community health centers. In addition, the legislation contains a requirement that state Medicaid plans to permanently cover medication-assisted treatment and creates a permanent state Medicaid option allowing treatment of substance use disorder at institutions.

**Among the key priorities for the hospital community in the health package:**

- **Delaying DSH Cuts:** The bill prevents cuts to the DSH program from going into effect through the end of the year.

## In this Issue:


**Federal Issues**

***Legislative***

- Congress Clears Partial Government Funding
- Biden Delivers State of the Union

***Regulatory***

- Change Healthcare Cyberattack Updates: CMS Issues MA and Part D Guidance & HHS Releases Statement
- FTC Launces Cross-Government Inquiry on Impact of Private Equity in Health Care
- Plan Feedback Requested on Innovation in Behavioral Health (IBH) Model
- CMS Announces Cell and Gene Therapy Access Model

**State Issues**

**New York**

***Legislative***

- Legislative Update

***Regulatory***

- DFS Issues Circular Letter On Change Healthcare
- 1332 Waiver Approved

- **Low-volume/Medicare-dependent:** The bill extends both the increased low-volume hospital payment adjustment and the Medicare dependent hospital program through 2024.
- **Physician payments:** The bill provides an increase in Medicare payments to physicians to partially offset payment cuts announced last fall.
- **Substance use disorder:** The bill requires for state Medicaid plans to cover Medication-assisted treatment.
- **Public health:** The bill extends funding for community health centers, the National Health Service Corps, and teaching health centers that operate graduate medical education programs through 2024.

**Yes, but what's not included?** Bigger ticket items that have seen activity on both sides of the Capitol over the last year - such as **PBM reform; health care transparency; and site neutral payments** – were left on the table after negotiators failed to reach consensus.

Also **not included was a reauthorization of the SUPPORT ACT**, expired legislation aimed at addressing the opioid epidemic.

It is possible that some of the remaining issues could be addressed after the 2024 elections at the end of the year when lawmakers will push to address expiring telehealth provisions.

**Pennsylvania**

***Legislative***

- **Department of Human Services Appropriation Committee Hearings**
- **State Officials Discuss Additional Priority Issues for Hospitals During Final Week of Budget Appropriation Hearings; Access to Care Discussed During Policy Hearing**

***Regulatory***

- **DOH Issues Guidance on Implementation of Act 43 of 2023 – Required Fentanyl and Xylazine Testing in Hospital Emergency Departments**

**West Virginia**

***Legislative***

- **Legislative Session Concludes**

## Industry Trends

**Policy / Market Trends**

- **Biden Administration Announces New Task Force to Address Health Care Costs**
- **OTC Contraception Will Be Available This Month**
- **CMS Publishes Chartbook for CAHPS HCBS Survey Database**
- **CMS Releases Updated Information on Unauthorized Plan Switching**
- **CMS Kicks Off IRA Medicare Drug Negotiations**

### Biden Delivers State of the Union

On Thursday, President Biden delivered his third State of the Union address, offering a preview of his legislative priorities ahead of the release of his 2025 budget proposal this week.

On health care, Biden touted his legislative achievements, namely a $35 copay cap on insulin for seniors and allowing Medicare to negotiate drug prices for the first time as well as making health care more affordable by extending enhanced ACA premium tax credits, set to expire in 2025.

**The president also called for:**

- Extending the Medicare $35 copay limit on insulin to the commercial market
- Extending the $2,000 out-of-pocket cap on Medicare Part D prescription drugs, set to go into effect in 2025, to all private insurance
- Expanding the number of drugs for which Medicare can negotiate to 500
- Making the enhanced Affordable Care Act tax credits permanent
- Codifying Roe v. Wade

**President Biden also referenced support for:**

- Mental health care access, where the administration is currently finalizing a rule to ensure parity within health plan coverage;
- Improving the availability of home care for Medicaid enrollees; and
- Bringing out-of-network billing restrictions ushered by the No Surprises Act to ground ambulance providers, which are currently exempt.

## Federal Issues

Regulatory

### Change Healthcare Cyberattack Updates: CMS Issues MA and Part D Guidance & HHS Releases Statement

On March 6, the Centers for Medicare & Medicaid Services (CMS) issued a memorandum to provide guidance to Medicare Advantage organizations (MAOs), Part D sponsors, and Medicare-Medicaid Plans addressing impacts related to the Change Healthcare cyberattack. CMS states that the agency expects plans “to continue to provide access to covered benefits without disruption by executing their business continuity plans and removing or relaxing utilization management and timely filing requirements as appropriate.” Furthermore, CMS is encouraging MAOs to offer advance funding to the most impacted providers. Specific guidance on prior authorization, payment, and business continuity plans is provided in the memorandum.

HHS released a statement regarding the cyberattack on Change Healthcare. They commented, “HHS recognizes the impact this attack has had on health care operations across the country. HHS’ first priority is to help coordinate efforts to avoid disruptions to care throughout the health care system... HHS is also leading interagency coordination of the Federal government’s related activities, including working closely with the Federal Bureau of Investigations (FBI), the Cybersecurity and Infrastructure Security Agency

(CISA), the White House, and other agencies to provide credible, actionable threat intelligence to industry wherever possible."

Details of the attack can be followed on the company's incident reporting page.

BCBSA & AHIP are coordinating with the Centers for Medicare & Medicaid Services (CMS) and other key health care sector cybersecurity leaders regarding the cyberattack.

**Additional context:** The HHS-designated group tasked with coordinating cybersecurity efforts unveiled its latest strategic plan to deal with growing cybersecurity threats in the health care sector. The 5-year plan developed by the Health Sector Coordinating Council Cybersecurity Working Group, crafted in partnership with AHIP, HHS, DHS, and other federal agencies, outlines several goals.

---

## FTC Launches Cross-Government Inquiry on Impact of Private Equity in Health Care

The FTC, DOJ, and HHS jointly launched a cross-government public inquiry into private-equity and other corporations' increasing control over health care.

**Why this matters:** The cross-government inquiry seeks to understand how certain health care market transactions may increase consolidation and generate profits for firms while threatening patients' health, workers' safety, quality of care, and affordable health care for patients and taxpayers. The agencies issued a Request for Information (RFI) requesting public comment on deals conducted by health systems, private payers, private equity funds, and other alternative asset managers that involve health care providers, facilities, or ancillary products or services. Comments are due on May 6, 2024.

---

## Plan Feedback Requested on Innovation in Behavioral Health (IBH) Model

In January, CMS announced a new Innovation in Behavioral Health (IBH) model through CMMI. IBH is a state-based model, led by state Medicaid Agencies, that integrates select primary care screenings and assessments into community-based behavioral health practices.

**Why this matters:** IBH will launch in Fall 2024 and is anticipated to operate for eight years in up to eight states. The focus beneficiaries include Medicare and/or Medicaid beneficiaries with moderate to severe BH and/or SUD conditions. For additional information regarding the IBH model, CMS has released a Fact Sheet, Press Release and FAQs.

Plans have inquired as to whether MA plans and other commercial health plans can participate in the IBH model. CMS announced during a recent webinar that MA plans are not eligible to participate at this time. The IBH model focuses on FFS and Medicaid plans, since those beneficiaries are at high risk for poor outcomes. CMS said it considers multi-payer alignment an essential part of the model, and aligning payers will help optimize behavioral health resources. As CMS starts to work with state Medicaid agencies on IBH, there may be an opportunity to have MA plans align with the model as well. CMS will share the details of the model and its quality measures and outcomes with MA plans so that these payers can leverage the model in their own programs.

---

## CMS Announces Cell and Gene Therapy Access Model

CMS announced the release of the Manufacturer Request for Application (RFA) for the Cell and Gene Therapy (CGT) Access Model.

**Why this matters:** This is a voluntary Medicaid-focused model which would establish a partnership among CMS, manufacturers and state Medicaid agencies, and would test a new approach for administering outcome-based arrangements (OBAs) to help Medicaid beneficiaries gain access to potentially life changing, high-cost specialty drugs. State Medicaid agencies would have the option to assign CMS to structure and coordinate multi-state OBAs with participating manufacturers. The model is expected to begin in 2025.

## State Issues

### New York

Legislative

### Legislative Update

Both the Senate and Assembly are expected to release and adopt their one-house budget proposals this week. Once the one-house proposals are introduced, negotiations on a final budget will begin in earnest. Meanwhile, the Senate Health Committee is scheduled to meet this week, with a few bills of interest to plans up for consideration.

**Senate Health Committee**

**March 12 at 12:00 noon, Room 124 CAP**

- **S.3227-A (Hoylman-Sigal)/A.6059 (Simone)** – This bill prohibits prior authorization for coverage for pre-exposure prophylaxis (PrEP) used to prevent HIV infection. Plans will argue it is unnecessary as protections already exist to ensure patients have appropriate access to PrEP.

- **S.4922 (Sepulveda)** – The proposal prohibits health plans that administer the Child Health Plus program from requiring that participating health care providers also sign up for the commercial health care network operated by the insurer.

- **S.6123 (Rivera)/A.5750 (Paulin)** – The bill requires home care providers to use forms approved by the federal Centers for Medicare and Medicaid Services to submit claims and would allow providers to submit claims directly to Medicaid managed care plans.

Regulatory

### DFS Issues Circular Letter On Change Healthcare

On Friday, the Department of Financial Services issued a circular letter outlining protocols it is encouraging plans to undertake with affected providers. The letter provides guidance for how plans should work with providers to avoid disruptions in care, which may include suspending certain utilization review requirements, appeal timeframes, claim submission timeframes, and eligibility verifications. The circular letter also strongly

urges insurers to work with providers to address cash flow disruptions to avoid disruption of health care services.
UnitedHealth Group, parent of Change Healthcare, announced it had reopened Change Healthcare's electronic prescribing platform and expects to restore other key parts of the system starting this week.

HPA has scheduled a call with plans to discuss the circular letter and provide any other updates.

---

### 1332 Waiver Approved

New York received the long-awaited approval of its 1332 Waiver addendum that will allow more residents to qualify for the Essential Plan by expanding eligibility to residents with incomes up to 250% of the Federal Poverty Level, as well as to individuals with Deferred Action for Childhood Arrival immigration status.

**Why this matters:** It is estimated the new eligibility rules will expand EP coverage to an additional 100,000 New Yorkers. The Waiver will also support grants to address the Social Determinants of Health such as programs to combat food insecurity, improve air quality for enrollees with persistent asthma to reduce the number of emergency room visits, and increase access to behavioral health providers and services.

---

## State Issues

### Pennsylvania

Legislative

### Department of Human Services Appropriation Committee Hearings

The Department of Human Services (DHS) had their annual House and Senate Appropriations Committee hearings on March 5 and 6. **Items of note from the hearings which were voiced in both chambers include:**

- **Proposed Section 1115 Waiver Application for the "Bridges to Success" program**
  - Expansion of Medicaid coverage for those under the age of 6 were voiced by all four caucuses as a potential expansion of CHIP benefits.
  - Reentry Medicaid benefits for those who are incarcerated were widely lauded in the House with many concerns being voiced in the Senate.
- **Concerns with PBM Programs were voiced by both chambers, with SB 1000 being raised by all four caucuses, seeking the position of the administration on the legislation**.
  - DHS and the Administration are still reviewing the legislation and developing a position.
- **Maternal Mortality rates were addressed, with members looking for expansion of Medicaid coverage to help expand prenatal care across FQHCs and rural areas which have lost OB services in existing health care facilities.**

**Items of note brought up by the House include:**

- Utilizing the Rural Health Model pilot program and the health information exchange to increase funding for health care facility infrastructure as well as specialty services in rural areas.
- Increased funding for Long-Acting Contraceptive medications.

- Misuse of MCO Medicaid funding by contractors, specifically mentioning Keystone First, in SEPA.

**Items of note brought up by the Senate include:**

- DHS' contracts with Change Healthcare and if any PHI within DHS' systems had been breached or compromised.
- Increased Medicaid funding and reimbursement for financially troubled healthcare networks.
- Concerns with potential Medicare Advantage cuts and impact on beneficiaries enrolled in Medicare Advantage plans.
- Medicaid costs and the impact of the enhanced Federal Medical Assistance Percentage (FMAP) expiring.

---

## State Officials Discuss Additional Priority Issues for Hospitals During Final Week of Budget Appropriation Hearings; Access to Care Discussed During Policy Hearing

The state House and Senate appropriations hearings ended last week, but the debate over the size and scope of the state budget is expected to remain a topic of debate in Harrisburg through June. Additionally, House lawmakers last week hosted a discussion on access to care that featured a strong emphasis on reversing "venue shopping" in medical liability cases.

**Budget Hearings** -- The appropriations hearings featured significant back-and-forth between parties about the scope of Shapiro's $48.3 billion general fund budget, which is in an 8.4 percent increase over last year.

For the second straight week, lawmakers emphasized the importance of supporting hospitals in the 2024–2025 spending plan. Notably for the hospital community:

- **Expediting licensure reviews:** Officials from the Department of State outlined changes in the licensure application process, such as reviewing applications only when they are complete; a chatbot to answer questions; and real-time status updates for applicant reviews and emails outlining any missing requirements in submissions.
- **Addressing emergency room boarding:** Representative Doyle Heffley (R-Carbon) asked Department of Human Services (DHS) officials to support hospitals with challenges discharging patients with complex health needs. This issue has become even greater following the closure of state hospitals. The challenge is heightened when it comes to discharging adults with mental illness and children with complex behavioral health needs.

**Access to Care Hearing** -- The Pennsylvania House Professional Licensure Committee and Health Committee hosted a joint hearing focused on improving access to care.

The hearing highlighted the roadblocks that stand in the way of care, including a shortage of providers, the commonwealth's challenging medical liability climate, and inadequate reimbursement that threatens the long-term sustainability of services throughout the health care continuum.

Hospital industry representatives emphasized that Pennsylvania's workforce shortage is among the most persistent and severe in the nation, and that the commonwealth's public payor reimbursement has not kept up with the cost of delivering care.

Lawmakers emphasized the financial pressures on hospitals, particularly following the return of venue shopping in medical liability cases. This puts stress on rural hospitals and their specialty services in areas like obstetrics.

## Regulatory

**DOH Issues Guidance on Implementation of Act 43 of 2023 – Required Fentanyl and Xylazine Testing in Hospital Emergency Departments**

On March 9, the Pennsylvania Department of Health published a Notice in the *Pennsylvania Bulletin* regarding implementation of Act 43 of 2023 – required testing of fentanyl and xylazine testing in hospital emergency departments.

**Background:** Act 43 requires fentanyl and xylazine testing when a urine drug screening is conducted in an emergency department within an acute care hospital to assist in diagnosing a patient's condition. Xylazine testing is only required if testing is available as part of the urine drug screening panel. If the urine drug screening performed under Act 43 detects fentanyl or xylazine, the de-identified results shall be reported to the Department of Health.

Under Act 43, DOH is required, in consultation with stakeholders, to set the screening threshold for the reporting of test results and the manner of submission of test results.

In order to provide feedback, the Hospital & Healthsystem Association of Pennsylvania (HAP) convened a stakeholder meeting in February where hospitals and DOH officials engaged in constructive dialogue regarding the many questions surrounding implementation. As a result of the productive discussion, DOH adopted many of the recommendations hospitals requested.

**The following are key provisions of the DOH guidance:**

- **Screening threshold:** Under 42 CFR 493.1253, laboratories are required to establish and verify test system performance specifications. Laboratories should follow manufacturer's instructions for waived tests. Laboratories should follow 42 CFR 493.1253 for nonwaived tests.

- **Submission requirements:** DOH has determined that, effective June 1, 2024, de-identified test results for fentanyl or xylazine shall be submitted in aggregate form to DOH on a monthly basis. Reporting will be done on the Act 43 of 2023—Urine Drug Screening Reporting—Fentanyl and Xylazine Form, which will be available on the DOH web site.

  Reporting of a positive test result for fentanyl is not required if a health care practitioner determines that the positive result is due to a legally prescribed course of treatment for the patient.

- **Responsible reporting party:** The emergency department conducting the urine drug screening is permitted to identify an appropriate reporter to submit this form to DOH.

- **Questions:** For additional information, contact Raina Workman, DOH, at (717) 547-3059.

## State Issues

### West Virginia
Legislative

### Legislative Session Concludes
The 2024 Regular Session of the West Virginia Legislature ended at midnight on Sunday, March 10.

**Bills of Interest That Did Pass**

- **SB 477—Prohibiting disclosure of personal information regarding healthcare workers on the internet.**
  This initiative was spearheaded by the West Virginia Hospital Association because of the collective experiences its members faced through online attacks and disclosure of personal information related to hospital executives, physicians and nurses for disputes arising with patients and family members during COVID. The definition of healthcare entity and worker is very broad in this new bill.

- **SB 533—Allowing EMS agencies to triage, treat or transport patients to alternative destinations.**
  Highmark negotiated with the EMS coalition on this legislation to limit the scope of expense exposure to the new "treat and not transport" law. Air ambulances were specifically excluded in the bill so that they do not qualify for the same reimbursement as do land ambulances.

- **SB 667—Creating Physician Assistant Compact.**
  This bill was not controversial and merely enacts a new PA compact that has been negotiated.

- **SB 714—Transferring duties and licensing from Board of Osteopathic Medicine to Board of Medicine.**
  This bill was an initiative of Senate Majority Leader Dr. Tom Takubo who is a DO and Pulmonologist by profession. The DO board opposed the legislation at the beginning of the legislative session but that opposition seemed to fade away fairly quickly before the bill was ultimately passed.

- **SB 841—Reforms to Unemployment Compensation system.**
  The House of Delegates greatly modified the bill Saturday evening to cap employer tax rates at a $9,500 salary base, freeze the maximum weekly benefit for unemployment compensation at $662 in perpetuity, maintain the current maximum number of weeks of eligibility at 26 and to allow those on benefits to work part-time without penalty and earn up to their benefit amount without penalty.

- **HB 4809—Health Care Sharing Ministries Freedom to Share Act.**
  The provisions of this legislation were negotiated between the interested parties and the Office of the Insurance Commissioner in 2023 but the bill did not pass until this year. The legislation contains extensive language making it clear that these voluntary healthcare expense sharing arrangements are not insurance and cannot be advertised as such. The Attorney General would manage any consumer complaints made against any sharing group under existing authority in Code.

- **HB 5105—To eliminate the vaccine requirements for virtual public schools.**

This bill passed the House of Delegates in a form proposing the creation of a self-declared religious belief exemption for parents desiring to have their school children excused from the state's mandatory school immunization requirements. The Senate, after weeks of contentious internal debate in the Republican caucus, created and passed a compromise bill on the final night of the session limiting any vaccine exemptions to virtual public schools only but also allowed private and parochial schools to develop their own vaccine policies but that any student at a private or parochial school that played sports or participated in other interscholastic extracurricular activities must be vaccinated. The bill proposes no modifications in the immunization requirements currently in place for public school students.

- **HB 5232—Business Liability Protection Act.**
  This legislation was passed in response to a court ruling narrowing the scope of a legislation from a previous year granting employees the right to have a firearm, unloaded and locked in a vehicle in their employer's parking lot.

- **HB 5338—Safe Harbor for Cybersecurity Programs.**
  This bill was originally part of a larger bill containing privacy protections but was separated out in the House Finance Committee and passed. The bill, if signed by Governor Justice, will become effective January 1, 2025.

- **HB 5690—Creating a West Virginia Task Force on artificial intelligence.**
  This bill does exactly what its title suggests—creates a task force on AI that is comprised of designated individuals and gubernatorial employees.

**Bills That Did Not Pass**

- **HB 4753—Relating to health insurance coverage covering biomarker testing.**
  This bill was contentiously debated throughout the legislative session by health plan representatives and the American Cancer Society and other disease advocates, which argued for a far more extensive and expensive benefit than the Legislature was willing to consider. In the end, even with the refined biomarker benefit in HB 4753, the projected costs of $2.9 million for the state's public health plans resulted in the bill dying on the final night of the session when it was moved to the inactive Rules Committee calendar.

- **HB 4956—Creating the Oral Health and Cancer Rights Act.**
  This bill mandated certain levels of health and dental insurance coverage for oral cancer patients. There was a surprise amendment made on the Senate floor late in the evening of the final night of the session to include the provisions of Delegate Daniel Linville's HB 5310 and create a framework for ISPs and health insurers to partner on providing broadband service for reasons of delivering telehealth services. While Delegate Linville styled this proposal as permissive in nature, it is clear that this provision will set up a scenario where a mandate for ISP discounts and health insurer coverage for broadband can be transitioned into a mandate in the future.

  HB 4956 was ultimately never considered in the House.

- **SB 178/HB 5417—NCOIL model bill on dental plan transparency.** After the American Dental Association pulled its support from a model bill that had been negotiated at the national level in NCOIL, the West Virginia Dental Association pulled its support as well and the previously agreed to bill died in the House Health Committee without being considered.

- **SB 228—Mandating coverage of cleft palate treatment.** This bill advanced from the Health Committee in the Senate only to die in the Finance Committee because of the potential costs to PEIA and Medicaid from the mandate.

- **SB 236—Coverage mandate for treating pediatric autoimmune disorders.** This bill has been introduced for many legislative sessions and has never been considered.

- **SB 250/HB 4024—Coverage mandate for infertility services.**

- **SB 362/HB 5340—Coverage mandate for non-opioid pain medication.** This bill was heavily pushed by Vertex Pharmaceuticals and was passed by the House in a narrow form so that the mandate only would apply in situations involving substance abuse patients. The bill dies in the Senate Banking & Insurance Committee and the opposition of its chairman, Senator Mike Azinger, to coverage mandates. As a note, the Vertex product has not been approved by the FDA and its prospective price for treatment was not known.

- **SB 383/HB 5577—Coverage mandate for increased autism treatment benefits.** This bill has also been introduced for a number of years without being considered.

- **SB 857—Coverage mandate for genetic testing.** This was a new mandate proposal and also included a prohibition against the treatment being subject to any cost-sharing by a plan member. The bill was not considered.

- **HB 4001, HB 5580—Proposing a Medicaid buy-in.** While this bill was a hot topic during the 2023 legislative session, it was not discussed in 2024.

- **HB 4174—Prohibiting the practice of "white bagging".**

- **HB 4617, HB 4937, HB 5618, SB 486, SB 586—All proposing a coverage mandate of some type for breast cancer screening.** Despite there being a large number of these bills introduced, none was considered this year. .

- **HB 4997—Coverage mandate for stuttering treatment.** This bill was not considered.

- **HB 5183—Coverage mandate for bioidentical hormone treatment.** This bill was not considered.

- **HB 5218—Proposing a cap on insurance co-pays.** This bill was not considered.

- **HB 5244—Relating to portable benefits plans.** This bill was not considered.

- **HB 5310—Remote Patient Outcome Act.**

- **HB 5621—Creating employee right of self-defense in workplace**

- **HB 5698—Data Privacy Act.** This was a tremendously significant proposal that affected the entire business and technology communities and passed the House before it died without being considered in the Senate. Entities under HIPAA – such as insurers and third-party administrators – would have been exempt.

## Industry Trends

Policy / Market Trends

### Biden Administration Announces New Task Force to Address Health Care Costs

The White House is set to launch a federal task force tackling high health care costs among other sectors, for Americans by cracking down on what they deem unfair and illegal business practices. Officials from the Justice Department (DOJ), the Federal Trade Commission (FTC), and the Department of Health and Human Services (HHS) will all be included.

**Why this matters:** According to the Administration, the panel will focus its efforts on key sectors where corporations may be violating the law and keeping prices high, including prescription drugs and health care.

---

### OTC Contraception Will Be Available This Month

Drug manufacturer Perrigo's non-prescription daily oral contraceptive Opill tablet has begun shipping nationwide and announced their over-the-counter (OTC) contraception Opill will become available for purchase later in March. They stated that the product will be priced at $19.99 for a 1-month supply, $49.99 for a 3-month supply, and $89.99 for a 6-month supply. The manufacturer has indicated that it will establish a cost-assistance program to help low-income and uninsured individuals obtain the product at low or no cost.

**Why this matters:** The Food and Drug Administration (FDA) approved the Opill tablet in July 2023 for non-prescription use to prevent pregnancy. This is the first daily oral contraceptive approved for use in the U.S. without a prescription.

Current federal policy does not require insurance coverage of OTC contraceptives with no cost-sharing without a prescription, though several states have passed laws requiring coverage of additional types of OTC contraception. The Departments released Preventive Services Frequently Asked Questions (FAQs Part 64) in January regarding contraceptive coverage requirements under the preventive services provisions of the ACA. The Departments are continuing to consider responses to the Request for Information on coverage of over-the-counter (OTC) preventive services, which BCBSA and AHIP responded to in December.

---

### CMS Publishes Chartbook for CAHPS HCBS Survey Database

The Centers for Medicare & Medicaid Services (CMS) published results from the Agency for Healthcare Research and Quality (AHRQ) 2024 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Home and Community Based Services (HCBS) Survey Database.

**Why this matters:** The survey asks adult Medicaid beneficiaries about their recent experiences receiving long-term services and supports (LTSS) offered through state HCBS programs. Measures include experience with physical safety, availability of staff to help with activities of daily living, and ratings of personal assistance and behavioral health staff. The 2024 survey database includes over 6,000 responses submitted by state Medicaid agencies and managed care plans from 24 HCBS programs. Read More

---

## CMS Releases Updated Information on Unauthorized Plan Switching

CMS has released an informational slide deck on unauthorized plan switching, including updated guidance on how issuers can help consumers resolve these issues.

**Why this matters:** The information includes unauthorized plan switching scenarios that outlines the step-by-step process by which the undesired policy is cancelled and the consumer's preferred coverage is reinstated. The slide deck can be found here.

---

## CMS Kicks Off IRA Medicare Drug Negotiations

All 10 drugmakers participating in the first-ever Medicare drug price negotiations rejected the Centers for Medicare and Medicaid Services' (CMS) opening offers, beginning a series of negotiations before prices are finalized. If CMS does not accept a company's counteroffer, the groups will meet up to 3 times to negotiate a "maximum fair price" that will take effect in 2026.

**Why this matters:** The latest in the negotiations comes as drug companies and industry groups continue to oppose the process enacted under the Inflation Reduction Act (IRA). Drug companies and industry groups have filed 9 lawsuits seeking to delay or strike down the negotiations. The negotiations window for the first set of drugs ends on August 1. CMS must release an explanation of the final prices no later than March 1, 2025.

**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/.**