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States Drive Change in Licensure, Transparency, Exemption; 'Ideas Spread Like Infections'

By Nina Youngstrom

Some state legislatures are starting to leverage licensure statutes to make health policy changes without burdensome regulatory and enforcement additions. For example, Florida is considering whether to require hospitals—as a condition of licensure—to refer patients to urgent care, medical homes or elsewhere when they come to the emergency room with nonemergency conditions in a way that would still comply with the Emergency Medical Treatment and Labor Act.

"They're not creating a separate enforcement requirement," said Martie Ross, a consulting principal at PYA. "They're proposing to amend the licensure statute to say hospitals have to help frequent fliers in the emergency room find a landing path to a primary care physician." She said other legislatures are starting to consider ways to use licensure requirements to regulate hospitals. That's one example of the flurry of activity happening in states across the country. It's affecting Medicaid, price transparency, no surprises laws and other state laws and regulations. "Legislative ideas spread like infections, from one statehouse to another," Ross said. They also foreshadow federal action. The laws that became HIPAA and the No Surprises Act (NSA) started as privacy and surprise billing laws at the state level, but they're just two examples, she noted.

Medicaid is a hub in many states in various ways. Ten states still haven't expanded Medicaid under the Affordable Care Act, but some of them are considering ways to increase access, Ross said. Arkansas, for example, is looking at a private-insurance version of Medicaid. Meanwhile, CMS has extended Medicaid coverage of postpartum coverage to 12 months and only eight states have said no. CMS's Innovation Center in December also announced the Transforming Maternal Health Model, a 10-year payment and care-delivery model that "will support participating state Medicaid agencies (SMAs) in developing and implementing a whole-person approach to pregnancy, childbirth and postpartum care for women with Medicaid and Children's Health Insurance Program (CHIP) coverage."[1] There are other programs that allow states to use Medicaid funds for social services with the idea they improve health, including state homelessness programs. Seven states, including Colorado, Maryland and Illinois, are using federal Medicaid dollars for gun violence initiatives, Ross said.

Some States Have Their Own Ideas About Transparency

Here are highlights of some other developments that have caught fire at the state level:

- Hospital price transparency. "I can't tell you how many states are looking to implement regulations or laws saying you must be in compliance with [CMS] price transparency requirements," said Kathy Reep, a senior manager at PYA. Here's the double whammy part: Some states will impose their own penalty for noncompliance with CMS's requirements, with the penalty taking the form of a fine or a prohibition on collecting fees from the patient. "And it's unclear who is the arbiter of compliance. Some states could be looking at federal penalties while others make their own determination," Reep explained. For example, in Texas the penalty for price transparency noncompliance is a dollar amount per day based on the hospital's gross revenue, while CMS's penalty is a maximum of $10 per bed per day for hospitals with a bed count of

31 to 550 beds, and a maximum of $5,500 per day for hospitals with more than 550 beds. Colorado has another angle, Reep said. Hospitals that don't comply with price transparency are not permitted to use a debt collector or negative credit report against a patient and the patient can sue the hospital if it pursues collection activity if it's noncompliant, she explained.

Some states also are passing price transparency laws "parallelling what you have to do on the federal level," Reep said, referring to the transparency requirement that hospitals post machine-readable files of their prices and a list of prices of 300 shoppable services. But CMS also allows hospitals to provide patients with a price estimator—which lets patients calculate a price for an item or service specific to their insurance—instead of the shoppable services, Reep explained. "A lot of hospitals have that in place." The problem is, as states implement requirements for shoppable services, they're not including the price estimator option. That's frustrating because "it's the price estimator the patient wants to see," Reep noted.

- Surprise billing. More than 30 states enacted laws that prohibit surprise billing before Congress passed the NSA, which takes a backseat to the state laws. Some state attorneys general (AGs) are starting to characterize NSA violations as deceptive trade practices under state law, Ross said. Rather than creating a separate penalty, the state will use its existing enforcement process for NSA violations, she explained. Also, some states may do a surgical strike on their surprise billing laws. For example, New Mexico is considering deferring to the NSA's independent dispute resolution process when payers and providers are unable to agree on a payment for out-of-network services.

- Quality standards and staffing. For example, although a few states are holding out, most have expanded Medicaid maternal health coverage and behavioral health care, Reep said. Some, like Arkansas, are requiring a depression screening for new mothers. And CMS Jan. 18 announced the Innovation in Behavioral Health Model to "test approaches for addressing the behavioral and physical health, as well as health-related social needs, of people with Medicaid and Medicare."[2] States also are investing money in increasing the number of primary care practitioners and finding "innovative ways" to pay for them, Reep said. A few states are looking to entice primary care physicians to decline hospital employment by offering tax credits to stay in private practice.

- Hospital tax exemptions. "A lot of states are beginning to look at tax-exempt status," Reep said.[3] For example, states are considering a cap on how much expenditures can grow from one year to the next at tax-exempt hospitals. More states already require 501(c)(3) hospitals to present their community benefit implementation plans to the public (e.g., on their websites) and the number is likely to grow. Illinois goes a step further with a requirement that hospitals show how "community benefit spending relates to the community needs assessment, so you're linking the two," Reep said. The overarching theme of the scrutiny is whether they're providing all the services they need to "and truly meeting the requirements of tax exemption and what they should do to maintain tax-exempt status."

- Payer regulations. Several states have adopted or are considering the American Medical Association's model legislation on regulating fully funded (not ERISA) health plans. That includes provisions on prior authorization that, among other things, set quick response times, prohibit after-the-fact denials if treatment was preauthorized and require public release of prior auth data, Ross said. "We'll see how that goes and how it intersects with the rule released by CMS" Jan. 17 on prior authorization.[4] There were other state laws in the payer arena, Ross said. For example, "there's a lot of activity" on cost-sharing, with some states now requiring payers to apply any amount paid by consumers to their annual cost-sharing.

- Telehealth. Many states are expanding the list of conditions eligible for telehealth services under Medicaid, but not the audio-only version. Physical presence in the state is a condition of Medicaid participation, Ross said. In terms of commercial payers, virtually every state now has coverage parity (i.e., if they cover a service, they must cover it whether it's delivered in person or via telehealth), but that's not the same as payment parity (i.e., paying the same either way). A growing number of states, however, are moving to payment parity or at least a required minimum payment for telehealth services, Ross said. To stay on top of state telehealth developments, she recommends the Center for Connected Health Policy website.[5]

- Licensure. States are considering how they can change licensure to encourage innovations like the Acute Hospital Care at Home program and Rural Emergency Hospitals—which are both CMS creations—Ross said. On another note, "there's lots of action in the certificate of need space." Some states are contemplating a repeal of certificate-of-need (CON) laws because they slow capital investments and building, she said. Other states may tighten the CON process or add to it. The question is whether states will "keep CON going but not create unnecessary hindrance to expanded services."

- Prescription drug affordability. There are developments all over the map—literally and figuratively. For example, Massachusetts and New York now require prescription manufacturers to justify price increases. Oklahoma won't allow pharmacy benefit managers to burden prescription drug coverage with excess costs. Michigan, Vermont and Wisconsin have created Prescription Drug Affordability Boards to establish upper price limits. And the Food and Drug Administration on Jan. 5 gave Florida approval to import drugs from Canada.[6] "This is an issue that should be positive for the patient and the provider who is purchasing the drugs to make available to the patient and for the payer, so a united front is probably the right way to go," Ross said.

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1 Centers for Medicare & Medicaid Services, "HHS to Improve Maternal Health Outcomes with New CMS Care Model that Expands Access to Services, Other Proven Maternal Health Approaches," news release, December 15, 2023, https://bit.ly/3OlTJ0z.
2 Centers for Medicare & Medicaid Services, "Innovation in Behavioral Health Model (IBH) Overview Factsheet," accessed January 25, 2024, https://bit.ly/3u41UI5.
3 Nina Youngstrom, "NY Develops Charity Care Compliance Program; CCOs Everywhere May Want to Review 990s," *Report on Medicare Compliance* 32, no. 31 (August 28, 2023), https://bit.ly/3UeONOJ.
4 Centers for Medicare & Medicaid Services, "Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program," 42 C.F.R. Parts 422, 431, 435, 438, 440, and 457, accessed Jan. 19, 2024, https://bit.ly/4bd2eom.
5 Center for Connected Health Policy, accessed January 25, 2024, https://www.cchpca.org.
6 U.S. Food and Drug Administration, "Re: Letter of Authorization for Florida's Section 804 Importation Program," January 5, 2024, https://bit.ly/495sq2D.