FEDERAL DEVELOPMENTS

CMS Announces New Opportunities for States to Expand Mental Health Treatment Services

On November 13, the Centers for Medicare & Medicaid Services ("CMS") announced a new Medicaid demonstration opportunity to expand mental health treatment services. In a letter sent to state Medicaid directors, CMS Deputy Administrator and Director of Medicaid and the Children's Health Insurance Program ("CHIP") Mary Mayhew outlined the new opportunities, which fall into two broad categories: "Strategies Under Existing Authorities to Support Innovative Service Delivery Systems for Adults with SMI and Children with SED"; and "SMI/SED Demonstration Opportunity."

Director Mayhew described the following strategies under the first category: earlier identification and engagement in treatment; integration of mental health care and primary care; improved access to services across the continuum of care, including crisis stabilization services; better care coordination and transitions to community-based care; and increased access to evidence-based services that address social risk factors.

Under the second category, states may conduct demonstration projects to improve care for adults with serious mental illness ("SMI") and children with serious emotional disturbance ("SED"). According to Director Mayhew's letter, the demonstration projects will allow states "to receive [Federal financial participation] for services furnished to Medicaid beneficiaries during short term stays for acute care in psychiatric hospitals or residential treatment settings that qualify as [Institutions for Mental Disease ("IMDs")] if those states are also taking action, through these demonstrations, to ensure good quality of care in IMDs and to improve access to community-based services." The Federal funds will allow for reimbursement for services that are normally not covered by Medicaid because they fall under the Medicaid payment exclusion for services provided to beneficiaries while residing in IMDs.

The letter to state Medicaid directors is available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

Sixth Circuit Rejects Medicaid DSH Payment Policy for Failure to Satisfy Notice-and-Comment Requirement

On November 14, the Court of Appeals for the Sixth Circuit issued a decision affirming the District Court's decision enjoining the Centers for Medicare & Medicaid Services ("CMS") from enforcing a policy related to the calculation of the hospital-specific DSH limit. CMS' policy was set forth in two FAQs from 2010 and requires states to subtract payments received from Medicare and private health insurance when calculating the DSH limit. The Tennessee Hospital Association and other hospitals filed a lawsuit in District Court challenging the policy on two grounds: 1) that it constitutes a legislative rule that was required to satisfy the requirements of notice-and-comment

Health Care Practice Group

Cinde Warmington
Chair
cwarmington@
shaheengordon.com

Steven M. Gordon
sgordon@
shaheengordon.com

Lucy J. Karl
lkarl@
shaheengordon.com

William E. Christie
wchristie@
shaheengordon.com

Kara J. Dowal
kdowal@
shaheengordon.com

Alexander W. Campbell
acampbell@
shaheengordon.com

www.shaheengordon.com

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rulemaking; and 2) that it violated the Medicaid Act. The District Court ruled in the plaintiffs' favor on both grounds. However, the Sixth Circuit declined to affirm the lower court's holding that the policy violated the Medicaid Act, instead affirming only the holding that it failed to satisfy the rulemaking requirements.

The Sixth Circuit's ruling is the latest court decision regarding CMS' policy. Earlier this year, the District Court for the District of Columbia vacated a rule issued by CMS in 2017 that "clarified" that the DHS limit must be calculated to account for Medicare and private insurance payments. The DC court's holding is currently pending before the Court of Appeals for the D.C. Circuit.

The Sixth Circuit's decision is available at: http://www.opn.ca6.uscourts.gov/opinions.pdf/18a0252p-06.pdf.

CMS Announces Reduction in Improper Payment Rates

On November 15, the Centers for Medicare & Medicaid Services ("CMS") announced that it achieved reductions in improper payment rates in Medicare Fee-for-Service ("FFS"), Medicare Part C, Medicare Part D, Medicaid, and Children's Health Insurance Program. In a fact sheet released by the agency, CMS reported that this is the first year in improper payment reporting history that all five major programs have had reductions in improper payment rates. CMS attributed the decrease in the Medicare FFS improper payment rate from 9.51 percent in 2017 to 8.12 percent in FY 2018 to the success of its action to address improper payments in home health and skilled nursing facility claims. CMS noted that the 8.12 percent FFS improper payment rate is the lowest since 2010 and that 2018 is the second consecutive year where the FFS rate is below the 10 percent threshold required under the Improper Payments Elimination and Recovery Act of 2010.

The CMS fact sheet may be read here: https://www.cms.gov/newsroom/fact-sheets/cms-achieved-improper-payment-rate-reductions-medicare-fee-service-ffs-medicare-part-c-medicare-part

OIG Issues Unfavorable Opinion for Proposal to Provide Free Drugs to Hospitals

On November 16, the Department of Health and Human Services Office of Inspector General ("OIG"), posted Advisory Opinion No. 18-14, in which it concluded that a proposed arrangement by a drug company to provide free products to hospitals to exclusively treat inpatients diagnosed with one particular condition (the "Proposed Arrangement"), could potentially generate prohibited remuneration under the anti-kickback statute and administrative sanctions under sections 1128(b)(7) or 1128A(a)(7) of the Social Security Act could potentially be imposed. The facts of the Proposed Arrangement involve a drug approved by the U.S. Food & Drug Administration ("FDA") in 1952 and used to treat patients with serious and rare conditions, with 19 indications currently approved by the FDA (the "Drug"). The Drug is injectable, frequently self-administered, and in some cases, administered to a patient during an inpatient hospital stay. The drug company certified that in cases where the drug was administered during an inpatient stay, payment for the inpatient stay would include payment for the Drug as well as room charges, diagnostic testing, nursing services, etc. as the Drug is not separately reimbursable in the inpatient setting. The drug company proposed that it would give free doses of the Drug to use exclusively for inpatients who are diagnosed for a specific epileptic syndrome (the "Syndrome"), by stocking the Drug at participating hospitals on a consignment basis, at no cost to the hospital or any payor. Physicians prescribing the Drug to an inpatient with the Syndrome would submit a referral to the Drug's reimbursement hub and therapy would be started using the free vial of the Drug, equivalent to three to five days of treatment. The reimbursement hub would then complete a benefits investigation on the patient's behalf and ship additional vials to the patient's caregiver for the caregiver to administer at home following discharge, with a second free vial provided to the

hospital if needed for a longer patient stay, and/or the Drug provided for free to the patient if the insurance coverage could not be obtained or until therapy was completed.

In its analysis, the OIG took the unusual step of including additional publicly available information to the facts provided and certified by the requesting drug company, stating that "if we are aware of additional relevant and material facts that might bear on the risks of a particular arrangement, we cannot ignore those facts simply because a requestor does not present them to us in its advisory opinion request." The additional information cited by the OIG includes: (1) that the Drug's list price has increased significantly in the past 15 years (from $40 for one vial in 2001 to Requestor's current list price of $38,892 per vial); (2) that the Drug is not new and has been used to treat the Syndrome for a long time; and (3) that the requesting drug company, without conceding to the allegations, settled FTC charges that it illegally acquired the rights to develop a competing drug to the Drug by outbidding several other companies who were looking at developing the drug and sell it at a significant discount to the requesting drug company's Drug. The FTC also alleged the requesting drug company preserved its monopoly with the drug acquisition, allowing it to maintain extremely high prices for the Drug.

In reaching its conclusion, the OIG cited the following six reasons why the Proposed Arrangement presents more than a minimal risk of fraud and abuse under the anti-kickback statute: (1) it would relieve a hospital of a significant financial obligation to stock the Drug (something hospitals are reluctant to do likely because of the high price) and having the Drug stocked for free would "pav[e] the way for the Drug to be administered to inpatients diagnosed with the Syndrome at the hospital"; (2) there would be no savings for the Federal health care programs because the amount a program would reimburse a hospital for an inpatient stay would not be reduced if the hospital received the Drug for free; (3) it could function as a seeding arrangement whereby a hospital could influence a physician's decision to prescribe the Drug and giving the Drug for free facilitates the requesting drug company's high price; (4) it could result in steering or unfair competition because there are various treatment options for the Syndrome and hospitals could influence prescribers to consider the Drug as the first option; (5) one of the principal reasons proposed for giving the Drug for free is that any delay in treatment presents increased risk to the patient, however, under the Proposed Arrangement, the Requestor would stock the Drug on a consignment basis at the hospital, meaning that it is willing to do so and could just consign the Drug onsite and require a purchase only if the hospital used it; and (6) that "Requestor's certification that receipt of the free vial of the Drug is not contingent on future purchases rings hollow" because a course of treatment cannot be discontinued without potential adverse health consequences, and therefore patients who have insurance coverage for the Drug would make future purchases in order to avoid those consequences.

OIG Advisory Opinion No. 18-14 may be read in full here:
https://oig.hhs.gov/fraud/docs/advisoryopinions/2018/AdvOpn18-14.pdf

CMS Reapproves Kentucky Medicaid Work Requirement

On November 20, the Centers for Medicare & Medicaid Services ("CMS") renewed its approval of Kentucky's Medicaid waiver to impose a work requirement for beneficiaries of Kentucky's Medicaid program. CMS had previously approved the work requirement in January 2018, however a District Court vacated the approval of the waiver on the ground that CMS "never adequately considered whether [the work requirement] would in fact help the state furnish medical assistance to its citizens." On July 19, 2018, in response to the District Court's order, CMS opened a new 30-day comment period to give interested stakeholders an opportunity to comment on the issues raised in the litigation and in the court's decision.

CMS' renewal of its earlier approval comes after this comment period and CMS' determination that the work requirement "is likely to assist in promoting Medicaid's objectives."

CMS' letter announcing its renewed approval is available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-ca.pdf.

New Online Tool for Surgical Procedure Cost Comparison

On November 27, the Centers for Medicare & Medicaid Services ("CMS") revealed a new online tool for consumers to compare Medicare payments and copayments for certain hospital outpatient departments and ambulatory surgical centers. The Procedure Price Lookup Tool provides national averages for Medicare payments to hospitals or ambulatory surgical centers and the national average copayment amount a beneficiary with no Medicare supplemental insurance pays to the provider. CMS Administrator Seema Verma stated "Price transparency in health care is a priority for the Trump Administration. Working with their clinicians, the Procedure Price Lookup will help patients with Medicare consider potential cost differences when choosing where to have a medical procedure that best meets their needs."

The Procedure Price Lookup Tool may be accessed here: https://www.medicare.gov/procedure-price-lookup/

More Options for ACA Waivers

On November 29, the Centers for Medicare & Medicaid Services ("CMS") announced the release of four waiver concepts for states to take advantage of under state innovation waivers under section 1332 of the Affordable Care Act ("ACA"). In a fact sheet, CMS explained that the waiver concepts are "an effort to spur innovation, reduce burden for states with potentially limited policy resources or legislative schedules, and illustrate how states might take advantage of new flexibilities provided in recently released guidance related to State Relief and Empowerment Waivers." The four waiver concepts include: Account-Based Subsidies; State-Specific Premium Assistance; Adjusted Plan Options; and Risk Stabilization Strategies.

Under the Account-Based Subsidies waiver concept, public subsidies would be used to fund a defined-contribution, consumer-directed account that individuals could use to pay for health insurance premiums or other health care expenses. The State-Specific Premium Assistance waiver concept allows states to design a subsidy program to meet the needs of its unique population so that there are more affordable health care options available to a wider range of individuals, that it can attract more young and healthy consumers to the market, or to address structural issues that create unintended incentives, such as the "subsidy cliff", where a consumer's income changes so that he or she is ineligible for the Premium Tax Credit ("PTC"). Under the Adjusted Plan Option, states would have the ability to give financial assistance for various types of health insurance plans, including non-Qualified Health Plans, or could expand the availability of catastrophic plans beyond eligibility limitations. Finally, under the Risk Stabilization Strategies waiver concept, states would have more flexibility to create reinsurance programs or high-risk pools. The CMS fact sheet emphasized that in order to obtain approval of a waiver request, states should ensure that applications meet section 1332 requirements, including satisfying the four statutory guardrails relating to comprehensiveness, affordability, coverage, and federal deficit neutrality.

The CMS Fact Sheet on the four waiver concepts may be accessed here: https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Fact-Sheet.pdf

DOJ Revises "Yates Memorandum" on Individual Accountability for Corporate Wrongdoing

On November 29, the U.S. Department of Justice ("DOJ") announced its revised policy to the Justice Manual, revising certain provisions of the so-called "Yates Memorandum." The "Yates Memorandum" is the set of guidelines on corporate prosecution, titled "Individual Accountability for Corporate Wrongdoing." The memo was sent on September 9, 2015 to federal prosecutors from Deputy Attorney General Sally Quillan Yates and presented six steps to be pursued in any DOJ investigation of corporate conduct, including a focus on individual misconduct. The Yates Memorandum also provided that, in order for a corporation to get credit for cooperating, it had to identify all individuals who had involvement with the conduct at issue. The revised policy from Deputy Attorney General Rod J. Rosenstein, focuses instead on more leniency towards achieving credit for cooperation, in that companies do not have to identify all of the individuals who were involved with the questionable conduct, but rather those who were "substantially involved."

The original "Yates Memorandum" can be read here: https://www.justice.gov/archives/dag/file/769036/download

Deputy Attorney General Rod J. Rosenstein's remarks on revisions to the policy may be read in full here: https://www.justice.gov/opa/speech/deputy-attorney-general-rod-j-rosenstein-delivers-remarks-american-conference-institute-0

OIG Announces 2018 Recoveries Expected to Reach $2.9 Billion

On November 30, the Department of Health and Human Services ("HHS") Office of Inspector General ("OIG") posted its Semiannual Report to Congress for its activities through the reporting period April 1, 2018 to September 30, 2018. In the report, OIG cited its "impressive results," such as $2.9 billion in expected investigative recoveries, criminal actions against 764 individuals or entities, exclusion of 2,712 individuals or entities, and civil actions against 813 individuals or entities. Inspector General Daniel R. Levinson identified OIG's continued priorities as the opioid epidemic, Medicaid fraud, safety of children, home- and community-based services, cybersecurity, and the shift to value-based care.

OIG's full report may be read here: https://oig.hhs.gov/reports-and-publications/archives/semiannual/2018/2018-fall-sar.pdf

OIG Reports Findings That 21% of Medicare Patients in Long-Term Care Hospitals Experience Serious Adverse Events

On November 30, the Department of Health and Human Services, Office of the Inspector General published a report titled "Adverse Events in Long-Term-Care Hospitals: National Incidence Among Medicare Beneficiaries." OIG reported its finding that 21 percent of Medicare patients in Long-Term Care Hospitals ("LTCHs") experienced adverse events, which OIG defined as particularly serious instances of patient harm resulting from medical care. OIG also found that an additional 25 percent of patients experienced temporary harm events, which OIG defined as patient harm that required medical intervention but did not cause lasting harm. The overall percentage of patients in LTCHs who experienced either type of harm was found to be 46 percent, higher than OIG found in hospitals (27 percent), skilled nursing facilities (33 percent), and rehabilitation hospitals (29 percent).

OIG recommended that the Agency for Healthcare Research and Quality ("AHRQ") and CMS – which have already been taking steps to address previous LTCH issues identified by OIG – should tailor their ongoing efforts to improve patient safety to address the specific needs of LTCHs. OIG recommended that

AHRQ and CMS collaborate to create and disseminate a list of potential harm events in LTCHs and that CMS should include information about patient harm in its outreach to LTCHs.

OIG's report is available at: https://oig.hhs.gov/oei/reports/oei-06-14-00530.pdf.

Opioids and Program Integrity at the Top of HHS Challenges Identified by OIG

The Department of Health and Human Services ("HHS") Office of Inspector General ("OIG") released its annual publication of *Top Management and Enforcement Challenges Facing HHS*, in which it identifies 12 of the top challenges for HHS in fulfilling its mission. The first identified challenge in the report is preventing and treating opioid misuse, citing the statistics leading to the President declaring the opioid crisis as a public health emergency, such as that up to 6 million Americans could have opioid use disorder, and that there were over 49,000 opioid-related overdose deaths in the U.S. in 2017. Also at the top of the OIG's list is ensuring program integrity in Medicare fee-for-service and effective administration of Medicare. The OIG explained that the program remains susceptible to risks associated with volume-based reimbursement, including incentives for inappropriate utilization, despite the efforts to transform Medicare into a value-based system. Other challenges identified by the OIG in the report include program integrity for Medicaid, protecting the health and safety of vulnerable populations, and ensuring the safety of food, drugs, and medical devices.

The full OIG report, *Top Management and Enforcement Challenges Facing HHS*, is found here: https://oig.hhs.gov/reports-and-publications/top-challenges/2018/2018-tmc.pdf

CMS Estimates That Most Hospitals Will See Value-Based Payments Increase in FY 2019

On December 3, the Centers for Medicare & Medicaid Services ("CMS") issued a fact sheet containing information about the Hospital Value-Based Purchasing ("VBP") Program for fiscal year 2019. The Hospital VBP Program adjusts Medicare payments to hospitals under the Inpatient Prospective Payment System based on the quality of inpatient care the hospitals provide to patients. For fiscal year 2019, CMS will reduce a portion of the base operating Diagnosis-Related Group payment amounts otherwise applicable to a participating hospital for each discharge by two percent (2.0%), and will redistribute the estimated sum total of these reductions to participating hospitals based on their performance on a previously-announced set of quality and cost measures. CMS estimates that the total amount available for value-based incentive payments in FY 2019 will be approximately $1.9 billion. More hospitals will have an increase in their Medicare payments in fiscal year 2019 than will have a decrease. In total, more than 1,550 hospitals (over 55 percent) will receive higher Medicare payments. According to CMS, almost 60 percent of hospitals will see a small change (between -0.5 and 0.5 percent) in their payments, with an average net payment adjustment of 0.17 percent.

CMS' fact sheet is available at: https://www.cms.gov/newsroom/fact-sheets/cms-hospital-value-based-purchasing-program-results-fiscal-year-2019.

CMS Announces One-Year Extension for Prior Authorization Model for Non-Emergent Ambulance Transports

On December 4, the Centers for Medicare & Medicaid Services issued a notice announcing a 1-year extension to the "Medicare Prior Authorization Model for Repetitive Scheduled Non-Emergent Ambulance Transport" that is applicable to certain Mid-Atlantic and Southern states. The 3-year Prior Authorization Model was first implemented in 2014, extended to include additional states in 2015, and extended for an additional year in 2017. The Prior Authorization Model includes a process for requesting prior authorization

for repetitive, scheduled non-emergent ambulance transport rendered by ambulance providers in the affected states.

The notice is available at: https://www.gpo.gov/fdsys/pkg/FR-2018-12-04/pdf/2018-26334.pdf.

Hospitals File Lawsuit Challenging CMS Rule Changing Payment for Off-Campus Provider-Based Departments

On December 4, the American Hospital Association, the Association of American Medical Colleges, and several hospitals filed a lawsuit challenging the Centers for Medicare & Medicaid's ("CMS") rule that reduced payment for certain services provided at hospital provider-based departments. Under the rule – published in November and effective January 1, 2019 – CMS will pay for clinical visits at "excepted" off-campus provider-based departments at the site-neutral Physician Fee Schedule rate, which is less than what CMS has previously paid. In their lawsuit, the plaintiffs argue that CMS is required by statute to pay differently for services provided at excepted and non-excepted off-campus provider-based departments, and that the new payment rule ignores this statutory distinction. They also argue that the rule fails to satisfy statutory budget-neutral requirements.

The plaintiffs' complaint is available at: https://www.aha.org/system/files/2018-12/complaint-challenging-site-neutral-payment-policy181204.pdf?utm_source=newsletter&utm_medium=email&utm_content=12042018-at-public&utm_campaign=aha-today.

CMS Corrects Risk Adjustment Methodology Rule in Response to Court Order

On December 7, the Centers for Medicare & Medicaid Services issued a final rule adopting a risk adjustment methodology for the 2018 benefit year. The methodology utilizes statewide average premium in calculating the risk adjustment rate. In February 2018, a district court vacated the use of statewide average premium in the risk adjustment methodology for the 2014 through 2018 benefit years because it determined that CMS had not adequately explained its decision to use the statewide average premium. The final rule comes after CMS' review of comments to its earlier proposed rule published in August, which included additional explanation about the methodology.

The final rule is available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-26591.pdf.

STATE DEVELOPMENTS

Open Enrollment in Health Care Marketplace Closes December 15th

Initial reports indicate that enrollment in NH marketplace insurance plans is down from last year. This may be due to decreased spending intended to alert eligible individuals of the open enrollment opportunity. An overall decrease may also result from a shorter enrollment period of 45 days compared with 3 months in prior years. Some speculate that the decrease in unemployment may have resulted in more individuals being covered under their employer's health plans thus reducing the need to purchase insurance in the health care marketplace.

Department of Insurance Cautions Consumers About Non-ACA-Compliant Insurance Plans

On November 9, the NH Department of Insurance issued guidance to consumers seeking to buy health insurance coverage. The Department cautioned consumers that there are three insurers offering

ACA –compliant plans through the marketplace including Ambetter, Anthem and Harvard Pilgrim. Other companies may be offering coverage that is not ACA-compliant that does not cover all the benefits of ACA-compliant plans. One company, Everest Reinsurance Company is authorized to sell short-term plans in New Hampshire. These plans are limited in duration to a maximum of 6 months with the option to buy another short-term plan, but only up to a total of 18 months. The Department warns that short-term plans may have lower premiums but also have limited benefits and, among other things, may deny or exclude coverage of pre-existing conditions. There are also “health care sharing organizations” operating in NH. The Department warns that these organizations do not offer health insurance and have no obligation to pay for any medical services or to cover any particular categories of health care services.

The press release may be found at: https://www.nh.gov/insurance/media/pr/2018/documents/press-release-buyer-beware-alt-coverage-110918.pdf

ACLU Files Suit on Behalf of Mental Health Patients

On November 10, the American Civil Liberties Union filed a class action lawsuit against Jeffrey Meyers, Commissioner of the NH Department of Health and Human Services, on behalf of mental health patients being held in hospital emergency rooms. The suit alleges that the practice of detaining mental health patients against their will without due process is in violation of the U.S. Constitution, the N.H. Constitution and NH State law. A patient being involuntarily detained is entitled to a hearing to determine whether there is probable cause to believe he poses a likelihood of danger to himself or others within 3 days. The ACLU states “[t]here is a systemic pattern and practice in New Hampshire where people who may be experiencing mental health crises are involuntarily detained in hospital emergency rooms without the State providing them with any due process, appointed counsel, or opportunity to contest their detention.” The suit seeks, among other things, an injunction against holding patients without a hearing within 3 days of their involuntary admission to a hospital emergency room.

DHHS Releases 10-Year Mental Health Plan

On November 20, 2018, the Department of Health and Human Services released its proposed 10-Year Mental Health Plan for public comment. A public hearing was held on December 3rd and written comments were accepted through December 10th. Governor Sununu commented that the Plan was “stakeholder driven” and derived from focus groups and state-wide public information sessions. The Plan offers a vision for New Hampshire’s Mental Health System that will include a central mental health “portal” and a regional “hub and spoke” system. The portal will be administered and supported through DHHS and will serve as a single source of telephone and online information and guidance. Through the portal, individuals will be connected to a “hub” in their geographical region where staff will assess and triage all callers to support a referral that meets their individual needs.

A copy of the 10-Year Plan may be found at: https://www.dhhs.nh.gov/ocom/documents/proposed-10-year-mh-plan.pdf

CMS Approves New Hampshire’s Medicaid Expansion Work Requirement

On November 30, CMS issued its approval of the Granite Advantage Health Care Program waiver, which will replace the New Hampshire Health Protection Program effective January 1, 2019. The CMS waiver authorizes the work and community engagement requirement for able bodied adults. DHHS is currently holding public information sessions to educate beneficiaries and providers on all aspects of the new program. It is estimated the new work requirement may affect 15,000 or more beneficiaries.

The schedule for these information sessions may be found at: https://www.dhhs.nh.gov/medicaid/granite/public-forums.htm

The approval letter issued by CMS may be found at: https://www.dhhs.nh.gov/ombp/medicaid/documents/ga-approval-letter-11302018.pdf

The CMS special terms and conditions for the waiver may be found at: https://www.dhhs.nh.gov/ombp/medicaid/documents/ga-stc-11292018.pdf

2019 LEGISLATIVE SERVICE REQUESTS

HB 2019-0024 Title: relative to qualifications for and exceptions from licensure for mental health practice. Sponsors: (Prime) Carol McGuire

HB 2019-0031 Title: permitting the department of health and human services to provide information from the case record to the child's primary health care provider under certain circumstances. Sponsors: (Prime) Skip Berrien

HB 2019-0037 Title: repealing the law relative to providing certain parameters for access to reproductive health care facilities. Sponsors: (Prime) Kurt Wuelper

HB 2019-0039 Title: relative to licensure of health facilities near a critical access hospital. Sponsors: (Prime) William Marsh

HB 2019-0040 Title: relative to the board of medicine. Sponsors: (Prime) Polly Campion

HB 2019-0046 Title: establishing a commission on mental health education programs. Sponsors: (Prime) Patricia Cornell

HB 2019-0091 Title: relative to group and individual health insurance market rules. Sponsors: (Prime) Edward Butler

HB 2019-0128 Title: establishing a New Hampshire health access corporation. Sponsors: (Prime) Peter Schmidt

HB 2019-0129 Title: establishing a commission to examine the feasibility of the New England states entering into a compact for a single payer health care program. Sponsors: (Prime) Peter Schmidt

HB 2019-0130 Title: relative to Medicare for all. Sponsors: (Prime) Peter Schmidt

HB 2019-0131 Title: relative to treatment alternatives to opioids. Sponsors: (Prime) Peter Schmidt

HB 2019-0140 Title: adding opioid addiction, misuse, and abuse to qualifying medical conditions under therapeutic use of cannabis. Sponsors: (Prime) Robert Renny Cushing

HB 2019-0153	Title: prohibiting release of certain information relative to users of therapeutic cannabis to federal agencies. Sponsors: (Prime) Caleb Dyer
HB 2019-0173	Title: relative to funding the New Hampshire granite advantage health care program. Sponsors: (Prime) James McConnell
SB 2019-0182	Title: relative to qualifying medical conditions for therapeutic cannabis. Sponsors: (Prime) John Reagan
SB 2019-0183	Title: adopting the model psychology interjurisdictional compact. Sponsors: (Prime) John Reagan
HB 2019-0196	Title: relative to serologic testing including Lyme disease. Sponsors: (Prime) William Marsh , Frank Kotowski, Jess Edwards, Walter Stapleton, Jerry Knirk, Jeffrey Salloway
HB 2019-0197	Title: relative to direct primary care. Sponsors: (Prime) William Marsh
HB 2019-0198	Title: relative to the controlled drug prescription health and safety program. Sponsors: (Prime) William Marsh , Jeb Bradley, Frank Kotowski, Karel Crawford, Walter Stapleton, Jerry Knirk, John MacDonald
Hb 2019-0203	Title: relative to a graduate physician pilot program. Sponsors: (Prime) William Marsh
HB 2019-0223	Title: relative to license requirements for certain mental health and drug counselors. Sponsors: (Prime) Jack Flanagan
SB 2019-0266	Title: relative to a duty to report when another person has suffered grave physical harm. Sponsors: (Prime) Jack Flanagan
HB 2019-0282	Title: prohibiting prescription drug manufacturers from offering coupons or discounts to cover insurance copayments or deductibles. Sponsors: (Prime) Garrett Muscatel
HB 2019-0302	Title: relative to insurance reimbursement for emergency medical services. Sponsors: (Prime) William Marsh , Jeb Bradley, Jerry Knirk, John MacDonald, Linda Camarota
HB 2019-0316	Title: relative to oral prophylaxis for dental patients. Sponsors: (Prime) Jean Jeudy
HB 2019-0345	Title: relative to the length of time an employer may lease an employee through an employee leasing company. Sponsors: (Prime) Richard Komi
HB 2019-0404	Title: adding qualifying medical conditions to the therapeutic use of cannabis law. Sponsors: (Prime) Wendy Thomas
HB 2019-0409	Title: relative to the regulation of art therapists. Sponsors: (Prime) Peter Schmidt

HB 2019-0411 Title: relative to licensure of polysomnographers by the board of respiratory care practitioners. Sponsors: (Prime) Peter Schmidt

HB 2019-0418 Title: establishing the psychology interjurisdictional compact (PSYPACT). Sponsors: (Prime) Al Baldasaro

HB 2019-0432 Title: relative to transparency and standards for acquisition transactions in health care. Sponsors: (Prime) David Luneau , Kermit Williams, Dan Feltes, William Marsh

HB 2019-0458 Title: establishing a licensed pharmacy assistant license. Sponsors: (Prime) Gary Merchant

HB 2019-0472 Title: removing the work requirement of the New Hampshire granite advantage health care program. Sponsors: (Prime) Rebecca McWilliams

HB 2019-0518 Title: relative to testing for Lyme disease. Sponsors: (Prime) Howard Moffett , Charles McMahon

HB 2019-0529 Title: establishing a commission to study a public option for health insurance. Sponsors: (Prime) Jerry Knirk

HB 2019-0530 Title: relative to the New Hampshire insurance department's annual hearing requirement. Sponsors: (Prime) Edward Butler

HB 2019-0531 Title: relative to ambulance billing, payment for reasonable value of services, and prohibition on balance billing. Sponsors: (Prime) David Luneau

HB 2019-0589 Title: relative to biennial controlled substance inventories conducted under the Controlled Drug Act. Sponsors: (Prime) Carol McGuire

HB 2091-0603 Title: relative to mental health professionals in private custody matters. Sponsors: (Prime) John Plumer

HB 2019-0605 Title: relative to certain procedures performed in teaching hospitals. Sponsors: (Prime) Peter Torosian

HB 2019-0610 Title: relative to an opioid reduction act. Sponsors: (Prime) David Lundgren

HB 2019-0618 Title: relative to therapeutic cannabis dispensary locations. Sponsors: (Prime) Wendy Thomas

HB 2019-0651 Title: establishing a commission to assess benefits and costs of a "health care for all" program for New Hampshire. Sponsors: (Prime) Jerry Knirk

HB 2019-0672 Title: relative to the regulation of pharmacies and pharmacists.
Sponsors: (Prime) Gary Merchant

HB 2019-0701 Title: relative to licensed prescribers of medical marijuana.
Sponsors: (Prime) Timothy Josephson

HB 2019-0731 Title: reforming the managed care program. Sponsors: (Prime) Peter Schmidt

HB 2019-0737 Title: relative to Medicaid care management contractor requirements for provider credentialing and prompt payment. Sponsors: (Prime) Jerry Knirk

HB 2019-0746 Title: requiring health care providers to provide an opioid disclosure form to patients for whom an opioid is prescribed. Sponsors: (Prime) John Janigian

HB 2091-0787 Title: relative to warning labels on prescription drugs containing opiates.
Sponsors: (Prime) Tom Loughman

HB 2019-0799 Title: establishing a commission to study the impact of financial initiatives for commercially insured members by drug manufacturers on prescription drug prices and health insurance premiums. Sponsors: (Prime) Edward Butler

HB 2019-0800 Title: relative to pharmacy benefit manager business practices, licensure, and transparency. Sponsors: (Prime) Edward Butler

HB 2019-0802 Title: relative to price increases of drugs under the managed care law.
Sponsors: (Prime) Edward Butler

HB 2019-0803 Title: relative to reporting of internal pharmaceutical costs.
Sponsors: (Prime) Edward Butler

HB 2019-0804 Title: relative to the cost of prescription drugs.
Sponsors: (Prime) Edward Butler

HB 2019-0806 Title: relative to providing notice of the introduction of new high-cost prescription drugs. Sponsors: (Prime) Edward Butler

HB 2019-0818 Title: relative to the board of mental health practice.
Sponsors: (Prime) Kendall Snow

HB 2019-0826 Title: relative to reimbursement rates for low-dose mammography coverage.
Sponsors: (Prime) Jeb Bradley

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Cinde Warmington, Kara J. Dowal, and Alexander W. Campbell contributed to this month's Legal Update.

BIOS

CINDE WARMINGTON, ESQ.
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.

KARA J. DOWAL, ESQ.
Kara Dowal practices health care law and corporate business law at Shaheen & Gordon, P.A. Kara works with health care providers on a variety of legal issues, including corporate governance, contracting, employment, regulatory compliance, and provider transition matters.

ALEXANDER W. CAMPBELL, ESQ.
Alex practices health care law and civil litigation at Shaheen & Gordon, P.A. Alex focuses his health care practice on assisting providers in regulatory compliance, contracting, provider transition, and litigation.

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