Chiropractic Fellowship of PA
Summary of Legislation
February 2018

House Insurance Committee Holds Hearing on "Network Adequacy"

The committee held an informational meeting on network adequacy on February 19.
Bill Wiegmann, Director of the Bureau of Managed Care, Department of Health (DOH), provided testimony on how DOH reviews and approves provider networks. He said DOH is given responsibility under the preferred provider organizations (PPO) regulations issued by the Insurance Department in section 630 of the Insurance Company Law for reviewing provider networks. Wiegmann explained that his bureau identifies the medical specialties necessary for a basic provider network, establishes time and distance standards to reach a provider as well as the steps a health plan must take when it cannot meet provider access standards. He noted that DOH does not require health plans to "create a capacity where none exists" and that consideration is given to counties who lack certain medical specialties or acute care hospitals. Regarding **subnetworks**, he said Act 68 does not prohibit their use, but that the limited subnetwork must meet access standards and notify members of the coverage so they do not incur out-of-pocket expenses. Wiegmann pointed out the department's position that a member who receives services from a non-participating facility provider only be required to cover the normal costs incurred had that network been a participant. On the approval process, he said upon receipt of a new application for a health plan, DOH reviews the network and if it is found to be "sufficiently developed to meet the access requirements of the regulations, it will be approved." If the county is not approved, they are able to resubmit the health plan as soon as they feel the network is "robust enough for approval," he said.

Wiegmann explained that there is ongoing oversight following approval including a report to DOH of any probable loss of any general acute care hospital or primary care provider within the network. He noted member and provider complaints as a key indicator of a network's weakness and said the plan must provide an explanation any time it is unable to meet the access standards for an individual and that it must be found acceptable by DOH in order to meet the regulatory requirement. He also pointed out that Medicare, Medical Assistance, the Children's Health Insurance Program (CHIP) and the Pennsylvania Health Care Exchange often have different network adequacy requirements that may require approval from those individual agencies.

Committee Chair Tina Pickett (R-Bradford) said the word "adequacy" is hard to define and asked Wiegmann to provide more explanation of what that definition is when a plan is deemed "adequate." She also wanted to know how a member outside of their network gets to a provider considered adequate for their plan. Wiegmann said the concept of "adequate" is that the network has to be sufficient meaning there must be enough providers to ensure that members have access to them. He added that when reviewing a benefits package DOH asks the network to explain how they will make sure there are providers for each service. Chairman Pickett clarified whether a network who lacks enough providers for a certain specialty expects the member to have the services paid for as if that provider were in the network. Wiegmann said either a provider of that specialty does not exist in the county or the provider exists and chooses not to contract with that network, which in that case the plan is still required to make arrangements for members to receive that service. Chairman Pickett asked how often DOH verifies the adequacy of networks. Wiegmann said once approved there is no regularly scheduled review of the network unless DOH receives complaints. He explained that complaints are often received from providers who are not in the network or from members themselves. He also reiterated the regulatory requirement that upon the loss of a hospital or provider the network must provide notification and an impact analysis.

Rep. Perry Warren (D-Bucks) asked whether DOH reviews the adequacy of networks specifically for the mental health treatment of children. Wiegmann said they do evaluate them on a plan by plan basis and looks for a range of service providers such as psychiatrists and psychologists. Rep. Warren questioned if DOH distinguishes between mental and physical health for children when determining whether adequacy exists. Wiegmann said they would be looked at "similarly" while focusing on a different type of provider, but that they ensure the same distance and time standards do exist.

Chair Pickett asked Wiegmann to discuss any problems he sees within the department that could be fixed. He said that as the market is changing there are some areas that are becoming problematic to consumers such as the

introduction of tiered networks. He said they are difficult to understand and shared a complaint from a member who was in the hospital for a broken ankle. He explained that this member had gone to a tier one hospital assuming it was the correct choice, but did not know that her surgery would be performed by a tier three doctor and wanted her expenses to be rebilled at the lower tier one cost. He noted the increase of similar complaints and said the network in that case was adequate, but the problem lies with members believing they are at one tier while ultimately being billed at a different tier. He mentioned narrow networks as well and said that most members do not realize how much it can cost them to go out of network for a medical expense. Additionally, he said the state's statutes and regulations do not currently apply to self-funded plans, but that legislation could be passed to set up a "registry" for self-funded companies who voluntarily comply with the new laws so that they could be put under public scrutiny.

Rep. Wendi Thomas (R-Bucks) said there have been instances of members receiving bills for utilizing service providers outside their network despite the department's position that the members should not pay those costs. She asked if the issue is that in order for these cases to be resolved the member must go through the three time appeal process resulting in many members just choosing to pay the bill. Wiegmann said the first thing the department looks at is whether the plan comes from self-funded coverage because nothing can be done in those instances. Otherwise, he said the regulations explain that a member who believes they were billed inappropriately is to use the appeals process. However, if these incidents keep occurring in the same plan DOH may institute a corrective action plan, he added.
Chairman Pickett asked whether the law requires network adequacy for emergency services particularly air ambulance services. Wiegmann said the regulations require that a member who believes they are having a medical emergency can go to any facility without prior approval. He added that there are no specific regulations for air transport. He opined that under a true emergency without any alternative then it should be covered, but would be looked at on a case by case basis. Chairman Pickett expressed concern over the response time of emergency service transports and asked Wiegmann if that falls under his guidance. He said he does not believe there are adequacy standards for response times, but would follow up.

House Health Committee Holds Info Hearing on Opiods with US DHHS

The committee held an informational hearing on the opioid crisis with the United States Department of Health and Human Services (HHS) on February 19. **Committee Chair Kathy Rapp (R-Warren)** explained that the purpose of the hearing was to get an overview of the opioid epidemic in the United States and noted that the guest speaker is the former chairman of the House Health and Human Services Committee, **Matt Baker, who now serves as region III director, United States Department of Health and Human Services (HHS).**

"We welcome you and we are very proud of you and appreciate your willingness to come here today to give us an overview of what is happening in our nation with regard to the opioid crisis," she stated. Baker delivered a PowerPoint presentation to the committee and provided an overview of the agency. He explained that HHS has an annual budget of $1.3 trillion and administers over 300 programs with 80,000 employees across the nation.
"The opioid crisis is a monumental challenge for all of us. It is one of the top four priorities of Sec. Azar," Baker stated.
"The opioid epidemic touches everyone. It touched me. I have friends and acquaintances that have passed away because of this and I'm sure you have as well. It's a very sad situation that we find ourselves in trying to combat and overcome the opioid epidemic," he stated. "In 2017, the five states with the highest rates of death were West Virginia, Ohio, Pennsylvania, Washington D.C., and Kentucky…Fentanyl right now is the biggest driver of overdose deaths. Fentanyl is a synthetic and it is 50 times more potent than heroin and 100 times more potent than morphine. Carfentanyl is 100 times more potent than fentanyl, so it gets even worse."

Baker shared the statistics on drug overdoses in the United States and highlighted the following:
• From 1999 to 2017, more than 700,000 people have died from a drug overdose;
• Around 68 percent of the more than 70,200 drug overdose deaths in 2017 involved an opioid;
• In 2017, the number of overdose deaths involving opioids (including prescription opioids and illegal opioids like heroin and illicitly manufactured fentanyl) was six times higher than in 1999;
• On average, 130 Americans die every day from an opioid overdose.
• Baker explained that 50 percent of opioid users received the drugs from a friend or family member and only 5.7 percent of pain relievers were obtained from a drug dealer. "Education about this is so important as well as the disposal of opioids. We have a lot of education ahead of us in making sure our family members know how

devastating an opioid addiction can be," he stated.
• Baker noted that on October 26, 2017, HHS declared a public health crisis at President Trump's request and highlighted the department's five point strategy to combat the opioid crisis:
• Better addiction prevention, treatment, and recovery services.
• Improving understanding of the crisis by supporting more timely and specific public health data and reporting, including through accelerating the Centers for Disease Control and Prevention's (CDC) reporting of drug overdose data.
• Better pain management by ensuring everything - payments, prescribing guidelines, and more - promotes healthy, evidence-based methods of pain management.
• Better targeting of overdose-reversing drugs by working to address the availability of lifesaving overdosereversing drugs. The president's 2019 budget includes $74 million in new investments to support this goal.
• Better research on pain and addiction by supporting cutting-edge research on pain and addiction, including through a new National Institutes of Health (NIH) public-private partnership.
"There are a lot of operational divisions and departments working on this and they are not all within HHS," Baker stated.
"There is a long road ahead to address this epidemic. There has been a 26 percent decrease in opioid prescribing by pharmacies…we have a 138 percent increase in naloxone prescriptions that have been filed…we see a 22 percent increase in buprenorphine and a 40 percent increase in naltrexone. We still have a long ways to go and there are a lot of challenges but we've definitely seen an uptick in medicated assisted treatment where needed and appropriate."

Baker explained that HHS is going to distribute billions of dollars in 2019 to combat the opioid epidemic and the department is continuing to issue guidance on the interpretation of regulations.
Chair Rapp asked what steps Pennsylvania should take to address the opioid epidemic. Baker noted that he doesn't lobby or advocate for any particular piece of legislation in his official capacity but said he introduced legislation in the past with the support of the Pennsylvania District Attorneys Association that addresses pain clinics. "It makes common sense to know what pain clinics are in existence in Pennsylvania and they are essentially unregulated in Pennsylvania. When top law enforcement people say there is a serious problem with this opioid crisis with some of these pain clinics, that might be something worthy of serious consideration," he stated. "I have spoken to the **Opioid Task Force** and it's a very impressive model. They have done a good job of collecting and sharing information across departments in Pennsylvania and it's a really good model for other states that have not instituted an opioid task force."
Chair Rapp inquired about the federal government's view of the **push to legalize recreational marijuana** in states across the country. Baker emphasized that marijuana is illegal and is still a Schedule I drug. He added that there will be new data collection in regard to neonatal abstinence syndrome (NAS) and said, "They are seeing combinations of opioids and drugs in mothers' blood systems, and just from an aspect of the NAS point of view, marijuana is one of the more common drugs that is coming up in the blood work." Baker recommended that the committee members examine information on marijuana by the National Institute on Drug Abuse and noted that there is an "uptick" in the number of vehicle accidents where drivers were impaired by marijuana.

Medical Assistance Advisory Committee February 21 Meeting Notes

The Medical Assistance Advisory Committee (MAAC) held its regular monthly meeting on February 21.
Chairman Russ McDaid, Pennsylvania Health Care Association, indicated that the minutes from this meeting, and the previous two meetings, would be approved during the committee's March meeting. March's meeting would also feature budget updates from the department's deputy secretaries, McDaid added.

OFFICE OF MEDICAL ASSISTANCE PROGRAMS (OMAP) UPDATE:
Jamie Buchenauer, director of the Bureau of Fee-for-Service Programs, said OMAP did not have a general update, aside from notice of the budget presentation at March's meeting.

Martin Ciccocioppo, director of the Pennsylvania eHealth Partnership Program, provided an update regarding the **Pennsylvania Patient & Provider Network (P3N),** the health information exchange in the commonwealth. He indicated that prior to **Act** 76 **of 2016**, the program operated as an independent agency to foster the development and maintenance of a health information exchange. All of the responsibilities of the independent agency transferred to the department, and this past year, the program was moved to the Office of Medical Assistance Programs,

Ciccocioppo said. Ciccocioppo stated that during the last five years, membership organizations have met monthly, and an advisory board of members was established recently. Since the program was incorporated by DHS, Ciccocioppo said the program leveraged managed care contracts, collected value-based data programs and federal high-tech funding, and increased provider and payer participation of the information exchange. He added that the program is onboarding a new health information organization by next month and also working with the Department of Corrections (DOC).
Ciccocioppo indicated four health information organizations (HIO) exist to streamline reporting and retrieving public health information. He added the program is working to enable interstate exchange by connecting to the national health exchange.
Ciccocioppo said the information exchange in Pennsylvania is structured for the provider to use their organization's health information exchange as their primary way of retrieving information. He said if the provider is connected to the regional health information organization, they can compare the clinical data depository with their HIO. Ciccocioppo said if the HIO is connected with the P3N, information about patients from other HIOs could be provided. Ciccocioppo indicated there were local, regional and statewide health care information exchanges in Pennsylvania, and the hope is to be connected to the national exchange this year.
Ciccocioppo said the four certified HIOs in Pennsylvania actively participate in information exchange and meet standard national guidelines. He added that Lancaster General Health was applying to be a certified HIO. Ciccocioppo stated the four regional HIOs were: **ClinicalConnect Health Information Exchange, HealthShare Exchange, Keystone Health Information Exchange and Mount Nittany Exchange**. Ciccocioppo indicated the DOC was updating their health record system in order to be shared across the network.
Ciccocioppo provided an explanation of how patient information is added into the system, stating that HIOs can view the information for the continuity of care. He indicated there was not a central depository of information, rather many accessible depositories with patient information. Ciccocioppo continued that the Public Health Gateway was infrastructure to allow HIOs to streamline public health reporting.
According to Ciccocioppo, organizations participating with HIOs varied across the commonwealth, but hospitals and longterm care providers have been most frequent users. He indicated a grant program is available for organizations which join P3N and that $8 million in funds has already been dispersed. Another grant program was available for encouraging providers to use the Public Health Gateway, Ciccocioppo added.
An opt-out registry was also established by Act 76, Ciccocioppo said, allowing residents to decline being a part of the health information exchange and not have their information shared. He continued that each HIO is currently working with the Public Health Gateway, providing information about the Prescription Drug Monitoring Program. Ciccocioppo said the system allows providers to be aware of emergency discharge messages from the hospital as well. He indicated the messages are evaluated for frequencies outside a patient's usual HIO, which then would be reported to the patient's HIO. Ciccocioppo said a state incentive program encouraged all emergency departments in hospitals to participate. Ciccocioppo said a strategic planning process was developed in 2017. Some of the initiatives include getting connected to the national health information exchange and other states' exchanges as well, he added. More objectives included expanding the Public Health Gateway, increasing provider connection to HIOs, increasing the amount of HIOs, and connecting with the DOC and the Department of Military and Veterans Affairs. Ciccocioppo said the registry would be enhanced to share more information about patient care.

UPDATE ON SUBCOMMITTEE STRUCTURE
McDaid explained that last month MAAC had a conversation about two potential motions that came from the executive group discussion on the configuration of subcommittees. He said the first motion is simple and the executive group met and said it was a concern that with the Managed Long-Term Services and Supports (MLTSS) Subcommittee, one out of three contracted plans has a seat on the committee while the others are guests. McDaid commented that the executive group stated that all should be appointed to the subcommittee or none should be appointed to the subcommittee. He explained that that recommendation is extended to HealthChoices and the Managed Care Delivery System (MCDS) Subcommittee as well. McDaid noted that as MAAC moves forward they would like to see behavioral health represented on every subcommittee, but at this point in time there are not enough seats to accommodate this to do so, so they will not be making that recommendation.
McDaid stated that MAAC recommends that each Managed Care Organization (MCO) contracted under the HealthChoices program be appointed to the MCDSS and MLTSS subcommittee during the duration of their contract as an MCO in Pennsylvania. **Shoemaker made the motion. Brookins seconded the motion. The motion passed.** Glinka commented that he believes they should put a date on the motion. McDaid suggested MAAC adds that it is to be done at the earliest time possible. He said it is important to have a date, but he does not want to limit the secretary.

Cubit asked if this is all dependent upon the secretary agreeing with the recommendation. McDaid replied yes, that they are an advisory committee and it is up to the secretary to make the final decision.
McDaid explained that the **second motion** involved the **Fee-for-Service (FFS) Delivery System Subcommittee**. He stated it was brought to them that the subcommittee had run its course and a number of issues could be handled by other committees. McDaid noted that it was the recommendation of the executive group to not entertain the motion and allow the subcommittee to meet in the near future and discuss the challenges that were raised in its previous meeting. He stated that MAAC will not act on the motion until the subcommittee is closer to unanimously agreeing that it has run its course. Shoemaker clarified that it was not her intention to get rid of the subcommittee, but to make sure that if the committee continues it is refocused or reinvigorated. She said she is more than OK with making the committee more relevant.
Glinka asked if bylaws will need to be updated if the FFS subcommittee is repurposed or redirected. McDaid replies yes, there will be.

SUBCOMMITTEE REPORTS
Consumer Subcommittee: The monthly February meeting was cancelled due to the weather and the next meeting will be in March.

Fee-For-Service Delivery System Subcommittee: Buchenauer stated the subcommittee met on Wednesday, February 13th, and had a robust discussion on the motion made by MAAC. She added there was an update on the new ambulance billing fees as well as Act 103. Buchenauer said there was also an update on non-emergency ambulance enrollment moratoriums that they impose on non-emergency ambulance providers. The Centers for Medicare and Medicaid Services (CMS) is no longer continuing that moratorium, Buchenauer said. She stated the committee was updated on several bulletins, specifically bulletin 99-18-11, which discusses the service location enrollment deadline. **The next meeting will be held on May 8, 2019.**

Long-Term Services and Supports Subcommittee: The monthly February meeting was cancelled due to the weather and the next meeting will be April 9, 2019.

Managed Long-Term Services And Supports Subcommittee: Vice Chair Barbara Polzer explained that Hancock provided updates on OLTL Community HealthChoices (CHC), which focused on the Phase III population and the Phase III communication timelines. She said they also talked about the Phase II launch indicators and gave enrollment updates. Polzer said they also provided enrollment updates for the southwest and southeast as they continue to monitor CHC in the southwest. She stated the MCOs briefly outlined how they are communicating with participants who require accommodations for communication, specifically alternate languages, deaf, deaf/blind or hearing impaired. They all discussed how they identify these participants and how many participants they are currently servicing using communication accommodations, Polzer said.
The next meeting will be held on March 7, 2019.

Managed Care Delivery System Subcommittee: Glinka raised the issue that there is a shortage of pediatric homecare shifts and moving forward they will look at what other provider types might be feasible so they do not have such a high no-show rate. He noted that the department last month wanted to put in a process or tool so when the subcommittee makes data requests they will be very concise. Glinka said they did approve the process and will provide updates as they use it. Glinka explained Hospital and Healthsystem Association (HAP) was present at the meeting with Vice President of Population Health Strategies **Robert Shipp** and Senior Director of Innovative Payment and Care Delivery **Kathryn Slatt.** He said from a fiscal health MCO standpoint, contractually 30 percent of the agreements now have to be value-based payment strategies. Glinka noted that standard will rise as it is rolled out as other states are way above 30 percent.

He continued that HAP is intensely focused on helping its members transform to **value-based payment methods**. He said Shipp and Slatt did go into some barriers as to what may be holding up progress, which included: difficulty in engaging physicians, complexity and unpredictable impact of the contracts, lack of information management infrastructure, lack of economic predictability, a decrease in profitability during the transition and a lack of taxable data. Glinka stated 33 percent of HAP's value-based payment survey respondents indicated that they are currently engaged in risk-based contracts.
Glinka noted anecdotally there seemed to be questions in the hospital health community about the availability of behavioral health services. He said in terms of believing there is adequate access to behavioral health services, 17

percent from rural health hospitals believe that is the case and in terms of urban hospitals 38 percent believe it. Glinka commented that how they go about clarifying the availability might be worth a discussion.
Glinka stated that another takeaway was the standardization of data in both clinical and social determinants will be helpful. He said it is not just data inside the health system but data outside the health system. Glinka explained social determinant data is helpful to HAP and some of the things identified by the association include: poverty, environmental threats, inadequate access to healthcare services, education inequalities, and walkability in the event there is no readily available transportation. He explained that HAP does provide on its website exhibits of the following items: challenges with low income, Pennsylvania county median household income compared to the state median, life expectancy within each Pennsylvania county, and food insecurity by county in relation to statewide need.
MAAC will next meet on Thursday, March 28, 2019.

Legislative Activity

The following bills and co-sponsorship memos for bills to be introduced of interest to CFoP were acted on by the General Assembly this past month.

Scope of Practice/Licensure Bills

HB 483 RE: Military Spouse License Portability Act (by Rep. Harry Readshaw, et al)
Provides that notwithstanding any other law, a licensing board shall issue a license to a military spouse to allow the military spouse to practice the military spouse's profession or occupation in this commonwealth if, upon application to the licensing board, the military spouse satisfies certain delineated conditions.
Introduced and referred to House Professional Licensure Committee, 2/12/2019

HB 517 RE: Direct On-Premises Supervision (by Rep. Stephen Barrar, et al)
Amends the Chiropractic Act, in preliminary provisions, defining "direct on-premises supervision"; in licensure and regulation, adding that the board may refuse to issue a license or may suspend or revoke a license for delegating an activity or duty to unlicensed supportive personnel who is not qualified by documented training, education or experience to perform the activity or duty; or failing to exercise direct on-premises supervision of unlicensed supportive personnel to whom the chiropractor has delegated an activity or duty. The bill outlines instances when delegation is, or is not, permissible.
Introduced and referred to House Professional Licensure Committee, 2/19/2019

Budget-Related Bills

NONE

Child Abuse Reporting

NONE

Health Care Bills

NONE

Health Care Work Force Bills

HB 601 RE: Restrictive Covenants (by Rep. Anthony DeLuca, et al)
Act limiting restrictive covenants in health care practitioner employment agreements.
Filed, 2/22/2019

HB 605 RE: Health Care Facility Retaliation (by Rep. Anthony DeLuca, et al)
Act providing for the protection of patients & medical personnel from health care facility retaliation, for prohibitions; for rebuttable presumptions; for evidence; for penalties; for restitution; for peer review & for exemption.
Filed, 2/25/2019

Health Insurance Bills

HB 469 RE: Definition of "Essential Health Benefits" (by Rep. Anthony DeLuca, et al)
Amends the Insurance Company Law adding a new section providing for coverage for essential health benefits. Requires a health insurance policy offered, issued, or renewed in Pennsylvania to include coverage for essential health benefits. Provides for a definition of "essential health benefits."
Introduced and referred to House Insurance Committee, 2/11/2019

HB 470 RE: Definition of "Essential Health Benefits" (by Rep. Dan Frankel, et al)
Amends the Insurance Company Law adding a new section providing a health insurance offered, issued, or renewed in Pennsylvania shall not establish a lifetime limit or annual limit of the dollar amount on essential health benefits for an individual. Provides a definition of "essential health benefits."
Introduced and referred to House Insurance Committee, 2/11/2019

HB 471 RE: "Preexisting Medical Conditions" (by Rep. Peter Schweyer, et al)
Amends the Insurance Company Law adding a new section providing a health insurer shall be prohibited from discriminating against a qualified group based on a preexisting medical condition. Provides a definition for "preexisting medical condition."
Introduced and referred to House Insurance Committee, 2/11/2019

HB 533 RE: Health Care Practitioner Credentialing Act (by Rep. Clint Owlett, et al)
Provides for the use of certain credentialing applications and for credentialing requirements for health insurers; imposes penalties; and confers powers and imposing duties on the Insurance Department. All health insurers licensed to do business in this Commonwealth shall be required to accept the CAQH (Council for Affordable Quality Healthcare) credentialing application or other form designated by the Insurance Department so long as the form is nationally recognized as an appropriate credentialing application when submitted by a health care practitioner for participation in the health insurer's provider panel. All health care practitioners shall use the CAQH or other designated form. An application shall be considered complete if the application is submitted through the CAQH electronic process or other process as designated by the Insurance Department and all required information is provided.
Introduced and referred to House Health Committee, 2/19/2019

HB 564 RE: Health Insurance Claim Forms (by Rep. Stan Saylor, et al)
Amends The Insurance Company Law, in uniform health insurance claim form, further providing for forms for health insurance claims.
Filed, 2/20/2019

HB 571 RE: Office of Consumer Advocate for Health Insurance (by Rep. Anthony DeLuca, et al)
Amends the Administrative Code, establishing the Office of Consumer Advocate for Health Insurance as an office within the Office of Attorney General and prescribing its powers and duties; and making editorial changes.
Filed, 2/21/2019

HB 600 RE: Health Care Provider Self-Referral (by Rep. Anthony DeLuca, et al)
Act providing for prohibition on health care provider self-referral.
Filed, 2/22/2019

HB 602 RE: Nondiscrimination by Payers (by Rep. Anthony DeLuca, et al)
Amends Title 40 (Insurance), in special provisions relating to particular classes of insurers, providing for nondiscrimination by payers in health care benefit plans.
Filed, 2/22/2019

Medical Assistance/DHS

SB 322 RE: Medicaid Decision System pilot program (by Sen. Scott Martin, et al)

Amends the Human Services Code adding a new section requiring the Department of Human Services to issue a request for proposals for a total population Medicaid Decision System pilot program in one Medicaid managed care region of the commonwealth that incorporates electronic evidence-based medicine into physical and behavioral health decisions concerning a medical assistance recipient and provides the department with utilization patterns, oversight, utilization trend analysis and health care evaluations through a data analytic system. Also requires the department and the offeror to issue a report at the end of the first six months and at the end of the subsequent six months if the contract is extended to chairs and minority chairs of the Senate Health and Human Services Committee and the House Health Committee. Provides for the content of the report. Also allows the department at the conclusion of the contract to expand the health initiative if certain conditions are met.
Introduced and referred to Senate Health and Human Services Committee, 2/22/2019

Opioid Reduction

SB 191 RE: Opioid Treatment Certification Fund (by Sen. Camera Bartolotta, et al)
Amends Title 35 (Health and Safety) adding a chapter providing for office-based opioid and non-narcotic opioid treatment provider certification; and establishing the Opioid Treatment Certification Fund. Each office-based opioid treatment provider and non-narcotic opioid treatment provider shall do all of the following: (1) Follow department-established treatment protocols consistent with section 303 of the Controlled Substances Act; (2) Follow standard medical practices in opioid treatment as outlined in the bill; (3) Develop an individualized treatment plan for each patient, which must be signed by the patient; (4) Require each patient to actively participate in appropriate behavioral counseling or treatment for the patient's substance abuse and document each visit that the patient is attending sufficient behavioral health treatment; (5) Provide ongoing toxicological testing; (6) Develop a drug abuse and diversion plan; and (7) Physically secure and maintain the confidentiality of all patient records.
Introduced and referred to Senate Health and Human Services Committee, 2/1/2019

Sales Tax Expansion

SB 76 RE: Property Tax Independence Act (by Sen. David Argall, et al)
Provides for tax levies and information related to taxes; authorizes the imposition of a personal income tax or an earned income tax by a school district subject to voter approval; provides for imposition of and exclusions from a sales and use tax for the stabilization of education funding, for increase to the personal income tax, for certain licenses, for hotel occupancy tax, for procedure and administration of the tax, for expiration of authority to issue certain debt and for reporting by local government units of debt outstanding; establishes the Education Stabilization Fund and the Education Cost Commission; provides for disbursements from the Education Stabilization Fund and for senior citizen property tax rent rebate assistance; and makes repeals. The bill provides for the elimination of school property taxes and authorizes school districts to levy, assess and collect a tax on personal income or a tax on earned income and net profits. The sales and use tax is replaced by the Sales and Use Tax for the Stabilization of Education Funding, which shall be seven percent.
Introduced and referred to Senate Finance Committee, 2/22/2019

Worker's Comp
NONE

Copies of bills described above can be obtained on-line at:
http://www.legis.state.pa.us/cfdocs/legis/home/session.cfm

Upcoming meetings of Interest
Some House Committee meetings and session can be viewed online at: http://www.pahousegop.com/
Senate Committee meetings and session can be streamed at: http://www.pasenategop.com/

WEDNESDAY - 3/6/19
House Labor and Industry Committee
10:00 a.m., Room G-50, Irvis Office Building
Public hearing on prescribing issues and worker's comp

TUESDAY - 3/12/19
House Health
9:30 a.m., Room 140, Main Capitol
Public hearing on barriers to employment in the health care field

WEDNESDAY - 3/13/19
House Professional Licensure Committee
10:00 a.m., Room B31, Main Capitol
Informational meeting with IRRC directly following a voting meeting on:
HB 64 (Readshaw) - Amends an act empowering the General Counsel to issue subpoenas for certain licensing board activities; for hearing examiners in the Bureau of Professional and Occupational Affairs; and for civil penalties and license suspension; and

HB 138 (C. Quinn) - Amends the Physical Therapy Practice Act further providing for qualifications for license and examinations for physical therapists and physical therapist assistants.

2019 SENATE SESSION SCHEDULE

March	**18, 19, 20, 25, 26, 27**
April	**8, 9, 10, 29, 30**
May	**1, 6, 7, 8**
June	**3, 4, 5, 10, 11, 12, 17, 18, 19, 24, 25, 26, 27, 28**

2019 HOUSE SESSION SCHEDULE

March	**11, 12, 13, 18, 19, 20, 25, 26, 27**
April	**8, 9, 10, 15, 16, 17, 29, 30**
May	**1, 6, 7, 8, 13, 14, 15, 22**
June	**3, 4, 5, 10, 11, 12, 17, 18, 19, 20, 24, 25, 26, 27, 28**

State Board of Chiropractic Board Meeting Schedule
Remaining 2019 dates: March 21, May 16, July 18, September 19, November 21
2020 dates: January 16, March 19, May 14, July 18, September 17, November 19, 2020
All Board meetings are held at Penn Center, 2601 N. 3rd Street, Harrisburg, PA, at 9 AM

DHS Medical Assistance Advisory Committee (MAAC)
ALL MEETINGS ARE SCHEDULED FROM 10:00 A.M. TO 12 NOON
Lecture Hall 246/248, Temple University Harrisburg
234 Strawberry Square, Harrisburg, PA
2019 meeting dates: February 21, March 28, April 25, May 23, June 27, July 25, No August meeting, September 26, October 24, No November meeting, December 12
For more information check the DHS MAAC website:
http://www.dhs.pa.gov/communitypartners/informationforadvocatesandstakeholders/medicalassistanceadvisorycommitteemaac/