Federal Issues
Legislative

Senate Committee Holds Hearing on Telehealth
On Wednesday, the Senate Health, Education, Labor, and Pensions (HELP) Committee held a hearing entitled “Telehealth: Lessons from the COVID-19 Pandemic”. Witnesses from the University of Virginia’s Center for Telehealth, American Telemedicine Association, Project ECHO, and BlueCross BlueShield of Tennessee shared how certain legislative and regulatory changes to expand access to virtual care during the public health emergency are benefiting patients and could in the future if continued. Members of the committee also shared specific examples of increased utilization in their local hospitals.

Why this matters: Telehealth use has surged since the beginning of the pandemic. Congress is looking to evaluate the landscape to determine which aspects of telehealth that were enhanced during the pandemic should be made permanent.

HELP Chairman Lamar Alexander (R-TN) indicated that he supports making permanent many of the provisions from the COVID crisis that expanded telehealth access. Witnesses and other Senators were in general agreement. In particular there seemed to be

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consensus around **eliminating geographic and originating site restrictions**, as well as considering making 29 other COVID-19 policy changes permanent.

BCBS of Tennessee Chief Medical Officer Dr. Andrea Willis described how BCBS of Tennessee partnered with in-network providers to bring telehealth services to members and noted that they are the first insurer to **permanently extend coverage of telehealth** beyond the COVID-19 pandemic.

Other witnesses testified about the importance of telehealth in mental health care.

A bipartisan group of 30 senators last week urged congressional leaders to make permanent provisions included in previous COVID-19 legislation to expand access to telehealth services for Medicare beneficiaries. Making expanded access to telehealth services permanent assures patients that their care will not be interrupted when the pandemic ends. It would also provide certainty to health care providers that the costs to prepare for and use telehealth would be a sound long-term investment.

**Hospital perspective:** The American Hospital Association has identified legislative and regulatory actions needed to maintain or extend these and other telehealth flexibilities implemented during the emergency. The actions address provider/patient location; providers and facilities eligible to deliver telehealth services; types of services; billing, payment, and coverage for telehealth.

**House Committee Examines COVID-19 Related Health Disparities**

- E&C Chairman Frank Pallone (D-NJ) noted that the COVID-19 pandemic has **disproportionately afflicted communities of color** and that social determinants, like institutionalized racism, are driving adverse health outcomes. Chairman Pallone also criticized Seema Verma, administrator of the Centers for Medicare & Medicaid Services (CMS), for not releasing COVID-19 data sorted by race, ethnicity, and gender.
- Republican Leader Greg Walden (R-OR) agreed that the pandemic has had a disproportionate impact on communities of color. He also pointed out that **relaxed state nursing home policies and the economic impact of stay-at-home orders** were particularly harmful to communities of color.
Witnesses testified about how available data shows stark inequities among minority populations, in COVID-19 mortality rates at the national level. They included Dr. Rhea Boyd of the Palo Alto Medical Foundation, Dr. Oliver Brooks of the National Medical Association, and Avik Roy of the Foundation for Research on Equal Opportunity.

MedPAC and MACPAC Release Reports to Congress
On June 16, the Medicare Payment Advisory Commission (MedPAC) released its annual June Report to Congress. The report covers refinements to Medicare payment systems and issues affecting the Medicare program, including broader changes in health care delivery and the market for health care services.

Topics include:
• Value-based payment and accountable care organizations;
• The impact of 21st Century Cures Act changes to risk adjustment for Medicare Advantage enrollees;
• Separately payable drugs in the hospital outpatient prospective payment system;
• A proposal for a new value incentive program to replace the existing Medicare Advantage (MA) Star Ratings program;
• Evaluation of changes to the CMS hierarchical condition category risk-adjustment model that CMS made in response to the Cures Act; and
• Ways to realign incentives in Medicare Part D and improvements to Medicare’s end-stage renal disease (ESRD) prospective payment system (PPS).

On the same day, the Medicaid and CHIP Payment and Access Commission (MACPAC) released its June 2020 Report to Congress on Medicaid and CHIP.

The report includes several recommendations to Congress and CMS, including:
• Ways to improve integration of care for dually eligible beneficiaries who have both Medicaid and Medicare coverage, including creating an exception to the special enrollment period for MMPs and providing additional federal funding for states to implement integrated care models;
• Changes to federal law to increase enrollment in the Medicare Savings Programs (MSPs) that use Medicaid funds to cover certain Medicare costs for low-income beneficiaries;
• Steps to improve coordination between Medicaid and TRICARE, to ensure that Medicaid remains the payer of last resort; and
• Medicaid’s role in maternal health.

Federal Issues
Regulatory

CMS Releases Proposed Rule for Development of Value-Based Payment Models
The Centers for Medicare & Medicaid Services (CMS) released a proposed rule entitled “Establishing Minimum Standards in Medicaid State Drug Utilization Review (DUR) Programs and Supporting Value-Based Purchasing (VBP) for Drugs Covered in Medicaid, Revising Medicaid Drug Rebate and Third Party Liability (TPL) Requirements”.


Why this matters: The proposed rule would revise and update federal regulations in the following areas:

- Provides regulatory flexibility relating to the calculation of Medicaid best price under commercial value-based payment (VBP) arrangements;
- Revises how drug manufacturers calculate the “average manufacturer price” (AMP) and “best price” of brand name drugs;
- Creates minimum standards in state Medicaid Drug Utilization Review (DUR) programs for reducing opioid-related fraud and abuse;
- Updates Medicaid drug rebate requirements to align with changes in federal law and the drug marketplace; and
- Updates coordination of benefits (COB) and third party liability (TPL) rules related to certain types of care and payment in Medicaid and Children’s Health Insurance Program (CHIP).

The proposed rule is scheduled for publication in the Federal Register on June 19; interested parties may submit comments to CMS during a 30-day comment period following publication.

DOL Issues Proposed Update to Mental Health Parity Self-Compliance Tool
The Department of Labor (DOL) issued a proposed update to its Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) self-compliance tool, in compliance with the 21st Century Cures Act.

The proposed updates generally take one of the following four actions:

- Integrate relevant guidance from FAQ Part 39 on implementation of MHPAEA;
- Revise examples of non-compliance included in the tool to explain how plans and issuers could come into compliance;
- Provide guidance on establishing a voluntary internal compliance plan with examples of the types of records plans and issuers should be prepared to provide in the event of a DOL investigation; and
- Provide additional examples of “warning signs” based on treatment limitations encountered in recent Federal and State enforcement efforts.

One such “warning sign” relates to provider reimbursement. The proposed update identifies inequitable reimbursement rates established via a comparison to Medicare and lesser reimbursement for MH/SUD physicians for the same evaluation and management (E&M) codes as potentially indicative of noncompliance. A new Appendix II has been included that provides a tool for comparing plan reimbursement rates to Medicare.

The DOL is requesting comments on the updated sections of the self-compliance tool by July 24, 2020.

Federal COVID-19 Policy Guidance and Other Developments
CDC Releases New Testing Recommendations:

- First, the CDC released “consolidated recommendations for COVID-19 testing” that separates diagnostic testing from public health surveillance. Testing is considered diagnostic when conducted among individuals with symptoms or among asymptomatic individuals with known or suspected recent exposure. Testing is considered surveillance when conducted among asymptomatic individuals without known or suspected exposure for early identification, or to detect transmission hot spots or characterize disease trends.
- Separately, the CDC released interim testing guidelines for nursing home residents and healthcare personnel which emphasizes weekly testing with more frequent testing if infection is identified.
Finally, the CDC released testing strategy options for high-density critical infrastructure workplaces after a COVID-19 case is identified.

The Department of Labor’s Occupational Safety and Health Administration (OSHA): issued guidance to assist employers reopening non-essential businesses and their employees returning to work during the evolving coronavirus pandemic. The guidelines provide general principles for updating restrictions originally put in place to slow the spread of the coronavirus.

Study Shows Convalescent Plasma Safe for Patients with Severe COVID-19: A study of the first 20,000 adults hospitalized with severe or life-threatening COVID-19 to receive convalescent plasma found the investigational therapy safe in this diverse group of patients, according to findings from the Food and Drug Administration’s Expanded Access Program for COVID-19 reported in Mayo Clinic Proceedings.

CDC Report Highlights Emergency Department Visits for Life-threatening Conditions Declined in Pandemic’s Early Months: A new study released by the Centers for Disease Control and Prevention shows emergency department visits dropped by 23% for heart attacks, 20% for strokes and 10% for hyperglycemic crises in first 10 weeks after the COVID-19 public health emergency declaration. The study’s authors said public health and health care professionals must publicly reinforce the importance of timely care for medical emergencies and give assurance that EDs are implementing infection prevention and control guidelines.

FDA Issues Guidance on Removed COVID-19 Antibody Tests and Encourages Reporting of Potential Medical Device Shortages: Clinical laboratories and health care providers should stop using any antibody tests on the Food and Drug Administration’s “removed” test list, evaluate prior results from the test and whether to retest the patient using an FDA-authorized test, the agency said. The FDA advises labs and providers to report any issues using COVID-19 tests. In other news, the FDA issued guidance implementing the Coronavirus Aid, Relief, and Economic Security Act requirement that medical device makers report supply disruptions during the COVID-19 emergency to prevent shortages.

Medicare to Cover COVID-19 Tests for Nursing Home Patients: Beginning July 6, both traditional Medicare and Medicare Advantage plans will cover diagnostic COVID-19 laboratory tests for nursing home residents and patients through the remainder of the public health emergency, the Centers for Medicare & Medicaid Services announced. The CDC recently recommended testing all nursing home residents and patients with COVID-19 symptoms or potential exposure. MA plans must continue not to charge cost sharing (including deductibles, copayments and coinsurance) or apply prior authorization or other utilization management requirements for COVID-19 tests and testing-related services.


GAO Report Says that HHS Should Improve National Disaster Medical System Workforce Planning: The Department of Health and Human Services should develop a workforce target for the National Disaster Medical System to ensure it can effectively respond to the nation’s current and future needs, according to a report by the Government Accountability Office. HHS responded to COVID-19, in part, by deploying doctors, nurses and others enrolled in the NDMS, who generally work outside the federal government but may assist with federal public health emergencies.
AHA Urges HHS to Extend Public Health Emergency: The American Hospital Association urged the Health and Human Services Secretary to extend the public health emergency beyond its current July 25, 2020 expiration date so “health care providers can continue to offer the most efficient and effective care possible during the continuing COVID-19 pandemic.” HHS Secretary Azar January 31 declared a public health emergency in response to the COVID-19 pandemic.

FDA Announces Project to Advance Diagnostics, Approves New Intubation/ventilation Drug: The Food and Drug Administration announced a public-private partnership to advance COVID-19 diagnostics. The project is a companion to a Therapeutic Evidence Accelerator launched by the Udall Foundation for the FDA and Friends of Cancer Research in April, which brings together experts in health data aggregation and analytics to inform the collective COVID-19 response. In other COVID-19 news this week, the FDA approved a new drug to facilitate tracheal intubation and muscle relaxation during surgery or mechanical ventilation; and issued warning letters to three companies for marketing unauthorized test kits directly to consumers for at-home use.

FDA Updates Authorization Templates for Asymptomatic, Pooled Testing; Revokes Antibody Test: The Food and Drug Administration issued updated templates for laboratories and manufacturers requesting emergency use authorization for molecular diagnostic tests that screen asymptomatic individuals for SARS-CoV-2 or use pooled samples. The updated templates outline the validation expectations for these testing options.

In other news this week, the agency:
- Revoked the EUA for a SARS-CoV-2 antibody test made by Chembio Diagnostic System Inc. due to performance concerns with the accuracy of the test.
- Posted FAQs and resources on reporting adverse events for medical devices under COVID-19 emergency use authorizations or other posted guidance.

SBA Updates and Simplifies Paycheck Protection Program Loan Forgiveness Application: The Small Business Administration released a revised loan forgiveness application for the Paycheck Protection Program, which implements provisions of the recently enacted PPP Flexibility Act. The agency also released an “EZ” version of the application (for borrowers who: are self-employed and have no employees; did not reduce employees’ salaries or wages by more than 25% and did not reduce employees or employee hours; or experienced reduced business activity due to COVID-19-related health directives and did not reduce employees’ salaries or wages by more than 25%). Both applications give borrowers the option of using the original eight-week covered period for loans made before June 5 or an extended 24-week covered period, the agency said.

The SBA released an interim final rule revising certain previous rules for the program to conform to the PPP Flexibility Act. The Coronavirus Aid, Relief, and Economic Security Act created the forgivable loans to help eligible small businesses keep workers on the payroll during the pandemic.

FDA Warns of Potential Drug Interaction Between Remdesivir and Hydroxychloroquine: The Food and Drug Administration said chloroquine phosphate and hydroxychloroquine sulfate could reduce remdesivir's antiviral activity. As a result, the FDA, citing a non-clinical lab study, does not recommend co-administration of the drugs. The agency revoked emergency use authorizations for chloroquine and hydroxychloroquine for COVID-19 treatment.
Study Updates Data on COVID-19 Hospitalizations for Those with Underlying Health Conditions: COVID-19 hospitalizations were six times higher and deaths 12 times more likely for patients with reported underlying health conditions compared with those with none, according to a new Centers for Disease Control and Prevention study. The study’s authors looked at outcomes from more than 1.3 million U.S. cases between January 22 and May 30 and found the most common problematic underlying conditions include cardiovascular disease, diabetes and chronic lung disease. The report also notes that death was most common among patients over age 80, regardless of the presence of underlying conditions.

UK Reports First COVID-19 Treatment to Reduce Mortality in Hospitalized Patients with Respiratory Complications: In a clinical trial of hospitalized patients in the United Kingdom, low-dose dexamethasone (a steroid) reduced deaths by one-third in ventilated patients and one-fifth in patients receiving oxygen only, the UK’s National Institute for Health Research reported.

HHS Issues New FAQs on Emergency Relief Fund Reporting: The Department of Health and Human Services recently updated its FAQs on the Coronavirus Aid, Relief, and Economic Security Act emergency relief fund, with specific attention to provider reporting related to these funds. Providers that have received emergency relief payments do not need to submit a quarterly report to HHS or the Pandemic Response Accountability Committee, according to the FAQs. The statutory requirement for quarterly reports related to these funds is being met by HHS’ public release of the data on each payment it has distributed.

The publicly available data on HHS’ Tracking Accountability in Government Grants System website includes the name and payment amount for each provider that has attested to receiving the emergency relief funds and agreed to the Terms and Conditions (or has retained their payment for more than 90 days). HHS also is working with the Department of Treasury to post each provider’s total emergency relief fund payment amount on this website. HHS confirms that the public data releases satisfy the CARES Act reporting requirement.

However, according to the FAQs, providers are still required to submit any reports requested by the HHS Secretary that are necessary to allow HHS to ensure compliance with payment Terms and Conditions. As such, HHS will be requiring recipients to submit future reports relating to the recipient’s use of its emergency relief payments. HHS will notify recipients of the content and due date(s) of such reports in the coming weeks.

Federal Reserve Board Proposes to Expand Main Street Lending Program to Nonprofit Organizations, Including Hospitals: The Federal Reserve Board announced it will seek public comments on a proposal to expand its Main Street Lending Program to provide access to credit for nonprofit organizations, including hospitals. The proposed expansion would offer loans to small and medium-sized nonprofits that were in sound financial condition before the COVID-19 pandemic and could benefit from additional liquidity to manage during the current pandemic. Making these loans also available quickly and on terms that take into account the circumstances of nonprofit hospitals will help eligible hospitals continue to keep their doors open during this crisis and to provide care for their patients and communities into the future.

The Equal Employment Opportunity Commission: issued updated guidance that forbids employers from requiring workers to take a COVID-19 antibody test before entering the workplace, citing CDC recommendations that these tests should not be used for return to work requirements and American’s with Disability Act Requirements (ADA). The EEOC has already said that COVID-19 viral tests are permissible under the ADA.
Cybersecurity and Infrastructure Security Agency (CISA): released a Disinformation Toolkit to help state, local, tribal, and territorial (SLTTs) officials bring awareness to misinformation, disinformation, and conspiracy theories related to COVID-19. The Toolkit includes talking points, frequently asked questions, and flyers, which provides simple steps that individuals can take to combat false or misleading information related to the pandemic.

Supreme Court Ruling Could Impact ACA Nondiscrimination Rule Changes

The Supreme Court ruled in a 6-3 decision that Title VII of the Civil Rights Act of 1964, which prohibits discrimination in the workplace, extends protection to gay, lesbian, or transgender employees from being disciplined or fired based on their sexual orientation or gender identity.

Background: HHS recently rolled back 2016 final rules regarding the interpretation of discrimination based on sex in HHS-funded programs and activities. The Section 1557 regulations in the Affordable Care Act will no longer:

1. Define sex discrimination to include gender identity and sex stereotyping;
2. Prohibit certain health plans and insurers from excluding any gender reassignment surgery;
3. Maintain specific grievance procedure requirements to address complaints of discrimination under section 1557;
4. Require the distribution of nondiscrimination notices and non-English language taglines regarding the availability of language assistance; or
5. Include enforcement procedures which protect aggrieved individuals against intimidation and retaliation.

Why this matters: The new final regulation will be subject to litigation, as prominent civil rights groups vowed to file suit. The litigants will seek to use or distinguish the Supreme Court’s recent ruling interpreting the Civil Rights Act’s Title VII’s protection against sex discrimination in employment to include sexual orientation and gender identity protections.

Insurer & Hospital perspective: AHIP President and CEO Matt Eyles released a statement following the finalization of the rule, stating that “[AHIP] resolutely disagrees with any attempt to remove protections in federal law that prohibit discrimination based on gender identity, sex stereotyping, and pregnancy status. We also firmly believe that non-English speakers should have ready access to health information. Discrimination is wrong – period.” AHIP previously submitted a comment letter on the proposed rule last August.

The American Hospital Association had strongly urged HHS not to finalize their proposal, expressing concerns that "narrowing the current regulation's protections against discrimination based on sex, including gender identity, sexual orientation, and sex stereotypes, could have an adverse impact on access to care and the health of individuals." The AHA also submitted a comment letter on the proposed rule last August.

CMS Releases ACA RADV Results for the 2018 Benefit Year
On June 12, 2020, the Centers for Medicare & Medicaid Services (CMS) released a new report on insurers’ ACA risk adjustment data validation (RADV) results for the individual and small group markets for the 2018 benefit year.

**Why this matters:** The report includes an overview of the RADV error rate methodology, a summary of the 2018 benefit year RADV results, and additional information to assist insurers in understanding their results. Notable findings include:

- An increase in the number of exempt issuers resulted in a significant decrease in the number of issuers participating in RADV as compared to the 2017 benefit year;
- Demographic and Enrollment (D&E) validation improved, but Prescription Drug Category (RXC) claims validation identified areas for improvement;
- The highest frequency HCCs in each HCC failure group only changed slightly between the 2017 and 2018 benefit years;
- Compared with 2017, the 2018 benefit year had an overall lower number of issuers who were outliers, but the proportion of negative outliers increased; and
- Small group market risk pools continue to have more outliers and more adjustments than individual market risk pools because of 2018 benefit year RADV.

Risk score adjustments based on the results will be applied to 2019 benefit year. The adjustments will be included in a separate report that will be released in August 2020, with adjustment amounts collected and distributed in the 2022 benefit year.

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**VA Endorses Veterans’ Use of Nearest Medical Facility During Emergencies**

The Department of Veterans Affairs’ Office of Community Care recently launched a national emergency care contact center for emergency care received in non-VA facilities to simplify care coordination, eligibility determination and payment authorization information. The agency urges all veterans to seek immediate medical attention at the nearest medical facility during a medical emergency.

Providers, veterans, and representatives should report instances of veterans presenting to community emergency rooms to the VA Community Care Centralized Notification Center within 72 hours of the start of emergent care, using one of the following options:

- Email: VHAEmergencyNotification@va.gov
- Phone: 1-844 72-HRVHA or 1-844-724-7842

**Why this matters:** Veterans do not need to check with the VA before calling for an ambulance or going to an emergency department. During a medical emergency, the VA encourages all Veterans to seek immediate medical attention without delay. A claim for emergency care will never be denied based solely on VA not receiving notification prior to seeking care. It is, however, important to promptly notify VA after receiving emergency care at a community emergency department. Notification should be made within 72 hours of admission to a community medical facility. This allows VA to assist the Veteran in coordinating necessary care or transfer, and helps to ensure that the administrative and clinical requirements for VA to pay for the care are met.

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**Appeals Court Rules Against Requiring Drug Pricing Disclosure in TV Ads**

The D.C. Circuit Court of Appeals affirmed the lower district court’s ruling that the Trump administration lacks the legal authority to require drug makers to disclose drug list prices in their television commercials.
The court’s unanimous opinion stated that the proposed rule amounted to “a sweeping disclosure requirement that is largely untethered to the actual administration of the Medicare or Medicaid programs.”

**Background:** The administration’s proposal was part of a comprehensive “blueprint” President Trump announced in 2018 to lower drug prices. Pillars of the original blueprint, including ending the manufacturer-provided rebate safe harbor and creating an International Price Index for Medicare Part B drugs, remain unimplemented, though the administration has successfully advanced numerous smaller initiatives.

“We applaud the administration’s commitment to direct-to-consumer list price disclosures, but in light of the court’s recent decision, Congress must step-in to provide greater transparency into Big Pharma’s pricing practices,” said The Campaign for Sustainable Rx Pricing (CSRxP) executive director Lauren Aronson. “Requiring Big Pharma to disclose list prices in DTC advertising will be an important deterrent to unbridled price hikes and out-of-control launch prices.”

### State Issues

**Delaware**

**Legislative**

**Insulin Cap Legislation Heads to the Governor for Signature**

*House Bill 263 w/ House Amendment 1* passed the Senate in a virtual session last week. This bill, which the House passed in January of this year, requires that individual, group, and State employee insurance plans cap the amount an individual must pay for insulin prescriptions at $100 a month. The Amendment revises House Bill No. 263 by doing the following:

- Requires at least 1 formulation of each type of prescription insulin be on the lowest tier of the drug formulary;
- Defines the "lowest tier of the drug formulary" as the lowest tier for generic drugs, if the insulin is a generic and the lowest tier for brand-name drugs, if the insulin is brand-name;
- Clarifies that the $100 per month cost-sharing cap includes deductible payments and cost-sharing amounts charged once a deductible is met;
- Corrects the date for the applicability of this Act so it includes insurance plans that begin on January 1, 2021; and
- Clarifies that the cap on the copay applies to covered individuals who are in compliance with the coordination of benefits policies under the State employee insurance plans.

### State Issues

**Delaware**

**Regulatory**

**Insurance Department Makes Recommendations Regarding Premium Forbearance During Emergency Order**

The moratorium on cancellations and non-renewal of insurance policies due to nonpayment for policyholders facing financial difficulty caused by COVID-19 continues through the duration of the State of Emergency. The Delaware Department of Insurance (DOI) made recommendations to Governor Carney’s
Office on the provisions for repayment of unpaid premiums, proposing that a future Emergency Order modification include a provision that will allow policyholders to repay unpaid premium either via equal payments over the remainder of the policy term, or within 90 days and up to three installments, whichever is longer. DOI expects that policies would not be cancelled or not renewed due to previous nonpayment while a policyholder is actively repaying according to these terms.

State Issues

Pennsylvania
Legislative

House to Elect New Speaker, Vote on Health Care Bills
The resignation of former Speaker of the House Mike Turzai (R-Allegheny) has set the stage for an election. The House is expected to nominate and cast votes for House Majority Leader Bryan Cutler (R-Lancaster) to become the next speaker.

Also slated to take place are votes on a list of bills that impact health care:

- **Senate Bill 595** would **expand breast cancer screening** by requiring full cost coverage of annual and physician-recommended mammographic examinations, including Magnetic Resonance Imaging (MRI) or ultrasound screening, if the treating physician believes the woman is at an increased risk for breast cancer.

- **House Bill 2352** would create a **Pennsylvania State False Claims Act to address fraud occurring in the Medicaid program**. According to the bill’s sponsor, Rep. Seth Grove (R-York), the proposal was specifically developed to target fraud in the Commonwealth, therefore it differs from other states’ false claims statutes. Prior to advancing the bill, the committee approved amendments to provide protections for whistleblowers, allowing them to notify their employers and the Office of the Attorney General, and language that ensures resources are specifically directed at combatting fraud.

- **House Bill 2350** would require a provider seeking to participate in the Medicaid program to use either a **National Provider Identifier (NPI)** or register for **State Provider Identifier (SPI)**. The measure also requires the Department of Human Services to establish and implement a standardized training program for individuals seeking to deliver services via the Medicaid program.

- **House Bill 2351** would **increase the penalties for making a false claim against the Medicaid Program** under section 1407 of the state’s Human Services Code: a felony of the second degree for claims $100,000 or more; felony of third degree for claims between $2,000 and $100,000; and third degree misdemeanor for claims $2,000 or less. The bill was amended to exclude persons receiving public services from being charged, unless they have committed a fraudulent act.

- **House Bill 2355** would **require any Medicaid Managed Care Organization (MCO) to enter into an agreement with the Department of Human Services (DHS) to allow the Department to re-coup**
any Medicaid funds which were spent on Provider Preventable Conditions (PPC). DHS is authorized to levy a fine ranging between .5% and 5% of the total claims the MCO made under Medicaid. The bill was amended to allow the DHS to annually adjust the Medical Assistance MCO financial reporting that is used as the basis of rate setting, by the value of provider-preventable conditions.

- **House Bill 1270** would amend the Early Intervention Services System Act to allow a child to qualify for early intervention services if a parent has been diagnosed with postpartum depression. Children born to mothers who experience postpartum depression are at an increased risk for adverse brain development.

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**Senate Public Hearing to Assess Relationships Between Medicaid MCOs and PBMs**

Legislation that would regulate Pharmacy Benefit Managers (PBMs) operating in the state Medicaid Managed Care program will be the focus of a Senate Health and Human Services Committee public hearing this week.

**House Bill 941** amends the Human Services Code to allow the Department of Human Services to conduct an audit or review a pharmacy, pharmacy benefit manager (PBM), pharmacy services administration organization, or other entity that manages, processes, and influences the payment for or dispenses pharmacy services to Medicaid Managed Care Organization (MCO) clients. The bill also sets forth prohibited language in contracts between entities and pharmacies.

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**State Issues**

**Pennsylvania**

**Regulatory**

**Pennsylvania Hospitals Receive Fifth Remdesivir Distribution**

Pennsylvania hospitals last week received the fifth distribution of the investigational antiviral medication, remdesivir—a drug that may prove effective in treating coronavirus patients. The U.S. Food and Drug Administration (FDA) issued an emergency use authorization for the unapproved product remdesivir on May 1, 2020. Preliminary clinical trial results indicate the drug accelerates recovery in serious COVID-19 cases.

Gilead Sciences, Inc. is making approximately 1.5 million vials available on an experimental basis. HHS has distributed the donated drugs to the states, with allocations staged during the course of nine weeks. Through seven weeks, Pennsylvania has received 747 cases. On June 19, the Pennsylvania Department of Health (DOH) announced the distribution of the fifth shipment of the drugs, which was sent to 82 hospitals.

**Why this matters:** A clinical panel of highly regarded physicians and pharmacists from leading academic medical centers to rural independent hospitals, with expertise in infectious disease, clinical research, and medical ethics, has been convened to provide recommendations to DOH to help guide a fair and reasonable distribution of the drug. The panel expressed the priority that the limited resource allocation of
remdesivir should be distributed and utilized in a way that can potentially help the most people in an equitable way.

State Issues

West Virginia
Legislative

AHIP Shares Concerns on West Virginia Law Governing Network Access
America’s Health Insurance Plans (AHIP) has voiced its concerns with the West Virginia Office of the Insurance Commissioner regarding their draft network access and adequacy rule. AHIP’s [letter](#), with input from insurer stakeholders, addresses the implementation of House Bill 4061, including:

**Network Access Plan Standards**
- Should be made available upon request and not be permanently placed on the health plan’s website, and that plans retain the right to mark certain information proprietary and confidential.

**Network Adequacy Standards**
- Reliance on time and distance standards does not take into account varying geographies and populations. Network adequacy standards should be about the sufficiency of a network, including low-income populations’ access to care without unnecessary travel or delay.
- Retain the provision which makes available telehealth services when making network adequacy determinations. This is an important provision that should be retained.
- Request confirmation that other than the geographic accessibility standard for pediatric dentists, there is not an access to service standard or ratio applied to dentists generally.

**Provider Directories**
- The printing of provider directories upon request within five business days, which become outdated as soon as they are printed.
- Health plans update their online provider directories frequently and consumers should be encouraged to use the online directory for the most current information.
- Provider directory maintenance remains a long-standing challenge for insurers.

State Issues

West Virginia
Regulatory

West Virginia Strong – the Comeback Enters Week 9
West Virginia’s [reopening plan](#) continues to move forward, entering Week 9:

Week 1: Thursday, April 30 – Sunday, May 3 (underway)
Week 2: Monday, May 4 – Sunday, May 10 (underway)
Week 3: Monday, May 11 – Sunday, May 17 (underway)
Guidance for West Virginia businesses permitted to open in Week 9, Monday, June 22, 2020:

- Youth sports games with spectators
- Outdoor sporting events with spectators
- Outdoor equestrian events with spectators
- Summer Youth Camps
- Outdoor motorsport and power sport racing with spectators
- In-person high school graduation ceremonies (Guidance from WV Dept. of Education)

Interested in reviewing a copy of a bill(s)? Access the following web sites:

- Pennsylvania Legislation: [www.legis.state.pa.us](http://www.legis.state.pa.us)
- West Virginia Legislation: [http://www.legis.state.wv.us/](http://www.legis.state.wv.us/)
- For copies of congressional bills, access the Thomas website – [http://thomas.loc.gov/](http://thomas.loc.gov/)

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