Pennsylvania Issues

Legislation

- **HB 2350**: Stroke Center of Care Act. On May 29, 2012, Governor Tom Corbett (R-PA) signed the Primary Stroke Designation Act into law. The act designates Primary Stroke Centers (PSC) for the care and treatment of stroke patients and requires that emergency medical service providers transport stroke patients to the closest PSC. On September 22, 2016, State Representative Ryan Mackenzie (R-Berks, Lehigh) introduced an amendment to the Primary Stroke Designation Act to recognize the three advanced levels of certification for stroke programs designated by the Joint Commission: PSCs, Acute Stroke-Ready Hospitals and Comprehensive Stroke Centers (CSC). The three-tiered system, which was developed in collaboration with the American Heart Association/American Stroke Association (AHA/ASA), would allow emergency responders to take stroke patients to the closest facility that offers the required level of care. According to Representative Mackenzie, transport time would be reduced and aggressive medical intervention would begin sooner by using the AHA/ASA classification system.

  Every St. Luke's University Health Network hospital is a certified PSC, with the exception of St. Luke's Hospital – Warren Campus and St. Luke's Hospital – Monroe Campus. St. Luke's University Hospital – Bethlehem Campus is in the process of obtaining certification as a CSC. Lehigh Valley Hospital – Cedar Crest is a CSC, and Lehigh Valley Hospital – Muhlenberg is a PSC. The AHA/ASA, the National Stroke Association and the Hospital & Healthsystem of Pennsylvania (HAP) support the bill, which is co-sponsored by Representatives Marcia Hahn (R-Northampton), Julie Harhart (R-Lehigh, Northampton) and Justin Simmons (R-Montgomery, Northampton). On October 18, 2016, the bill was approved by the House Health Committee, and it has been placed on the House legislative calendar.

- **HB 1841**: Perfusionist Permits. As previously reported, fewer than 150 individuals graduate annually from sixteen accredited perfusion training programs nationwide, resulting in a shortage of qualified perfusionists. The situation is even more tenuous in Pennsylvania, where an individual seeking to be licensed as a perfusionist receives a temporary permit to work under the direct supervision of a licensed perfusionist for two years, during which time the trainee must pass several licensing exams. If the trainee fails one of the required exams for licensing, the temporary permit is revoked, and the trainee is ineligible for licensing. These stringent licensing requirements make it much more difficult for Pennsylvania hospitals to hire persons interested in pursuing a career as a licensed perfusionist. On February 18, 2016, Representative Thomas Killion (R-Delaware) introduced legislation which would allow trainees to retake the licensing exams during the two year training period. On April 4, 2016, the House of Representatives unanimously approved the bill, and the Senate passed the bill on October 19, 2016. The bill has been forwarded to the Governor for his signature. Michael Homishak, St. Luke's University Health Network's Manager of Perfusionist Services and Vice President of the Pennsylvania State Perfusion Society, was instrumental in the passage of the bill through the House and Senate.

- **HB 1619**: Interstate Medical Licensure Compact Legislation. As previously reported, on October 14, 2015, Representative Jesse Topper (R-Bedford, Franklin, Fulton) introduced legislation which would authorize Pennsylvania to join the Interstate Medical Licensure Compact. The compact was created by the Federation of State Medical Boards (FSMB) to serve as a new licensing option for physicians seeking to practice in multiple states. Once operational, the compact would be administered and enforced by an interstate commission, which would grant expedited licenses to eligible physicians. The compact would also permit physicians licensed in one state to treat patients in other participating states via telehealth. In order for a physician to be eligible, he or she must be certified in a medical specialty, have a medical license for a

minimum of three years and have no prior record of being penalized by a court, a medical licensing agency or the United States Drug Enforcement Agency. Sixteen states have approved the legislation, and ten other states have introduced comparable legislation.

The FSMB asserts that the requirements for licensure vary widely across different states and that the licensing process can be unnecessarily lengthy and difficult. According to Representative Topper, participation in the compact would expand access to health care, especially in rural and underserved communities. Several national physician organizations, including the Association of Physicians and Surgeons and the Pennsylvania Osteopathic Medical Association, oppose the bill based on their concerns that the compact would supersede protections for physicians established by state licensing boards. HAP supports the bill. The Pennsylvania Medical Society has remained neutral on the legislation. On June 15, 2016, the bill was unanimously approved by the House of Representatives, and the Senate passed the bill on October 16, 2016. The bill has been forwarded to the Governor for his signature.

New Jersey Issues

Advocacy

- **Princeton University Settles Lawsuit with Property Taxpayers**: On October 14, 2016, Princeton University announced its agreement to pay more than $18 million to settle a lawsuit brought by Princeton residents who disputed the university's property tax exemption. The settlement awards $10 million for property tax relief for eligible residents, and the town of Princeton will receive $6.96 million. The remainder will be paid over three years to a local nonprofit agency. The New Jersey Hospital Association (NJHA) has been following the case closely as it advocates for legislative relief to protect property tax exemption for not-for-profit hospitals. There are currently twelve New Jersey municipalities challenging the tax exempt status of not-for-profit hospitals in their communities.

Federal Issues

Advocacy

- **Medicare Access and CHIP Reauthorization Act (MACRA)**: On April 16, 2015, President Obama (D) signed into law the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which permanently repealed the Sustainable Growth Rate (SGR) formula. MACRA introduces the Quality Payment Program, which refocuses payments from fee-for-service parameters to methodologies based on efficiency and care coordination. The Quality Payment Program pertains to all physicians, physician assistants, nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists who bill Medicare more than $30,000 per year and provide care for more than 100 Medicare patients per year.

  On October 14, 2016, the Centers for Medicare & Medicaid Services (CMS) published its final rule for implementing the Quality Payment Program. The Quality Payment Program establishes two payment model pathways: the Advanced Alternative Payment Models (Advanced APMs) and the Merit-Based Incentive Payment System (MIPS). Advanced APMs are intended to reduce costs of care and/or support high-value services not typically covered under the Medicare fee schedule. Participants in an Advanced APM may earn an incentive payment based on results achieved during annual performance periods beginning on January 1, 2017. Given the complexity of Advanced APMs, most providers are expected to remain in the traditional Medicare Part B plan and participate in MIPS, which is a modified fee-for-service model with performance-based payment adjustments beginning on January 1, 2019. MIPS components will include quality, resource usage, advancing care criteria and clinical practice improvement activities.

  The final regulation is nearly 2,400 pages long. The American Medical Association (AMA) issued a statement praising CMS for adopting several AMA recommendations, including reducing reporting requirements for physicians to avoid penalties, creating a more realistic and flexible transition period, increasing the low-volume threshold that exempts more physicians and eliminating the cost category in calculating the 2017 composite performance scores for MIPS participants. However, the American Hospital Association expressed disappointment that the rule narrowly defines Advanced APMs, meaning that less than 10% of clinicians will be rewarded for care transformation. HAP has scheduled workshops to assist its members adjust to the new regulations. NJHA expects to issue additional information to help its members prepare for the Quality Payment Program.