NEW JERSEY STATE SOCIETY OF ANESTHESIOLOGISTS

The NJSSA Pulse

August 2015

FROM THE PRESIDENT
PETER GOLDZWEIG, DO

I hope everyone is enjoying the summer. The NJSSA newsletter will now be bi-monthly instead of monthly. As always, we will continue to email membership immediately with any information that cannot wait for the next newsletter.

We continue to work on Out Of Network issues led by our VP John Azzarati and lobbyist AJ Sabath. We have also been working with Jason Hansen, ASA Director of State Affairs to coordinate with several other states that have or potentially will have OON legislation.

The CMS proposed fee schedule was recently released and within it several codes Anesthesiologists use was mentioned as possibly misvalued including endoscopy (00740 and 00810). This is not a surprise as the 2015 CMS physician fee schedule mentioned the increase of anesthesia services with these codes and now covers anesthesia services for screening colonoscopy. Please remember if anesthesia services are provided for endoscopy, CMS is currently paying for moderate sedation AND anesthesia services. We will continue to work with the ASA and pass along information as we gather it.

Thank you and enjoy the rest of the summer.

Save The Date!

NJSSA 2016 Annual Meeting

March 12, 2016

The Hyatt Regency

New Brunswick, NJ

FROM THE STATEHOUSE
ADVOCACY & MANAGEMENT GROUP
AJ SABATH, LYNN HAYNES AND CHARLES BURTON

Summer Recess

Following enactment of the Fiscal Year 2016 budget at the end of June, the Senate and Assembly took a break for the summer. However, the Legislature has not officially recessed and the Senate has been holding pro forma sessions to prevent the Governor from making recess appointments. They will not be voting on anything substantive or controversial because of the election. All eighty seats of the Assembly are up for election in November and as a result of this they are not expected to meet again until mid-November. At that time the Legislature will hold its lame duck session in the remaining weeks of the current legislative term, which will end in mid January 2016.

Out-of-Network Update

There has been a break in the silence during the Legislature's summer regarding the Out-of-Network (OON) issue. After slowing down the OON bill's progress in June, we have been contacted by Senator Vitale, Assemblyman Coughlin, Assemblyman Schaer and Assemblyman Singleton with a request to provide specific changes to the (OON) committee substitute and then to participate in a stakeholders meeting at the end of August. In response to this request, we have been working with the Board and the Advocacy Committee, along with our allies from the Access to Care Coalition, the large coalition of providers including hospitals and the Medical Society of New Jersey as well as a host of other surgical specialties and physician organizations that work in a hospital setting and/or Ambulatory Surgery Centers.

You may recall that after months of behind the scenes wrangling and upon completion of two lengthy "discussion only" legislative hearings in the State Senate and General Assembly in June, the New Jersey Legislature took a break this Summer before enacting any significant Out-of-Network (OON) reform and will return to usual business after the 2015 Legislative Elections in November. As a reminder, the "discussion only" hearing in the Assembly Financial Institutions Committee in early June and a subsequent attempt to pass the bill out of the Senate Commerce Committee failed. Amendments were made public but not adopted that scaled back the legislation, but not enough to limit the tremendous opposition from the provider community. As a result of the continued opposition, the Senate Commerce Committee ultimately only discussed the bill and did not vote to release it because there were not enough votes to pass it out of Committee. The sponsors now want recommendations on the scaled-back version of the bill that was never voted on.

We have been working independently meeting with legislators, key staff and other pertinent officials in the Governor's office. We have also been attending fundraisers on your behalf and continue to communicate your concerns with the OON bill to important decision makers. We will also begin implementing on your behalf a strategy to further educate legislators and staff on any new developments or existing concerns. We will also continue to work to replenish our political war chest to enable us to maintain an active presence at political fundraisers.

Virtua Health Lawsuit

In July, Virtua Health and Capital Health System filed a lawsuit against the State of New Jersey seeking to stop the implementation of a recently-enacted emergency medical services (EMS) law that allows Level 1 trauma centers Cooper University Hospital (Cooper) in Camden, Robert Wood Johnson University Hospital (RWJ) in New Brunswick and University Hospital in Newark to take over paramedic services in their regions by January 2016. Cooper and RWJ are expected to take over these services in Camden and Hamilton, respec-

tively. RWJ and University Hospital already provide EMS services in this municipality so this legislation is perceived to be more of a benefit to Cooper Hospital.

A special provision of the law will allow RWJ to take over EMS services in Hamilton. Virtua has been providing the Advanced Life Support (ALS) to the City of Camden for 38 years and Capital Health has provided ALS services since 1977. Virtua and Capital Health System contended in court documents that this new law violates the New Jersey Constitution's clause against special legislation. This new law allows Cooper Hospital to bypass a state Department of Health (DOH) process that requires a hospital system seeking to provide EMS service in a region to submit a comprehensive certificate of need application to the DOH.

This law was fast-tracked in the Legislature as it was introduced in early June, passed by both the Senate and the Assembly by the end of that month and was signed into law by the Governor in early July. We opposed this legislation all throughout the process and will continue to monitor the lawsuit.

Regulating One-Room Surgery Centers

On June 25, 2015, Senator Joseph Vitale, Chairman of the Senate Health, Human Services and Senior Citizens Committee introduced S3051 (Vitale/Addiego) which would strengthen the requirements for accreditation, inspection, and general oversight of "surgical practices."

The bill would require surgical practices, as a condition of their registration with the Department of Health (DOH), to: (1) obtain ambulatory care accreditation from an accrediting body recognized by the Centers for Medicare and Medicaid Services (CMS), in addition to obtaining certification from CMS as an ambulatory surgery center provider; and (2) provide the DOH with proof of such accreditation and certification. Current law requires a surgical practice registrant to obtain, and provide proof of, either accreditation or certification, but not both.

The bill would also provide that, whenever the DOH conducts an inspection of a surgical practice, it will be required to post, at a publicly-accessible location on its Internet website, the results of the inspection; and whenever a complaint is filed against a surgical practice that does not accept Medicare, the DOH will be required to post, at a publicly-accessible location on its Internet website, the facility's plan of correction.

In each legislative session Senator Vitale introduces a bill that would regulate one-room surgery centers. There is no Assembly companion bill yet. The Assembly will not return until after the November election so no bills will be voted on until after the Legislature reconvenes in mid-November. The Senate is not expected to vote on anything substantive or controversial because of the election. We will continue to monitor this bill and track any new developments.

LEGAL REPORT

JOHN FANBURG, ESQ.
PARTNER, BRACH EICHLER LLC

NEW JERSEY DEVELOPMENTS

A. Prescription Monitoring Program Bill Signed Into Law

On July 18, 2015, Senate Bill S1998/S2119 (A3062) was signed into law by Governor Chris Christie. The new law amends certain provisions of the New Jersey Prescription Monitoring Program ("PMP") to, among other things, require pharmacists to submit information regarding individuals who pick up prescriptions for controlled dangerous substances ("CDS") if the pharmacist suspects that the individual may be picking up the prescription for a reason other than delivering it to the patient for which the prescription was written, (effective once the PMP is ready to accept such information).

The new law also requires the Division of Consumer Affairs to evaluate whether any person obtaining a prescription for CDS is doing so in a manner indicative of misuse, abuse or diversion. In addition, the new law automatically enrolls pharmacists and health care practitioners to participate in the PMP as part of their registration to prescribe or dispense CDS. Finally, the new law requires health care practitioners to consult the PMP the first time that they prescribe a CDS to a patient and quarterly thereafter. Most of the provisions of the new law become effective November 1, 2015.

FEDERAL DEVELOPMENTS

CMS Releases New Data to Increase Transparency on Hospital and Physician Utilization

On June 1, 2015, the Centers for Medicare & Medicaid Services released new Medicare data on hospital and physician utilization. This is the third annual release of Medicare hospital utilization and payment data (inpatient and outpatient) and the second annual release of physician and other supplier utilization and payment data.

The third annual release of hospital utilization and payment data contains the average amount hospitals billed for inpatient and outpatient visits for calendar year 2013. The two previous releases consisted of data from 2011 and 2012. The data provides utilization and payment information for the 100 most common Medicare inpatient stays and 30 selected outpatient procedures at over 3000 hospitals throughout the United States. The top 100 inpatient stays accounted for over $62 billion in Medicare payments and over 7 million discharges.

The second annual release of physician and other supplier utilization and payment data provides information on the number and type of health care services that individual physicians and other health care providers furnished under the Medicare Part B fee-for-service program and the amount that Medicare paid for these services. The 2013 data set covers over 950,000 providers throughout the United States who collectively received $90 billion in Medicare payments. The data shows payment and submitted charges by health care provider, allowing for comparisons by physician, specialty, location, types of medical services and procedures delivered.

B. CMS Proposes Several Important Changes in the 2016 Medicare Physician Fee Schedule Rule

On July 15, 2015, the Centers for Medicare & Medicaid Services ("CMS") published its 2016 Physician Fee Schedule Proposed Rule. CMS proposes to finalize changes to the Physician Quality Reporting System ("PQRS") and the Physician Value-Based Payment Modifier (Value Modifier), and also proposes new physician payment and quality monitoring policies. The proposal contains certain clarifications and new exceptions to the federal law that prohibits self referrals (known as the Stark Law). If the PFS is finalized in its present form, payment to anesthesiologists under the PFS is estimated to remain the same on average, while payment for interventional pain management is expected to increase by one percent, on average.

Under the proposal, 2016 will be used as the reporting period for 2018, and CMS proposes a 2% payment reduction for individual eligible providers or group practices that do not satisfactorily report data on PQRS quality measures, or in lieu of reporting, participate in a qualified clinical data registry. The Rule proposes the addition and elimination of certain quality measures, equaling a total of 300 measures in the PQRS set for 2016 if all proposals are finalized.

Consistent with past years, the 2018 Value Modifier will be applied based on PQRS participation by individual providers and group practices. The maximum upward and downward adjustment factors remain at 4.0% for groups of 10 or more eligible providers and 2.0% for groups of fewer than 10 as well as solo practitioners.

Additionally, CMS proposes to establish a new exception to the Stark Law for certain timeshare arrangements between physicians and hospitals. To qualify (i) a licensee would be required to use the licensed premises, equipment, personnel, items, supplies and services predominantly to furnish evaluation and management services to patients of the licensee, and (ii) the arrangement could not involve advanced imaging equipment, radiation therapy equipment or clinical or pathology laboratory equipment. The exception would be limited to timeshare arrangements in which hospitals and physician organizations are the licensors. It would not protect timeshare arrangements offered by other types of health care organizations, including clinical laboratories. The proposed exception would not be available to protect part-time and exclusive leases of office space, which would continue to be measured under the current exception for real property leases.

CMS also proposes to establish another new exception to the Stark Law for payments made by a hospital, Federally Qualified Health Center or Rural Health Center to a physician to assist the physician in employing a non-physician practitioner ("NPP") in the donor's geographic service area. NPPs would include physician assistants, nurse practitioners, clinical nurse specialists and certified nurse midwives. The proposed exception would apply only to situations in which the NPP is a bona fide employee of the physician or physician practice receiving the support, and the purpose of the employment is to provide primary care services to patients of the physician practice. The proposed exception includes a cap on the amount of remuneration and a two-year limit on assistance.

According to CMS, the requirement of many Stark Law exceptions for a "writing" or "written agreement" need not be satisfied by evidence of a single contract. Instead, depending on the facts and circumstances, a collection of contemporaneous documents, including documents evidencing the course of the parties' conduct, may suffice. As a result, the Rule proposes to clarify that Stark exceptions conditioned on a term of at least 1 year do not require a written contract or other document with an explicit provision identifying the term of the arrangement. Rather, an arrangement that lasts at least 1 year satisfies this requirement. In addition the Rule proposes to allow parties 90 days (instead of 30) to obtain required signatures to an agreement, irrespective of whether the failure to secure a timely signature is knowing or inadvertent.

C. CMS and AMA Attempt to Ease Transition to ICD-10

On July 6, 2015, the Centers for Medicare & Medicaid Services ("CMS") and the American Medical Association ("AMA") announced joint efforts to prepare providers for the transition from ICD-9 to ICD-10 coding for medical diagnoses and inpatient hospital procedures, including educating providers through webinars, on-site training, educational articles and national provider calls.

ICD-10 is set to begin on October 1 and is required for everyone covered by HIPAA. According to CMS, ICD-10 will help to better identify illnesses, early warning signs of disease outbreaks and adverse drug events. Some of the major differences between ICD-9 and ICD-10 are as follows:

- Codes are grouped by anatomical site rather than by injury.
- Change from 14,000 codes to 69,000 codes.
- Extensive combination codes to better capture complexity.

An ICD-10 Ombudsman will be named to triage and answer questions about claims submissions.

CMS Begins Implementation of Key Payment Legislation

Date

2015-07-08

CMS Begins Implementation of Key Payment Legislation

Proposed Update to Physician Fee Schedule is First Since Repeal of SGR

Today, CMS released the first proposed update to the physician payment schedule since the repeal of the Sustainable Growth Rate through the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The proposal includes a number of provisions focused on person-centered care, and continues the Administration's commitment to transform the Medicare program to a system based on quality and healthy outcomes.

"CMS is building on the important work of Congress to shift the Medicare program toward a system that rewards physicians for providing high quality care," said Andy Slavitt, Administrator of CMS. "Thanks to the recent landmark Medicare and children's health insurance program legislation, CMS and Congress are working together to achieve a better Medicare payment system for physicians and the American people."

In the proposed CY 2016 Physician Fee Schedule rule, CMS is also seeking comment from the public on implementation of certain provisions of the MACRA, including the new Merit-based Incentive payment system (MIPS). This is part of a broader effort at the Department to move the Medicare program to a health care system focused on the delivery of quality care and value.

The proposed rule includes updates to payment policies, proposals to implement statutory adjustments to physician payments based on misvalued codes, updates to the Physician Quality Reporting System, which measures the quality performance of physicians participating in Medicare, and updates to the Physician Value-Based Payment Modifier, which ties a portion of physician payments to performance on measures of quality and cost. CMS is also seeking comment on the potential expansion of the Comprehensive Primary Care Initiative, a CMS Innovation Center initiative designed to improve the coordination of care for Medicare beneficiaries.

The proposed rule also seeks comment on a proposal that supports patient- and family-centered care for seniors and other Medicare beneficiaries by enabling them to discuss advance care planning with their providers. The proposal follows the American Medical Association's recommendation to make advance care planning services a separately payable service under Medicare.

The release of the rule triggers a 60-day comment period, during which time CMS welcomes the input of stakeholders and the public. A final rule will be published this fall. For a fact sheet on the proposed rule, please see here. For further information, please see the rule on display here.