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Tenacity, Creativity and Results are the three words that best describe Shaheen & Gordon's approach to addressing complex legal issues. Our health care team closely monitors the rapidly changing legal environment so that our clients are prepared to meet the challenges of today as well as tomorrow. Relying on a wealth of experience, we offer practical advice and assist in implementing recommendations tailored specifically to meet the needs of both large and small health care clients.

FEDERAL DEVELOPMENTS

Final Rule Expands Use of HRAs

In a press release on June 13, the Trump administration announced a final rule allowing employers to use health reimbursement arrangements ("HRAs") to reimburse employees for the cost of individual health insurance premiums. The final rule, published June 20 in the *Federal Register*, was issued collectively by the Department of Labor, Department of Treasury, and the Department of Health and Human Services. The rule reverses an Obama administration prohibition and comes in response to President Trump's Executive Order to increase choice and competition. The press release estimated that the expanded use of HRAs "will benefit approximately 800,000 employers, including small businesses, and more than 11 million employees and family members, including an estimated 800,000 Americans who were previously uninsured."

The press release may be read here:
https://www.hhs.gov/about/news/2019/06/13/hhs-labor-treasury-expand-access-quality-affordable-health-coverage.html

The final rule is available here:
https://www.federalregister.gov/documents/2019/06/20/2019-12571/health-reimbursement-arrangements-and-other-account-based-group-health-plans

Court Rules Noncompliance with LCDs Not Material to Government's Payment Decision

On June 14, the U.S. District Court for the Central District of California granted summary judgment to a durable medical equipment ("DME") supplier on claims alleging that the supplier violated the False Claim Act. The relator in the case alleged that the DME supplier submitted false claims because they were allegedly noncompliant with several local coverage determinations ("LCDs") addressing negative pressure wound therapy. In granting summary judgment for the DME supplier, the court found that the relator failed to show the noncompliance was material to the government's decision to pay the claims under the standard set forth in *Universal Health Services, Inc. v United States ex rel. Escobar*, 136 S. Ct. 1989, 1996 (2016).

The court's opinion, *United States ex rel. Hartpence v. Kinetic Concepts, Inc.,* No. 2:08-cv-01885-CAS-AGR (C.D. Cal. Jun. 14, 2019), may be found here:
https://assets.law360news.com/1173000/1173584/hartpence.pdf

Supreme Court Declines Review of Contraceptive Mandate

On June 17, the Supreme Court of the United States declined to review the legal dispute over the Trump Administration's expansion of the religious and moral objection exemption under the Affordable Care Act's ("ACA") contraceptive coverage mandate. The Court denied certiorari on a

Ninth Circuit panel ruling from December 2018 that the interim final rules expanding the exemption likely violated the Administrative Procedures Act by bypassing the required notice-and-comment rulemaking procedures, and should therefore be enjoined. *California v. Azar,* No. 4:17-cv-05783-HSG (9th Cir. Dec. 13, 2018). The rules, one addressing religious objections and the other addressing moral objections to the contraceptive mandate, applied to both for-profit private companies as well as non-profits and were released in October 2017.

The petition to the Supreme Court for a Writ of Certiorari may be read here: https://www.supremecourt.gov/DocketPDF/18/18-1192/91895/20190313152230556_No.-__%20Cert%20Petition%20only.pdf

Little Sisters of the Poor v. California, No. 18-1192 *cert denied.* (U.S. Jun. 17, 2019).

CMS Releases Guidance Regarding Medicaid Expansion Eligibility

On June 20, the Centers for Medicare & Medicaid Services ("CMS") released guidance on the oversight of State Medicaid expansion eligibility requirements. The guidance was issued partly in response to concerns raised by the Office of Inspector General following state audits showing that some states were not always determining eligibility for their expansion populations as required. The guidance states that there are four main areas of priority for a state to ensure proper claiming of the federal match to support their Medicaid program: "1. Development of necessary program integrity protections, 2. Implementation of appropriate system and financial oversight controls, 3. Monitoring the program effectively, and; 4. Documentation and evidence to support this activity." The guidance also includes a Program Readiness Checklist for states to use to make accurate eligibility determinations and to use to prepare for audits and program reviews.

The guidance is available here: https://www.medicaid.gov/federal-policy-guidance/downloads/cib062019.pdf

CMS Announces Option to Settle IRF Appeals

On June 17, the Centers for Medicare & Medicaid Services ("CMS") announced the ability for inpatient rehabilitation facilities ("IRFs") to settle pending appeals at the Medicare Administrative Contractor ("MAC"), the Qualified Independent Contractor ("QIC"), the Office of Medicare Hearings and Appeals ("OMHA"), and/or Medicare Appeals Council levels of review for 69% of the net payable amount. Requests for redetermination must have been filed with the MAC no later than August 31, 2018 in order to eligible for the settlement option. Expressions of Interest to participate in the settlement option are being accepted until September 17, 2019.

Information on the settlement initiative and process may be found here: https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Appeals-Settlement-Initiatives/Inpatient-Rehabilitation-Facility-Appeals-Initiative.html

CMS Proposes Rule on Medicare Part D Prior Authorizations

On June 19, the Centers for Medicare & Medicaid Services ("CMS") issued a proposed rule on the Medicare Part D e-prescribing program as required under the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act ("SUPPORT for Patients and Communities Act"). The goal of the proposed rule is to ensure secure electronic prior authorization request and response transmissions. The proposed rule provides that clinicians will be able to complete prior

authorizations online, in real time, before a prescription is transmitted to a pharmacy. Comments on the proposed rule were due August 16.

The proposed rule may be found here: https://www.govinfo.gov/content/pkg/FR-2019-06-19/pdf/2019-13028.pdf

Supreme Court Will Review Liability for ACA Risk Corridor Payments

On June 24, the U.S. Supreme Court granted review of three consolidated cases where federal circuit courts found the government not liable for paying millions in unpaid risk corridor payments, despite Affordable Care Act ("ACA") requirements, because appropriations riders enacted in fiscal years 2015 and 2016 made the program budget neutral, effectively repealing the government's obligation. *Moda Health Plan Inc. v. United States*, No. 2017-1994 (Fed. Cir. June 14, 2018); *Land of Lincoln Mutual Health Ins. Co. v. United States*, No. 2017-1224 (Fed. Cir. June 14, 2018). The temporary risk corridors program established under Section 1342 of the ACA was designed to provide for the sharing of insurers' gains and losses that resulted from inaccurate rate setting between 2014 and 2016 between the government and qualified health plans. However, when the Centers for Medicare & Medicaid Services ("CMS") announced in October 2015 that it would pay only 12.6% of the $2.87 billion requested by insurers for 2014, it sparked a number of lawsuits seeking to recover the now almost $12.3 billion in risk corridor payments.

Maine Community Health Options v. United States, No. 18-1023, *cert. granted* (U.S. Jun. 24, 2019); *Moda Health Plan, Inc. v. United States* No. 18-1028, *cert. granted* (U.S. Jun. 24, 2019); *Land of Lincoln Mutual Health v. United States,* No. 18-1038, *cert. granted* (U.S. Jun. 24, 2019).

States to Receive $50 Million for Medicaid Substance Use Disorder Services

On June 25, the Centers for Medicare & Medicaid Services ("CMS") announced in a press release a Notice of Funding Opportunity, allowing state Medicaid agencies the opportunity to apply for planning grants to assist with treatment and recovery of substance use disorders, including opioid use disorder. CMS stated that the goals of the grants are to increase capacity of Medicaid providers; to offer recruitment, training and technical assistance for Medicaid providers offering SUD treatment and recovery services; and improve reimbursement for SUD treatment. In order to apply, states had to submit an 18-month proposal by August 9 for increasing the capacity of Medicaid providers in their state and quickly delivering SUD treatment and recovery services within local communities. According to the press release, CMS would choose at least 10 state proposals and would award grants totaling $50 million.

The press release can be read here: https://www.cms.gov/newsroom/press-releases/cms-commits-50-million-assist-states-substance-use-disorder-treatment-and-recovery

Kidney Care Payment Changes

On July 10, President Trump issued an executive order addressing the new *Advancing American Kidney Health* initiative, with the stated purpose of advancing American kidney health. The order cited kidney disease as the 9th leading cause of death in 2017. The initiate includes a three-part policy of: (a) preventing kidney failure through better diagnosis, treatment, and incentives for preventive care; (b) increasing patient choice for affordable treatment for end-stage renal disease ("ESRD"), including encouraging higher-value care, educating patients on alternative treatments, and encouraging development of artificial kidneys; and (c) increasing access to kidney transplants. Concurrently with the release of the executive order, the Centers for Medicare & Medicaid Services ("CMS") issued a proposed rule on the ESRD Treatment Choices ("ETC") Mandatory Model to encourage increased use of home dialysis and kidney

transplants for patient with ESRD. CMS also announced four voluntary models, the Kidney Care First ("KCF") Model and the Comprehensive Kidney Care Contracting ("CKCC") Graduated, Professional, and Global Models, designed to offer financial incentives to health care providers to encourage them to manage the care of patients with chronic kidney disease and stage 4 and 5 ESRD, to delay the start of dialysis, and to encourage kidney transplantation. Comments on the proposed rule are due September 16.

The executive order may be found here: https://www.whitehouse.gov/presidential-actions/executive-order-advancing-american-kidney-health/

The CMS proposed rule is here: https://www.federalregister.gov/documents/2019/07/18/2019-14902/medicare-program-specialty-care-models-to-improve-quality-of-care-and-reduce-expenditures

CMS' Fact Sheet regarding the mandatory model may be read here: https://www.cms.gov/newsroom/fact-sheets/proposed-end-stage-renal-disease-treatment-choices-etc-mandatory-model and the Fact Sheet for the option models may be found here: https://www.cms.gov/newsroom/fact-sheets/kidney-care-first-kcf-and-comprehensive-kidney-care-contracting-ckcc-models

CMS Proposes Rule on Radiation Oncology Bundled Payment Model

On July 10, the Centers for Medicare & Medicaid Services ("CMS") issued a proposed rule aimed at improving the quality of care for patients receiving radiation oncology ("RO") treatment. The proposal would test whether prospective site-neutral, episode-based payments to physician group practices ("PGPs"), hospital outpatient departments ("HOPD"), and freestanding radiation therapy centers for radiotherapy ("RT") episodes of care would result in reduced Medicare expenditures without sacrificing quality of care. Comments are due on September 16.

The proposed rule may be found here: https://www.federalregister.gov/documents/2019/07/18/2019-14902/medicare-program-specialty-care-models-to-improve-quality-of-care-and-reduce-expenditures

A CMS Fact Sheet on the proposed rule is found here: https://www.cms.gov/newsroom/fact-sheets/proposed-radiation-oncology-ro-model

Recommendation by MedPAC to Eliminate "Incident to" Billing by APRNs and PAs

On June 14, the Medicare Payment Advisory Committee ("MedPAC") released its semi-annual report to Congress on the Medicare program. In its report, the independent congressional agency recommended that Congress eliminate "incident to" billing for advance practice registered nurses ("APRNs") and physician assistants ("PAs"). Instead, it recommended that these midlevel providers bill under their own national provider identifiers ("NPIs"). Explaining its reasoning for the recommendation, MedPAC cited the fact that Medicare's "incident to" rules were not designed for the services currently being provided by midlevel providers, that it would potentially save the Medicare program millions of dollars, and that the level of care provided to Medicare beneficiaries would not be reduced.

MedPAC's full report may be found here: http://www.medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf?sfvrsn=0

Four-Month Delay of Health Care Conscience Rule

On June 28, the Department of Health and Human Services ("HHS") agreed in a court stipulation filed in the U.S. District Court for the Northern District of California that it would delay the effective date of the Health Care Conscience Rule from July 22 to November 22. Multiple lawsuits have been filed seeking to enjoin the Rule, and HHS cited the delay as "the most efficient way to adjudicate the Final Rule on the merits." Lawsuits allege that the rule exceeds HHS' statutory authority, is unconstitutional and violates the Administrative Procedure Act because HHS did not consider its impact on patients. They argue that the rule would allow health care providers to refuse services, even in emergencies, for religious or personal beliefs.

The unpublished final rule is available here: https://www.hhs.gov/sites/default/files/final-conscience-rule.pdf

FAQs Issued for Psychiatric Hospitals on EMTALA Obligations

On July 2, the Centers for Medicare & Medicaid Services ("CMS") issued a Frequently Asked Questions ("FAQs") Memorandum on the Emergency Medical Treatment and Labor Act ("EMTALA") and its impact on psychiatric hospitals. CMS cited "confusion and misconceptions" about EMTALA's applicability to psychiatric hospitals, as the reason for the memorandum. The FAQs state that there is not an expectation that psychiatric hospitals provide the same level of assessment that an acute care hospital could provide, but that hospitals must perform medical screening examinations and stabilizing treatment within their capabilities. They are also expected to provide ongoing assessments of patients, address immediate needs, and keep patients as safe and stable as possible prior to transfer.

The FAQs memorandum is available here: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO-19-15-EMTALA.pdf

Administration Withdraws Drug Rebate Proposed Rule

On June 10, the Trump Administration withdrew a proposed rule that would eliminate safe harbor protection for rebates for prescription drugs under the Anti-Kickback Statute. The proposed rule would have also created a new safe harbor for point-of-sale rebates to patients and for fixed-fee service agreements between drug makers and pharmacy-benefit mangers ("PBMs"). The Congressional Budget Office ("CBO") had recently opined that the proposed rule would have the effect of increasing federal spending and premiums.

The withdrawn proposed rule may be read here: https://www.federalregister.gov/documents/2019/02/06/2019-01026/fraud-and-abuse-removal-of-safe-harbor-protection-for-rebates-involving-prescription-pharmaceuticals

Ambulatory Blood Pressure Monitoring to be Covered by Medicare

On July 2, the Centers for Medicare & Medicaid Services ("CMS") issued a decision memorandum expanding coverage of Ambulatory Blood Pressure Monitoring ("ABPM") from patients with "white coat hypertension" to those patients with suspected "masked hypertension," citing "sufficient evidence" for the expansion. "White coat hypertension" is when blood pressure increases in the clinical setting due to anxiety and "masked hypertension" is when blood pressure taken in a physician office is lower than that outside the clinical setting. ABPM involves tracking a patient's blood pressure over 24-hour cycles using a non-invasive device. ABPM is covered once per year for eligible patients.

The Decision Memorandum may be found here: https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=294

OIG Reports on Risks of Hospice Deficiencies

On July 9, the Department of Health and Human Services ("HHS") Office of Inspector General ("OIG") issued two related reports regarding the risks that hospice deficiencies pose to Medicare beneficiaries. In one report, *Hospice Deficiencies Pose Risks to Medicare Beneficiaries*, the OIG found that deficiencies found in its first-ever review of national hospice deficiencies indicate that the Centers for Medicare & Medicaid Services ("CMS") needs to strengthen its oversight of the Medicare hospice program. The OIG examined data that showed that from 2012 through 2016, 87% of hospices had failed to meet at least one Medicare participation requirement, and 20% had at least one serious condition-level deficiency, meaning the ability to furnish adequate care was substantially limited. Furthermore, one-third of all hospices providing care to Medicare beneficiaries had a complaint filed against them during the five-year review period, and half of those were classified as "severe." The OIG recommended in its report that CMS: (1) expand the deficiency data that accrediting organizations report and use these data to strengthen its oversight of hospices; (2) seek statutory authority to include information from accrediting organizations on Hospice Compare; (3) include the survey reports from state agencies on Hospice Compare; (4) include on Hospice Compare the survey reports from accrediting organizations, once authority is obtained; (5) educate hospices about common deficiencies and those that pose particular risks to beneficiaries; and (6) increase oversight of hospices with a history of serious deficiencies.

In the report titled *Safeguards Must Be Strengthened To Protect Medicare Hospice Beneficiaries From Harm*, the OIG examined 12 specific incidents of beneficiary harm in hospices, identified the vulnerabilities that led to the harm, and recommended ways to prevent the harm in the future. The OIG identified that insufficient reporting requirements, limited reporting requirements for surveyors, barriers in making complaints, and the lack of serious consequences for hospices, were some of the vulnerabilities leading to harm. The OIG recommended that CMS: (1) strengthen requirements for hospices to report abuse, neglect, and other harm; (2) ensure that hospices are educating their staff to recognize signs of abuse, neglect, and other harm; (3) strengthen guidance for surveyors to report crimes to local law enforcement; (4) monitor surveyors' use of immediate jeopardy; and (5) improve and streamline the process for beneficiaries and caregivers to make complaints.

The report, *Hospice Deficiencies Pose Risks to Medicare Beneficiaries* is available here: https://oig.hhs.gov/oei/reports/oei-02-17-00020.pdf?utm_source=summary-page&utm_medium=web&utm_campaign=OEI-02-17-00020-PDF

The report, *Safeguards Must Be Strengthened To Protect Medicare Hospice Beneficiaries From Harm* is available here: https://oig.hhs.gov/oei/reports/oei-02-17-00021.pdf?utm_source=summary-page&utm_medium=web&utm_campaign=OEI-02-17-00021-PDF

CMS Proposes $250 Million Increase in Home Health Payments

On July 11, the Centers for Medicare & Medicaid Services ("CMS") issued a proposed rule increasing payments to home health agencies ("HHAs") in calendar year 2020 by an estimated 1.3%, or $250 million. The proposed rule implements the Patient-Driven Groupings Model ("PDGM"), which, instead of paying for 60-day episodes of care and using the number of therapy visits to determine payment, eliminates "therapy thresholds" and uses a 30-day unit of payment as required under the Bipartisan Budget Act of 2018. The proposed rule also addresses implementation of a new home health benefit for infusion therapies

beginning in calendar year 2021 as required by the 21st Century Cures Act. A CMS fact sheet on the rule explained that in order for providers and suppliers to prepare for the home infusion therapy benefit, it is proposing to group home infusion drugs into three payment categories, each with a single unit of payment. CMS also proposes higher payment amounts for the first home infusion therapy visit, followed by a small decrease in the payment amounts for each subsequent visit.

The proposed rule as published in the *Federal Register* may be found here: https://www.federalregister.gov/documents/2019/07/18/2019-14913/medicare-and-medicaid-programs-cy-2020-home-health-prospective-payment-system-rate-update-home

A CMS Fact Sheet on the proposed rule is found here: https://www.cms.gov/newsroom/fact-sheets/cms-proposes-calendar-year-2020-and-2021-new-home-infusion-therapy-benefit-and-payment-and-policy

OIG Reports Failure to Run Fingerprint Background Checks Putting Medicaid at Risk

On July 15, the Department of Health and Human Services ("HHS") Office of Inspector General ("OIG") issued a report that the Medicaid program is vulnerable because some states have not implemented fingerprint-based background checks for high-risk medical providers. Required as part of the Medicaid provider enrollment, as of January 1, 2019, 13 states did not have the checks in place. Five of those 13 had not collected any fingerprints from their high-risk providers, while the remaining states had made some partial progress. The five states without any progress cited a lack of authority, a lack of resources, and delays in determining disqualifying criminal histories as reasons for their delay. In its report, the OIG explained that the Centers for Medicare & Medicaid Services ("CMS") has two loopholes that could result in providers evading criminal background checks. The first is that CMS allows states to skip background checks for high-risk providers already enrolled in Medicare, even though the Medicare program may not have conducted the checks. Secondly, high-risk providers can conceal owners who require criminal background checks. Although CMS agreed with OIG's recommendation that it should ensure states conduct criminal background checks for all high-risk providers and use any available enforcement tool, including financial disallowances, CMS did not agree with the OIG's recommendation that it close the loophole allowing states to skip background checks for providers already enrolled in Medicare, explaining that it was unnecessary as a contractor was already conducting criminal background checks on remaining Medicare providers. CMS also did not agree with the OIG's recommendation that it should work with states to identify discrepancies in self-reported ownership information across Medicare and Medicaid citing the fact that it would be too burdensome for states with paper records.

The full report, *Problems Remain for Ensuring That All High-Risk Medicaid Providers Undergo Criminal Background Checks*, is available here: https://oig.hhs.gov/oei/reports/oei-05-18-00070.pdf

Leapfrog Group's Expanded Never Events Standard Not Followed by One in Four Hospitals

A 2018 survey of 2,000 hospitals reveals that approximately twenty-five percent (25%) of U.S. hospitals are not meeting the Leapfrog Group's standard for responding to "never events" – those mistakes and errors in a hospital that are so egregious that they should never happen to a patient, such as surgery on the wrong body part or death from a medication error. In 2007, the Leapfrog Group issued five principles for providers to follow when a never event occurs: (1) apologize to the patient; (2) report the event; (3) perform a root cause analysis; (4) waive direct costs; (5) provide a copy of the never events policy upon request. The group then expanded the protocol in 2017 to add the following principles: (1) involve patients and families in the root cause analysis; (2) inform the patient and family of action that the hospital will take in the future to

prevent similar events; (3) have a protocol in place for support for caregivers and make it known to all caregivers and affiliated clinicians; and (4) perform an annual review to ensure compliance. Although the Leapfrog Group acknowledged a decline in compliance was likely down due to the 2017 expansion (prior compliance was around 80%), it emphasized that compliance should be at 100%.

The full survey report may be accessed here: https://www.leapfroggroup.org/never-events-report-2019

CMS Issues Final Rule on Nursing Home Pre-Dispute Arbitration

On July 16, the Centers for Medicare & Medicaid Services ("CMS") issued a final rule repealing the prohibition on Long Term Care ("LTC") facilities using pre-dispute binding arbitration agreements. The final rule also aims to make arbitration agreements and arbitration in LTCs more transparent. The proposed rule received over 1,000 public comments, and partly in response to some of the comments, the final rule prohibits arbitration agreements used by LTCs as a condition of admission, or as a requirement for a resident to continue receiving care. A CMS fact sheet on the rule states that "[t]he rule is part of the agency's five-part approach to ensuring a high-quality nursing home system that focuses on strengthening requirements for nursing homes, working with states to enforce statutory and regulatory requirements, increasing transparency of nursing home performance, and promoting improved health outcomes for nursing home residents."

The final rule may be found here: https://www.govinfo.gov/content/pkg/FR-2019-07-18/pdf/2019-14945.pdf

A CMS Fact Sheet may be found here: https://www.cms.gov/newsroom/fact-sheets/medicare-and-medicaid-programs-revision-requirements-long-term-care-facilities-arbitration

House Votes to Repeal "Cadillac" Tax

On July 17, by a bipartisan vote of 419-6, the House voted to permanently repeal the so-called "Cadillac" tax of the Affordable Care Act ("ACA"), which imposes a 40% excise tax on high-cost employment-based health plans with values that exceed $11,200 for individuals and $30,100 for families. The Cadillac tax was included in the ACA as a way to raise revenue and reduce health care costs. Congress had previously delayed the original 2018 start date of the tax, and so it had never gone into effect. The Congressional Budget Office estimated the cost to the government of repealing the tax would be $200 billion in revenue over ten years.

OIG Highlights Top 25 Unimplemented Regulations

On July 22, the Department of Health and Human Services ("HHS") Office of Inspector General ("OIG") issued its annual list of unimplemented recommendations. The publication, *Solutions to Reduce Fraud, Waste, and Abuse in HHS Programs: OIG's Top Recommendations*, focuses on the top 25 unimplemented recommendations that the OIG perceives would accomplish the most with respect to cost savings, program effectiveness and efficiency, and public health and safety. The majority of the recommendations (18 of 25) relate to the Centers for Medicare & Medicaid Services ("CMS"), including, under the Medicare Parts A & B heading, that CMS should seek statutory authority to establish additional remedies for hospices with poor performance and legislative authority to comprehensively reform the hospital wage index system. It also included its recommendation that CMS should reevaluate the inpatient rehabilitation facility payment system. Under Medicare Parts C & D, OIG highlighted its recommendation that CMS should collect comprehensive data from plan sponsors, including on potential fraud and abuse in

order to improve its oversight of their efforts to identify and investigate potential fraud and abuse. Regarding Medicaid, OIG emphasized that CMS should ensure that national Medicaid data are complete, accurate, and timely.

The publication is available here: https://oig.hhs.gov/reports-and-publications/compendium/files/compendium2019.pdf

Proposed Rule Requires Hospital Disclosure of Negotiated Rates

On July 29, the Centers for Medicare & Medicaid Services ("CMS") issued a proposed rule implementing Section 2718(e) of the Public Health Service Act requiring hospitals to establish, update, and make publicly available an annual list of standard charges. The Proposed Rule, published in the August 9 *Federal Register*, is in response to President Trump's Executive Order "Improving Price and Quality Transparency in American Healthcare to Put Patients First." The Rule proposes definitions for "hospital", "standard charges", and "items and services"; makes specific requirements for the online public file to be machine-readable; requires that payer-specific negotiated charges for "shoppable" services (those able to be scheduled by a health care consumer in advance) be made public in a consumer-friendly manner; and proposes monitoring by CMS for hospital noncompliance including audits, corrective action plans, and potential penalties of $300 per day. The Proposed Rule also encourages site-neutral payment between certain Medicare sites of services and proposes updates and changes under the Medicare Hospital Outpatient Prospective Payment System ("OPPS") and Ambulatory Surgical Center ("ASC") Payment System.

The deadline for submitting comments on the Proposed Rule is September 27, 2019.

The Proposed Rule as published in the August 9 Federal Register may be accessed here: https://www.federalregister.gov/public-inspection/2019/08/09

A CMS Fact Sheet on the Proposed Rule may be found here: https://www.cms.gov/newsroom/fact-sheets/cy-2020-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center

D.C. Circuit Court Reverses Dismissal of ACLA Action on Clinical Lab Payment Regulation

On July 30, the D.C. Circuit Court reversed a lower court's dismissal of a lawsuit brought by the American Clinical Laboratory Association ("ACLA") challenging a rule promulgated under the Protecting Access to Medicare Act ("PAMA"). PAMA requires "applicable laboratories" to report private payor data to the Secretary of the Department of Health and Human Services ("HHS") in order for HHS to set Medicare reimbursement rates for laboratory tests with prices paid in the private market. The ACLA, a trade association of laboratories, alleged that the HHS rule defining "applicable laboratories" unlawfully excluded most hospital laboratories from PAMA's reporting requirements, by defining an "applicable laboratory" as one that "[b]ills Medicare Part B under its own National Provider Identifier ("NPI")." Since hospital laboratories tend to charge higher prices than standalone laboratories, the result would be that the payment rates for Medicare were lower than they would have been. The lower court dismissed the ACLA's suit for lack of subject matter jurisdiction, citing a provision in PAMA prohibiting judicial review of "the establishment of payment amounts." However, in reversing and remanding the case, the D.C. Circuit opined that the prohibition on judicial review does not cover the data-collection provision of the statute.

The D.C. Circuit Court's decision, *American Clinical Lab. Ass'n v. Azar*, No. 18-5312 (D.C. Cir. July 30, 2019), is available here:

https://www.cadc.uscourts.gov/internet/opinions.nsf/1BE206FFFAE7440F8525844700511E0E/$file/18-5312-1799669.pdf

New Guidance on Monitoring Opioid Misuse

On August 5, the Centers for Medicare & Medicaid Services ("CMS") released guidance for the implementation of the new Medicaid Drug Utilization Review ("DUR") provision of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act ("SUPPORT Act"). In order to alert health professionals of potential opioid abuse, the SUPPORT Act requires states to implement drug use review procedures, including opioid prescription claim reviews at the point of sale ("POS") and retrospective reviews; monitoring and management of antipsychotic drugs in children; identification of processes to detect fraud and abuse; and mandatory DUR report updates. October 1 is the deadline for states to implement the new requirements. States must submit an amendment to their Medicaid state plan by December 31.

The guidance can be read here: https://www.medicaid.gov/federal-policy-guidance/downloads/cib080519-1004.pdf

Medicare Payments to Hospitals Expected to Increase by $3.8 Billion in FY 2020

On August 2, the Centers for Medicare & Medicaid Services ("CMS") issued a final rule under the inpatient prospective payment system ("IPPS") and the Long-Term Care Hospital ("LTCH") Prospective Payment System ("PPS") that is expected to increase payments to hospitals by approximately $3.8 billion and $43 million respectively in fiscal year ("FY") 2020. Under the rule, operating rates for inpatient stays in general acute care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting Program and demonstrate meaningful use of electronic health records would increase by about 3.1% in FY 2020, reflecting a 3% market basket update, a positive 0.5 percentage point adjustment required by law, and a negative 0.4% productivity adjustment, In addition to the rate changes, a CMS fact sheet on the final rule called changes in policies under the rule for the way many low wage index, often rural, hospitals are paid "historic." The rule increases the wage index of hospitals with a value below the 25th percentile and since Medicare pays lower payment rates to hospitals with wages below the national average, commenters argued that it was exacerbating the disparities between low and high index hospitals. The final rule is effective October 1, 2019.

A CMS fact sheet on the final rule is available here: https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2020-medicare-hospital-inpatient-prospective-payment-system-ipps-and-long-term-acute-0

The final rule as published in the *Federal Register* on August 16 is available here: https://www.federalregister.gov/documents/2019/08/16/2019-16762/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the

Reversal of Injunction on Medicaid DSH Payment Rule

On August 13, the D.C. Circuit Court reversed a lower district court's injunction vacating a Centers for Medicare & Medicaid Services ("CMS") final rule regarding the calculation of disproportionate share hospital ("DSH") payments. The Medicaid Act provides that the federal government fund states payments that the state distributes to hospitals that serve a disproportionate number of low-income patients, but the DSH payment to a hospital must not exceed the "costs incurred" by hospital during the year of furnishing hospital services to Medicaid-eligible and uninsured individuals. The CMS final rule at issue required that payment

from Medicare and private insurers be subtracted from the calculation of "costs incurred," thereby lowering the threshold that DSH payments could not exceed. In March of this year, the U.S. District Court for the District of Columbia had agreed with the plaintiffs in the case (a group of children's hospitals) that the final rule's definition of "costs incurred" was contrary to the Medicaid Act. *Children's Hosp. Ass'n of Tex. v. Azar,* No. 17-844 (EGS) (D.D.C. Mar. 6, 2018). In reversing the District Court's decision, the Circuit Court based its opinion partly on its conclusion that the Medicaid Act did not exclusively specify which payments *could* be used to calculate "costs incurred." *Children's Hosp. Assn. of Texas v. Azar*, No. 18-5135 (D.C. Cir. Aug. 13, 2019).

To read the full D.C. Circuit Court's opinion, go to: https://law.justia.com/cases/federal/appellate-courts/cadc/18-5135/18-5135-2019-08-13.html

Star Ratings Announced Ahead of 2020 Open Enrollment

On August 15, the Centers for Medicare & Medicaid Services ("CMS") announced the first ever use of the five-star Quality Rating System for health plans on the Health Insurance Exchanges for the 2020 Open Enrollment Period. The star ratings are intended to help consumers compare health plan choices using the five-star rating of each plan. Similar to the rating system used on the Nursing Home Compare website and Medicare Advantage, health plans offered on the Exchange are given stars on a one-to-five scale, with five stars for the plans with the highest quality. Ratings are earned based on three categories, medical care, member experience, and plan administration.

The CMS press release is available here: https://www.cms.gov/newsroom/press-releases/cms-bringing-health-plan-quality-ratings-all-exchanges-first-time

A CMS fact sheet on the star ratings is available here: https://www.cms.gov/newsroom/fact-sheets/health-insurance-exchange-quality-ratings-system-101

OIG Updates Work Plan

On August 15, the Department of Health and Human Services Office of Inspector General ("OIG") added several items to its Work Plan, including examining the number of admission-related outpatient services that were not covered by the Medicare diagnosis-related group ("DRG") window policy in 2018. The OIG also added that it will look at: the use of telehealth to provide behavioral health services in Medicaid Managed Care; Medicare Payments of Positive Airway Pressure Devices for Obstructive Sleep Apnea Without Conducting a Prior Sleep Study; the Centers for Medicare & Medicaid Services ("CMS") oversight of nursing home survey agencies; Medicaid assisted living services; and Medicare Part B services provided to beneficiaries residing in nursing homes during non-Part A stays.

The full list of newly-added items to the OIG Work Plan can be accessed here: https://oig.hhs.gov/reports-and-publications/workplan/updates.asp

HHS Appeals Decision Vacating Rule on List Prices in Drug Ads

On August 21, the Department of Health and Human Services ("HHS") filed an appeal of *Merck & Co., Inc. v. United States Dep't of Health and Human Servs.,* No. 19-cv-01738 (APM) (D.D.C. July 8, 2019) where the U.S. District Court for the District of Columbia held that HHS exceeded its authority under the Social Security Act by regulating the marketing of prescription drugs. The final rule at issue in the litigation was published by HHS in May and would have been effective July 9. It required television ads to include wholesale acquisition cost for prescription drugs and biological products covered by Medicare or Medicaid if

their list prices are more than $35 for a month's supply for the usual course of therapy. Merck & Co., Eli Lilly & Co., Amgen Inc., and the Association of National Advertisers, Inc. filed the lawsuit arguing that the law exceeded HHS' authority and violated the First Amendment.

The *Merck & Co., Inc.* opinion may be found here: https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2019cv1738-32

The final rule requiring list prices in advertisements can be read here: https://www.govinfo.gov/content/pkg/FR-2019-05-10/pdf/2019-09655.pdf

SAMHSA Issues Proposed Revisions Regarding Disclosure Rules

On August 22, the Substance Abuse and Mental Health Services Administration ("SAMHSA") issued a proposed rule revising privacy rules for substance use disorder ("SUD") records. The proposal updates the regulations at 42 C.F.R. Part 2 (known as "Part 2"), which were intended to limit the disclosure of SUD records so that patients were not deterred from seeking treatment. The proposed rule eases some of the restrictions of Part 2 that make it difficult for providers treating patients with SUD. For example, it would allow patients to consent to disclosure of their records to an entity such as the Social Security Administration, halfway houses, and sober homes without, as Part 2 currently requires, having to name a specific individual to receive the information. The rule also clarifies that records of an entity that does not meet the definition of a Part 2 entity are not subject to Part 2 merely because the records contain information about a patient's SUD or SUD treatment. Comments to the proposed rule are due October 25.

The proposed rule is available to read here: https://www.federalregister.gov/documents/2019/08/26/2019-17817/confidentiality-of-substance-use-disorder-patient-records

CMS Issues Final Rule to Fight Fraud

On September 5, the Centers for Medicare & Medicaid Services ("CMS") issued a final rule with comment period to implement requirements of the Social Security Act for Medicare, Medicaid, and Children's Health Insurance Program ("CHIP") providers and suppliers to disclose any direct or indirect affiliation with a provider or supplier that: (1) has uncollected debt; (2) has been or is subject to a payment suspension under a federal health care program; (3) has been or is excluded by the Office of Inspector General ("OIG") from Medicare, Medicaid, or CHIP; or (4) has had its Medicare, Medicaid, or CHIP billing privileges denied or revoked. The proposal then permits the Secretary to deny enrollment based on the affiliation if the Secretary determines the affiliation poses an undue risk of fraud, waste, or abuse. The rule also includes other tools to help CMS fight fraud, including the ability to deny or revoke enrollment, if a provider or supplier: circumvents rules by coming back into the program under a different name; bills for services/items from a non-compliant location; exhibits a pattern of abusive ordering or certifying Part A or Part B items, services or drugs; or has an outstanding debt to CMS from an overpayment that was referred to the Treasury Department. Comments are due November 4, 2019.

The final rule may be found here: https://www.federalregister.gov/documents/2019/09/10/2019-19208/medicare-medicaid-and-childrens-health-insurance-programs-program-integrity-enhancements-to-the

A CMS press release on the final rule may be found here: https://www.cms.gov/newsroom/press-releases/cms-announces-new-enforcement-authorities-reduce-criminal-behavior-medicare-medicaid-and-chip

STATE DEVELOPMENTS

New Administrative Rules Proposed by the NH Department of Health and Human Services

New administrative rules proposed by the Department of Health and Human Services since our last update include:

- Home Health Care Providers Licensing (He-P 809): The proposed rules may be found at https://www.dhhs.nh.gov/oos/aru/documents/hep809varip.pdf
- Ambulatory Surgery Centers (He-P 812): The proposed rules may be found at https://www.dhhs.nh.gov/oos/aru/documents/hep812ip.pdf
- Residential Treatment and Rehabilitation Facilities (He-P 807): The proposed rules may be found at https://www.dhhs.nh.gov/oos/aru/documents/hep807ip.pdf

Federal Judge Prohibits NH Medicaid Work Requirement

On July 11, NH DHHS sent a letter to all Granite Advantage members notifying them of the suspension of the Work and Community Engagement requirement until September 30, 2019 following a decision by the Governor to suspend the requirement due to implementation issues.

On July 29, U.S. District Court Judge for the District of Columbia, James E. Boasberg, struck down New Hampshire Medicaid's work requirement. New Hampshire's requirements under its "Granite Advantage" program, called for 100 monthly hours of employment or other "community engagement" activities for non-disabled Medicaid beneficiaries between the ages of 19 and 64. The decision follows Judge Boasberg's similar opinions in two other states, Kentucky and Arkansas, that the approval of the work requirements by the Department of Health and Human Services ("HHS") was arbitrary and capricious in that it failed to adequately consider the effect of the work requirement on Medicaid coverage.

On August 9, 2019, following the decision by the U.S. District Court prohibiting New Hampshire from implementing its Work and Community Engagement requirement, the Department sent notification to Granite Advantage members impacted by the decision. The notification assures members that the decision does not result in a loss of coverage.

Philbrick v. Azar, No. 19-773 (JEB) (D.D.C. July 29, 2019).

The decision in *Philbrick v. Azar* may be read in full here: https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2019cv0773-47

LEGISATIVE UPDATES

House Bills

HB 113: An Act relative to qualifications for and exceptions from licensure for mental health practice. This bill allows experience as a master licensed alcohol and drug counselor to qualify as experience for licensure as a clinical social worker or clinical mental health counselor. The bill also clarifies the mental health license exemption for psychotherapy activities and services of psychologists and master licensed alcohol and drug counselors. Introduced and referred to House HHS Committee. Voted Ought to Pass with Amendment by Committee. Amendment adds additional requirements related to the substitution of training hours. House voted Ought to Pass with Amendment. Referred to Executive Departments and Administration. Voted Ought to Pass by House. Introduced and referred to Executive Departments and Administration. Voted Ought to Pass by Committee (5-0) and by full Senate. **Signed by the Governor and was effective as of August 17, 2019.**

HB 118: AN ACT requiring a child's primary health care provider to be notified of a report of suspected abuse or neglect and relative to access to the department of health and human services case record. This bill requires the department of health and human services to notify a child's primary health care provider of a report of suspected abuse or neglect regarding the child. The bill also permits a child's primary health care provider to access the child's case record if such access is necessary to provide treatment or services or to determine the status of a report under investigation by the department. Introduced and referred to House Children and Family Law Committee. Voted Ought to Pass with Amendment by Committee (15-2). The amended bill directs DHHS to develop a methodology for notifying the child's primary health care providers of a report of abuse and neglect and clarifies immunity and confidentiality requirements in such cases. Introduced in the Senate and referred to Judiciary Committee. Voted Ought to Pass by Committee and by full Senate. **Signed by the Governor to be effective January 1, 2020.**

HB 127: AN ACT relative to the board of medicine and the medical review subcommittee. This bill clarifies the service of the medical director on the board of medicine and the employment of the medical review subcommittee investigator. Introduced and referred to House HHS Committee. Voted Ought to Pass with Amendment by Committee. Amendment provides that physician to serve as medical review subcommittee investigator shall be contracted. Voted Ought to Pass with Amendment by the House**.** Introduced in the Senate and referred to Executive Departments and Administration Committee. Voted Ought to Pass with Amendment by the Committee (5-0) and the full Senate. The amendment adds an entire new section to the bill requiring certain health care professionals to complete a survey or an opt-out form for collecting data on the primary care workforce. **House concurred with Senate Amendment. Signed by the Governor Chapter 254;I, Sections 1& 2 to be effective September 17, 2019, the remainder was effective on July 1, 2019.**

HB 233: AN ACT relative to the group and individual health insurance market. This bill establishes the provisions of the Patient Protection and Affordable Care Act of 2009, Public Law 111-148, as amended in statute. Introduced and referred to House Commerce Committee. Voted Ought to Pass with Amendment by the House. The Amendment prohibits health carriers from establishing lifetime or annual limits on the dollar value of essential health benefits, but not for health benefits that are not essential. Introduced in the Senate and referred to Commerce Committee. Committee voted to re-refer the bill to Committee.

HB 239: AN ACT relative to license requirements for certain mental health and drug counselors. This bill reduces the number of hours or work experience required for licensure as a master licensed alcohol and drug counselor, a licensed alcohol and drug counselor, a licensed clinical supervisor, a clinical social worker, and a clinical mental health counselor. Introduced and referred to House HHS Committee. Voted Ought to Pass with Amendment by the House. The amendment deletes all of the originally proposed language and instead proposes changes to the statute to provide that the location of the supervision of mental health and drug counselors take place in a location that is convenient to both the supervisor and the candidate for licensure. Introduced in the Senate and referred to Executive Departments and Administration. Voted Ought to Pass with Amendment by the Committee and passed by the full Senate with further amendment. The amendments serve to further clarify that the supervision will take place in a mutually convenient location**. House concurred with Senate amendment. Signed by the Governor to be effective September 19, 2019.**

HB 250: AN ACT relative to oral prophylaxis for dental patients. This bill allows a dental patient to have an oral prophylaxis performed even if the supervising dentist determines that a dental procedure or surgery is required. Introduced and referred to House HHS Committee**.** Bill retained in Committee.

HB 277: AN ACT establishing a commission to study a public option for health insurance. This bill establishes a commission to study a public option program for health insurance in New Hampshire. Introduced and referred to House Commerce Committee. Voted Ought to Pass by Committee (11-7) and by the full House. Introduced in the Senate and referred to the Commerce Committee. Voted Ought to Pass with Amendment by Committee and full Senate. The amendment completely eliminates the language of the bill as passed by the House. The bill as amended authorizes the insurance commissioner to enforce the federal Mental Health Parity and Addiction Act of 2008. **House non-concurs with Senate Amendment and requests committee of conference. Senate refused to accede to request for Committee of Conference.**

HB 278: AN ACT relative to the New Hampshire insurance department's annual hearing requirement. This bill updates the insurance commissioner's annual public hearing requirement relative to premium rates. This bill is a request of the insurance department. Introduced and referred to House Commerce Committee. Voted Ought to Pass with Amendment by Committee and House. The Amendment changes the report to look at variations in premium rates, rather than only increases. Introduced in the Senate and referred to Commerce Committee. Voted Ought to Pass by Committee. **Voted Ought to Pass by the full Senate and Signed by the Governor. The bill was effective July 9, 2019.**

HB 284: AN ACT relative to biennial controlled substance inventories conducted under the Controlled Drug Act. This bill requires persons required by federal law to conduct biennial controlled substance inventories to conduct them every odd-numbered year. Current law provides specific dates for such inventories. Introduced and referred to House HHS Committee. Voted Ought to Pass with Amendment by Committee. Amendment permits the pharmacy board to enact rules to ensure compliance. Voted Ought to Pass with Amendment by House. Introduced in the Senate and referred to Health and Human Services Committee. Voted Ought to Pass by Committee and Senate. **Signed by the Governor with an effective date of July 9, 2019.**

HB 335: AN ACT relative to therapeutic cannabis dispensary locations. This bill clarifies where a second dispensary may be geographically located for the purposes of the use of cannabis for therapeutic purposes law. Introduced and referred to House HHS Committee. Voted Ought to Pass by Committee and

House. Introduced in the Senate and referred to Executive Departments and Administration. Voted Ought to Pass by Committee (5-0) and by the full Senate**. Signed by the Governor with an effective date of September 8, 2019.**

HB 350: AN ACT relative to licensed prescribers of medical marijuana. This bill adds physician assistants as prescribing providers for purposes of the use of cannabis for therapeutic purposes law. Introduced and referred to House HHS Committee. Voted Ought to Pass with Amendment by Committee and House. The Amendment requires the physician assistant to have express consent of the supervising physician to prescribe cannabis for therapeutic purposes. Introduced in the Senate and referred to Health and Human Services. Voted Ought to Pass with Amendment by Committee and full Senate. The amendment changes the title of the bill. The House concurred with the Senate Amendment. **Signed by the Governor to be effective August 20, 2019.**

HB 359: AN ACT relative to warning labels on prescription drugs containing opiates. This bill requires any drug which contains an opiate dispensed by a health care provider or pharmacy to have a red cap and a warning label regarding the risks of the drug. Introduced and referred to House Commerce Committee. Voted Ought to Pass with Amendment by the Committee and House. The Amendment changes the bill to require a red sticker with the word “opioid” on the cap or dispenser rather than requiring a red cap. Introduced in the Senate and referred to Health and Human Services. Voted Ought to Pass with Amendment by the Senate. The amendment changes the color of the required sticker to orange and text of the warning label to state “Risk of addiction and overdose.” The bill also requires the health care provider or pharmacist to provide a handout which shall include guidance on the risks of opioid use and how to mitigate them. **Signed by the Governor to be effective January 1, 2020.**

HB 366: AN ACT adding opioid addiction, misuse, and abuse to qualifying medical conditions under therapeutic use of cannabis. This bill adds opioid addiction, misuse, and abuse to the qualifying medical conditions under therapeutic use of cannabis. Introduced and referred to House HHS Committee. Retained in Committee.

HB 369-FN: AN ACT relative to the controlled drug prescription health and safety program. This bill clarifies the rule regarding querying the controlled drug prescription health and safety program when writing an initial opioid prescription for a patient's pain or substance use disorder. Introduced and referred to House HHS Committee. Voted Ought to Pass by Committee and House. Introduced in the Senate and referred to Health and Human Services Committee. Voted Ought to Pass with Amendment by Committee (5-0), however full Senate voted Ought to Pass as introduced. **Bill was signed by the Governor with an effective date of July 14, 2019.**

HB 461-FN: AN ACT adding qualifying medical conditions to the therapeutic use of cannabis law. This bill adds certain medical conditions to the definition of "qualifying medical condition" for the purposes of the use of cannabis for therapeutic purposes law**.** Introduced and referred to House HHS Committee. Retained in Committee.

HB 463-FN: AN ACT relative to voluntary licensure of pharmacist assistants. This bill establishes voluntary licensure of pharmacist assistants to allow persons working as pharmacist assistants for supervising pharmacists to be licensed to perform certain pharmacist tasks. Introduced and referred to House Executive Departments and Administration Committee. Voted Ought to Pass with Amendment by Committee and House. The Amended bill establishes the duties of and requirements for the licensure of

pharmacist assistants working in a pharmacy under a supervising pharmacist. Introduced in the Senate and referred to Executive Departments and Administration. Voted Ought to Pass with Amendment by Committee. The Amendment changes all references to pharmacist assistant to "licensed advanced pharmacy technician." **House concurred with Senate Amendment. Signed by the Governor with an effective date of July 1,2019.**

HB 483-FN: AN ACT adopting the psychology interjurisdictional compact (PSYPACT). This bill enacts the adoption of the psychology interjurisdictional compact (PSYPACT). Introduced and referred to House HHS Committee. Retained in Committee.

HB 490: AN ACT relative to testing for Lyme disease. This bill requires health care providers to provide certain information to persons being tested for Lyme disease. Introduced and referred to House HHS Committee. Voted Ought to Pass by Committee and House. The amended bill establishes a commission to study the use of limitations of serological diagnostic tests to determine the presence or absence of Lyme and other tick-borne diseases and the development of appropriate methods to education physicians and the public with respect to the inconclusive nature of prevailing test methods. Introduced in the Senate and referred to Health and Human Services Committee. Bill was re-referred to Committee.

HB 508: AN ACT relative to direct primary care. This bill declares that primary care providers providing direct primary care pursuant to a primary care agreement are not subject to the insurance laws, provided that certain conditions are met. Introduced and referred to House HHS Committee. Voted Ought to Pass with Amendment by Committee. Amendment makes minor changes to conditions. Voted Ought to Pass with Committee Amendment by House. Re-referred to Commerce Committee. Voted Ought to Pass with Amendment by Commerce Committee and full House. The Amendment completely changes the language of the bill and now establishes a study committee to study direct primary care. Introduced in the Senate and referred to HHS Committee. Voted Ought to Pass with Amendment by Committee (5-0) and Senate. The amendment returns the bill to its original subject matter with some deleted language and eliminates the establishment of a study committee. **House non-concurs with the Senate on amendment and requests committee of conference. Committee of Conference Report was adopted by House and Senate. Signed by the Governor with Chapter 330, Sections 1- 4 effective October 15, 2019 and the remainder effective August 16, 2019.**

HB 528-FN: AN ACT relative to insurance reimbursement for emergency medical services. This bill requires insurers to consider the presenting symptoms rather than the final diagnosis when determining whether to cover and pay for emergency services. Introduced and referred to House Commerce Committee. Voted Ought to Pass with Amendment by Committee and House. The Amendment is a significant change to the bill as introduced and requires that the insurer's retrospective review of a claim for emergency services include consideration of the presenting symptoms along with the final diagnosis. It eliminates the proposed prudent layperson standard for defining emergency medical conditions. Introduced in the Senate and referred to Commerce Committee. Voted Ought to Pass by Committee (5-0) and Senate. **Signed by the Governor with an effective date of July 9, 2019.**

HB 546-FN: AN ACT relative to the regulation of art therapists. This bill establishes the regulation and licensure of persons engaged in the practice of professional art therapy by the office of professional licensure and certification and includes licensed professional art therapists in certain insurance coverage provisions. Introduced and referred to House Executive Departments and Administration Committee. Bill retained in committee.

HB 552-FN: AN ACT relative to transparency and standards for acquisition transactions in health care. This bill clarifies the standards for acquisition transactions involving health care charitable trusts and the review required by the director of charitable trusts. Introduced and referred to House Judiciary Committee. Voted Ought to Pass with Amendment by Committee and House. The amendment allows the Charitable Trusts Unit to obtain certain confidential information from other state agencies when reviewing the acquisition transactions of health care charitable trusts and amended the applicability to make it clear it would apply only to health care transactions filed on or after the effective date. Introduced in the Senate and referred to Judiciary Committee. Voted Ought to Pass with Amendment by Committee and Senate. Amendment requires a health care charitable trust to demonstrate an acquisition transaction is in the best interest of communities it serves rather than the entire state and postpones the effective date until January 1, 2020. **House concurred with Senate Amendment. Signed by the Governor to be effective January 1, 2020.**

HB 615: AN ACT relative to the regulation of pharmacies and pharmacists. This bill makes various changes to the regulation of pharmacies and pharmacists by the board of pharmacy, including procedures of the board, exceptions to possessing prescription drugs, license expirations and renewals, and establishing the licensure of drug distribution agents. Introduced and referred to House Executive Departments and Administration Committee. Voted Ought to Pass with Amendment by Committee (20-0) and full House. The amendment makes technical changes to the bill. Introduced in the Senate and referred to Executive Departments and Administration Committee. Voted Ought to Pass by Committee (5-0) and Senate. **Signed by the Governor to be effective September 17, 2019.**

HB 656: AN ACT establishing a commission to study the impact of financial initiatives for commercially insured members by drug manufacturers on prescription drug prices and health insurance premiums. This bill establishes a commission to study the impact of financial initiatives for commercially insured members by drug manufacturers on prescription drug prices and health insurance premiums. Introduced and referred to House Commerce Committee. Voted Ought to Pass by House. Introduced in the Senate and referred to Commerce Committee. Voted to be Re-referred by Committee. Motion to re-refer failed on Senate floor. Voted Ought to Pass with Amendment by Senate. Amendment changes the establishment of a commission to the establishment of a study committee. **House concurred with Senate Amendment. Signed by the Governor with an effective date of July 19, 2019.**

HB 670-FN: AN ACT relative to the cost of prescription drugs. This bill requires health insurance carriers to maintain certain information relative to prescription drug costs within their data systems for purposes of the managed care law. Introduced and referred to House Commerce Committee. Voted Ought to Pass with Amendment by House. The amendment provides that carriers either maintain or have access to the prescription information. Introduced in the Senate and referred to Commerce Committee. Voted Ought to Pass by Committee (5-0) and Senate. **Signed by the Governor with an effective date of August 24, 2019.**

HB 671-FN: AN ACT relative to pharmacy benefit manager business practices, licensure, and transparency. This bill establishes an RSA chapter governing pharmacy benefit managers. Introduced and referred to House Commerce Committee. Retained in Committee.

HB 685-FN: AN ACT relative to ambulance billing, payment for reasonable value of services, and prohibition on balance billing. This bill clarifies ambulance billing under the law governing emergency and

medical trauma services. Introduced and referred to House Commerce Committee. Retained in Committee.

HB 690-FN: AN ACT removing the work requirement of the New Hampshire granite advantage health care program. This bill removes the work and community engagement requirements of the New Hampshire granite advantage health care program. Introduced and referred to House HHS Committee. Retained in Committee.

HB 703-FN: AN ACT relative to providing notice of the introduction of new high-cost prescription drugs. This bill requires prescription drug manufacturers to provide certain notice to the office of the attorney general if they are introducing a new prescription drug to market at a wholesale acquisition cost that exceeds the threshold set for a specialty drug under the Medicare Part D program. Introduced and referred to House Commerce Committee. Voted Ought to Pass with Amendment by Committee (13-7) and House. The Amendment requires reporting to the Insurance Department rather than the Office of the Attorney General. Introduced in the Senate and referred to Commerce Committee. Committee (5-0) and Senate voted to rerefer the bill to committee.

HB 717-FN: AN ACT prohibiting prescription drug manufacturers from offering coupons or discounts to cover insurance copayments or deductibles. This bill prohibits with limited exceptions, prescription drug manufacturers from offering coupons or discounts to cover insurance copayments, or deductibles. Introduced and referred to House Commerce Committee. Voted Ought to Pass with Amendment by Committee (12-8) and House. The Amendment changes the prohibition from prohibiting manufacturers from offering discounts, repayments, product vouchers, etc. to prohibit pharmacies from accepting them as payment from a patient on behalf of a person who manufactures a prescription drug. It also adds a parallel section prohibiting contracts between a health carrier and a pharmacy to permit the pharmacy to accepting the discounts, repayments, vouchers, etc. as payment. Introduced in the Senate and referred to Commerce Committee. **Voted by Committee (5-0) and Senate to rerefer bill to Committee.**

HB 725-FN: AN ACT including Medicaid managed care organizations under the managed contractor requirements for provider care law. This bill includes Medicaid managed care organizations for the purposes of the managed care law pursuant to RSA 420-J. Introduced and referred to House Commerce Committee. Voted Ought to Pass with Amendment by Committee (19-1) and by the House. As amended, the bill does not include Medicaid managed care organizations under the Managed Care Law but does establish certain credentialing standards and quality assurance standards for Medicaid managed care organizations. Introduced in the Senate and referred to Commerce Committee. Voted Ought to Pass by Committee (5-0) and Senate. **Signed by the Governor effective September 8,2019.**

Senate Bills

SB 4: AN ACT relative to the group and individual health insurance market. This bill establishes the provisions of the Patient Protection and Affordable Care Act of 2009, Public Law 111-148, as amended in statute. Introduced and referred to Senate HHS Committee. Voted Ought to Pass with Amendment by Committee and Senate. The Amendment prohibits health carriers from establishing lifetime or annual limits on the dollar value of essential health benefits, but not for health benefits that are not essential and adds a non-discrimination provision. Introduced in the House and referred to Commerce Committee. Voted Ought to Pass (11-8) by Committee and House. **Signed by the Governor and effective September 10, 2019.**

SB 11-FN-A: AN ACT relative to mental health services and making appropriations therefor. This bill: I. Authorizes the department of health and human services to use general surplus funds for designated receiving facilities and for voluntary inpatient psychiatric admissions. II. Makes an appropriation to the department of health and human services for the purpose of renovating certain existing facilities. III. Provides for rulemaking for involuntary admission hearing requirements. IV. Makes an appropriation to the affordable housing fund, established in RSA 204-C:5, for transitional housing for persons leaving mental health treatment facilities. V. Requires insurers to reimburse certain facilities for emergency room boarding. Introduced and referred to Senate HHS Committee. Voted Ought to Pass with Amendment by Committee and Senate. Rereferred to the Senate Finance Committee. Voted Ought to Pass with Amendment by Committee and Senate. As amended, the bill removes the provision related to appropriations to the Affordable Housing Fund but increases amounts available to HHS to contract with programs to provide affordable, supported housing. It also directs HHS to solicit RFPs for a fourth mobile crisis team of second behavioral health crisis treatment center. Voted Ought to Pass with Amendment by Finance Committee and Senate. The Amendment changes the appropriation amounts, modifies the required period insurers must pay for boarding mental health patients in hospital emergency rooms and add a new appropriation for a new mobile crisis team of behavioral health crisis treatment center. Introduced in the House and referred to HHS Committee. **Voted Ought to Pass by Committee (19-0) and House. Signed by the Governor. The section requiring insurers to reimburse for emergency room boarding of patient subject to involuntary admission is effective July 1, 2019. All other provisions were effective upon passage, May 21, 2019.**

SB 26: AN ACT relative to the New Hampshire health care quality assurance commission. This bill changes the name of the New Hampshire health care quality assurance commission to the New Hampshire health care quality and safety commission. This bill also removes the prospective repeal of the commission. Introduced and referred to Senate Executive Departments and Administration Committee. Voted Ought to Pass with Amendment by Committee and Senate. Amendment changes composition of Commission to include one representative of each licensed hospital rather than each acute care and specialty care hospital and adds the CEO of NH Hospital or his designee to the Commission. Introduced in the House and referred to HHS Committee. Voted Ought to Pass with Amendment (22-0) and by House. The amendment adds language to allow the state epidemiologist to designate someone to serve in his place on the commission. **Senate concurred with House amendment. Signed by the Governor and effective July 12, 2019.**

SB 33: AN ACT relative to the therapeutic use of cannabis. This bill authorizes the department of health and human services to collect certain data regarding the therapeutic use of cannabis. This bill also requires the commissioner of the department of health and human services to adopt rules regarding disclosure of information resulting from inspections and investigations under RSA 126-X. Introduced and referred to Senate HHS Committee. Voted Ought to Pass with Amendment by Committee (5-0) and Senate. The Amendment changes the bill to permit HHS to release collected data with the approval of the Commissioner consistent with HIPAA standards. Introduced in the House and referred to HHS Committee. Voted Ought to Pass by Committee (21-1) and House. **Signed by the Governor with an effective date of August 17, 2019.**

SB 58: AN ACT relative to reimbursement rates for low-dose mammography coverage. This bill clarifies the reimbursement rates for low-dose mammography. Introduced and referred to Senate HHS Committee. Voted Ought to Pass by Committee (5-0) and Senate. Introduced in the House and referred to Commerce.

Voted Ought to Pass with Amendment by Committee (14-6) and House. The amendment requires that the payment include distinct recognition and additional payment for industry standard coding for mammography using 3-D tomosynthesis. **Senate concurred with House amendment. Signed by the Governor with an effective date of September 10, 2019.**

SB 88-FN: AN ACT relative to registry identification cards under the use of cannabis for therapeutic purposes law. This bill makes certain changes in the use of cannabis for therapeutic purposes law, including: I. Eliminating the time frame for a provider-patient relationship. II. Repealing the requirement for a photograph of an applicant's face for purposes of the registry identification card. Introduced and referred to Senate HHS Committee. Voted Ought to Pass with Amendment by House. The Amendment eliminates the originally proposed repeal of the requirement for a photograph of the applicant's face for the registry identification card. Introduced in the House and referred to HHS Committee. Voted Ought to Pass with Amendment by Committee and House. The amendment specifies information to be included on the written certification. **Senate concurred with House amendment. Bill vetoed by Governor.**
SB 90-FN: AN ACT relative to certain disclosures by health care provider facilities. This bill extends immunity to staff licensed by the division of health professions, office of professional licensure and certification, to disclose certain employment information. Introduced and referred to Senate Judiciary Committee. Rereferred to Committee.

SB 97: AN ACT relative to licensure of health facilities near a critical access hospital. This bill requires an applicant seeking to construct certain health care facilities for licensure under RSA 151 to submit a report showing how the proposed project will affect certain health care services. This bill is a request of the department of health and human services. Introduced and referred to Senate Executive Departments and Administration Committee. Voted Ought to Pass with Amendment by the Senate. The Amendment completely changes the bill. As amended the bill clarifies rulemaking regarding special health care services licensing and establishes a study committee to study providing certain health care services while ensuring increased access to affordable health care services in rural areas of the state. Introduced in the House and referred to HHS Committee. Voted Ought to Pass by Committee (21-0) and House. **Signed by the Governor and effective on July 1, 2019.**

SB 111: AN ACT relative to the collection of health care data. This bill clarifies the collection of health care data. This bill is a request of the department of health and human services. Introduced and referred to Senate Executive Departments and Administration Committee. Voted Ought to Pass with Amendment. The Amendment adds a provision allowing data to be released to the Insurance Department, the Department of Justice land other state and federal agencies. Introduced in the House and referred to HHS Committee. Voted Ought to Pass by Committee (13-7) and House. **Signed by the Governor and effective on July 12, 2019.**

SB 119: AN ACT directing hospitals to develop an operational plan for the care of patients with dementia. This bill requires hospitals licensed under RSA 151 to complete and implement an operational plan for the recognition and management of patients with dementia or delirium in acute-care settings. Under this bill, each hospital shall keep the plan on file and make it available to the bureau of health facilities administration, department of health and human services, upon request. Introduced and referred to Senate HHS Committee. Voted Ought to Pass with Amendment by Committee and Senate. Amendment provides hospitals with two additional years, until January 1, 2023 to comply. Introduced in the House and referred to HHS Committee. Voted Ought to Pass by Committee (19-2) and House. **Signed by the Governor to be effective January 1, 2020.**

SB 145: AN ACT relative to the organization of alternative treatment centers. This bill permits alternative treatment centers to organize as business corporations and limited liability companies and provides the procedure for alternative treatment centers organized as voluntary corporations to convert to business corporations or limited liability companies. Introduced and referred to Senate Commerce Committee. Voted Ought to Pass with Amendment. The Amendment clarifies the intent of the bill by affirmatively stating that alternative treatment centers may be operated on a for-profit or not-for-profit basis. Introduced in the House and referred to Commerce Committee. Voted Ought to Pass by Committee (16-3) and House. **Vetoed by Governor.**

SB 175: AN ACT relative to qualifying medical conditions for therapeutic cannabis. This bill changes the definition of qualifying medical condition for the purposes of the law governing the use of cannabis for therapeutic purposes. Introduced and referred to Senate HHS Committee**. The bill was rereferred to Committee.**

SB 177: AN ACT relative to the use of physical restraints on persons who are involuntarily committed. This bill clarifies when physical restraints may be used to transport a person being admitted to New Hampshire hospital or a designated receiving facility. Introduced and referred to Senate HHS Committee. Voted Ought to Pass with Amendment by Committee (5-0) and Senate. The amendment repeals the entire current statute governing the delivery of individuals to designated receiving facility after completion of an inpatient admission. Introduced in the House and referred to HHS Committee. Voted Ought to Pass with Amendment by Committee (21-0) and House. The amendments make minor modifications to the requirements for determining the means of transport and the use of physical restraints. **Senate concurred with House amendment. Signed by Governor to be effective January 1, 2020.**

SB 178: AN ACT relative to telemedicine for spectacle and contact lenses. This bill clarifies the procedure for health care providers who prescribe spectacle lenses and contact lenses by telemedicine. Introduced and referred to Senate HHS Committee. Voted Ought to Pass by Committee and Senate. Introduced in the House and referred to HHS Committee. Voted Ought to Pass by Committee (21-0) and House. **Signed by the Governor with effective date of September 8, 2019.**

SB 179: AN ACT relative to pharmacist administration of vaccines. This bill modifies the authority for pharmacists and pharmacy interns to administer vaccinations by including vaccines listed in the recommended adult immunization schedule by the Centers for Disease Control and Prevention. Introduced and referred to Senate HHS Committee. The bill was rereferred to Committee.

SB 182: AN ACT relative to a duty to report when another person has suffered grave physical harm. This bill establishes a duty to report when another person has suffered grave physical harm. Introduced and referred to Senate Judiciary Committee. The bill was rereferred to Committee.

SB 210: AN ACT relative to emergency medical and trauma services. This bill makes certain reference changes and adds a definition of "telecommunicators" to the law governing emergency medical and trauma services. Introduced and referred to Senate Executive Departments and Administration Committee**.** Voted Ought to Pass with Amendment by the Committee and Senate. The Amendment changes the bill so that it is effective upon passage rather than 60 days after passage. Introduced in the House and referred to Executive Departments and Administration Committee. Voted Ought to Pass with

Amendment by Committee (19-0) and House. The amendment adds a definition of "local dispatcher." **Senate concurred with House amendment. Signed by the Governor and effective July 12, 2019.**

SB 222-FN: AN ACT relative to licensure of pharmacy benefits managers. This bill establishes the licensure and regulation of pharmacy benefits managers by the insurance commissioner. Introduced and referred to Senate Executive Departments and Administration Committee. Rereferred to Committee

SB 226-FN: AN ACT relative to registration of pharmacy benefit managers and reestablishing the commission to study greater transparency in pharmaceutical costs and drug rebate programs. This bill establishes the registration and regulation of pharmacy benefits managers by the insurance commissioner. This bill also reestablishes the commission to study greater transparency in pharmaceutical costs and drug rebate programs. Introduced and referred to Senate Executive Departments and Administration Committee. Voted Ought to Pass with Amendment by Committee. The Amendment changes the section of the RSA where the bill will be codified, adds contracting standards for PBMs, changes the effective date for certain sections of the bill from November 2019 to November 2020, and makes other technical changes. Voted Ought to Pass with Amendment by Senate. Introduced in the House and referred to Commerce Committee. Voted Ought to Pass with Amendment by Committee (12-8) and House. Amendment expands the definition of pharmacy benefits manager and makes numerous other changes. **Senate voted to nonconcur with House amendment and requested Committee of Conference. Committee of Conference report adopted by House and Senate. Signed by the Governor with effective dates for different sections ranging from August 12, 2019 through November 1, 2020.**

SB 232: AN ACT adopting the model psychology interjurisdictional compact. This bill enacts the adoption of the psychology interjurisdictional compact (PSYPACT). Introduced and referred to Senate Executive Departments and Administration Committee. Voted Ought to Pass by Committee and Senate. Introduced in the House and referred to HHS Committee. Voted Ought to Pass by HHS Committee (13-8) and referred to Executive Departments and Administration Committee. Voted Ought to Pass by Executive Departments and Administration Committee (12-6) and by House. **Signed by the Governor and effective September 8, 2019.**

SB 255-FN: AN ACT relative to dementia training for direct care staff in residential facilities and community-based settings. This bill requires dementia training for direct care staff in residential facilities and community-based settings. The bill grants rulemaking authority to the commissioner for the purposes of the bill. Introduced and referred to Senate Executive Departments and Administration Committee. Voted Ought to Pass with Amendment by Committee (5-0) and the Senate. The Amendment eliminates the requirement for the Department to identify and designate approved trainings and makes other technical changes. Introduced in the House and referred to HHS Committee. Bill retained in Committee.

SB 258: AN ACT relative to telemedicine and telehealth services. This bill adds definitions to and clarifies the statute governing telemedicine and Medicaid coverage for telehealth services. Introduced and referred to Senate HHS Committee. Voted Ought to Pass with Amendment by Committee and Senate. The Amendment does not significantly change the substantive purpose of the bill. Introduced in the House and referred to HHS Committee. Voted Ought to Pass with amendment by Committee (21-0) and by House. Amendment changes the effective date so that designated sections are effective January 1, 2020. **Senate concurred with House amendment. Signed by the Governor with Sections 3 & 4 effective January 1, 2020 with the remainder effective October 11, 2019.**

SB 259-FN: AN ACT expanding eligibility for the Medicaid for employed adults with disabilities (MEAD) program. This bill directs the department of health and human services to submit an amendment to the state Medicaid plan to expand coverage under the MEAD program, which provides Medicaid for employed adults, to individuals 65 years of age and older. Introduced and referred to Senate HHS Committee. Voted Ought to Pass with Amendment by HHS Committee and Senate. Referred to Finance Committee and voted Ought to Pass. Bill laid on table by Senator Feltes.

SB 260-FN: AN ACT relative to a program for prescription drug costs for certain seniors and making an appropriation therefor. This bill directs the department of health and human services to develop a prescription drug assistance program to pay out-of-pocket prescription drug costs for seniors who have reached the gap in standard Medicare Part D coverage. The bill also makes an appropriation to the department of health and human services to fund the program. Introduced and referred to Senate HHS Committee. Voted Ought to Pass with Amendment by Committee. As amended the bill no longer directs HHS to develop a prescription drug assistance program but establishes a pharmaceutical assistance pilot program for seniors and makes an appropriation to HHS to fund the pilot program. Voted Ought to Pass with further amendment by the Senate. The amendment limits the number of participants in the pilot to the first 1000 applicants and limits the timeframe for assistance under the program to January 1, 2020-January 1, 2021. Referred to Finance Committee which voted Ought to Pass with Amendment by Finance Committee and Senate. The Amendment appropriates the amount of $1,250,000 for the program. Bill Laid on Table by Senator D'Allesandro.

SB 272-FN: AN ACT relative to mental health parity under the insurance laws. This bill authorizes the insurance commissioner to enforce the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and requires the commissioner to examine and evaluate health insurers, health service corporations, and health maintenance organizations for compliance. Introduced and referred to Senate Commerce Committee. Voted Ought to Pass with Amendment by Committee and Senate. The amendment requires the Insurance Commissioner to periodically examine and evaluate provider reimbursement practices rather than provider reimbursement rates. Introduced in the House and referred to Commerce Committee. Voted Ought to Pass with Amendment by Committee (14-5). Amendment failed on House floor. Voted Ought to Pass by House (same version passed by Senate.) **Signed by the Governor to be effective January 1, 2020.**

SB 273-FN: AN ACT relative to the regulation of nursing assistants by the board of nursing. This bill changes the regulation of licensed nursing assistants to certified nursing assistants and makes administrative changes for the board of nursing. Introduced and referred to Senate Executive Departments and Administration Committee. Voted Ought to Pass with Amendment by Committee and Senate. The amendment completely deletes the original language and instead establishes a study committee to study the regulation of nursing assistants. Introduced in the House and referred to Executive Departments and Administration Committee. Voted Ought to Pass with Amendment by Committee (19-0) and House. The amendment adds changes to the regulation of nurses concerning fees for specialty certificates. **Senate concurred with House amendment. Signed by the Governor and effective on July 19, 2020.**

SB 279-FN: AN ACT relative to access to fertility care. This bill requires insurers to cover fertility treatment. Introduced and referred to Senate Commerce Committee. Voted Ought to Pass with Amendment by Committee and Senate. The Amendment makes numerous changes to the specific

requirements for the provision of fertility treatment and excludes certain plans/policies (SHOP and extended transition to ACA Compliant policies) plans from the requirements. Introduced in the House and referred to Commerce Committee. Voted Ought to Pass with Amendment by Committee (12-8) and House. Amendment provides additional detail on coverage requirements**. Senate nonconcurred with House amendment. Committee of Conference meets. Committee of Conference report adopted by House and Senate. Signed by the Governor to be effective January 1, 2020.**

SB 289: AN ACT relative to health and human services. This bill: I. Requires collection stations, not just those operated by laboratories, to be licensed under RSA 151 and revises the responsibilities of an individual home care service provider to include health support services. II. Authorizes reimbursement for a legally responsible relative who provides personal care services under RSA 161-I. III. Requires services provided to individuals with disabilities by area agencies and authorized agencies to comply with RSA 171-A and the federal requirements for the home and community-based care waiver. IV. Requires that home-based long-term care services provided under RSA 151-E comply with the federal requirements for the home and community-based care waiver. V. Provides that the committee for the protection of human subjects shall defer to the institutional review board designated by the federal agency responsible for funding in certain cases. VI. Clarifies the authority of pharmacies to dispense prescription drugs and removes the requirement that the protocol and criteria for dispensing drugs be approved by the department of health and human services. VII. Revises the medical support obligation for purposes of determining parental rights and responsibilities and child support to mean the obligation to provide health care coverage for a dependent child whether in the form of private health insurance or public health care. The bill is a request of the department of health and human services. Introduced and referred to Senate HHS Committee. Voted Ought to Pass with Amendment. The amendment adds physician assistants to the list of providers who may dispense certain noncontrolled prescription drugs and vaccines in certain settings and makes other technical changes**.** Voted Ought to Pass with Amendment by HHS Committee, Finance Committee and House. Amendments provide clarification regarding dispensing of controlled substances and to the definition of "Area agency." **Senate concurred with House amendment. Signed by Governor with sections 1 & 2 effective September 17, 2019, Sections 3-9 on July 1, 2019 and the remainder effective on July 19, 2019.**

SB 290-FN: AN ACT relative to the New Hampshire granite advantage health care program. This bill makes various changes to the New Hampshire granite advantage health care program, some of which include: I. Allowing general funds to be used for the program. II. Clarifies which beneficiaries may be subject to the work and community engagement requirement. III. Reducing the number of hours for the work and community engagement requirement. IV. Adding exemptions for certain persons from the community engagement requirement. V. Adding circumstances for the elimination of the community engagement requirement. Introduced and referred to Senate HHS Committee. Voted Ought to Pass with Amendment by Committee and Senate. The Amendment reverses the effort to lower the number of hours needed to meet the work and community engagement program, eliminates the proposed exemption for individuals over age 50, modifies the childcare exemption to apply to those caring for a child under the age of 13 old, allows for the use of general funds for the program under certain specific circumstances, and imposes certain standards for the review and evaluation of the program. Introduced in the House and referred to HHS Committee. Voted Ought to Pass by Committee and House. Amendment provides individuals with an opportunity to cure the failure to comply with the work or community engagement requirements. **Senate nonconcurred with House amendment and requested Committee of Conference. Committee of Conference report adopted by House and Senate. Signed by Governor and effective on July 8, 2019.**

SB 292-FN: AN ACT relative to implementation of the new mental health 10-year plan. This bill requires the commissioner to submit a report containing the procedures for implementation of New Hampshire's 10-year mental health plan of 2018 within 6 months of finalization of the plan to the president of the senate, the speaker of the house of representatives, and the governor. Under this bill, the commissioner of the department of health and human services shall fully implement the plan within 2 years of the date when it was finalized. Introduced and referred to Senate HHS Committee. Voted Ought to Pass with Amendment by the Committee and Senate. The amended bill requires the commissioner to submit a report containing the priorities for implementing the 10-year mental health plan and thereafter submit an annual report on the status of implementation. Introduced in the House and referred to HHS Committee. Voted Ought to Pass with Amendment by Committee and House. Amendment requires the commissioner to report on the 10-year mental health plan to be made by September 1, 2020. **Senate concurred with House amendment. Signed by Governor and effective on July 12, 2019.**

SB 293-FN: AN ACT relative to federally qualified health care centers and rural health centers reimbursement. This bill requires the department of health and human services to reimburse federally qualified health care centers and rural health centers for services provided to persons whose Medicaid eligibility has been suspended for failure to comply with the work and community engagement requirement established under the New Hampshire granite advantage health care program. Introduced and referred to Senate HHS Committee. Voted Ought to Pass by Committee and Senate. Introduced in the House and referred to HHS Committee. Voted Ought to Pass by Committee (16-4). Referred to Finance. Bill was retained in Committee.

SB 308-FN-A: AN ACT relative to the health care workforce and making appropriations therefor. This bill: I. Increases the Medicaid provider rates. II. Requires certain health care professionals to complete a survey collecting data on the primary care workforce. III. Requires the department of health and human services to amend the income standard used for eligibility for the "in and out" medical assistance policy. IV. Permits the department of safety to contract with a private agency to process background check applications and requires the department to accept and process background check applications online. V. Amends the definitions and services covered through telemedicine. VI. Makes appropriations to the department of health and human services, rural health and primary care section to establish new positions and programs to develop and enhance the state's healthcare workforce. VII. Makes an appropriation to the governor's scholarship program for scholarships to students majoring in a health care field and to postsecondary educational institutions to develop and enhance programs of study offered in health care. Introduced and referred to Senate Executive Departments and Administration Committee. Voted Ought to Pass with Amendment by Committee and Senate. The amendment delays the 5% increase in Medicaid provider rates for an additional year to June 30, 2020 and the additional 7% increase to June 30, 2021. It also eliminates some of the proposed changes to the telemedicine requirements. The amount of the appropriate for the Governor's Scholarship Program was reduced from $5M to $1.25M. Bill was Laid on Table by Senator D'Allesandro.

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Cinde Warmington, Kara J. Dowal and Alexander W. Campbell contributed to this month's Legal Update.

BIOS

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Cinde, a partner at Shaheen & Gordon, leads the Health Care Practice Group and focuses her practice entirely on representing health care clients. Her prior clinical and administrative experience makes her uniquely qualified to assist providers in facing a rapidly changing regulatory environment.

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