Issues for the week ending Nov. 1, 2019

Federal Issues
Legislative

Senate Votes Down Resolution Concerning 1332 Waivers
On Wednesday, the Senate voted 52-43 against the passage of S.J. Res. 52 which would have disapproved the October 2018 guidance on 1332 waivers issued by the Centers for Medicare and Medicaid Services (CMS).

Why it matters: While it did not pass, the vote, forced by Democrats under the Congressional Review Act, was designed to put Republican Senators on the defensive on the issue of pre-existing conditions.

Background
- Under Section 1332 of the Affordable Care Act (ACA), states can waive specific ACA provisions.
- To date, states have primarily used the waivers to set up reinsurance programs. CMS stated that the purpose of the 2018 guidance is to expand flexibility and empower states to address serious problems in their individual insurance markets.
- Democrats have argued that non-ACA compliant plans are substandard as they are

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not held to the same requirements of providing the same level of benefits and pre-existing condition protections.

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**House Passes Two PBM Transparency Bills**

On October 28, the House unanimously passed two drug transparency bills requiring public disclosure of the discounts pharmaceutical companies give to pharmacy benefit managers (PBMs).

**Why it matters:** The goal of these bills, which would apply to Medicare Part B and Part D, Medicaid and Affordable Care Act (ACA) exchange plans, is to obtain more data that will help Congress understand the role of PBMs as they try to address concerns that PBMs may be contributing to higher drug prices.

- **H.R. 2115** requires PBMs to publicly report aggregate drug rebates, discounts, and other price concession data received from manufacturers.
- **H.R. 1781** grants MedPAC and MACPAC access to drug payment and rebate data under Medicare and Medicaid, respectively.

Senate action is uncertain but the two bills could be included in an end of year spending package.

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**Senator Toomey Puts Focus on Improper Medicaid Payments**

During a Senate Finance Committee hearing, Senator Pat Toomey (R-PA) used his role as chairman of the Health Care Subcommittee to consider **compliance with eligibility requirements under the Medicaid program**. The subcommittee heard testimony from a panel of experts who have oversight or experience in reviewing Medicaid eligibility compliance.

Senator Toomey **expressed concern regarding improper payments**, stating that nearly 10 percent of Medicaid payments have been reported as improper in recent years. Absent accurate and robust eligibility reporting, the estimate could be much larger.

Ranking Member Debbie Stabenow (D-MI) shared support for efforts to target fraud within Medicaid, but also:

- Emphasized the importance of expanding coverage
- Cautioned about circumstances in which eligible individuals may lose Medicaid coverage due to administrative barriers, such as a ten-day window to comply with paperwork requirements

Senator Bob Casey (D-PA) echoed many of those same themes, emphasizing the importance of Medicaid expansion for Pennsylvania. Senator Casey read from a statement submitted for the record offering the comments of Teresa Miller, Secretary of the Pennsylvania Department of Human Services, who stated: "Presently, over 680,000 individuals have health care coverage because of Medicaid expansion. More than 1.4 million people—or about 1 in 7 Pennsylvanians aged 19–64—have been covered by Medicaid.
expansion since February 2015… It is a lifeline for people who otherwise cannot access or afford health insurance.”

Why this matters: Medicaid spending represents one-sixth of the national healthcare economy, and Medicaid serves more people, including some of the Nation’s most vulnerable individuals, than any other Federal healthcare program. In order to protect Medicaid from fraud, waste, and abuse, a strong program integrity strategy starts with prevention. Correctly determining beneficiary eligibility prevents Medicaid from making improper payments for people who are not eligible for the program.

Federal Issues
Regulatory

CMS Releases Outpatient Prospective Payment System/Ambulatory Surgical Center Final Rule, Delays Hospital Transparency Rule
The Centers for Medicare & Medicaid Services late Friday issued a final rule that increases Medicare hospital outpatient prospective payment system rates by a net 2.6% in calendar year 2020 compared to 2019.

In addition, the rule:
- finishes phasing in use of the site-neutral rate (40% of the OPPS rate) for clinic visits provided in grandfathered off-campus departments for CY 2020
- continues cuts to drugs purchased under the 340B drug savings program
- delayed a rule that would require hospitals to disclose negotiated rates

Price transparency provisions: CMS states it will issue a separate final rule regarding the requirement that hospitals disclose payer-specific negotiated rates, which was initially proposed as part of the OPPS rule. CMS Administrator Seema Verma said the Administration wants the rule to be more comprehensive and they are currently working to include insurers in the rule.

Under the proposal hospitals would have to report rates in machine readable formats. The rates would then be aggregated by third party companies. Hospitals would also be required to post negotiated rates for approximately 300 elective services. If a hospital failed to comply, they could face a fine of up to $300 a day.

Hospital and insurance industry position
- The American Hospital Association (AHA) has stated that hospital and health systems are deeply committed to ensuring patients have the information they need to make informed health care decisions, including timely, accurate estimates of their out-of-pocket costs.
- However, CMS’s proposed approach would confuse – not help – patients in understanding their potential out-of-pocket cost obligations, would severely disrupt contract negotiations between providers and health plans, and exceeds the Administration’s legal authority. America’s Health Insurance Plans (AHIP) continues to emphasize to the Administration and lawmakers that requiring the public disclosure of negotiated rates would have adverse consequences, driving up health care costs.
AHIP has noted that consumers need access to actionable data – primarily their own out-of-pocket costs and, and that having access to negotiated prices is not only actionable but will raise their costs.

**Site-neutral payment rates:** CMS acknowledges that the district court vacated its site-neutral clinic visit cut for CY 2019 and notes that it is working to ensure affected CY 2019 claims for clinic visits are paid consistent with the court’s order but is still considering whether to appeal from the final judgment.

**Hospital industry position:** The AHA noted that final rule’s continued payment cuts for hospital outpatient clinic visits not only threatens access to care, especially in rural and other vulnerable communities, but it goes against clear congressional intent to protect the majority of clinic services. There are many real and crucial differences between hospital outpatient departments and the patient populations they serve and other sites of care. Now that a federal court has sided with the AHA and found that these cuts exceed the Administration’s authority, CMS should abandon further illegal cuts. Instead, CMS should promptly repay the affected hospitals the full OPPS rate, and CMS should pay the full OPPS rate for all clinic visit claims going forward.

**340B drug program payment cuts:** CMS also continues its current policy of cutting the payment rate for certain drugs purchased under the 340B program to average sales price minus 22.5%. The AHA, along with other hospital associations and member hospitals, successfully challenged the previous cuts to the 340B program in court.

While the agency did not put forward a possible remedy, CMS did state that it will continue efforts to pursue future policy changes related to Medicare Part B drugs acquired through the 340B program through a new data collection effort as well as use the data collected to develop a remedy if required by the courts.

**Hospital industry position:** The AHA stated that the perpetuation of cuts in payments for 340B drugs also defies the judgement of the courts, further straining hospitals serving their communities. After previous cuts to the 340B program were ruled illegal and overturned in court because they exceeded the Administration’s authority, continuation of that policy is wholly unwarranted. CMS should instead offer a plan to swiftly restore in full the funds to those 340B hospitals affected by the illegal cuts. This could be done in a non-budget neutral manner, so it does not unfairly penalize other hospitals.

**Other key provisions in the final rule:**

- CMS finalized a policy to change the minimum required level of supervision from direct supervision to general supervision for all hospital outpatient therapeutic services provided by hospitals and critical access hospitals. The AHA has long advocated for such a change, which would reduce burden on rural hospitals.
- CMS finalized changes to the area wage index. Among other policies, the rule will increase the wage index for hospitals with a wage index value below the 25th percentile. It also will decrease the wage index for hospitals with values above the 75th percentile to make this policy budget neutral.
- CMS will implement, starting July 1, 2020, a prior authorization process for five categories of hospital outpatient department services: blepharoplasty, botulinum toxin injections, panniculectomy, rhinoplasty and vein ablation.
- CMS removed total hip arthroplasty, six spinal procedure codes and five anesthesia codes from the inpatient-only list, making these services eligible to be paid by Medicare in both the hospital inpatient
and outpatient settings. In a related policy, CMS established a two-year exemption from certain medical review activities relating to patient status for procedures removed from the inpatient-only list beginning in CY 2020 and subsequent years.

The final rule takes effect Jan. 1.

**CMS Finalizes Updates to Physician Fee Schedule for CY 2020**
The Centers for Medicare & Medicaid Services issued a [final rule](#) updating physician fee schedule rates very slightly in calendar year 2020 — increasing the conversion factor by 5 cents.

**Key provisions in final rule:**

- CMS finalized a revised approach to paying for evaluation and management (E/M) services. Specifically, CMS will revert back to setting separate payment rates for all levels of E/M visits rather than blending payment rates for certain levels (as it finalized last year).
- Building on changes in last year’s PFS rule related to teaching physician documentation, CMS will now permit physicians and certain non-physician practitioners to review and verify, rather than re-document, notes made in the medical record by other members of the medical team.
- Adopts several provisions related to treatment of opioid use disorder. Specifically, the agency will implement a new statutorily required Medicare Part B benefit for OUD treatment services by Jan. 1, 2020; a new monthly bundled payment for management and counseling for OUD; and add three new codes describing a bundled episode for OUD treatment to the approved list of telehealth services.
- CMS adopted several updates to the Merit-based Incentive Payment System. Specifically, CMS will not increase the weight of the MIPS cost category for the CY 2020 reporting year. Additionally, CMS finalizes higher performance standards for earning positive payment adjustments under the MIPS. Starting with CY 2021 reporting, CMS will begin a phased implementation of MIPS Value Pathways that, over time, the agency believes will reduce burden and better align reporting requirements across the four MIPS performance categories.

The final rule takes effect Jan. 1.

**CMS Finalizes CY 2020 Home Health Rule with New Payment Model**
The Centers for Medicare & Medicaid Services released its home health prospective payment system final rule with [comment period](#) for calendar year 2020, which increases payments by a net 1.3% ($250 million) relative to 2019.

**Key provisions in the final rule:**

- It continues the rulemaking initiated last year to implement a new home health payment model, known as the “patient-driven groupings model,” which has a new 30-day unit of payment. To attempt to implement the model in a budget-neutral manner in CY 2020, CMS included a behavioral offset of -4.36% rather than the proposed amount of -8.01%.
As proposed, the rule allows therapist assistants, rather than only therapists, to perform maintenance therapy. CMS states that this would allow them to practice at the top of their state licensure, give flexibility to home health providers and improve beneficiary access to these services.

With respect to quality, the rule removed one and added two quality measures regarding the transfer of patient information. In addition, CMS added several standardized patient assessment data elements. However, CMS did not finalize its proposal to remove one question related to pain from the Home Health Consumer Assessment of Healthcare Providers and Systems survey, which is part of the Home Health Quality Reporting Program.

While this final rule with comment period takes effect on Jan. 1, CMS will take comments through Dec. 30 on certain policies.

State Issues

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Surprise Balance Billing Legislation Clears House Committee
The Surprise Balance Bill Protection Act, House Bill 1862, cleared the House Insurance Committee this week. The proposal, a priority for Highmark and the Allegheny Health Network (AHN), is sponsored by House Insurance Committee Chairwoman Tina Pickett (R-Bradford) and is likely to be an agenda item for the House of Representative’s “Health Care Week,” which is tentatively scheduled to begin November 18.

Background
House Bill 1862 would provide consumers with protections from balancing billing practices by certain out-of-network (OON) health care providers—specifically emergency services and services provided at an in-network facility by an OON provider. Both of these limited instances involve customer/patient being involuntarily exposed to an OON provider.

Why this matters
House Bill 1862 would:
- Ensure that consumers are only responsible for their in-network cost-sharing obligations;
- Allow consumers to trigger protections if they do receive a balance bill; and
- Instruct OON providers to bill insurers directly, and in return they would be paid directly—a fair, market-based rate.

While it remains critically important for providers to join an insurer’s network, this bill would prohibit insurers from credentialing, auditing, and applying quality controls on OON providers.

Senate Approves Telemedicine Measure
Following the Senate Banking and Insurance Committee’s approval, the Senate voted 47-1 to advance Senator Elder Vogel’s (R-Butler) Senate Bill 857, a proposal that mandates coverage for and governs the use of telemedicine in the Commonwealth. The bill has been sent to the House Insurance Committee for further consideration.
**Senate Acts on PHC4 Reauthorization**

Legislation that would reauthorize the Pennsylvania Health Care Cost Containment Council (PHC4), **Senate Bill 841**, was approved by the Senate. Sponsored by Senator Scott Martin (R-Lancaster), the bill would reestablish the PHC4 as an independent council consisting of public officials and representatives from business communities, organized labor, consumers, hospitals, physicians, nurses and the insurance industry to collect and disseminate health care cost data. PHC4 currently operates under a gubernatorial executive order.

**Why this matters**

During the bill’s consideration by the Senate Health and Human Services Committee, two amendments were adopted to remove the requirement that insurers must maintain data and authorize PHC4 with the authority to establish all payer claims database (APCD). The bill also includes a five-year sunset date.

The legislation was referred the House Health Committee for further consideration.

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**Workplace Safety Legislation Advances in Senate and House**

Two measures that would impact workplace safety, particularly in the hospital community, were considered this week in the Senate and House of Representatives, respectively. The Senate voted 49-0 to approve **Senate Bill 351**, sponsored by Senator Judy Ward (R-Blair). The proposal would add all health care practitioners to a protected class in the event of an on-duty assault and increase established penalties. The bill was referred to the House Judiciary Committee for further consideration.

The House Health Committee voted to advance **House Bill 1880**, which would remove the requirement for last names to be displayed on health care employees’ identification badges. Sponsored by Representative Keith Gillespie (R-York), the bill is now on the House voting calendar.

**Why this matters**

According to the Hospital and Healthsystem Association of Pennsylvania (HAP), 60 percent of all workplace assaults occur in health care facilities. While the current aggravated assault statute covers some health care incidents, such as those against doctors, registered nurses, and emergency medical technicians, it does not cover all health care workers. Senate Bill 351 would close this loophole. House Bill 1880 would protect workers from being targeted by name.

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**State Issues**

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**DHS Posts Statewide Medicaid Preferred Drug List for Use Effective January 1**

The Pennsylvania Department of Human Services (DHS) has posted the [Statewide Preferred Drug List](#) (PDL) for the Pennsylvania Medicaid program. The PDL will become effective for both fee-for-service (FFS) and managed care on January 1, 2020.
The final list, approved by DHS Secretary Teresa Miller, was developed after an extensive public process where numerous stakeholder groups could ask questions and raise concerns.

The DHS web page includes prior authorization guidelines for drugs and products in the Statewide PDL. For any drug or product that is not included in the Statewide PDL, providers must refer to each MCO’s website for MCO-specific prior authorization requirements.

**Why this matters:** For some time, Pennsylvania providers have been seeking a single, Statewide PDL for Medicaid. The current process allows each Medicaid managed care organization (MCO) to create its own list of preferred medications. As providers work to provide the best possible patient care, these multiple medication lists increase administrative challenges.

**Insurance Department and Health Insurance Exchange Authority Issue Guidance Regarding Marketplace Compliance**

The Pennsylvania Insurance Department and the Pennsylvania Health Insurance Exchange Authority jointly issued guidance to insurance producers and exchange assisters. The Department and the Exchange Authority want to insure that the producers and assisters know that for the 2020 coverage year, including the open enrollment period beginning November 1, 2019, Pennsylvania will be operating as a state-based exchange on the federal platform. As a result, eligibility and enrollment activities will occur through HealthCare.gov.

The Department and Exchange Authority want to make certain that insurance producers and exchange assisters understand that continued compliance with all applicable federal and state laws and regulations is an expectation. Compliance includes marketplace annual training requirements for producers and the marketplace annual training requirements for exchange assisters.

Questions concerning the guidance may be directed to either: the Pennsylvania Insurance Department, Licensing Service Division, Office of Market Regulation, or the Pennsylvania Health Insurance Exchange Authority, at 1326 Strawberry Square, Harrisburg, PA 17120, or RA-IN-healthexchasst@pa.gov.

The Pennsylvania General Assembly is in recess the week of November 4.

The Delaware Legislature has adjourned for the year.

The West Virginia Legislature has adjourned for the year.

**Congress**

The U.S. Senate is in session the week of November 4.
Interested in reviewing a copy of a bill(s)? Access the following web sites:

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

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