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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

Star Ratings Released for Drug Plans

On October 11, 2017, the Centers for Medicare & Medicaid Services ("CMS") announced its release of Star Ratings for 2018 health and drug plans in advance of Medicare's open enrollment on October 15. The Star Ratings provide a method for individuals to compare the quality of health and drug plans being offered by giving health and drug plans a rating between 1 and 5 stars, with a 1 star reflecting poor performance and 5 stars reflecting excellent performance.

The Star Ratings are available through the online Medicare Plan Finder tool at: https://www.medicare.gov/find-a-plan/questions/home.aspx

CMS Effective at Preventing Capitation Payments for Deceased Beneficiaries

On October 12, 2017, the U.S. Department of Health and Human Services Office of Inspector General ("OIG") released a report finding that the Centers for Medicare & Medicaid Services ("CMS") is generally effective at ensuring that Medicare does not make capitation payments to Medicare Advantage ("MA") organizations for deceased beneficiaries. The report, titled *CMS's Policies and Procedures Were Generally Effective in Ensuring That Capitation Payments Were Not Made After Beneficiaries' Dates of Death*, revealed that from years 2012 through 2015, CMS adjusted and recouped $2.96 billion from MA organizations for Parts A and B capitation payments made for deceased beneficiaries. Nevertheless, OIG noted that CMS had not recouped $2.4 million in improper capitation payments to MA organizations for deceased individuals as of March 7, 2017, and recommended that CMS recoup those payments and implement system enhancements to help identify, adjust and recoup improper payments in the future. CMS agreed with the recommendations.

The report may be read in full at:
https://oig.hhs.gov/oas/reports/region7/71605087.pdf

Executive Order Expands Access to Health Plans

On October 12, 2017, President Donald Trump signed an executive order aimed at facilitating the purchase of insurance across State lines and the development and operation of a high-quality affordable healthcare system. The executive order identified three areas the Trump administration will focus on in the near future, including expanding access to, and flexibility of, alternatives to "expensive, mandate-laden PPACA insurance", such as association health plans ("AHPs"), short-term, limited-duration insurance ("STLDI"), and health reimbursement arrangements ("HRAs"). It also provided that the Administration would focus on "promoting competition in healthcare markets and limiting excessive consolidation throughout the healthcare system."

The executive order called for the Secretary of Labor, within 60 days of the order, to consider proposing regulations or revising guidance to expand access to health coverage by allowing more employers to form AHPs. Specifically, President Trump instructed the Secretary to "consider expanding the conditions that satisfy the commonality-of interest requirements under current Department of Labor advisory opinions interpreting the definition of an "employer" under section 3(5) of the Employee Retirement Income Security Act of 1974" and to "promote AHP formation on the basis of common geography or industry."

Also within 60 days of the order, President Trump stated the Secretaries of the Treasury, Labor, and Health and Human Services shall consider expanding the availability of STLDI, including allowing it to cover longer periods and be renewed by the consumer, while criticizing the previous administration for restricting access to the STLDI market by reducing the allowable coverage period and preventing extensions by policyholders.

Finally, within 120 days of the order, the Secretaries of Treasury, Labor, and Health and Human Services shall consider proposing regulations or revising guidance "to increase the usability of HRAs, to expand employers' ability to offer HRAs to their employees, and to allow HRAs to be used in conjunction with nongroup coverage."

The executive order requires the Secretary of Health and Human Services to provide a report to the President within 180 days and every 2 years thereafter detailing the extent to which State and Federal laws, regulations, guidance, requirements, and policies fail to conform to the policies of the executive order and identifying State or Federal actions that could further the policies.

The executive order is available at: https://www.whitehouse.gov/the-press-office/2017/10/12/presidential-executive-order-promoting-healthcare-choice-and-competition

President Trump Announces Elimination of Cost-Sharing Reduction Subsidies

On October 12, 2017, shortly after issuing his executive order to make changes in the health care system, the Trump administration announced it was eliminating cost-sharing reduction ("CSR") subsidies paid to insurers for reducing copayments, deductibles, and other out-of-pocket costs for low-income individuals. The U.S. Department of Health and Human Services ("HHS") Acting Secretary, Eric Hargan, and Centers for Medicare & Medicaid Services ("CMS") Administrator, Seema Verma, released the following statement, explaining that "The Obama Administration unfortunately went ahead and made CSR payments to insurance companies after requesting - but never ultimately receiving - an appropriation from Congress as required by law. . . . After a thorough legal review by HHS, Treasury, OMB, and an opinion from the Attorney General, we believe that the last Administration overstepped the legal boundaries drawn by our Constitution. Congress has not appropriated money for CSRs, and we will discontinue these payments immediately."

Proponents of the CSR subsidies emphasize that the payments are critical to stabilizing the individual insurance markets and keeping premiums low. In an August 2017 report, the Congressional Budget Office ("CBO") estimated that ending the CSR payments would increase the federal deficit by $194 billion from 2017 through 2026 because the federal government provides tax credits to eligible individuals that are tied to premiums. The report explained that without CSR payments to insurers, the average tax credit would increase and the number of people receiving them would increase. The CBO's report also predicted that ending the CSR subsidies would result in insurers withdrawing from or choosing not to enter into

marketplaces because of "substantial uncertainty about the effects of the policy on average health care costs for people purchasing plans."

In New Hampshire, both the Commissioner of the Insurance Department and the Governor expressed regret at the action taken by the President. They cited concerns that the elimination of CSR patients could cause instability in the insurance marketplace but also noted that New Hampshire had prepared for this possibility by allowing insurers to file rates that assumed these payments would not be made. The Commissioner noted that all three insurers offering plans next year filed rates assuming federal payments would not be made.

The press release from HHS and CMS is available here:
https://www.hhs.gov/about/news/2017/10/12/trump-administration-takes-action-abide-law-constitution-discontinue-csr-payments.html

The CBO report may be read in full here:
https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53009-costsharingreductions.pdf

Bipartisan Short-Term Legislation to Stabilize ACA

On October 19, 2017, a group of 24 senators – 12 Republicans and 12 Democrats – released a short-term bill called, "The Bipartisan Health Care Stabilization Act of 2017" to stabilize premiums and access to insurance in individual health insurance markets. With regard to cost sharing payments, the legislation appropriates cost sharing reduction subsidies ("CSRs") for 2017-2019. The legislation will also protect existing patient protections under the Affordable Care Act ("ACA") including, the prohibition on charging more for pre-existing conditions, guaranteed issue, the provision of adult child coverage up to age 26, and the prohibition on annual and lifetime limits. It streamlines the 1332 waiver application process by allowing Governors to apply for a waiver without needing additional state legislation, reducing the Health and Human Services ("HHS") review period from 180 to 90 days, and establishing a fast-track, 45-day approval process. Section 1332 of the ACA permits a state to apply for a State Innovation Waiver to pursue innovative strategies for providing their residents with access to health insurance while retaining the basic protections of the ACA. Once waivers are approved, they will last for 6 years, which is an increase from the current maximum of 5 years. Additionally, the legislation allows all individuals, regardless of age or hardship status, to purchase a lower-premium "copper plan," also known as a catastrophic health plan. Also, HHS is required to report on consumer outreach and education activities, and promulgate regulations for the implementation of Health Care Choice Compacts, which would allow plans to be sold across state lines in the individual or small group market.

On October 25, 2017, the nonpartisan Congressional Budget Office ("CBO") issued a cost estimate for the bill, showing that it would reduce the budget deficit by $3.8 billion over ten years. The CBO estimate also states that the bill would not be expected to substantially change the number of people with health insurance coverage, and would not increase net direct spending or on-budget deficits in any of the four consecutive ten-year periods beginning in 2028.

The bill may be reviewed at:
https://www.help.senate.gov/imo/media/doc/THE%20BIPARTISAN%20HEALTH%20CARE%20STABILIZATION%20ACT%20OF%202017-%20TEXT.pdf

A section-by-section summary of the bill is available at: https://www.help.senate.gov/imo/media/doc/THE%20BIPARTISAN%20HEALTH%20CARE%20STABILIZATION%20ACT%20OF%202017-%20SECTION%20BY%20SECTION.pdf

The CBO cost estimate is available at: https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/bipartisanhealthcarestabilizationactof2017_0.pdf

New Items Added to 2017 OIG Work Plan

In October 2017, the Department of Health and Human Services Office of Inspector General (OIG) added a number of action items to its 2017 work plan, a process the OIG previously announced it would do on a monthly basis in an effort to improve transparency. New items include the following:

- Secretary Price's Use of Chartered Aircraft for Federal Travel
- Specialty Drug Coverage and Reimbursement in Medicaid
- FDA Oversight of Risk Evaluation and Mitigation Strategies to Address Prescription Opioid Abuse
- Drug Traceability Test
- Review of Medicare Payments for Bariatric Surgeries

The complete list of active work plan items can be found on the OIG's website here: https://oig.hhs.gov/reports-and-publications/workplan/active-item-table.asp

President Trump Declares the Ongoing Opioid Crisis a Public Health Emergency

On October 26, 2017, President Trump officially declared the ongoing opioid crisis in the United States a public health emergency. The declaration allows the Department of Health and Human Services additional flexibility to shift and refocus personnel and other resources to combat the epidemic. President Trump's action comes after his announcement in August that he planned to declare a public health emergency following an interim report issued by the White House Commission on Combatting Drug Addiction and the Opioid Crisis recommending that a public health emergency be declared. President Trump also stated when making the declaration that the federal government would look into pursuing "very major lawsuits against people and against companies that are hurting our people."

Many Democratic lawmakers and others criticized the declaration as a "half-measure," because President Trump failed to seek emergency funding to assist in combatting the opioid epidemic. Democratic Senators Ed Markey and Bob Casey introduced legislation on October 25 that would allocate $45 million to fight the opioid crisis.

President Trump's declaration can be read at: https://www.whitehouse.gov/the-press-office/2017/10/26/remarks-president-trump-combatting-drug-demand-and-opioid-crisis

OIG Report Concludes that CMS Ensured that Beneficiaries Were Properly Assigned to ACOs

On October 23, 2017, the Office of the Inspector General ("OIG") released a report concluding that the Centers for Medicare & Medicaid Services ("CMS") ensured that Medicare Shared Savings Program ("MSSP") beneficiaries were properly assigned to only one Accountable Care Organization ("ACO") and were not assigned to other shared savings programs. OIG conducted a review of CMS' administration of the MSSP as part of its body of work covering CMS' administration and testing of payment and service delivery models. OIG's objective was to determine whether CMS complied with certain Federal requirements when assigning beneficiaries to ACOs in the MSSP during plan years 2013 through 2015.

Each plan year, CMS assigns a Medicare beneficiary to an ACO based on where he or she receives a plurality of primary care services as determined by the highest Medicare allowed amount for services when compared with other ACOs, individual providers, or provider organizations. As part of its efforts to avoid beneficiary enrollment in more than one ACO, CMS works to ensure that any ACO participant that provides primary care services is a participant in no more than one ACO, so that beneficiaries who receive primary care services from that participant are assigned to only a single ACO in the MSSP.

To determine whether CMS was properly assigning beneficiaries, OIG conducted a review of approximately 9.7 million beneficiaries that were assigned by CMS to ACOs during the first three plan years. After conducting its review, OIG concluded that CMS had sufficient processes in place to ensure compliance, including determining whether an ACO participant belonged to only one ACO during the ACO application process, and requesting that the ACO work with the participant to select one ACO. CMS also had processes in place to determine whether beneficiaries were assigned to other shared savings programs and to resolve the beneficiary overlaps. OIG made no recommendations to CMS in connection with its review.

OIG's report, *CMS Ensured That Medicare Shared Savings Program Beneficiaries Were Properly Assigned: Beneficiaries Were Assigned to Only One Accountable Care Organization and Were Not Assigned to Other Shared Savings Programs*, is available at: https://oig.hhs.gov/oas/reports/region9/91703010.pdf

CMS Publishes Final Rule on 2018 Physician Fee Schedule

On November 2, the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services ("CMS") issued a final rule on the 2018 Physician Fee Schedule ("Final Rule"). The Final Rule includes various changes to payment provisions, including: changes in valuation for specific services based on recommendations from the Relative Value Scale Update Committee; a 0.41 percent overall increase to payments under the Physician Fee Schedule, resulting in a conversion factor in 2018 of $35.99, up from $35.89 in 2017; a 20 percent reduction to payment rates under the Physician Fee Schedule for certain items and services furnished by certain off-campus hospital outpatient provider-based departments; the addition of several new codes for telehealth services; and increasing payments for in-office behavioral health services to better recognize overhead payments. Additional changes were made to payments for drugs under Medicare Part B, the Physician Quality Reporting System, Medicare Shared Savings Program, and the 2018 Value Modifier.

The Final Rule is available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-23953.pdf

CMS' Fact Sheet on the Final Rule is available at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-02.html

CMS Issues Final Rule on OPPS, ASCs, 340B Program

On November 1, the U.S. Department of Health & Human Services Centers for Medicare & Medicaid Services ("CMS") issued a final rule on changes and updates to the Hospital Outpatient Prospective Payment System ("OPPS") and the Ambulatory Surgical Center ("ASC") Payment System for calendar year 2018 ("Final Rule"). The Final Rule increases OPPS payment rates by 1.35 percent for 2018, based on the hospital market basket increase of 2.7 percent, a 0.6 percentage reduction for multi-factor productivity, and a 0.75 percent adjustment required by law. CMS estimates that the payment rate increase, when other policy

changes are factored in, will result in an overall impact of a 1.4 percent payment increase for providers under the OPPS.

The Final Rule also includes adjustments to the payment rate for ASCs, based on the Consumer Price Index for urban consumers ("CPI-U") along with a multi-factor productivity ("MFP") adjustment. For 2018, the CPI-U is 1.7 percent, and the MFP adjustment is 0.5 percent, resulting in an overall payment update factor of 1.2 percent. With other changes, CMS estimates payments to ASCs to increase by 3 percent in 2018.

The Final Rule also finalizes a controversial change to the 340B drug discount program that was first included in the proposed rule in July. Beginning on January 1, 2018, CMS will pay for separately payable drugs and biologics purchased through the 340B Program at the amount equal to the average sales price ("ASP") minus 22.5 percent, rather than the ASP plus 6 percent that was paid in the past. CMS will continue to pay for non-340B Program drugs at ASP plus 6 percent. This change is expected to decrease drug payments by $1.6 billion. Rural Sole Community Hospitals, PPS-exempt Cancer Hospitals, and Children's Hospitals are exempt from this change in 2018. CMS has stated that its goal in implementing this payment change is to reduce drug co-payment costs for beneficiaries.

The Final Rule is available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-23932.pdf

CMS' Fact Sheet on the Final Rule is available at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-01.html

OCR Issues Guidance on How Covered Entities May Respond to the Opioid Crises under HIPAA

On October 27, the U.S. Department of Health and Human Services, Office for Civil Rights ("OCR") issued new guidance titled "How HIPAA Allows Doctors to Respond to the Opioid Crisis," which contains information on how the HIPAA Privacy Rule allows covered entities to share certain information with a patient's family members without the patient's consent "during certain crisis situations." The guidance highlights provisions of the Privacy Rule that allow for sharing patient information without consent, including sharing information with someone involved in the patient's care when the patient is incapacitated or unconscious, and informing persons in a position to prevent or lessen a serious and imminent threat to a patient's health or safety. The guidance confirms that a patient who has the capacity to make his or her own decisions must be given the opportunity to object to the sharing of their information with family, but also notes that a patient's decision-making capacity may change during the course of treatment, and that covered entities and their employees must respect the patient's wishes if decision-making capacity is regained during treatment, despite any previous disclosure to family members. The guidance also discusses the Privacy Rule provision for disclosures to a patient's personal representative under state law. Providers should remain vigilant about disclosures which are subject to more stringent privacy protections under other state and federal laws including but not limited to 42 CFR Part 2 governing the privacy of patient records in substance abuse treatment programs.

OCR's guidance is available at: https://www.hhs.gov/sites/default/files/hipaa-opioid-crisis.pdf

IRS Announces Change to Policy on Health Coverage Requirements under ACA and Offers Information on ACA Tax Requirements

The Internal Revenue Service ("IRS") recently announced that: "For the upcoming 2018 filing season, the IRS will not accept electronically filed tax returns where the taxpayer does not address the health coverage requirements of the Affordable Care Act." This includes when the taxpayer fails to indicate "whether they had coverage, had an exemption or will make a shared responsibility payment." Additionally, the IRS announcement states that even "returns filed on paper that do not address the health coverage requirements may be suspended pending the receipt of additional information and any refunds may be delayed." This announcement was made on the IRS' "ACA Information Center for Tax Professionals" ("Information Center"), a repository of information for complying with the tax requirements for individuals and employers under the ACA.

The link to the Information Center where the IRS made the announcement is located at: https://www.irs.gov/tax-professionals/aca-information-center-for-tax-professionals

CMS Issues Quality Payment Program Rule for Year 2

On November 2, the Centers for Medicare & Medicaid Services ("CMS") issued a final rule with comment period for the Quality Payment Program ("QPP") Year 2, as well as an interim final rule with comment. The QPP, established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), is a quality payment incentive program for physicians and other eligible clinicians, which rewards value and outcomes in one of two ways: through the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

With regard to MIPS, many of the transition year policies were retained. Minor changes include: (1) Raising the performance threshold to 15 points in Year 2 (from 3 points in the transition year); (2) Allowing the use of 2014 Edition and/or 2015 Certified Electronic Health Record Technology (CEHRT) in Year 2, and giving a bonus for using only 2015 CEHRT; (3) Giving up to 5 bonus points on final scores for treatment of complex patients; (4) Automatically weighting the Quality, Advancing Care Information, and Improvement Activities performance categories at 0% of the final score for clinicians impacted by natural disasters; and, (5) Adding 5 bonus points to the final scores of small practices.

With regard to APMs, CMS has provided more details on how it will incentivize clinicians who participate in APMs offered by payers other than Medicare, starting in 2019. It has updated its policies to further encourage and reward participation in APMs in Medicare including: (1) Providing more detail on how eligible clinicians participating in selected Advanced Alternative Payment Models (APMs) will be assessed under the APM scoring standard; and, (2) Creating additional flexibilities and pathways to allow clinicians to be successful under the All Payer Combination Option.

The provisions of the final rule with comment period and the interim final rule with comment period are effective on January 1, 2018. Comments must be received no later than January 1, 2018.

The final rule is scheduled to be published on November 16, 2017. An unpublished version can be read at: https://www.federalregister.gov/documents/2017/11/16/2017-24067/medicare-programs-cy-2018-updates-to-the-quality-payment-program-and-quality-payment-program-extreme

An Executive Summary of the rule can be read at: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-Year-2-Executive-Summary.pdf

House Passes Five-Year Extension of CHIP Funding

On November 3, 2017, the House voted to approve legislation that reauthorizes funding to the Children's Health Insurance Program ("CHIP"), whose funding ran out on September 30. The Championing Health Kids Act (H.R. 3922) extends funding for five years for CHIP allotments, the Child Enrollment Contingency Fund, the Childhood Obesity Demonstration Project, the Pediatric Quality Measures Program, and specified outreach and enrollment grants. It provides two year extensions of funding for additional public health programs. The measure also eliminates the Medicaid Disproportionate Share Hospital (DSH) reductions included in the Affordable Care Act (ACA) for fiscal years 2018 and 2019, and provides $1 billion for the Medicaid programs in Puerto Rico and the Virgin Islands through fiscal year 2019 to address shortfalls caused by recent hurricanes. The bill passed by the House and the bill in the Senate have some differences which would need to be resolved before passage of a final bill. The House bill includes provisions which offset the cost of extending CHIP which are not included in the current version of the Senate bill.

H.R. 3922 can be viewed at: https://policy.house.gov/legislative/bills/hr-3922-championing-healthy-kids-act-2017

Medicare Payments to Home Health Agencies to Decrease $80 Million in 2018

On November 1, 2017, the Centers for Medicare and Medicaid Services ("CMS") issued a final rule (CMS-1672-F) that updates the calendar year 2018 Medicare payment rates and the wage index for home health agencies ("HHAs") serving Medicare beneficiaries, and finalizes proposals for the Home Health Value-Based Purchasing ("HHVBP") Model and the Home Health Quality Reporting Program (HH QRP).

According to a fact sheet issued by CMS, it projects that Medicare payments to HHAs in calendar year 2018 will be reduced by 0.4 percent, or $80 million, based on the finalized policies. This decrease reflects the effect of a one percent home health payment update percentage ($190 million increase); a -0.97 percent adjustment to the national, standardized 60-day episode payment rate to account for nominal case-mix growth for an impact of -0.9 percent ($170 million decrease); and the sunset of the rural add-on provision ($100 million decrease).

Notably, the rule does not finalize the Home Health Groupings Model which was included in the July 2017 proposed rule. After receiving criticism on the model, CMS stated in the fact sheet that it "will take additional time to further engage with stakeholders to move towards a system that shifts the focus from volume of services to a more patient-centered model."

The final rule includes several changes to the HHVBP Model. It also adopts three new quality measures beginning with the calendar year 2020 HH QRP to meet the requirements of the Improving Medicare Post-Acute Care Transformation Act of 2014.

The final rule, published in the November 7 *Federal Register, can be viewed at:* https://www.federalregister.gov/public-inspection.

CMS Announces Initiative to Reduce Quality Reporting Burden

On October 30, 2017, Centers for Medicare and Medicaid Services ("CMS") issued a press release announcing a "Meaningful Measures" initiative to reduce the burden of quality reporting measures on health care providers. CMS Administrator Seema Verma announced the initiative and stated, "We need to move from fee-for-service to a system that pays for value and quality – but how we define value and quality today

is a problem." CMS aims to focus on outcome-based measures going forward, as opposed to trying to micromanage processes.

The press release can be viewed at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-10-30.html

STATE DEVELOPMENTS

NH Department of Health and Human Services Creates New Division of Long Term Supports and Services

On October 20, Jeffrey Meyers, the Commissioner of the Department of Health and Human Services announced the creation of the Division of Long-term Supports and Services. This new division will include the Bureau of Elderly and Adult Services, the Bureau of Developmental Services, and Special Medical Services. The Division will be led by Christine Santaniello, who has, since October 2016, served as the Director of the Bureau of Developmental Services. The division was formed in response to current state demographics and the anticipation of the future needs of the state's aging and disability population groups. Commissioner Meyers stated as follows: "We recognize the similarities and differences among these bureaus and believe that by bringing them together under one division, we can strengthen the services and supports we provide our residents."

Open Enrollment for the Individual Health Insurance Market Began November 1

On October 31, New Hampshire Insurance Department issued a press release reminding individuals of the open enrollment period for the individual health insurance market beginning on November 1. There are 53,000 New Hampshire residents who obtain coverage through the marketplace. The enrollment period is shorter this year than in prior years and will close on December 15. The Department also alerted individuals that they may receive a letter indicating that their premiums will be increasing substantially. For those who do not qualify for a federal subsidy, the average increase will be 52%. However, individuals who receive subsidies may or may not see increases and will need to check on healthcare.gov to estimate the new subsidies and premium amounts. Individuals are also reminded that Minuteman Health is no longer offering plans in the marketplace and Harvard Pilgrim has limited its offering to its ElevateHealth network. The press release provides contact information for those needing assistance in obtaining coverage.

The press release may be found at https://www.nh.gov/insurance/media/pr/2017/documents/10-31-17-nhid-open-enrollment-begins-nov-1.pdf

DHHS Issues Proposed Rules Regarding DSH Payments and Uncompensated Care Reporting

The Department of Health and Human Services issued proposed rules regarding the payments to non-public disproportionate share hospitals and uncompensated care fund reporting requirements (NH Administrative Rules He-C 5001 and He-C 5002). The Notice of Rulemaking states that the change in the definition of "uncompensated care" is needed to bring state regulations into compliance with federal law. It indicates that the federal law has been clarified to require that all third-party payments are to be included in determining which costs remain uncompensated when a hospital provides care to a Medicaid eligible patient, and not just payments received from Medicaid. The definition of a "disproportionate share non-public hospital" has been changed to remove rehabilitation hospitals for the purposes of the DSH program. The proposed rules amend the annual Medicaid uncompensated care data request form and changes the filing deadline from the first Friday in March to the last Friday in January. The public hearing on the proposed rules is scheduled for November 27, 2017. The deadline for submission of written comments is Monday,

December 4.

The proposed rule may be found at: https://www.dhhs.nh.gov/oos/aru/documents/hec5001ip.pdf

DHHS Proposes Increased Copayment for Participants in Premium Assistance Program

The Department of Health and Human Services has issued a proposed amendment to the rules governing alternative benefit plans and premium assistance program copayments (NH Admin. Rule He-W 512.06). Under the proposed rule, participants in the Premium Assistance Program with income greater than 100% of the federal poverty level will see an increase in copayment amounts on specific services. Copayments for primary care provider visits, laboratory outpatient visits, physical and occupational therapy visits, and high technology radiology imaging will all be increased. Changes will also be made to the pharmacy co-payment amounts depending on the type of drug. No changes in the copayment amounts are proposed for physician specialty visits, speech therapy visits or inpatient admissions. A public hearing on the proposed rule will be held on November 27. The deadline for the submission of written comments is December 4.

The proposed rule may be found at: https://www.dhhs.nh.gov/oos/aru/documents/hew512ip.pdf

DHHS Issues Proposed Rule on Opioid Treatment Programs

The Department of Health and Human Services has issued proposed amended rules governing the certification of opioid treatment programs (He-A 304). The current interim rules are set to expire on November 16, 2017. The proposal makes numerous changes to the current rule and expands the scope of the rule to include buprenorphine treatment programs as well as previously regulated methadone programs. The comment period closed Thursday, October 26. The Department has not yet released its final proposed rule to be considered by the Joint Legislative Committee on Administrative Rules (JLCAR).

The proposed rules may be found at: https://www.dhhs.nh.gov/oos/aru/documents/hea304ip.pdf

New Law Governing the Release of Deceased Individuals Records Becomes Effective January 1, 2018

The recently enacted law governing the release of medical records of deceased individuals to next of kin goes into effect on January 1, 2018. Prior law, which allowed the surviving spouse access to the deceased spouse's records under certain circumstances, has been expanded to allow specified "next of kin" to access records. Next of kin is defined to include adult children when there is no surviving spouse and a parent when there is no surviving spouse or adult child. Access under this statute is only permitted when there is no estate administration and requires the person seeking the records to complete a notarized affidavit and submit certain documentation. The statute does not permit access to mental health records or other records afforded additional protection under state or federal law. A flow sheet to aid providers navigate the new statute is attached.

2018 LEGISLATIVE UPDATES

2018-2004 HB	**Title:**	**relative to the New Hampshire health protection program.**
2018-2010 HB	**Title:**	**relative to the transparency and cost control of pharmaceutical drug prices.**
2018-2032 HB	**Title:**	**relative to information regarding abortion.**

2018-2033 HB	Title:	relative to regulation of assistant physicians.
2018-2034 HB	Title:	relative to maintenance of certification by physicians or applicants for a license to practice medicine in New Hampshire.
2018-2116 HB	Title:	prohibiting Medicaid from paying for sex reassignment surgery.
2018-2147 HB	Title:	establishing an office of inspector general.
2018-2161 HB	Title:	deleting the sunset provision on the law relative to the practices of pharmacy benefit managers.
2018-2203 HB	Title:	prohibiting release of certain information relative to users of therapeutic cannabis to federal agencies.
2018-2204 HB	Title:	establishing a commission to assess benefits and costs of a "health care for all" program for New Hampshire.
2018-2205 HB	Title:	relative to newborn screening for Krabbe Leukodystrophy.
2018-2207 HB	Title:	making hormonal contraceptives available directly from pharmacists by means of a collaborative pharmacy practice agreement.
2018-2209 HB	Title:	relative to notification procedures and certain sunset provisions of the New Hampshire health protection program.
2018-2222 HB	Title:	relative to the rights of conscience for medical professionals.
2018-2233 HB	Title:	establishing a New Hampshire single payor health care system.
2018-2236 HB	Title:	establishing a commission to examine the feasibility of the New England states entering into a compact for a single payor health care program.
2018-2245 HB	Title:	authorizing an alternative recovery monitoring program for nurses licensed by the board of nursing.
2018-2272 HB	Title:	requiring health care providers to provide an opioid disclosure form to patients for whom an opioid is prescribed.
2018-2300 HB	Title:	relative to the administration of anesthesia by dentists.
2018-2345 HB	Title:	relative to health and dental benefits under the workers' compensation law.
2018-2359 HB	Title:	relative to coverage for hearing aids under Medicare supplemental insurance.
2018-2360 HB	Title:	establishing a nursing professionals' health program.
2018-2390 HB	Title:	establishing a commission to study legislative oversight activities related to the department of health and human services.
2018-2399 HB	Title:	relative to telemedicine.
2018-2400 HB	Title:	relative to packaging of certain controlled drugs.
2018-2416 HB	Title:	establishing a New Hampshire health access corporation.
2018-2439 HB	Title:	relative to naturopathic health care practice.
2018-2478 HB	Title:	authorizing individuals and certain businesses to purchase health insurance from out-of-state companies.
2018-2494 HB	Title:	removing tetanus from the law requiring certain immunizations.
2018-2495 HB	Title:	relative to definitions under the law immunization regarding

		requirements.
2018-2548 HB	Title:	relative to digital foot scanning at hospitals.
2018-2563 HB	Title:	relative to insurance coverage for pediatric autoimmune neuropsychiatric disorders.
2018-2609 HB	Title:	relative to balance billing.
2018-2627 HB	Title:	relative to costs of blood testing orders.
2018-2646 HB	Title:	relative to Medicaid managed care.
2018-2647 HB	Title:	relative to the law regarding Medicaid expansion.
2018-2648 HB	Title:	relative to automobile medical payments.
2018-2651 HB	Title:	enabling the department of health and human services to enter into a contract with an Academy Society of Addiction Medicine certified physician.
2018-2684 HB	Title:	relative to payments for covered prescription medications under the managed care law.
2018-2685 HB	Title:	allowing pharmacists to disclose information relative to lower cost drugs under the managed care law.
2018-2689 HB	Title:	requiring criminal history records checks for applicants for allied health professional licensure or certification.
2018-2690 HB	Title:	relative to terms of appointment of members of governing boards for allied health professionals.
2018-2691 HB	Title:	relative to the authority of the governing boards of allied health professionals.
2018-2723 SB	Title:	relative to medication synchronization.
2018-2727 SB	Title:	relative to members of the dental profession.
2018-2740 SB	Title:	relative to an exemption from the board of registration of medical technicians.
2018-2744 SB	Title:	relative to the office of professional licensure and certification.
2018-2824 SB	Title:	deleting immunization/vaccination requirements for Hepatitis B.
2018-2826 SB	Title:	relative to testing for Lyme disease.
2018-2834 SB	Title:	relative to the nursing facility bed moratorium.
2018-2860 SB	Title:	relative to balance billing under the managed care law.
2018-2879 SB	Title:	establishing a commission to assess benefits and costs of a "health care for all" program for New Hampshire.
2018-2887 SB	Title:	relative to the controlled drug prescription health and safety program.
2018-2890 SB	Title:	relative to licensure of facilities located within 15 miles of a critical access hospital.
2018-2920 SB	Title:	limiting the use of electroconvulsive therapy.
2018-2922 SB	Title:	establishing positions in the office of professional licensure and certification and making an appropriation therefor.
2018-2931 SB	Title:	establishing a committee to study the consolidation of the board of mental health practice and the board of licensing for alcohol and other drug use professionals.
2018-2948 SB	Title:	relative to disciplinary action for certain licensees.

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