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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

Medicare and Medicaid

Bipartisan Proposal Introduced to Reform Medicare Physician Payments

On February 6, the House Energy and Commerce Committee, House Committee on Ways and Means, and Senate Finance Committee reached a bipartisan agreement on reforming the Medicare physician payment system. Legislation reflecting the agreement, known as the *Medicare Patient Access and Quality Improvement Act of 2013*, was introduced into the House, but will still need to pass both chambers of Congress and be signed by the President before becoming law.

As introduced, the legislation will repeal the "Sustainable Growth Rate" formula by which Medicare physician payments were subject to potential cuts at the start of each new calendar year. It provides for five years of 0.5% annual payment increases (from 2014 to 2018) while transitioning to a new system based upon "quality, value, and accountability."

As expected, the legislation will consolidate existing quality programs into a program that rewards physicians who meet quality measures and engage in clinical practice improvement activities. These changes take effect starting in 2019. Each year, by November 15, the Secretary of Health and Human Services must finalize a set of performance thresholds to apply for a twelve month "performance period." Physicians will be scored for each performance period on a scale of 0 to 100. Physicians who remain in the fee for service program, and who earn a score of 67 or higher will receive a 1% bonus; those who score at least 34 but below 67 will receive no bonus, and those who score below 34 will receive a 1% decrease. One year's score will have no effect on the following year's score. Except for those professionals with a very low caseload, eligible professionals who do not submit data for the performance period will be paid at 95% of the fee schedule amount they would otherwise receive.

Physicians may choose to leave the fee for service system and opt instead for alternative payment models, including patient-centered medical home, accountable care, bundled payments for episodes of care, or other models. Starting in 2018, the legislation would provide a 5% bonus to physicians who receive a significant portion of their revenue from an alternative payment model or patient centered medical home. The threshold for "significant" increases over time, starting with 25% in 2018 and 2019.

The bill contains various other provisions, including incentives for care coordination efforts for patients in need of chronic care starting in 2015 and an expansion of the use and availability of Medicare data.

The legislation, however, does not include provisions for how Congress will pay for the repeal of the Sustainable Growth Rate formula, which is estimated to cost between $120 billion and $150 billion.

Moratorium Imposed on New Medicare Hearings and Appeals

On December 24, 2013, the Office of Medicare Hearings and Appeals (OMHA) sent letters to Medicare providers and suppliers who had a large number of Medicare appeals pending, noting that OMHA was experiencing a significant backlog of Medicare appeals. According to the letter, in January 2012, OMHA received an average of 1,250 appeals per week; in December 2013, OMHA received over 15,000 Medicare appeals per week. However, the letter noted, resources to adjudicate appeals have not been increased, and were temporarily decreased during the sequestration process.

To manage the backlog, OMHA announced that while it will continue to assign and process requests for appeals filed directly by Medicare beneficiaries, as of April 1, 2013, other requests for hearing are being retained in OMHA's Central Operations Division and not assigned to Administrative Law Judges until they are able to "accommodate additional workload on their dockets," a delay that OMHA expects to last for at least 24 and up to 28 months. Moreover, even after an appeal has been assigned, OMHA expects the wait time for a hearing to continue to be longer than six months. Accordingly, providers and suppliers filing new appeals at the ALJ level (the third level of appellate review following a Request for Redetermination and a Request for Reconsideration) should expect a wait time of at least 30 months from initial filing to final disposition.

As a reminder, a physician can avoid recoupment entirely through only the first two levels of appeal, by filing a request for redetermination within 30 days and, if redetermination is denied, a request for reconsideration within 60 days. If reconsideration is denied, Medicare will initiate recoupment pending the resolution of any appeals at the ALJ level or higher, and will also collect interest based upon the delay in recoupment while the redetermination and reconsideration requests were pending. However, if the provider or supplier then wins at the ALJ level or higher, Medicare will return the improperly recouped amount as well as any interest collected, and will also pay the provider or supplier interest based upon the amount of time since Medicare recouped and retained the amount determined improperly to be an overpayment. The current interest rate for overpayments and underpayments, as of January 21, 2014, is 10.25%.

CMS Extends Delay of Enforcement of Two-Midnight Rule Through September 30, 2014

On January 31, CMS announced a six-month extension of the partial enforcement delay of the "Two Midnight" Rule and the corresponding "probe and educate" period. Under the "Two Midnight" Rule, an inpatient admission is presumed to be appropriate for a Medicare Part A payment if a physician expects a beneficiary's treatment to require a two night hospital stay and the physician admits the patient under that assumption. The Recovery Auditors were set to begin enforcing the rule on October 1, 2013, but that deadline was previously delayed until March 31, 2014. CMS' recent announcement pushes this deadline out another six months, requiring Recovery Auditors to wait until September 30, 2014 to begin using the rule during audits.

In the interim, Medicare Administrative Contractors ("MACs") will continue to select claims for review with dates of admission between March 31, 2014 and September 30, 2014. MACs will continue to continue to review and deny claims not found in compliance with the "Two-Midnight" Rule. These reviews, however, are intended to be educational and will be limited to a sample of between 10 and 25 claims per hospital.

OIG Reports on High Cumulative Part B Payments

The Office of Inspector General of the U.S. Department of Health and Human Services (OIG) recently issued a report focusing on individual clinicians who generated high cumulative Medicare Part B payments (defined as more than $3 million worth of Part B services) in 2009. The OIG identified 303 clinicians who met this criterion and 34% of those were identified for improper payment reviews. As of December 31, 2011, they were tied to $34 million in overpayments. In addition, three of the clinicians had their medical licenses suspended and two were indicted. Since existing procedures may not always identify clinicians responsible for high cumulative payments in a timely manner, the OIG recommends that CMS: (1) establish a cumulative payment threshold – taking into consideration costs and potential program integrity benefits – above which a clinician's claims would be selected for review; and (2) implement a procedure for timely identification and review of clinicians' claims that exceed the cumulative threshold.

CMS partially concurred with the OIG recommendations and stated that it would work with its contractors to develop an appropriate, cumulative payment threshold.

CMS Releases Tools and FAQs Related to Implementation of Hospital Presumptive Eligibility for Medicaid

The Affordable Care Act requires that all states implement a program of "Presumptive Eligibility" (PE) for Medicaid enrollment, under which hospitals that participate in Medicaid can make PE determinations to provide temporary Medicaid coverage to qualifying individuals. (New Hampshire currently operates presumptive eligibility programs for Family Planning Medical Assistance and under the Choices for Independence (Home and Community Based Care for the Elderly and Chronically Ill) Medicaid programs.)

Starting in January 2014, states are required to develop programs by which hospitals may immediately (but temporarily) enroll other likely eligible patients. Individuals are determined to meet PE requirements based upon submitting information about income and household size, and (at state option) information about citizenship, immigration status, and residency. A simplified method of determining income is permitted for PE, and full MAGI-based eligibility determinations cannot be used to determine PE. Hospital PE is not limited to patients of the hospital; hospitals may enroll family members and other eligible individuals.

Once a valid PE determination has been made, an individual will be deemed eligible for Medicaid through end of the month following the month that PE is determined (if no Medicaid application is submitted), or when full Medicaid eligibility (following an application) is approved or denied. Other health care providers, not just hospitals, will receive payment for services provided during the PE period.

Each hospital may elect whether or not to participate in the PE process. In addition, states and hospitals may elect to have different processes for the new hospital PE and the existing PE programs.

The hospital PE provision went into effect on January 1, 2014, but states have until March 31, 2014 to submit a state plan amendment.

CMS to Evaluate Requests for Individual Doctors' Medicare Pay on Case-by-Case Basis

On January 14, CMS announced that it had revised its policy regarding the release of information on the amounts paid to individual physicians by Medicare. Under a previous policy, and a 1979 court injunction that was lifted in May 2013, HHS would not release Medicare physician reimbursement data that would identify specific physicians. Under the new policy, effective in sixty days, CMS will make case-by-case

determinations in response to Freedom of Information Act requests, weighing the privacy interest of individual physicians and the public interest in disclosing such information. CMS also plans to create and make available to the public "aggregate data sets" regarding Medicare physician services.

Medicare Fraud Strike Force Set Records for Cases Filed and Jury Trial Convictions

The Medicare Fraud Strike Force, which has existed since 2007, set records in fiscal year 2013 for the number of individuals charged, number of cases filed, and number of jury trial convictions reached. There were 137 cases filed, 345 individuals charged, 234 guilty pleas, and 46 jury trial convictions, with an average prison sentence for those convicted of more than four years.

CMS Announces Temporary Enrollment Moratoria on Some Home Health Agencies and Ambulance Suppliers

On January 30, CMS announced a temporary moratorium on Medicare enrollment of home health agencies operating in Fort Lauderdale, Dallas, Houston and Detroit. It also announced a temporary moratorium on Medicare enrollment of ambulance suppliers in Philadelphia. In addition, CMS announced a six-month extension of the current Medicare enrollment moratoria on home health agencies in Chicago and Miami and on ambulance services in Houston. Existing providers and suppliers in these areas can continue to provide and bill for services, but no new provider or supplier applications will be approved during the moratoria.

Under the Affordable Care Act, CMS is authorized to impose a temporary moratorium on the enrollment of new Medicare, Medicaid or CHIP providers and suppliers if the agency determines it is necessary to prevent or combat fraud, waste or abuse under these programs. In making this decision, CMS considered fraud trends and consulted with law enforcement about geographic areas where fraud and abuse are prevalent. This is CMS's second temporary Medicare enrollment moratorium. The first took effect on July 30, 2013.

Affordable Care Act Implementation

Employer Mandate Further Delayed for Medium-Sized Employers, and Phased in for Large Employers

On February 10, the U.S. Department of the Treasury and Internal Revenue Service issued final regulations governing implementation of the Affordable Care Act's "employer mandate," formally known as the Employer Shared Responsibility provisions.

The final regulations provide "transition relief" for 2015 that further delays enforcement of the "employer mandate" for employers with between 50 and 99 full-time equivalent employees, and phases in the requirement for employers with 100 or more full-time equivalent employees. (The employer mandate was supposed to take effect on January 1, 2014, and had already been delayed one year to January 1, 2015.)

Specifically, employers with between 50 and 99 full-time equivalent employees will not need to comply until 2016. Employers with 100 or more employees will have to offer coverage to at least 70% of full-time employees in 2015 to avoid needing to pay a penalty.

Starting in 2016, all employers with 50 or more full-time equivalent employees will need to offer coverage to 95% or more of their employees to avoid needing to pay a penalty. The coverage must also be

affordable (costing the employee 9.5% of annual household income or less) and must meet minimum value (covering at least 60% of the total allowed cost of benefits expected to be incurred under the plan).

Health Insurance Marketplace Enrollment Going Smoothly

Anthem Blue Cross Blue Shield of New Hampshire reports that it has received 10,000 applications for health coverage through the federal health insurance marketplace. Northeast Delta Dental reports that it has processed about 1,000 applications through the marketplace. Representatives for both companies say that applications through the healthcare.gov site are moving smoothly.

A representative for the state Department of Health and Human Services reports that healthcare.gov is still not able to send information to the state for applicants who apply to purchase coverage but are eligible for Medicaid. People who apply for Medicaid coverage, but are ineligible, are connected to healthcare.gov, but the reverse is not yet happening. Thirty-five other states using healthcare.gov are reporting a similar problem.

ACA Projected to Lead to Fewer Total Hours Worked

On February 4, the Congressional Budget Office released a report predicting that the ACA will result in a reduction of hours worked and full-time employment. The analysis reasons that now that the ACA has expanded the availability of insurance coverage, some people will choose not to work or to work fewer hours than they might have otherwise worked in order to get employer-provided insurance available only for full-time workers. Other factors will also contribute to a reduction in total hours worked. Premium subsidies will increase household income for certain individuals, potentially leading them to work less. Higher taxes on very wealthy households' wage-earnings may also reduce the incentive to work. Finally, some businesses may reduce the hours of individual employees below 30 hours per week to avoid needing to provide health insurance coverage under the employer mandate that goes into effect in 2015. The report does not predict that the law will negatively impact the creation of jobs in the private sector.

Federal Court Holds that Tax Credits Available for State-Run and Federally Facilitated Marketplaces

On January 15, the U.S. District Court for the District of Columbia upheld an IRS rule providing that otherwise qualified individuals who purchase health insurance on health insurance marketplaces may receive federal tax credits for plans purchased on both state-run and federally facilitated marketplaces. The issue arose because language in the Affordable Care Act (ACA) provides that a tax credit is to be calculated based on the cost of insurance purchased on "an Exchange established by the State." Challengers argued that credits should not be available for insurance purchased through a federally-facilitated marketplace. The IRS promulgated a rule, however, providing that eligible taxpayers were allowed tax credits if "enrolled in one or more qualified health plans through an Exchange," which was in turn defined to include both state and federally-facilitated exchanges (now called marketplaces).

In rejecting the challenge to the rule, the Court held that the IRS was entitled to deference because Congress delegated to it the authority to resolve ambiguities. While the single provision in the ACA, read in isolation, seemed to support the challengers' position, other ACA provisions and congressional intent suggested otherwise.

Other Federal Developments

CMS Publishes Final Rule Allowing Patients or their Representatives Direct Access to Laboratory Test Results

On February 6, CMS published a final rule, amending CLIA regulations and the HIPAA Privacy Rule, in order to permit patients or their representatives direct access to their laboratory test results.

As amended, under the CLIA regulations, laboratories are permitted to provide copies of completed test reports upon request of a patient or the patient's personal representative. The report must be able to be identified, using the laboratory's authentication process, as belonging to that patient. As amended, under the HIPAA Privacy Rule, laboratories must provide patients, their representatives, or a person designated by the patient, with completed test reports within 30 days of a request. (Previously, the CLIA regulations provided that a laboratory could release completed test reports directly to a patient only if the ordering provider expressly authorized it at the time the test was ordered or state law expressly allowed for it, and the HIPAA Privacy Rule carved out such reports from a patient's general right of access to his or her health information.) Laboratories will not be required to explain results to patients, which will remain the role of the providers who ordered the tests.

The rule preempts any state laws to the contrary. The amended CLIA rule (permitting laboratories to provide copies of test reports upon request) goes into effect on April 7, 2014. The amended HIPAA Privacy Rule (requiring that they do so) goes into effect on April 7, 2014, but compliance is not required until October 6, 2014. Laboratories will need to update their HIPAA Notice of Privacy Practices and to amend any internal policies to reflect these new rights of access.

OCR Proposes HIPAA Amendments

On January 7, the OCR issued a Notice of Proposed Rulemaking that seeks to modify the HIPAA Privacy Rule to expressly permit certain HIPAA covered entities to report directly to the National Instant Criminal Background Check System ("NICS"). The NICS is a national database administered by the FBI, listing individuals who are subject to a Federal "mental health prohibitor" that disqualifies them from possessing or receiving a firearm. This includes individuals who have been involuntarily committed to a mental institution, found incompetent to stand trial, or have been adjudicated to be a danger to themselves or others as a result of mental illness. The proposed rule would not affect the scope of the NICS or the Federal mental health prohibitor.

Under the proposed rule, only covered entities with lawful authority to make adjudication or commitment decisions to the Federal mental health prohibitor, or that serve as repositories of information for NICS reporting purposes, would be permitted to disclose information needed for these purposes. A mental health diagnosis would not, by itself, make an individual subject to this reporting requirement. The proposed rule would permit, but not require covered entities to report to the NICS. Comments on the Proposed Rule are due by March 10.

OIG Warns About Vulnerabilities in Electronic Health Records

On January 8, the second time in two months, the OIG published a report warning about potential flaws in electronic health records (EHRs) and their potential for fraudulent activity. The report, entitled "CMS and Its Contractors Have Adopted Few Program Integrity Practices to Address Vulnerabilities in EHRs" criticizes CMS for providing only limited guidance to Medicare contractors on EHR fraud vulnerabilities. Specifically, the OIG found that few contractors review EHRs differently from paper medical records and not

all contractors reported being able to determine whether a provider had copied language or over-documented in a medical record. In addition, CMS had provided limited guidance to Medicare contractors on EHR fraud vulnerabilities.

The OIG recommends that CMS provide guidance to contractors on detecting fraud associated with EHRs. CMS agreed with this recommendation. The OIG also recommended that CMS direct its contractors to use providers' audit logs to help demonstrate that EHR documentation supports claims for services. CMS concurred in part with the second recommendation, stating that it intends to develop guidance on the appropriate use of the copy-paste feature in EHRs. It also stated that audit logs may not be appropriate in all circumstances and that use of such logs requires special training. CMS said it is working with its contractors and other agencies and workgroups on this issue.

OIG Releases Fiscal Year 2014 Work Plan

On January 31, 2014, OIG released its work plan for FY14, identifying the programs OIG will review in the upcoming year. The work plan also provides updates for OIG's ongoing projects listed in previous work plans, and identifies new work on OIG's docket. The work plan is usually released in October to coincide with OIG's fiscal year but was delayed.

The Work Plan identifies several areas of oversight related to the implementation of the Affordable Care Act. Specifically, the OIG expects to expand its review of the health insurance exchanges this year. The OIG has prioritized four key areas to ensure that the exchanges operate efficiently and effectively: (1) payment accuracy; (2) eligibility systems; (3) contracts – planning, acquisition, contracting, management, and performance; and (4) security of data and consumer information. The OIG will also monitor and review Medicaid expansion to promote the effectiveness and efficiency of the growing Medicaid program.

Certain new projects OIG will focus on in 2014 include:

- Analyzing the Two-Midnight Rule and its impact on hospital billing and Medicare payments.
- Reviewing Medicare costs associated with defective medical devices and the resulting impact on the Medicare Trust Fund.
- Reviewing whether providers are complying with assignment rules to determine to what extent beneficiaries are inappropriately billed in excess of amounts allowed by Medicare.
- Reviewing physicians' coding on Medicare Part B claims for services performed in ambulatory surgical centers and hospital outpatient departments to determine whether they properly coded the places of services.
- Determining the extent to which selected payments for evaluation and management ("E/M") services were inappropriate and identifying EHR that appears cloned.
- Reviewing Medicare Part B payments for imaging services to determine whether the services reflect expenses incurred and whether the utilization rates reflect industry practices.
- Analyzing billing and payments for chiropractic services to identify trends in payment, compliance and fraud vulnerabilities and offering recommendations to improve detected vulnerabilities.

Federal Court of Appeals Affirms that Medical Clinic is Not Liable for Employee's Disclosure of Patient Data

On January 27, the U.S. Court of Appeals for the Second Circuit affirmed a lower court's decision holding that a plaintiff could not sue a medical corporation directly for a non-physician employee's unauthorized disclosure of confidential medical information where the employee acted outside the scope of her employment. Following certification to New York's highest court, that court held that "a medical corporation's duty of safekeeping a patient's confidential medical information is limited to those risks that are reasonably foreseeable and to actions within the scope of employment."

In this case, the plaintiff went to a clinic for treatment of a sexually transmitted disease (STD). A nurse recognized the plaintiff as her sister in law's boyfriend, accessed his medical records, and learned he was being treated for an STD. She then informed her sister in law, who informed the plaintiff, who complained to the clinic's administrator. The nurse was fired, and the clinic promptly confirmed to the plaintiff that his confidential information had been improperly accessed and disclosed, and that appropriate disciplinary action had been taken.

The Court of Appeals had previously held that the nurse's actions were not foreseeable to the clinic and were not taken within the scope of her employment. The court reasoned that the employee's conduct was motivated solely by personal reasons unrelated to the furtherance of the employer's business. Accordingly, they could not be imputed to the medical corporation on a theory of vicarious liability.

The plaintiff had nevertheless argued that medical corporations were strictly liable for breaching their fiduciary duty to keep personal health information confidential. Finding the authority on the issue sparse, the Court of Appeals certified this question to the New York court; following the New York court's determination that medical corporations were not so liable, the Court of Appeals dismissed the case.

OIG Issues Advisory Opinion on Paying Referral Fees to Independent Placement Agencies

On January 21, OIG issued Advisory Opinion No. 14-01 in response to a nonprofit senior housing and geriatric care provider's question of whether it may pay an independent placement agency a fee for referring new residents of certain facilities. Despite concerns that the arrangement could potentially generate prohibited remuneration under the Anti-Kickback Statute, the OIG found that the facts and circumstances of the arrangement sufficiently mitigated any risk of fraud and abuse.

NEW HAMPSHIRE DEVELOPMENTS

New Hampshire Legislature Reaches Bipartisan Deal to Expand Medicaid

On February 6, the Senate reached a bipartisan agreement on a framework to expand Medicaid. Lawmakers are in the process of writing a bill to implement the framework, the text of which could be released as soon as this week. It is expected that the bill will be voted on by the House and Senate in March.

Only a few details of the proposed bill have been released. The bill would expand access to private insurance by subsidizing employer-based insurance and by buying private coverage through the federal health insurance marketplace. Under the Affordable Care Act, the federal government would fully fund the cost of the expansion for three years, and would fund at least 90% after that. The proposed bill calls for Medicaid expansion to terminate once the federal funding falls below 100%, unless the legislature voted to

continue the program.

Such a plan would require a waiver from CMS, and the proposed bill would set a deadline of June 30, 2015, for obtaining such a waiver. It remains unclear what the overall timeline for implementation of the expansion would be.

Thirteen New Urgent Care Centers Found Not Subject to CON Review

On January 16, the Health Services Planning and Review Board, which grants Certificates of Need, granted Not Subject to Review Petitions for thirteen nonemergency walk-in centers. The proposed centers include locations in Claremont, Portsmouth, Keene, Belmont and Hillsborough. These facilities will bring the total number of urgent care centers in the state to 42. As of August 2013, there were only 23 such facilities licensed in the state. Applications for two other urgent care centers to be located in West Lebanon and Pittsfield will be considered at the Board's February 20 meeting.

The timing of the surge in applications is likely connected to a change in state law that went into effect February 1. The Board has interpreted this change in state law to require inclusion of the full fair market value of leased property and equipment in determining whether a facility or project meets the threshold at which a Certificate of Need is required.

Legislative Update

Proposed State Legislation Would Increase Transparency of Health Care Costs

Senator Bradley recently introduced proposed legislation that would require the state Department of Health and Human Services to release certain claims processing data to the public upon request. New Hampshire law currently requires all health insurers and other entities providing health coverage, as well as licensed third party administrators to provide encrypted claims data to the state. The amendment would add a provision requiring the release of such data (as a "limited use" data set) to a requestor who seeks the data "for purposes of facilitating transparency in health care costs."

Bill to Expand Role of Dental Hygienists Voted Down

On January 30, the Senate voted down an effort to expand the role of some dental hygienists to allow them, under the supervision of a dentist, to pull baby teeth and fill cavities. Instead, the Senate amended SB-193 to establish a commission to work through November 15, 2015 to analyze and evaluate how this bill would meet the needs of underserved residents for oral health services in New Hampshire. The New Hampshire Dental Society opposed the bill, while advocates argued it would expand access to oral health care, especially in rural and low-income communities. So far only Alaska and Minnesota have approved similar measures. Maine, Vermont and 10 other states are also debating the issue.

Summary Legislative Update

The Legislature reconvened in early January and several new bills affecting health care were filed. Here is a brief overview of bills we will watch:

Executive Departments and Administration

HB 1219, *relative to the work schedule of pharmacists*. This bill establishes requirements for the staffing and work schedule for a pharmacy by a pharmacist. Violations are subject to disciplinary action by the board of pharmacy.

Health, Education and Human Services

HB 1434, *allows a mentally competent adult to make medical decisions for an adult who lacks health care decision making capacity*. This bill would allow a person's next of kin to make health care decisions without involving court action when there is no advance directive.

HB 1539, *relative to the repeal date of the certificate of need law*. This bill changes the repeal date of the certificate of need law from June 30, 2016 to June 30, 2015.

SB 213, *establishing a registry for physician orders for life-sustaining treatment*. This bill establishes the New Hampshire POLST (provider order for life-sustaining treatment) Registry Act. Under this bill, a patient may execute a form to be signed by the patient and his or her physician relative to life-sustaining treatment to ensure that the patient's preferences are known in the event of an emergency. This bill establishes a statewide registry for the collection and dissemination of physician orders for life-sustaining treatment to help ensure that medical treatment preferences for an individual nearing the end of his or her life are honored. The Senate passed the bill, which has been referred to the Senate Finance Committee.

SB 226, *relative to reporting of health care associated infections.* DHHS requested this bill to clarify the limitations to collecting data for reporting of health care associated infections. DHHS has a statewide database of all reported infection information in order to monitor quality improvement and infection control activities in hospitals and ambulatory facilities. Under current law, the hospitals and ambulatory surgical facilities are not allowed to provide DHHS with data that identifies an individual patient. Under the proposed bill, those providers may provide to DHHS data or patient identifiers as set forth in the protocols established by the National Healthcare Safety Network. However, a patient's name, address, phone number and social security number may not be included.

SB 250, *relative to ambulatory surgical facilities*. This bill authorizes ambulatory facilities to allow patients to stay in the facility for 48 hours from the time of admission. Currently law requires that after 24 hours the patient shall be either discharged or transferred to another health care facility.

SB 256, *requiring health care facilities to implement a process to inform patients about palliative care options*. This bill requires health care facilities to implement a process to inform patients about palliative care options as part of the licensure and re-licensure requirements. On January 30th, the Senate voted to refer the bill for "interim study."

SB 308, *relative to innovation in the delivery of health care*. This bill establishes the Health Care Delivery Innovation Through Cooperation Act. Under this bill, the attorney general may issue certificates for cooperative agreements among health care providers and entities govern the sharing of personnel, facilities, and other assets. Under the proposed law, health care providers are not required to enter into cooperative agreements or to request approval of a cooperative agreement from the attorney general. However, parties to a cooperative agreement approved by the attorney general will be entitled to state action immunity under federal antitrust laws.

SB 360, *relative to the issuance of itemized medical bills for medical services*. This bill requires health care providers to issue an itemized bill to every patient. Current law allows providers to offer an itemized bill free of charge if the patient requests it.

Commerce

SB 340, *requiring the insurance department to hold public hearings before approval of products to be sold on the health exchange*.

Commerce and Consumer Affairs

HB 544, *repealing the prohibition on a state-based health exchange*. This bill as amended by the House establishes the NH Access to Health Coverage Act to provide health insurance to the newly eligible Medicaid population permitted under the Affordable Care Act.

HB 1294, *requiring that all providers be allowed to participate in the health exchange*. This bill would require an insurer participating in New Hampshire's health insurance exchange to provide any willing provider the opportunity to negotiate to participate in its provider network.

HB 1328, *relative to licensure of insurance exchange navigators*. This bill requires that insurance exchange navigators be licensed by the insurance department. Under this bill, insurance exchange navigators shall submit to a background check as a condition of licensure. A U.S. District Judge in Missouri recently temporarily blocked a similar law there, finding the state was barred from interfering with a program set up under the federal ACA. This ruling may call into question the constitutionality of this bill.

Judiciary

HB 1325, *relative to death with dignity for certain persons suffering from a terminal condition*. This bill allows a mentally competent person who is 18 years of age or older and who has been diagnosed as having a terminal condition by the patient's attending physician and a "consulting physician" to request a prescription for medication which will enable the patient to control the time, place, and manner of such patient's death. The bill provides for immunities from civil and criminal liability and professional disciplinary action for participating in good faith compliance with the scheme, including being present when the patient takes the medication to end his or her life. No health care provider would be under any obligation to participate.

SB 297, *relative to apportionment of damages*. This bill provides that damages in a civil action shall be based on the proportionate fault of the parties who are not immune from liability.

Ways and Means

HB 1509, *relative to including nonprofit charitable enterprises in the business enterprise tax and lowering the rate of the tax*. This bill includes in taxation under the business enterprise tax the enterprise value of nonprofit charitable organizations organized under Internal Revenue Code section 501(c)(3) that exceed $1.5 million in gross annual operating expenditures or $75,000 in enterprise value tax base. The bill also lowers the rate of the business enterprise tax.

HB 1613 and SB 369, *relative to payment of the Medicaid enhancement tax*. This bill changes payments of the Medicaid enhancement tax to quarterly. It is a request of the Medicaid enhancement tax study commission.

Update on Bills from 2013

HB 217, ***imposing an extended term of imprisonment for assault against a health care provider***. On January 29, 2014, the House voted it was inexpedient to legislate.

HB 255, ***(New Title) establishing a commission to study medical costs and payments under workers' compensation law***. On January 8, 2014, the House voted it ought to pass with amendment.

HB 329, ***requiring purchasers of medical equipment to be notified of the actual cost of such equipment at time of sale***. On January 8, 2014, the House voted it was inexpedient to legislate.

HB 469, ***relative to time limits for regulatory boards and commissions to hold disciplinary proceedings***. This bill provides that occupational and professional boards will lose jurisdiction over a disciplinary matter when statutory time limits for holding hearings on disciplinary actions are not met. On January 8, 2014, the House voted it ought to pass with amendment.

HB 476, ***relative to medical care price disclosure and transparency***. On January 8, 2014, the House sent this to an interim study.

HB 582, ***(New Title) relative to early offers for medical injury claims***. On January 22, 2014, the House voted it ought to pass with amendment. The amended bill modifies definitions relating to early offers for medical claims; requires any waiver of rights by an injured patient to be signed 60 days or more after the medical injury; and modifies time limits regarding waiver of rights.

HB 583, ***relative to proceedings of medical injury claims screening panels***. This bill modifies procedures for screening panels for medical injury claims. On January 30, 2014, the Senate found it was inexpedient to legislate.

HB 584, ***relative to covered prescription drugs***. This bill requires insurers to allow covered persons to purchase their 90-day supply of covered prescriptions drugs at the pharmacy of their choice. On January 8, 2014, the House voted it ought to pass with an amendment providing that the insured can choose the pharmacy of their choice within their insurance network.

HB 597, ***relative to mandatory drug testing for certain health care workers***. On January 22, 2014, the House voted it ought to pass with a proposed amendment that would require health facilities to develop policies for a drug-free workplace that includes procedures for drug testing when reasonable suspicion exists. The Senate has not scheduled a hearing yet.

HB 658, ***relative to registration for medical technicians***. This bill establishes the medical technician registration board. On January 29, 2014, the House voted it ought to pass with amendment and the bill was referred to the Ways and Means Committee.

EMPLOYMENT LAW

National Labor Relations Board Strikes Down Hospital Employee Code of Conduct

In a ruling issued January 30, the National Labor Relations Board ("NLRB"), struck down two provisions of an employee code of conduct policy for hospital workers. The first provision prohibited employees from making verbal "comments or physical gestures directed at others that exceed the bounds of fair criticism," and the second provision prohibited employees from engaging in conduct that was "counter to promoting teamwork." The administrative law judge ("ALJ") found these provisions to be ambiguous, overbroad, and to potentially prohibit discussions and complaints that are protected by law. In the same decision, the ALJ ruled in favor of the hospital for terminating two employees accused of bullying newly hired nurses. This decision is the most recent in a string of NLRB decisions warning employers that they must implement workplace policies with caution, particularly code of conduct and non-disparagement policies. Such policies should be carefully tailored to ensure they do not interfere with or prohibit protected concerted activity.

OSHA Launches New Website

On January 15, OSHA launched a new educational resource site, http://www.osha.gov/hospitals, geared toward helping hospitals to prevent worker injuries and to promote and improve a culture of safety. In providing new tools, OSHA is emphasizing the need for worker safety in hospitals. According to the site, hospitals remain among the most hazardous places to work. Recognizing the continuing concern for hospital workers, the OSHA site explains, "OSHA created a suite of resources to help hospitals assess workplace safety needs, implement safety and health management systems, and enhance their safe patient handling programs. Preventing worker injuries not only helps workers—it also helps patients and will save resources for hospitals." Hospitals and other healthcare employers are encouraged to explore the new resources OSHA has made available and to devote 2014 to increasing worker safety. Employers should consult with counsel to assist in drafting policies and programs, and in implementing these programs, in order to combat the growing risk associated with workplace safety issues.

QUESTIONS

Sunshine Act Question

There was a question from some of the members whether under the Sunshine Act a pharmaceutical company may still come and bring lunch for a practice. Would such a lunch be reportable?

For meals in a group setting (other than buffet meals provided at conferences or other similar large-scale settings), the manufacturer must report the per person cost (not the per covered recipient cost) of the food or beverage for each covered recipient *who actually partakes in the meals.* For example, if a representative brings a $125 lunch for 3 physicians and 7 staff members, $12.50 will be reported for each physician. If the per person cost of the lunch is less than $10, it will not be reported, unless the total annual value of transfers from that manufacturer to an individual physician exceeds $100.

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BIOS

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