Federal Issues

Legislative

House Democrats Introduce ACA Enhancement, Health Infrastructure Bills
Democrats in the House unveiled the Patient Protection and Affordable Care Enhancement Act, legislation aimed at expanding access to health care, strengthening protections for people with pre-existing conditions, reducing racial and ethnic health coverage disparities, and bolstering the Affordable Care Act (ACA).

Why it matters: The bill serves as a political messaging vehicle ahead of the November elections as the Administration continues to challenge the constitutionality of the ACA in the Texas case.

Highlights of the bill include:
- Expanded eligibility for premium tax credits beyond 400% of the federal poverty line and increases the size of tax credits for all income brackets;
- Creating a national reinsurance program;
- Offering funding for states to establish their own State-Based Marketplaces;
- Renewing the ACA’s expanded federal matching for states that adopt Medicaid expansion;
House Democrats also last week released text of the Moving Forward Act, a $1.5 trillion plan to rebuild American infrastructure including broadband access and health care infrastructure.

The bill appropriates $100 billion to promote competition for broadband internet infrastructure to unserved and underserved rural, suburban, and urban communities. It also includes $30 billion for hospitals to increase capacity and strengthen care, help community health centers respond to COVID-19 and future public health emergencies, improve clinical laboratory infrastructure, support the Indian Health Service’s infrastructure, and increase capacity for community-based care.

Both pieces of legislation are expected to be taken up by the House this week.

COVID-19 Hearings Continue
Several committees held hearings last week to examine the impact of COVID-19:

- The House Education and Labor Committee looked at how the pandemic has widened racial inequities in education, healthcare, and the workforce.
- The Senate Health, Education, Labor and Pensions (HELP) Committee met to examine lessons learned from the ongoing public health crisis and ways to prepare for future pandemics. Committee members heard from public health officials, including former Health and Human Services (HHS) Secretary Michael Leavitt, on diverse topics such as healthcare disparities, vaccine development, supply chains and manufacturing, telehealth, and potential industry reforms.
- The House Energy and Commerce Committee held an oversight hearing on the Administration’s response to the COVID-19 pandemic. Members of the White House’s Coronavirus Task Force testified before lawmakers about testing, the virus’ disproportionate impact on Black Americans,
treatments and other topics. Dr. Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases, told lawmakers that several states were seeing a “disturbing surge” in new COVID-19 cases and that he was “cautiously optimistic” a vaccine will be available by early next year. The witnesses also denied being asked by the White House to slow down testing.

- The Ways and Means Subcommittee on Health convened to investigate the COVID-19 nursing home crisis, featuring testimony from a diverse range of healthcare industry experts and advocates. Dr. David Grabowski, professor of health care policy at Harvard Medical School, explained to lawmakers how nursing homes are acutely susceptible to COVID-19 outbreaks, given the close proximity of residents and high-touch care model. Witnesses also raised concerns about nurse staffing levels, access to personal protective equipment (PPE) and state policies toward nursing homes during the COVID-19 pandemic, particularly in New York.

Related: The Government Accountability Office (GAO) has published a report to Congress on COVID-19 and opportunities to improve federal response and recovery efforts.

Federal Issues
Regulatory

Tri-Agencies Publish Additional FAQs for Commercial Plans on COVID-19 Testing Coverage Issues
The Department of Labor, Health and Human Services and the Treasury (the Tri-Agencies) released several frequently asked questions (FAQs) regarding implementation of the Families First Coronavirus Response Act (the FFCRA), and the Coronavirus Aid, Relief, and Economic Security Act (the CARES Act) addressing commercial market health insurance.

Why this matters: The FAQs address a number of issues including: COVID-19 testing services that must be covered, notice requirements regarding changes to benefits, telehealth only group health plans, grandfathered health plans, mental health parity, wellness programs, and individual market Health Reimbursement Arrangements.

Regarding requirements that health plans waive cost-sharing for COVID-19 diagnostic testing, the FAQs clarify this only applies to testing of individuals with signs or symptoms compatible with COVID-19, as well as asymptomatic individuals with known or suspected recent exposure. Any such testing must be determined medically appropriate by the individual’s health care provider after consulting CDC guidance. The requirement does not apply to public health surveillance testing or occupational health testing. In addition, the Tri-Agencies clarify that health plans must cover at-home tests and repeat COVID-19 diagnostic tests.

DOJ and Republican AGs File Briefs in ACA Lawsuit
Last Thursday, 18 Texas-led states, two individual plaintiffs, and the Federal Government each filed their opening briefs in Texas v. U.S., the lawsuit challenging the constitutionality of the Affordable Care Act (ACA) following the zeroing out of the individual mandate penalty. The case is now pending in the U.S. Supreme Court and additional briefing is scheduled to occur over the next several months and conclude in mid-August.
**Insurer perspective:** AHIP filed an *amicus brief* in mid-May supporting the California-led states’ and U.S. House of Representatives’ efforts to defend the ACA. Oral arguments are expected to be held next term, perhaps as early as this Fall. A decision in the case isn’t expected until next year.

**Why this matters:** The briefs reiterate many of the same points made in the lower courts. This includes the Texas-led states and individual plaintiffs arguing that: 1) each have standing to challenge the law in court; 2) the ACA’s zeroed-out individual mandate is unconstitutional; 3) because the rest of the ACA cannot be severed from the individual mandate, it must also be invalidated; and 4) invalidation of the ACA must apply nationwide.

The Federal Government largely agreed with those arguments. And while the Department of Justice adopted a slightly different position regarding which parties have standing to challenge the law and the appropriate relief the Court should consider, it continued to assert that the entire ACA cannot be severed from the individual mandate and must be invalidated.

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**Federal Judge Rules Against Hospitals in Price Transparency Case**

A federal judge ruled against the American Hospital Association and others in a *lawsuit* attempting to block a Health and Human Services *final rule* pushing for price transparency. Under the final rule issued during November 2019, hospitals are required to disclose the standard charges, including payor-specific negotiated rates, for all services beginning January 1, 2021.

The AHA and other hospital associations filed suit in the U.S. District Court for the District of Columbia on December 4, 2019, and argued that HHS lacked the statutory authority to require public disclosure of individually negotiated rates between commercial insurers and hospitals. They further alleged that the rule violated the First Amendment because it requires "highly confidential" negotiated rates to be disclosed. HHS argued that this action is necessary for price transparency that will ultimately lower the overall cost of health care.

Both sides filed motions for summary judgment, and Judge Carl Nichols with the U.S. District Court for the District of Columbia granted HHS’ motion and denied the hospital groups’ motion on June 23.

Nichols said HHS acknowledged and considered the arguments of provider organizations and payors when it issued the final rule and "did not act arbitrarily and capriciously in concluding that the final rule could have substantial benefits." He also highlighted the steps HHS took to address some of the concerns raised about the rule, including proposing a complementary rule that would require insurers to post data, such as negotiated rates, and delaying the effective date of the rule by a year. "In sum, CMS [the Centers for Medicare & Medicaid Services] considered commenters' concerns, echoed here in plaintiffs' briefs, about the rule but determined that those concerns were not persuasive," reads the opinion. "By acknowledging conflicting data and articulating which information it found most convincing, the agency fulfilled its duty to examine the evidence before it and connect it to the final rule."

Nichols was not persuaded by AHA’s argument that forcing hospitals to publicly disclose rates violates their First Amendment rights by forcing them to reveal proprietary information nor did he agree with the claim that it would chill negotiations between providers and payors. However, Nichols seemed convinced that the
requirement will empower patients, noting that "all of the information required to be published by the Final Rule can allow patients to make pricing comparisons between hospitals."

**Why this matters:** Hospitals believe the proposal does nothing to help patients understand their out-of-pocket costs. It also imposes significant burdens on hospitals at a time when resources are stretched thin and need to be devoted to patient care. Furthermore, hospitals and health systems have consistently supported efforts to provide patients with information about the costs of their medical care. This is not the right way to achieve this important goal.

**Next steps:** The AHA plans to appeal the court’s decision and seek an expedited review. However, with the January effective date still in place, hospitals should continue to take operational steps toward compliance with the final rule. In a separate rulemaking CMS has proposed health plans also release information on negotiated rates. This rule is pending finalization by the U.S. Departments of Health and Human Services (HHS), Labor, and the Treasury and is expected to be finalized later this year.

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**New CMS Office to Focus on Burden Reduction and Health Informatics**

The Centers for Medicare & Medicaid Services has created an Office of Burden Reduction and Health Informatics to build on its Patients over Paperwork initiative across Medicare, Medicaid, the Children’s Health Insurance Program and Health Insurance Marketplace and use health data to foster innovation and better care.

Specifically, the work of this new office will be targeted to help reduce unnecessary burden, increase efficiencies, continue administrative simplification, increase the use of health informatics, and improve the beneficiary experience.

The new office will leverage health data and technology to promote and prioritize innovation, interoperability, improved patient outcomes and care coordination. For example, the new office intends to create tools that will allow patients to own and carry their personal health data “seamlessly, privately, and securely.” CMS stated that this could bring about new efficiencies, and such initiatives will likely work in tandem with the recent Interoperability and Patient Access regulations that were finalized earlier this year.

**Background:** This new office is an offshoot of CMS’ Patients over Paperwork (PoP) Initiative and is part of the administration’s ongoing efforts to reduce administrative and regulatory costs to healthcare providers. The PoP Initiative, part of a 2017 Executive Order, sought to respond to healthcare community complaints of excessive regulation. By developing the new office, CMS aims to create a culture of burden reduction. Building on this work, CMS and the new office will continue identifying and reducing burdens on providers who serve Medicare and Medicaid beneficiaries.

While it remains unclear what direct and substantive impact the new office will have on healthcare providers and other healthcare entities, the move stresses CMS’ longer-term commitment to improving efficiency in healthcare.

**Why this matters:** The agency expects the office to engage more with clinicians, providers and health plans to understand how various regulatory burdens impact health care delivery. Stakeholders should look for opportunities to provide input as the new office develops its strategies and policy initiatives. The AHA last year recommended a number of actions the agency could take to reduce the burden of clinical documentation.
Key takeaways:

- While CMS has not provided much by way of substantive detail about the new office’s concrete plans, it is clear that CMS intends for the new office to dovetail with CMS’ goals to promote the reduction of administrative and regulatory burdens and increase efficiencies in the healthcare system.
- Hospitals should look for opportunities to provide CMS and the new office with input about the regulatory burdens they face, proposals to relieve these burdens and feedback on strategies and policies implemented by the new office.
- Hospitals should also remain vigilant about potential changes in reporting requirements, CMS-mandated compliance and other processes that could impact administration and clinical care. This move by CMS signals its continued commitment to burden reduction, and healthcare providers should expect more changes in future that may require working closely with compliance, legal, clinical and finance teams to implement changes and assess their impact.
- Lastly, hospitals should consider leveraging tools or strategies developed by the new office to simplify and cut administrative costs, streamline healthcare provision and improve patient care delivery.

Federal COVID-19 Policy Guidance and Other Developments

Hospitals to Receive Additional Remdesivir Allocations: The Department of Health and Human Services announced an agreement with drug maker Gilead Sciences to allow U.S. hospitals to purchase up to 500,000 treatment courses of remdesivir through September, which HHS and state health departments will allocate as they did the previous 120,000 treatment courses donated by the drug maker.

Under the agreement, hospitals will pay no more than the wholesale acquisition price for the drug, or $3,200 per treatment course, which AmerisourceBergen likely will ship to them every two weeks. The investigational drug has shown encouraging results treating certain COVID-19 patients in early clinical trials.

CDC Releases Results from Geographic Serology Survey: SARS-CoV-2 infections may be 10 times higher than reported cases, according to new data from a Centers for Disease Control and Prevention partnership with commercial laboratories to test de-identified clinical blood specimens for antibodies in Connecticut, South Florida, the New York City area, Missouri, Utah, and western Washington state. The survey includes people who had blood specimens tested for SARS-CoV-2 antibodies for reasons unrelated to COVID-19, such as for a routine or sick visit. CDC is working with state and local health departments to publish additional results from California, Louisiana, Minnesota, and Pennsylvania. The survey aims to test about 1,800 samples from each of the 10 areas every 3 to 4 weeks to track changes in the percentage of people tested who have antibodies against SARS-CoV-2 in each area.

CMS Extends Hospice Model Through 2021: The Centers for Medicare & Medicaid Services said it will extend the Medicare Care Choices Model by one year, through December 31, 2021; already participating hospices can enroll eligible beneficiaries through June 30, 2021. CMS said the extension will allow more Medicare beneficiaries to receive supportive care services from certain hospice providers, but does not affect other operations or policies.

FDA Adds Portable Resuscitator to Ventilator EUA List: The Food and Drug Administration added the AustinP51 emergency-use system to its list of ventilator authorized for emergency use in health care
settings to treat adults during the COVID-19 pandemic. The device is a portable emergency use resuscitator designed to provide either continuous or intermittent ventilatory support for patients requiring mechanical ventilation through volume control. The agency said the AustinP51 should only be used by professionals who are qualified and trained in the use of general ventilation equipment, or who are specifically trained on the AustinP51 system.

COVID-19 ‘Cocktail’ Therapy Moves to Clinical Trial: A therapeutic, two-antibody COVID-19 treatment “cocktail” from Regeneron and the Biomedical Advanced Research and Development Authority moved to its first clinical trial, the developers earlier this month announced. The REGN-COV2 treatment contains two neutralizing monoclonal antibodies. It is believed to have the potential to be one of the first therapeutics specifically designed to inhibit SARS-COV-2.

Updated CDC List of People at Risk for Severe COVID-19 Illness Eschews Specific Age Thresholds: The Centers for Disease Control and Prevention has updated and expanded its list of people at risk of severe COVID-19 illness, the agency said. The CDC removed a specific age threshold for those more susceptible to COVID-19 infection as part of the update. Instead, CDC said the risk of severe illness increases steadily the older an individual is, mainly because underlying health conditions develop as a person ages. In addition, CDC said it updated the list of health conditions that could exacerbate COVID-19 illness, including chronic kidney disease and Type 2 diabetes. “We have to recognize reality,” said CDC Director Robert Redfield, M.D. “Our nation isn’t as healthy as some other nations, particularly if you look at obesity and some other medical conditions.”

AMA Releases CPT Code for Antigen Tests: The American Medical Association announced a new Current Procedural Terminology code (87426) for reporting antigen testing to detect SARS-CoV-2 infection on medical claims. The Food and Drug Administration last month issued the first emergency use authorization for a COVID-19 antigen test, which can quickly detect the SARS-CoV-2 virus in a nasal swab sample.

CMS Urged to Extend Certain COVID-19 Flexibilities: The American Hospital Association urged the Centers for Medicare & Medicaid Services to temporarily extend certain waivers and make others permanent beyond the COVID-19 public health emergency to allow hospitals to provide better and more cost effective care to their patients and communities. For example, AHA recommends permanently expanding the services that can be provided via telehealth and via audio-only connection; the locations where these services can be delivered; and the practitioners and providers, such as hospital outpatient departments, that can bill for these services.

It also recommends CMS continue to support increased bed capacity in rural areas in an emergency, optional quality measurement reporting during the pandemic and delaying certain reporting requirements to focus clinical resources solely on patient care.

Reports Find Suicides Outpacing Opioid-related Deaths and May Be Accelerating: Suicide deaths increased by 37% between 2000 and 2018, with 41 states experiencing statistically significant increases over the same period, according to a pair of reports released this month by the State Health Access Data Assistance Center. Over that 19-year period, the data shows suicide deaths killed over 700,000 people, more than the roughly 450,000 killed by opioids. The report comparing states’ trends said increases in suicide deaths ranged from 10-20% to more than 80%, but some states with higher increases are still below the national average. The study does not include projections from “deaths of despair” related to the COVID-19 pandemic.
Clinicians Can Apply for COVID-19 MIPS Exception: Clinicians participating in the Quality Payment Program Merit-based Incentive Payment System in 2020 whose practice was significantly impacted by the COVID-19 public health emergency may apply for an exception to reweight the MIPS performance categories, the Centers for Medicare & Medicaid Services recently announced. For more information, see the exception applications fact sheet and webpage.

CMS Clarifies Pause on LTCH Policy: The Centers for Medicare & Medicaid Services recently confirmed that Medicare contractors will not calculate an average length of stay for long-term care hospitals for cost reporting periods that include the COVID-19 public health emergency, which took effect March 1. In April, CMS implemented a blanket waiver of the LTCH policy requiring an average length of stay of greater than 25 days. Contractors will resume evaluating compliance with the policy for the first cost reporting period that does not include the public health emergency.

HHS Announces MENTAL Health Innovation Challenge: The Department of Health and Human Services invites stakeholder teams, including health care providers, to submit innovative proposals through September 8 for an online platform to connect older adults, veterans, disabled people, and other vulnerable populations to technologies and social engagement programs that can address loneliness and social isolation. The Mobilizing and Empowering the Nation and Technology to Address Loneliness and social isolation (MENTAL) Health Innovation Challenge plans to announce in January the winning system, which will become part of a national public awareness campaign.

Project to Evaluate Repurposing Drugs to Treat COVID-19: The Food and Drug Administration has partnered with the Critical Path Institute and National Center for Advancing Translational Sciences to launch the CURE Drug Repurposing Collaboratory, a forum for exchanging clinical practice data to inform potential new uses for existing drugs to treat unmet medical needs, beginning with COVID-19.

CDRC will use data collected via the CURE ID platform to aggregate global clinician treatment experiences and identify existing drugs that demonstrate possible treatment approaches warranting further study.

HHS, Morehouse School of Medicine Launch $40 Million Effort to Address COVID-19 Health Disparities: The Department of Health and Human Services said its Office of Minority Health will partner with the Morehouse School of Medicine to deliver education and resources on the COVID-19 pandemic’s impact on racial- and ethnic-minority, rural, and socially vulnerable communities. The three-year, $40 million National Infrastructure for Mitigating the Impact of COVID-19 within Racial and Ethnic Minority Communities initiative will enlist community-based organizations via a strategic network of national, state, territorial, tribal, and local organizations.

The agency’s announcement mirrors actions collectively requested by American Hospital Association, the American Medical Association and American Nurses Association in an April 16 letter to HHS Secretary Alex Azar, in which the groups urge the development of “a series of culturally appropriate PSAs, fact sheets, and other communication tools to help ensure that communities of color receive factual, reliable, and culturally appropriate messages about safe practices, social distancing, prevention, testing and treatment” of COVID-19.

Medicare Releases Preliminary Demographic Data on COVID-19 Cases, Hospitalizations: Hospitalization rates for COVID-19 were nearly four times higher for black, and two times higher for Hispanic, Medicare beneficiaries than for white Medicare beneficiaries, according to data on COVID-19
cases and hospitalizations released yesterday by the Centers for Medicare & Medicaid Services. The analysis also showed that hospitalization rates were over three times higher for urban than rural Medicare beneficiaries, and that those who have end-stage renal disease or are dually eligible for Medicaid had the highest hospitalization rates. The findings reflect Medicare claims data from January 1 through May 16. CMS intends to provide a monthly snapshot of COVID-19 case and hospitalization data for Medicare beneficiaries broken down by race/ethnicity, dual-eligible status, age, gender, and rural/urban geography.

The Centers for Disease Control and Prevention (CDC) released updated general COVID-19 FAQs covering disease basics, spread, prevention, testing, and many other subjects. The Centers for Disease Control and Prevention (CDC) issued a call to action for health care stakeholders to engage their communities around vaccines and encourage consumers to not delay routine and recommended immunizations.

CDC calls on its health care partners to help protect communities by:

- Reviewing vaccine protocols, especially for at-risk and vulnerable populations;
- Reading and sharing the Interim Guidance for Immunization Services During the COVID-19 Pandemic;
- Reviewing the available resources from CDC and other federal partners;
- Supporting patients in their vaccine decisions by stressing the safety and effectiveness of vaccines;
- Sharing information on the Vaccines for Children program for those who may be eligible; and
- Reviewing the updated influenza vaccine recommendations and proactively identifying strategies to improve influenza vaccine coverage.

The Centers for Medicare and Medicaid Services released a Special Trends Report: Enrollment Data and Coverage Options for Consumers During the COVID-19 Public Health Emergency. According to the report, almost five hundred thousand consumers gained coverage in states with Exchanges using the HealthCare.gov platform following a loss of other coverage, an increase of 46% from the same time period last year.

State Issues

Delaware
Regulatory

Governor John Carney Delays Phase III of Economic Reopening

Governor John Carney announced a delay in moving to Phase III of Delaware’s economic reopening, and issued the following statement: “I know many Delawareans expected us to move into Phase III of economic reopening on Monday, June 29 – and that had been my hope, as well. But we are delaying that decision so we can get a better handle on what’s going on in Delaware and around the country. Too many Delawareans and visitors are not following basic public health precautions. We’ve heard and seen concerns especially in our beach communities, in restaurants, in gyms, and at sporting events.”

The state has been in Phase II protocols since June 15, which generally allows most businesses to operate at 60% of the venue’s rated safe occupancy, while observing additional restrictions.
Pennsylvania
Legislative

The House of Representatives elected House Majority Leader Bryan Cutler (R-Lancaster) as the new Speaker of the House. He replaces former Speaker Mike Turzai (R-Allegheny), who resigned from the position to take a job in the private sector. As a result of Cutler’s ascension, other changes occurred among House Republican leadership, including:

- Majority Leader: Kerry Benninghoff (R-Centre)
- Appropriations Chairman: Stan Saylor (R-York)
- Whip: Donna Oberlander (R-Clarion)
- Caucus Chair: Marcy Toepel (R-Montgomery)
- Caucus Secretary: Mike Reese (R-Westmoreland)
- Caucus Administrator: Kurt Masser (R-Northumberland)
- Policy Chair: Martin Causer (R-McKean)

Breast MRI / Ultrasound Bill Clears General Assembly, Sent to Governor for Approval
The Senate voted unanimously on June 24 to approve amendments made by the House to Senate Bill 595, legislation that 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. The bill has been sent to Governor Wolf for his signature.

On a related note, the Senate voted 50-0 to approve House Bill 1457, which also amends the section of the Insurance Company Law that addresses health insurance coverage for mastectomy and breast cancer reconstruction. The bill clarifies the definition for “prosthetic devices” to also include “custom artificial devices”. The legislation has been sent to Gov. Wolf for signing.

Medicaid Managed Care False Claim Bills Advance
Two bills addressing fraud within Medicaid Managed Care Organizations (MCOs) were passed unanimously this week by the House of Representatives:

- **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.
- **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.
The pair of bills, which are part of the House’s Medicaid Managed Care Fraud package, has been sent to the Senate for further consideration.

### NAIC Life and Health Guaranty Association Model Law Receives Consideration

*Senate Bill 1195*, a proposal that would enact National Association of Insurance Commissioners (NAIC) model legislation addressing changes to the Life and Health Guaranty Association (GA) and assessments related to long-term care insurance, was amended this week in the Senate. The amendment, sought and recommended by the Pennsylvania Insurance Department (PID), would provide consistency with the NAIC model bill on this subject.

### Senate Bill Would Recognize Nurse Licensure Compact

Legislation that would authorize Pennsylvania to join the Nurse Licensure Compact, *Senate Bill 655*, was passed by the Senate by a 50-0 margin. Under the bill Pennsylvania would recognize mutual agreements regarding the licensing of nurses and streamline the transfer of licenses between participating states. The bill has been sent to the House of Representatives for further consideration.

### Senate Public Hearing Addresses PBM Operations with Medicaid MCOs

On June 22, the Senate Health and Human Services Committee held a public hearing to receive testimony from representatives of the community pharmacy and Pharmacy Benefit Managers (PBMs) communities to address operations impacting the state Medicaid Managed Care program. *House Bill 941* would amend 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, 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. Participating in the public hearing included representatives from the Department of Human Services, Community Pharmacists, Medicaid Managed Care Organizations, Pharmacy Benefit Managers, Pharmacy Services Administration Organizations, and the Insurance Federation of Pennsylvania.

Sally Kozak, Deputy Secretary, Office of Medical Assistance Programs, Department of Human Services, discussed how the HealthChoices program agreements with Managed Care Organizations (MCO) have always had a willing provider provision for pharmacists. Contracts with Pharmacy Benefit Managers (PBMs) to manage pharmacy benefits are strictly between the MCO and the PBM. DHS has continued to work with pharmacists to address concerns that have been identified and will continue to do so, such as spread pricing by PBMs, moving to a preferred drug list, requiring a certain level appeal process, requiring transparent reporting of benefits, and requiring MCOs to submit policies and procedures for payment methodologies for network pharmacies.

Community pharmacists, who support *House Bill 941*, want PBMs to contract equally with all pharmacies; prohibit spread pricing; allow the DHS to audit the contracts between MCOs and PBMs; prohibit claw backs after a claim is paid; prohibit steering; prohibit charging transmission fees; and prohibit PBMs to require the pharmacy in their network to also be in another network as a condition to participate in Medicaid. They also want fair reimbursement to pharmacists and more transparency.
The Pennsylvania Coalition of Medical Assistance MCOs (PAMCO) cited their opposition to House Bill 941. They believe DHS oversight of contracts already allows for enforcement of many key PBM payment provisions. They also highlighted provisions not currently in pharmacy MCO contracts, for reasons related to costs, quality, and to prevent disclosure of proprietary information should not be codified in statute.

State Legislative Activity Impacting Hospitals
Last week’s busy week in Harrisburg yielded a number of advancements on legislative issues important to Pennsylvania hospitals.

Workplace Safety Bills Poised for Signature: The legislature sent the following two bills to the Governor’s desk for his signature that would help to protect health care workers against violence in the work place:

- **Senate Bill 842**, sponsored by Senator Phillips-Hill (R-York), eliminates a state requirement for photo identification badges in health care facilities to include the employee's last name.
- **Senate Bill 351**, sponsored by Senator Ward (R-Blair), increases the penalty for an assault on a health care worker from a misdemeanor to a felony.

The governor is expected to sign both bills and has until July 4 to do so.

Expanding Broadband Access Priority for Lawmakers: The Senate advanced the following three bills to provide tools for delivering broadband services to rural communities:

- **Senate Bill 835**, sponsored by Senator Langerholc (R-Cambria), increases funding for broadband in underserved areas.
- **Senate Bill 1118**, sponsored by Senator Pittman (R-Indiana), and **House Bill 2438**, sponsored by Representative Owlett (R-Tioga), are identical bills to expand broadband access using existing infrastructure.

Additionally, Governor Wolf joined eleven other governor’s urging Congress to make critical investments in the expansion of broadband infrastructure.

House Sends Medicaid Reform Package to Senate: The State False Claims Act was reported out of the state House Human Services Committee. After advocacy by hospitals and other stakeholders, **HB2352**, sponsored by Representative Grove (R-York), was one of two bills that was not considered as part of a Medicaid reform package by the full House this week as negotiations continue.

However, the following other components of the package were considered by the full House and were sent to the Senate for its consideration:

- **HB2355** (Rep. Sankey, R-Cambria): Provider preventable conditions
- **HB2351** (Rep. Thomas, R-Bucks): Increases penalties for submitting fraudulent claims
- **HB2353** (Rep. Gaydos, R-Allegheny): Directs the Office of Inspector General to review agency programs with regards to improper payments
- **HB2354** (Rep. Owlett, R-Tioga): Establishes a Do-Not-Pay Initiative in the Treasury Department for the purpose of monitoring improper payments across Commonwealth agencies
- **HB2350** (Rep. Kaufer, R-Luzerne), requiring a provider ID, was the other bill that did not pass the full House.
State Issues

West Virginia
Regulatory

West Virginia Strong – the Comeback Enters Week 10
West Virginia moves into Week 10 of its reopening plan this week:

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)
Week 4: Monday, May 18 – Sunday, May 24 (underway)
Week 5: Monday, May 25 – Sunday, May 31 (underway)
Week 6: Monday, June 1 – Sunday, June 7 (underway)
Week 7: Monday, June 8 – Sunday, June 14 (underway)
Week 8: Monday, June 15 – Sunday, June 21 (underway)
Week 9: Monday, June 22 – Sunday, June 28 (underway)
Week 10: Monday, June 29 – Sunday, July 5

Guidance for West Virginia businesses permitted to open in Week 10, Monday, June 29, 2020:

- Fairs, festivals, amusement parks and rides
- Outdoor open-air concerts
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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