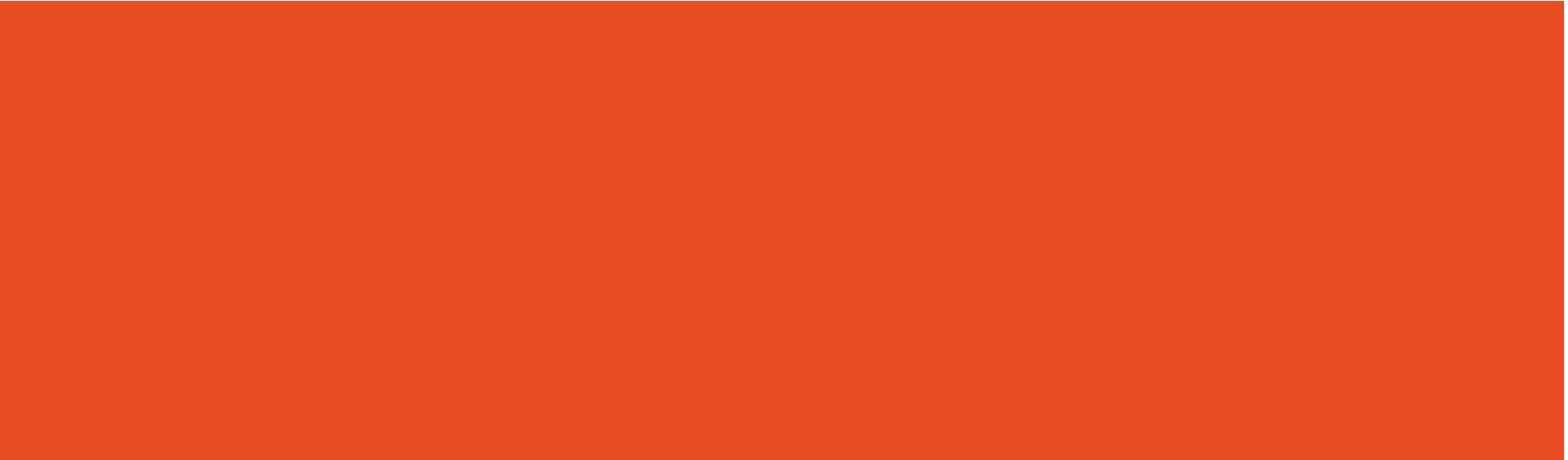




SKYGEN REGULATORY UPDATES

OCTOBER 2026



AGENDA

- Fee schedule updates
- Passed bills
- To watch

CA AB 280: PROVIDER DIRECTORIES (PASSED)

COMMERCIAL, MEDICARE ADVANTAGE

- Passed 9/27/26
- Effective 7/1/27
- Department of Managed Health Care to designate a third-party central utility for health plans and insurers to use
- Providers will be able to update their information in the utility once, and all plans they contract with can use this centralized information to update their directories
- Health plans must annually submit their directories to the central utility for evaluation
- When a member relies on an inaccurate, misleading, or incomplete directory listing, insurers must provide coverage at no extra cost to the member
- Providers must confirm and update their information within 30 calendar days of any change
- A health plan must ensure the accuracy of a request to add back a provider who was previously removed from a directory and approve the request within 10 business days, if accurate
- A health plan may include a specified statement in the provider listing before removing the provider from a directory if the provider does not respond within 5 calendar days of the plan's annual notification
- Action items: assign owner(s), watch for publishing of central utility (use this as first test of new regulatory implementation document)

CA SB 1049: HEALTH CARE CLAIMS REIMBURSEMENT (PASSED)

COMMERCIAL, MEDICAID

- Passed 9/30/26
- Effective 1/1/27
- If a plan denies a claim and sends a notice of overpayment based in whole or in part on a defect that may be remedied by submitting a corrected claim, the claimant has 90 calendar days from the plan's most recent action to submit a corrected claim
- A plan shall not deny a corrected claim submitted pursuant to this section on the grounds that the claim was not submitted within an applicable claim filing deadline other than the deadline specified above (90 calendar days). A dispute related to a corrected claim submitted pursuant to this section shall be eligible for submission to the plan's fast, fair, and cost-effective dispute resolution mechanism
- "Corrected claim" is the resubmission of an entire previously processed claim to replace it due to omitted charges, typos, or altered billing information
- Action items: discuss filing deadline question from last meeting
- Owners: Amy Conatty, BCM

OH SB 162: RECOUPMENT (PASSED-REMINDER)

COMMERCIAL, MEDICAID

- Passed 7/8/26
- **Effective 10/7/26**
- A payment made by a third-party payer to a provider shall be considered final one year (used to be 2 years) after payment is made (except in the case of fraud)
- In order to recover payment, a third-party payer shall inform the provider of its determination of overpayment, give the provider an opportunity to appeal, and shall not charge for the appeal
- If the provider fails to respond to notice within 60 days (used to be 30 days), or their appeal is denied, the third-party payer may initiate recovery
- The notice shall be in writing (can be electronic if agreed upon), and include the following:
 - Name of beneficiary, date(s) of service, amount of overpayment, claim number(s), explanation of basis for determination, method, date, and check # of payment, right to appeal within 60 days, method by which recovery would be made
- Action items: Recoupment documents have been updated, confirm that system updates have been made

CALIFORNIA AI BILLS (PASSED)

ALL BUSINESS LINES

■ CA SB 503

- Passed 9/30/26
- Effective 1/1/27
- Most impact is to developers of clinical decision support systems (CDSS), to identify and eliminate known or foreseeable risks of biased impacts in health programs or activities
- Developers must provide deployers with a statement of intended uses and known risks, and documentation covering training data demographics, evaluation methodology, bias mitigation efforts, and monitoring recommendations.
- Deployers must regularly monitor CDSS and take reasonable steps to mitigate biased impacts

■ CA AB 1609

- Passed 9/30/26
- Effective 1/1/27
- Customer service obligations for large private businesses that deploy chatbots in California (\$500M in annual gross revenue nationwide)
- “Customer service chatbot” is any AI system with a “natural language interface” that provides adaptive, human-like responses and is used for direct customer service or support relating to the sale or delivery of goods or services
- Covered businesses must not represent that a customer service chatbot is a human and must affirmatively disclose when AI is being used if a reasonable person would be misled.
- During regular business hours, covered businesses must provide feature enabling customers to request a human customer service agent. The business must make a good faith effort to connect the customer to a human agent within 15 minutes of the request, or offer a specific appointment time within one business day.
- For telephonic customer service platforms, the business must ensure that calls are answered promptly, that a customer is not placed on hold for more than 15 minutes at any point after the call is answered, and that cumulative hold times do not exceed an hour total.

HI SB 1035: ALL GOVERNMENT (PASSED)

- Passed
- Effective 1/1/26
- Exempts hospitals, clinics, pharmacies, and medical or dental providers from the state's General Excise Tax (GET) on goods and services reimbursed by Medicare, Medicaid, or TRICARE
- Action items: CE to reach out to clients to determine next steps

CALIFORNIA DENIAL REASONS COMMERCIAL

- Per audit, brought to attention that we must update denials in CA to align with Article 6.5 (Unfair Practices):
 - (13) Failing to provide promptly a reasonable explanation of the basis relied on in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement.
- Action items: assign owners, determine changes needed and if CE communication needed for updates

PA MCO MEMO #08/2026-011

MEDICAID, DENTAL AND VISION

- PH-MCOs, their Dental and Vision Benefit Managers, and any other Subcontractor responsible for contracting with or credentialing Providers on behalf of the PH-MCO should permit Providers previously terminated from the Network to re-apply for participation in the Network beginning one year (twelve months) after the effective date of the termination
- Action items: Emails regarding this have circulated, want to talk about the process for things like this

MI HB 5478 TIME TO RETRIEVE PAYMENT (TO WATCH)

COMMERCIAL

- Status: Introduced
- Effective: N/A
- A health plan shall not attempt to retrieve a payment made to a health professional, health facility, home health care provider, or durable medical equipment provider after 90 days after the payment is made unless the person that submitted the claim was convicted of submitting a fraudulent claim.
- A health plan shall not attempt to retrieve a payment unless the health plan provides the health professional, health facility, home health care provider, or durable medical equipment provider, as applicable, with the following information:
 - An explanation of why the health plan is retrieving payment.
 - The date of service.
 - The service code, or if there is not a service code available, a description of the service.
 - The amount of money to be retrieved.
 - The health plan's telephone number and email address, or mailing address.
- Action items: watch, discuss recoupment vs. time to retrieve payment

OH SB 386/HB 780: MEDICAID SAVINGS ACT (TO WATCH)

MEDICAID

- Introduced
- Would replace OH MCOs with administrative services organization (ASO) vendors paid to run the Medicaid program without bearing risk
- Would end capitation payments for every MCO in OH