New Hampshire LEGAL UPDATE June 10, 2015

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FEDERAL DEVELOPMENTS

Affordable Care Act Implementation

Maine Community Health Options, Minuteman Health, and Assurant Request Substantial Rate Increases

On June 1, the Federal government released data on insurers seeking rate increases of 10% or more for 2016. The data indicates that Maine Community Health Options (MCHO), Minuteman Health, and Assurant, all of which were new entrants to the New Hampshire health insurance marketplace in 2015, are requesting substantial premium increases for 2016. The requests by MCHO range from 18.96% to 21.94%, for Minuteman Health, from 41.78% to 51.27%, and for Assurant, 13.02%.

MCHO has contended that the rate increase is necessary because of the introduction of adults formerly covered by the New Hampshire Health Protection Program into the health insurance marketplace. MCHO estimated that the medical costs for this new population will be 61% higher than that of the current single risk pool in the individual market, increasing the overall claims cost of the individual market by roughly 25%.

Anthem Blue Cross and Blue Shield and Harvard Pilgrim have not made such requests. Of the 47,262 individuals enrolled in individual plans through the New Hampshire health insurance marketplace in May 2015, 27,592 enrolled in Anthem plans, 5,131 in Harvard Pilgrim's Elevate Health Plans, 1,753 in Harvard Pilgrim's New Hampshire Network Plans, 4,047 in MCHO plans, 8,728 in Minuteman Health plans, and 11 in Assurant plans.

The proposals by MCHO, Minuteman Health, and Assurant are subject to the approval of the New Hampshire Insurance Department and are likely to be revised several times over the next few months before final rates are set.

Other Federal Developments

CMS Unveils New ACO Model

On March 10, CMS launched a new accountable care organization (ACO) model in which providers will assume greater risk while also potentially sharing in more savings. The so-called Next Generation Accountable Care Organization Model "will have a stable, predictable benchmark and flexible payment options that support ACO investments in care improvement infrastructure that provides high quality care to patients." The new model will offer a selection of payment mechanisms to enable a graduation from fee-for-service reimbursements to capitation, the Centers for Medicare & Medicaid Services said. The CMS said the new ACO model "is an initiative for ACOs that are experienced in coordinating care for populations of patients. It will allow these provider groups to assume higher levels of financial risk and reward than are available under the current Pioneer Model and Shared Savings Program (MSSP)."

CMS will accept ACOs into the Next Generation ACO Model through two rounds of applications in 2015 and 2016, with participation expected to last up to five years. Organizations interested in applying must have submitted a Letter of Intent by May 1, 2015 and an application by June 1, 2015. CMS expects between 15 and 20 ACOs to participate in the new ACO model with representation from a variety of provider organization types and geographic regions.

OIG Recommendations Could Have Saved Billions of Dollars

On March 17, the OIG released its annual report, "Compendium of Unimplemented Recommendations," in which sets forth the top 25 unimplemented recommendations made by the OIG to various HHS programs. In the 2015 report, the OIG concluded that CMS could have saved billions of dollars if it took action on several recommendations made by the OIG. For example, an April 2014 report from the OIG estimated CMS could have saved $2 billion over a two-year period by strengthening its oversight of the face-to-face requirement for home-health payments. While CMS agreed with the recommendation after the original report was issued, a plan for additional oversight has not been completed.

Other unimplemented recommendations included:

- Requiring CMS to create new policies and procedures to detect and recover improper payments made to prisoners;
- Requiring CMS to create a program to limit the number of prescribers or pharmacies high-risk Medicare beneficiaries can use;
- Requiring CMS to improve the process for determining an individual's eligibility for enrolling in a qualified health plan under the health-insurance marketplaces;
- Requiring CMS to ensure that the Transformed Medicaid Statistical Information System is complete and accurate; and
- Requiring CMS and the National Coordinator for Health Information Technology to create a plan to focus on any fraud vulnerabilities contained in electronic health records.

Federal Anti-Fraud Efforts Recovered $3.3 Billion in FY 2014

According to the Departments of Justice (DOJ) and Health and Human Services (HHS) annual Health Care Fraud and Abuse Control Program (HCFAC) report, health care anti-fraud programs recovered $3.3 billion in FY 2014. The recoveries represent a $1 billion decrease from FY 2013. According to HHS, the HCFAC recovered $7.70 for every $1 spent looking into potential health care related fraud and abuse over the past three years. According to the report, in FY 2014, the DOJ convicted 734 defendants of health care fraud related crimes; filed criminal charges in 496 health care fraud cases involving 805 defendants; and opened 924 investigations into criminal health care fraud. Overall, the Medicare Trust Fund has recovered more than $27.8 billion through the HCFAC since it began in 1997.

EHR Meaningful Use Rules Released

On March 20, CMS and the Office of the National Coordinator (ONC) both released proposed rules aimed at providers participating in the meaningful use program. CMS's rule would establish a single reporting period for all providers based on the calendar year and reduce the overall number of meaningful

use requirements for providers from 20 to 8. Stage 3 of the meaningful use program is set to start in 2017, but the proposed rule allows most providers the option to wait until 2018 to move from Stage 2 to Stage 3. The ONC's rule covers the 2015 Edition Health IT Certification Criteria that apply to EHR products used by participants in the meaningful use program. The deadline to submit comments for both rules was May 29.

On April 10, CMS issued a proposed rule that would change the meaningful use program to align Stage 1 and Stage 2 measures and objectives with the long-term proposals for Stage 3. The proposed rule calls for reducing the overall number of objectives, removing redundant measures, changing the timeframe for the 2015 reporting year so that hospitals would participate on the calendar year rather than the fiscal year and allowing for a 90-day reporting period in 2015 to accommodate the implementation of the proposed changes. The changes are intended to reduce complexity and simplify providers' reporting requirements. Comments are due by June 15.

President Obama Signs into Law Repeal of Sustainable Growth Rate

On April 16, President Obama signed into law the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) which permanently repeals Medicare's sustainable growth rate (SGR) for physician reimbursement. The legislation, which enjoyed broad bipartisan support in both the House (392-37) and Senate (92-8), replaces the current SGR formula with new value-based systems for establishing annual updates to physician payment rates under Medicare.

MACRA replaces the SGR with the following updates:

- Beginning July 1, 2015 and each calendar year thereafter through 2019, Medicare physician payments will be updated by 0.5%.
- Beginning January 1, 2020 through 2025, physician payments will not be updated.
- Beginning January 1, 2026 and each year thereafter, physicians payments will be updated by 0.75% for physicians who adequately participate in qualified alternative payment models (APMs) and by 0.25% for those who do not.
- Beginning in 2019, the Merit-based Incentive Payment System (MIPS) will go into effect. It combines the existing incentive programs (PQRS, Value-based modifier and EHR meaningful use programs). Providers who perform well will be rewarded and those who do not will be penalized (starting at 4% in 2019 and increasing to 9% by 2022). There will also be additional bonuses for exceptional performers.
- Starting in 2019 through 2024, physicians will receive 5% incentives for performing in APMs.

The bill includes dozens of other changes not detailed here. Among other things, it extends the Children's Health Insurance Program (CHIP) through 2017, imposes some payment reductions on hospitals, delays enforcement of the two-midnight rule, requires removal of Social Security Numbers from Medicare cards and eliminates civil money penalties for certain gainsharing arrangements.

OSHA Offers Updated Guidance on Violence in the Health Care Industry

On April 2, OSHA released guidance calling for written prevention programs to reduce workplace violence against health care workers. The five basic building blocks of the prevention program are:

- Management commitment and employee participation;
- A worksite analysis;
- Hazard prevention and control;

- Training; and
- Record keeping and evaluation;

The guidance may be found at https://www.osha.gov/Publications/osha3148.pdf.

OIG Provides Guidance for Health Care Boards

On April 20, the Health and Human Services Office of the Inspector General issued new guidance for health care governing boards regarding the responsibility for board oversight of compliance programs. The guidance, a collaborative effort by the OIG, the Health Care Compliance Association, the Association of Healthcare Internal Auditors and the American Health Lawyers Association, offers suggestions for fostering a culture of compliance. The publication identifies a key element of board compliance oversight is to ask questions of management necessary to determine the adequacy and effectiveness of the organization's compliance program. It encourages regular consultation with regulatory, compliance or legal experts and suggests adding someone with compliance expertise to the board. The guidance comes in the wake of increasing concern that directors who do not meet their oversight responsibilities may become targets of OIG enforcement efforts. The guidance may be found at https://oig.hhs.gov/newsroom/news-releases/2015/guidance-release2015.asp.

New Proposed Rules and Guidance on Wellness Programs Issued

On April 20, the EEOC published proposed rules under the Americans with Disabilities Act (ADA) to permit the implementation of certain wellness programs initiatives that were previously deemed by the EEOC to be discriminatory. The rules give guidance on the extent to which employers are permitted to offer incentives to employees to participate in voluntary wellness programs, but places limits on the amount of the rewards or penalties (30% of the cost of employee-only coverage). In accordance with the rules, an employee health program must be "reasonably designed to promote health or prevent disease." For a program to be considered voluntary, an employer may not require an employee to participate in the program and may not deny or limit coverage based on an employee's nonparticipation. The rules are similar, but not identical, to the HIPAA regulations implemented in 2006. In the past, an employer could adopt a program in compliance with the HIPAA regulations and still run afoul of the ADA. The comment period closes on June 19.

Separately, on April 16, the departments of the Treasury, Labor and Health and Human Services offered guidance on the definition of "reasonably designed" noting that programs designed to dissuade or discourage enrollment by workers who are sick or might have higher insurance claims will be considered illegally discriminatory. Finally, on the same day, the Office of Civil Rights posted new guidance on HIPAA and Workplace Wellness Programs advising employers that PHI created and collected about participants in a wellness program offered through a group health plan is covered by HIPAA. If the wellness program is offered by the employer directly and not through a group health plan, the information collected is not covered by HIPAA, but may be covered by other state or federal laws.

ONC Issues New HIPAA Guide to Privacy and Security of Electronic Health Information

The Office of the National Coordinator for Health Information Technology recently released Version 2.0 of its Guide to Privacy and Security of Electronic Health Information. While the Guide provides no new requirements, it is a useful overview of various law governing Privacy and Security including, HIPAA, HITECH and the meaningful use requirements. It can be found at http://www.healthit.gov/sites/default/files/pdf/privacy/privacy-and-security-guide.pdf.

OIG Issues Four Advisory Opinions

The OIG has issued four Advisory Opinions since our last update. Opinion 15-04, issued on March 18, considered a laboratory's proposal to "enter into agreements with physician practices to provide all laboratory services for the practice's patients and waive all fees for those practices' patients who are enrollees of certain insurance plans that require the patients to use a different laboratory." Noting that the laboratory would be providing free services to certain patients in order to secure all the practice's business, the OIG determined that the proposed arrangement potentially implicates the anti-kickback statute and the prohibition on charging Medicare or state health care programs substantially in excess of the provider's or supplier's usual charge.

Advisory Opinion 15-05 deals with the use of a preferred hospital network as part of Medicare Supplemental Health Insurance policies where the insurer would indirectly contract with hospitals for discounts on the Medicare inpatient deductible and would in exchange provide a premium credit of $100 off the policyholder's next renewal premium. Following the same logic used in other similar opinions, the OIG determined that although the proposed arrangement could potentially generate prohibited remuneration, it would not impose administrative sanctions on the insurer.

Advisory Opinion 15-06 addresses a proposal by a nonprofit, tax-exempt, charitable organization to provide financial assistance to individuals with chronic diseases, including cancer, to assist with the costs of health insurance and drug and device therapies. Eligibility to receive assistance would be based on Federal poverty guidelines and assistance would be awarded on a first-come, first-served basis. Donors who make contributions to the charitable organization would have no control over the distribution of funds and would not receive data that would enable them to correlate the amount or frequency of its donations with the amount or frequency of the use of its drugs or devices. The OIG concluded that the proposed arrangement would 1) not constitute grounds for the imposition of civil monetary penalties for inducements to beneficiaries, and 2) that while the arrangement could potentially generate prohibited remuneration under the anti-kickback statute, the OIG would not impose administrative sanctions.

Advisory Opinion 15-07 involves the provision of certain subsidies by a medical device manufacturer to patients participating in a clinical research study. The study was designed by the manufacturer, in consultation with CMS, to evaluate the effectiveness of using the manufacturer's system for treating patients with lumbar spinal stenosis. The double-blind study involves patients who are assigned to a treatment group and those who are assigned to a control group. The treatment group undergoes a percutaneous image-guided lumbar decompression (PILD) procedure utilizing the manufacturer's system while the control group receives a sham surgery involving anesthesia and an incision but no treatment. CMS will provide coverage for beneficiaries enrolled in the study. Those receiving the treatment would ordinarily be responsible for their own copayments, however, it would not be appropriate to charge copayments to patients in the control group since they actually would not receive any services. Charging one group but not the other would alert patients about whether they were in the treatment group or the control group. The manufacturer proposes to pay the applicable Medicare co-payments for patients receiving treatment in order to protect the integrity of the study. In addition, once a patient reaches an endpoint after surgery, patients in the control group will be offered the opportunity to receive the PILD procedure with the manufacturer assuming responsibility for the costs. The OIG determined that no sanctions would be imposed because, among other things, the proposed arrangement will assist CMS in determining the effectiveness of the treatment and that the subsidies are necessary to enable a randomized, double-blind study.

CMS Releases Proposed Rule to Update Hospital Inpatient Prospective Payment System

On April 17, CMS released the IPPS update. The rule is voluminous and extensive and, thus, this report only touches on the highlights. The proposed increase in operating payment rates to acute care hospitals which successfully participate in the Hospital Inpatient Quality Reporting and are meeting meaningful use requirements is 1.1 percent. CMS proposes a decrease in DSH payments of $1.3 billion primarily resulting from the decrease in uncompensated care due to the decline in the number of uninsured patients. CMS intends to update the measures of the Hospital Inpatient Quality Reporting to add a total of eight new measures and also intends to expand the number of Hospital Value-Based Purchasing measures. Changes to the Hospital Readmissions Reduction Program include a refinement of the pneumonia readmission cohort and the formal adoption of an extraordinary circumstance exception policy. CMS anticipates that 19.4% of hospitals are anticipated to be penalized with a 1% reduction in MS-DRG payments due to Hospital Acquired Condition Program performance.

New National Practitioner Data Bank Guidebook Released

On April 16 the Health Resources Services Administration, a division of HHS, released a final revised National Practitioner Data Bank Guidebook. This is the first update since 2001. It incorporated changes in legislation and regulations, including the merger of the NPDB with the Healthcare Integrity and Protection Data Bank (HPDB). It attempts to clarify longstanding confusion about whether certain actions are reportable and offers new guidance about when an investigation by a health care provider has commenced which may result in increased reporting. Investigations and routine peer review activities are distinguished. In a departure from prior guidance, the new Guidebook identifies proctorships as reportable if, a proctor is for a period of longer than 30 days as a result of a professional review action. The Guidebook may be found at http://www.npdb.hrsa.gov/resources/NPDBGuidebook.pdf.

CMS Updates Part D Prescribing Regulations

CMS published an interim final rule on May 6 that modifies a previously adopted regulatory requirement related to the qualifications of professionals to prescribe Part D drugs. The previous final rule required Part D sponsors to deny pharmacy claims or beneficiary requests for reimbursement if the prescribing physician or other eligible professional was not either enrolled or validly opted-out of Medicare. CMS has since learned that some states allow pharmacists and other provider types, who do not meet the definition of a physician or eligible professional, to prescribe. In response, the new interim final rule provides that pharmacy claims and beneficiary requests for reimbursement written by prescribers who are authorized to prescribe under state law, other than physicians and other eligible professionals, will not be rejected if all other requirements are met. This action was taken in response to concerns about the potential interruption to beneficiaries' access to medications. Comments on the rule will be accepted until July 6.

Supreme Court Rejects Extended Statute of Limitations Period for False Claims Act Cases Brought by Whistleblowers

In a decision involving the interplay between the Wartime Suspension of Limitations Act and the False Claims Act, the Supreme Court held that civil suits brought by whistleblowers under the False Claims Act are subject to a six-year statute of limitations that cannot be tolled by the Wartime Suspension of Limitations Act. The Court held that the former Act, which purports to toll certain statutes of limitations during wartime, applies only to criminal offenses.

In the same decision, the Court held that once a whistleblower suit under the False Claims Act is dismissed, it is no longer "pending," and does not operate as a bar to future whistleblower suits.

CMS Releases Proposed Rule to Modernize Medicaid Managed Care Regulations and Align Them with Rules Governing Marketplace Plans and Medicare Advantage Plans

On May 26, CMS issued a proposed rule with the goal of aligning the rules governing Medicaid managed care with those of other major sources of health coverage, including those governing qualified health plans purchased through the health insurance marketplace and Medicare Advantage plans. The original Medicaid managed care regulations were published in 2002. Since that time, the use of managed care in Medicaid has expanded significantly, and a number of laws have altered the Medicaid program, including the Affordable Care Act. By aligning the Medicaid managed care rules with those of other sources of coverage, CMS believes it will benefit Medicaid programs and enrollees by enhancing beneficiary protections and enabling smoother transitions between various sources of health care coverage.

The proposals are extensive. They include creating a Medicaid managed care quality rating system, the setting of a minimum medical loss ratio of 85 percent, the requirement that states have a monitoring system for managed care plans, including annual assessments, and new protections for beneficiaries.

OIG issues Fraud Alert Regarding Physician Compensation Arrangements

On June 9, the OIG issued a Fraud Alert warning physicians who enter into compensation arrangements, such as medical directorship agreements, of the risk of violating the anti-kickback statute. Citing recent settlements with 12 physicians who entered into “questionable” medical directorship agreements, the OIG noted that the agreements constituted improper remuneration because they took into account the volume or value of physician referrals and did not reflect fair market value. It identified as problematic arrangements where affiliated health care entities paid the salaries of the physicians’ front office staff thereby relieving the physicians of a financial burden they would have otherwise incurred. The alert cautions providers about criminal, civil and administrative sanctions which may be imposed against those committing health care fraud.

STATE DEVELOPMENTS

New Hampshire DHHS Seeks to Add Another Medicaid Managed Care Organization

On April 1, the NH Department of Health and Human Services issued a request for applications for a healthcare company to become part of the Medicaid Care Management program in the state. Currently there are two managed care organizations operating in the State. Commissioner Nicholas Toumpas stated, “Our goal is that our clients have a choice of managed care organizations. We are issuing this RFA to ensure that we maintain the value of the Medicaid Care Management program through strong partnerships with the organizations providing services to our clients.”

Five New Hampshire Hospitals Join with Tufts to Form New Insurance Plan

Catholic Medical Center, Concord Hospital, LRGHealthcare, Southern New Hampshire Medical Center and Wentworth-Douglass Health System, the five hospitals which make up the Granite Health Network, have joined together with Tufts to offer a new insurance plan. Tufts Health Freedom Plan has applied for licensing from the New Hampshire Insurance Department and expects the plan to be available by January 1, 2016.

Enrollment in the New Hampshire Health Protection Program Reaches a Milestone

As of April 27, more than 39,000 New Hampshire residents were receiving care through the New Hampshire Health Protection Program. The percentage of the population now being served is highest in Coos County at 4.94% and lowest in the Hanover/Lebanon area at 1.50%. Emergency room visits by the

uninsured have dropped by 22% this year and inpatient admissions by 27%. Despite the popularity of the program, its future remains in question as the program will sunset on December 31, 2016 unless the legislature votes to reauthorize it. Efforts to obtain reauthorization have been unsuccessful in this legislative session. Those voting in opposition have called for more information about the program including the transition to private insurers on the exchange scheduled to begin on January 1, 2016.

New Hampshire Selects Three Companies to Operate Medical Marijuana Treatment Centers

Of the 14 companies who applied to operate medical marijuana treatment centers, 3 have been selected to operate centers in 4 geographic areas of the state. Prime Alternative Treatment Centers of NH was selected for Area 2 (Concord, Manchester, Franklin and Nashua). Sanctuary ATC was selected to serve Area 4 which covers much of the northern part of the state and Temescal Wellness was selected to operate centers in Areas 1 and 3 (Portsmouth, Exeter and Salem on one side of the state and Hanover, Lebanon and Keene on the other). The state anticipates operation may begin in another 8-9 months.

Legislative Update

The budget process continues. The House and Senate have approved different versions of HB 1 and HB2, and the House has appointed members to a Committee of Conference. We will report on the budget upon its final adoption. We are monitoring the following bills:

- HB 151: Establishes a committee to study end-of-life decisions. The bill was **passed** by both the House and the Senate, but was **vetoed** by the Governor.

- HB 271: This bill exempts from the provisions of the Controlled Drug Act a health care professional or other person who prescribes, dispenses, distributes, or stores an opioid antagonist, or who administers it to an individual suffering from an apparent opioid-related overdose. Voted **Ought to Pass with Amendment** by the House. The amendment changes the effective date of the bill from January 1, 2016 to the date of passage. The Senate **passed** the amended bill, and the Governor **signed** it. It became law on June 2.

- HB 326: This bill clarifies certain membership positions on the board of registration of medical technicians by adding registered or certified health care providers to the list of those who can serve on the board. **Voted Ought to Pass with Amendment** by the House. The amendment changes the membership of the board to allow the inclusion of a medical technician, provides for sharing of the board's data with the OIG and other administrative changes. The Senate **passed** the amended bill.

- HB 330: This bill establishes an oversight commission for medical cost transparency to monitor and further develop the NH HealthCost Internet website. Voted **Ought to Pass with Amendment** by the House. The amendment changes the composition of the commission. Voted **Ought to Pass with Amendment** by the Senate. This amendment also changes the composition of the commission.

- HB 413-FN: This bill establishes the governing board of polysomnographic technologists within the allied health professionals, defines the practice of polysomnography, and requires licensure of persons engaged in the practice. Voted **Inexpedient to Legislate** by the House.

- HB 422-FN: This bill allows physician assistants to certify death certificates and to authorize involuntary commitment and voluntary admission to state institutions. Voted **Ought to Pass with Amendment** by

House Health and Human Services Committee (17-0). The amendment deletes the authority to authorize involuntary commitment and voluntary admission to state institutions. The Senate **passed** the amended bill and amended the bill in enrollment to correct grammatical errors. The House approved the amendment.

- HB 476-FN: This bill adds several medical conditions to the definition of "qualifying medical condition" for the purposes of the law governing the use of cannabis for therapeutic purposes including epilepsy, lupus, Parkinson's disease, and dementia associated with Alzheimer's disease. Voted **Ought to Pass with Amendment** by the House. The bill was then introduced in the Senate and referred to the Health and Human Services Committee where it was voted **Ought to Pass with Amendment** (to add colitis). The bill was further amended on the Senate floor (colitis deleted) and **passed as amended**. The House **concurred** with the Senate amendments.

- HB 477- FN: This bill changes the weekly compensation for temporary total disability, permanent total disability, and temporary partial and permanent partial disability. This bill also requires the Labor Commissioner to establish medical payment schedules. Introduced and referred to House Labor, Industrial and Rehabilitative Services Committee. The bill has been **Retained in Committee**.

- HB 484: This bill modifies definitions, adds requirements for members appointed to the board of nursing and adds exemptions from licensure for administration of medications by assistive personnel and for attendant care services. **Voted Ought to Pass with Amendment** by the Executive Departments and Administration Committee (16-0). The amendment proposes language to clarify the authority of LNAs to administer medication in home care, residential care and adult day care settings and adds an exemption from regulation. The Senate **voted ought to pass with amendment** to add hospice as an additional setting. The House **concurred** with the Senate amendment.

- HB 508: This bill establishes a procedure for the dissolution of the New Hampshire medical malpractice Joint Underwriting Association (NHMMJUA). Introduced to House Judiciary Committee. **Voted Ought to Pass with Amendment** by Committee on Commerce and Consumer Affairs (15-1). The Amendment makes several technical changes but also includes a provision providing that the bill shall not be construed to alter any vested contractual rights that any class of NHMMJUA policyholders may have with respect to excess surplus of the NHMMJUA. The bill was introduced in the Senate and referred to the Executive Departments and Administration Committee. The Committee voted **Ought to Pass with Amendment**, as did the full Senate, adding two floor amendments. The Senate Committee Amendment makes some structural changes to the dissolution process but carries forward the provision regarding vested contractual rights. One floor amendment requires creation of a dissolution reserve for satisfying hardship claims by current policyholders. The other adds a provision that requires insurers covering oral anti-cancer therapies to require the same copayment, deductible or coinsurance amount for patient administered medication as for injected or intravenously administered anti-cancer medication. The bill now returns to the House.

- HB 548: This bill establishes the federally-facilitated health exchange as the health exchange for New Hampshire. Voted **Inexpedient to Legislate** by the House.

- HB 564-FN: This bill declares that a managed care health benefit plan offering prescription drug benefits to Medicaid recipients shall not require prior authorization for certain drugs used to treat mental illness. Voted **Ought to Pass with Amendment** by the House Health and Human Services Committee (13-4).

The amendment makes the bill applicable to Medicaid managed care organizations rather than all managed care organizations. The Senate voted **ought to pass with amendment**. The amendment requires a managed care organization offering prescription benefits to Medicaid recipients to suspend prior authorization requirements for a community mental health program for drugs used to treat mental illness and also requires HHS to report to an oversight committee. The House **Concurred** with the Senate amendment.

- HB 593-FN: This bill permits qualifying patients and registered caregivers to cultivate cannabis for therapeutic use. Voted **Inexpedient to Legislate** by the House Health and Human Services Committee (9-8). With this close vote, watch for the debate on the floor of the full House. The full House considered the bill and voted **Ought to Pass**. The Senate introduced the bill and referred it to Health and Human Services which **voted to re-refer** the bill to committee.

- HB 600-FN: This bill requires employers to provide paid sick leave for employees. Voted **Inexpedient to Legislate** by House.

- HB 628-FN: This bill declares that any facility licensed under RSA -151 may provide employment information to any other facility regarding an employee or prospective employee if the information is provided in good faith. The facility, its directors and employees will be immune from civil liability for providing the information unless the information provided is proven to be false and was provided with knowledge of its falsity. **Voted Ought to Pass with Amendment** by the House Health and Human Services Committee (17-0). The amendment changes this from a disclosure that a facility "may" make to one that it "shall" make. One word with a big difference. The bill was introduced in the Senate and referred to Health and Human Services where it was amended to remove the obligation to provide information and rather to expand the immunity for making such amendment and voted **Ought to Pass**. The bill was then re-referred to Committee.

- SB 7: This bill requires the joint health care reform oversight committee to provide oversight, policy direction and recommendations for legislation regarding implementation of managed care and the NH Health Protection Plan. Introduced and referred to Senate Health and Human Services Committee. The bill was **retained in Committee.**

- SB 23: This bill allows certain advanced practice registered nurses to authorize involuntary commitment and voluntary admission to state institutions. Voted **Ought to Pass** by the Senate Health and Human Services Committee. The bill was introduced in the House and referred to the Health and Human Services Committee. It was voted **Ought to Pass with Amendment** by the Committee and then the full House. The amendment corrected a technical error in the bill. Senator Sanborn concurred with the amendment and the bill was **Enrolled**.

- SB 45: This bill requires an injured worker and his or her health care provider to enter into an opioid treatment agreement outlining the procedures for opioid use under workers' compensation. The Senate voted Ought to Pass with Amendment. The Amendment required employer or its insurance carrier to cover the cost of any drug testing required under the opioid treatment agreement. The bill was introduced in the House and referred to the Labor, Industrial and Rehabilitative Services Committee. It was **retained in Committee**.

- SB 84: This bill clarifies when it is appropriate to use telemedicine. Under this bill, a practitioner shall

not prescribe controlled drugs, Schedule II-IV, by means of telemedicine. Voted **Ought to Pass** by the Senate. The House voted **Ought to Pass with Amendment**. The amendment allowed for the prescribing of controlled drugs, Schedule II-IV after an initial in-person examination by a practitioner licensed to prescribe and then an annual in-person exam thereafter. The Senate did not concur and requested a committee of conference. The House acceded to the request and appointed a Committee of Conference.

- SB 108-FN: This bill make changes to the law governing the reporting of health care associated infections including expanding the list of facilities with a reporting requirement to include end-stage renal dialysis centers, nursing and other residential care facilities and assisted living residences. It is requested by the Department of Health and Human Services. Voted **Ought to Pass with Amendment** by the Senate. The amendment changed the requirement for tracking and reporting influenza vaccination rate of patients and health care personnel and deleted language relative to how facilities will be assessed for the cost of program. The House voted **Ought to Pass with further Amendment**. The House amendment added back the requirements for tracking and reporting requirements for coverage rates for influenza vaccination rates but also added language making it clear that the bill does not mandate or require influenza vaccinations for health care workers or patients/residents in health care facilities. Senator Sanborn moved for noncurrence and the Senate requested a Committee of Conference.

- SB 112: This bill requires Medicaid coverage under RSA-420-J to cover telemedicine services. The Senate voted **Ought to Pass with Amendment**. The amendment codifies the definition of telemedicine and the coverage requirement under the Medicaid statute rather than the insurance statute. The House voted **Ought to Pass with Amendment**. The amendment references CMS requirements of telehealth, conditions the section on approval of a Medicaid State Plan Amendment and establishes an advisory committee for implementation of Medicaid telehealth services. The bill was then referred to the Finance Committee. The Committee and full House voted **Ought to Pass with Amendment**. This amendment makes a slight wording change and also directs that the program shall commence on July 1, 2016, but not without approval of the fiscal committee of the general court by February 1, 2016, and requires the Department of Health and Human Services to report on the program's financial impact for its first six months by March 1, 2017. Senator Sanborn concurred with the House Amendments.

- SB 130: This bill establishes an opt out option for participation in the immunization registry. It is requested by the Department of Health and Human Services. Introduced and referred to Senate Health and Human Services Committee. The bill has been **Laid on Table**.

- SB 133-FN: This bill requires certain encrypted health care information collected by the insurance department to be available to the public upon request to the Department of Health and Human Services under certain circumstances. Voted **Ought to Pass with Amendment** by the Senate Commerce Committee. The amendment adds language to include workers compensation medical claims data in the New Hampshire comprehensive health information system and to make such data available to the public. The House voted **Ought to Pass with Amendment**. The bill was then referred to the Labor, Industrial and Rehabilitative Services Committee where an amendment was introduced to require the Insurance Department to develop and publish a workers' compensation fee schedule. The full House voted **Ought to Pass with Amendment**, and Senator Sanborn concurred. That amendment deleted the requirement to make data available to the public and the requirement to develop and publish a workers' compensation fee schedule, instead providing simply that the Commissioner shall consult and make a report on options for including workers' compensation medical claims data in the New Hampshire

comprehensive health information system on or before December 1, 2015. Significantly, the amendment also proposes to amend the workers' compensation law by providing that the employer shall pay the reasonable value of medical services provided and that the health care provider shall have the burden of establishing that its bill for services is reasonable. Under the proposal, if the payor and health care provider cannot resolve a dispute about the reasonable value of services, the Commissioner or its representative has exclusive authority to hold a hearing to resolve the issue.

- SB 176: 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 certain conditions are met. Voted **Inexpedient to Legislate** by the Senate.

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Cinde Warmington and Benjamin Siracusa Hillman contributed to this month's Legal Update. Our last update was on March 11, 2015 and our next update will be on September 9, 2015.

BIOS

CINDE WARMINGTON
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.

BENJAMIN SIRACUSA HILLMAN
Ben assists individual practitioners, group practices, and hospitals with a variety of health related business, regulatory, and litigation issues, and advises small businesses on compliance with the Affordable Care Act. Ben also practices in the areas of civil litigation, elder law, estate planning and probate.

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