NEW JERSEY STATE SOCIETY OF ANESTHESIOLOGISTS

# The NJSSA Pulse

**October 2015**


## FROM THE PRESIDENT
## PETER GOLDZWEIG, DO

I hope everyone enjoyed the summer. As fall sets in the ASA Annual Meeting takes place October 24th-28th, 2015 in San Diego, CA. Dr. Henry Rosenberg will be awarded the 2015 Distinguished Service Award by the American Society of Anesthesiologists on Monday, October 26th, during the Rovenstine Lecture at 8 AM at the ASA's Annual Meeting in San Diego. MHAUS, the New Jersey State Society of Anesthesiologists, and Barnabas Health would like to invite you to join us prior to his actual presentation on Saturday, October 24th, from 6:30 - 8:30 pm at a Cocktail Reception held at the Marriott Marquis Marina in the San Diego Ballroom A, Lobby Level to honor this impressive achievement. All are invited to attend!

Novitas (NJ's Medicare carrier) has two local coverage determinations that maybe of interest for those who practice chronic pain. We are working with several other states and the ASA to submit comments. We have also reached out to the NJ Pain Representatives to Novitas. They are as follows:

**Facet Joint Injections (DL34974)**

https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=36432&ContrId=323&ver=6&ContrVer=1&Date=&DocID=DL34974&bc=iAAAAAgAAAAAAA==&

**Nerve Blockade for Treatment of Chronic Pain and Neuropathy (DL35033)**

https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=36447&ContrId=323&ver=5&ContrVer=1&Date=&DocID=DL35033&bc=iAAAAAgAAAAAAA==&

The ASA 2016 Practice Management meeting takes place on January 29th-31st in San Diego, CA. Succeed in today's evolving health care environment and transform your practice by staying at the forefront of practice management. More information can be found at: https://www.asahq.org/meetings/practice-management-2016

I hope to see you in San Diego.

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

**OMNIA Alliance**

The Senate Health, Human Services & Senior Citizens and the Senate Commerce Committee held a joint hearing on October 6, 2015 at the State House to review testimony from invited guests regarding the recently announced OMNIA Health Alliance formed by Horizon Blue Cross and Blue Shield (Horizon) of NJ. The hearing lasted more than eight hours.

The new plans, developed by the **S**tate's largest private insurer, Horizon, creates two tiers of hospitals. At 34 so-called Tier 1 hospitals, patients will pay lower co-pays and deductibles. The other 38 hospitals in the insurer's network fall into Tier 2. The plans have been widely criticized by legislators, physicians and hospitals relegated to Tier 2.

Senators on both sides of the aisle were critical of Horizon's OMNIA plan. At the end of the proceedings , Senators Joe Vitale and Nia Gill, who chair the Senate Health and Commerce committees, respectively, called upon Acting Attorney General John Jay Hoffman to investigate the OMNIA Health Alliance and tiered benefit plans. It is expected that the New Jersey General Assembly will conduct a set of similar hearings after November's election. There is a possibility that the new developments with Omnia will have an impact on Out-of-Network (OON) reform.

**Out-of-Network Legislation**

We have participated in a number of recent meetings as part of the Access to Care Coalition, which includes the Medical Society of New Jersey, the New Jersey Hospital Association, and a host of physician specialty representatives. As we've previously reported, we've been reviewing information on the New York Out-of-Network (OON) Law with regard to transparency and disclosure.

The recent announcement of the Horizon Blue Cross and Blue Shield of New Jersey OMNIA Alliance will have an unknown effect on the OON push. We have gathered information that suggests sponsors of the OON bill will continue despite a similar announcement recently made by Aetna creating a similar alliance. We expect the new tiered plan announcements may complicate hopes to fast-track the OON bill when both the Senate and Assembly begin regularly meeting following the November 3, 2015 election for the lame-duck legislative period.

**November 3rd election and Lame Duck**

On Tuesday, November 3rd all 80 seats of the New Jersey General Assembly are up for election. The Senate

does not have an election until 2017. The Assembly is controlled by the Democrats who maintain a 48-32 majority. It is widely expected that they will remain as the majority party and Speaker Vincent Prieto, Majority Leader Louis Greenwald and Budget Committee Chairman Gary Schaer will return for another term as the top three Assembly leaders. The week after Election Day we anticipate both houses of the Legislature will begin meeting. All committees are expected to meet at least twice and each house will have several voting sessions between mid-November and the second Tuesday of January when the new legislative session will begin. The lame duck session is a time when many bills are voted on and sent to the **G**overnor for action**,** otherwise those initiatives will have to start anew at the beginning of the legislative process in mid-January. It will be a very busy time of the year and we have been working throughout the Summer and Fall on legislation that we expect will be considered during the lame duck session.

# Save The Date!

## NJSSA 2016 Annual Meeting

*March 12, 2016*

The Hyatt Regency

New Brunswick, NJ

## LEGAL REPORT

JOHN FANBURG, ESQ.
PARTNER, BRACH EICHLER LLC

NEW JERSEY DEVELOPMENTS

Bill Introduced to Limit Payment for Out-of-Network Medical Services

On May 14, 2015, Senate Bill S20 (A4444), entitled the "Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act" was introduced into the New Jersey State Senate. The bill, if passed into law, would, among other things:

Require health care facilities and health care professionals to provide written disclosures to patients at least 30 days prior to their non-emergency or elective procedures, the facility's and the health care professional's network status, the patient's personal financial responsibility based upon that status, and a description of the procedure.

Require carriers to disclose in writing, a list of providers that are in-network, to be updated at least every 20 days and to disclose whether in-network providers become out-of-network providers.

Prohibit health care facilities and health care professionals from billing patients for emergency or urgent care services beyond the covered person's deductible, copayment or coinsurance responsibilities.

Establish a binding arbitration process between health care providers and carriers.

A provision of the original form of the bill that would have capped the price of out-of-network services was eliminated from the present form of the bill. In addition, on June 11, 2015, it was reported that the bill stalled in the Senate Commerce Committee and would not move forward to the Senate Budget Committee and the full Senate because of strong opposition from certain physicians and hospitals. More recently, on July 31, 2015, the Senate Pension and Health Benefits Commission recommended that the bill be enacted into law.

Senator Sweeney Pushing For Taxation of Hospitals

The New Jersey Tax Court recently determined, in AHS Hospital Corp. v. Town of Morristown, that property owned by AHS Hospital Corp., which operates Morristown Medical Center at the property, was no longer entitled to its New Jersey property tax exemption. In light of this ruling, State Senator Stephen Sweeney has stated that he is in the process of developing legislation for hospitals to either make payments in lieu of taxes, to require the payment of taxes based upon a percentage of a hospital's revenue, or impose a property tax on hospital property.

Senator Sweeney stated that he agreed with the court's ruling that concluded that hospitals generally no longer function as nonprofit entities. In the opinion, Tax Court Judge Vito Bianco found that Morristown Medical Center functioned like a for-profit hospital, "with corporate structures intertwined with both nonprofit and for-profit subsidiaries and unaffiliated corporate entities."

FEDERAL DEVELOPMENTS

Most New Jersey Hospitals Will Face Readmission Penalties in Fiscal Year 2016

On August 3, 2015, it was reported that the Centers for Medicare & Medicaid Services ("CMS") will impose penalties on 2,592 hospitals nationwide for readmitting too many Medicare Patients, including 63

hospitals in New Jersey. Nationally, it is estimated that hospitals will lose a total of $420 million in Medicare payments in FY 2016 (October 1, 2015 – September 30, 2016). In New Jersey, hospitals will lose $23 million in Medicare payments on average. As it did in FY 2015, for FY 2016, under the Hospital Readmissions Reduction Program ("HRRP"), CMS reduces payment to hospitals with high readmissions rates by up to 3% of every payment to the hospital for a patient stay. HRRP was implemented by CMS in October 2012 and established under the Patient Protection and Affordable Care Act.

No New Jersey hospital will receive the full 3% reduction. The following are the top ten hospitals to receive penalties for high readmission rates in New Jersey:

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| • Palisades Medical Center, North Bergen | 2.49% |
| • Kennedy University Hospital, Stratford | 2.15% |
| • St. Joseph's Regional Medical Center, Paterson | 2.15% |
| • Saint Peter's University Hospital, New Brunswick | 2.01% |
| • Capital Health Medical Center – Hopewell, Pennington | 1.77% |
| • Virtua West Jersey Hospital, Berlin | 1.67% |
| • Carepoint Health – Christ Hospital, Jersey City | 1.54% |
| • JFK Medical Center, Edison | 1.51% |
| • St. Michael's Medical Center, Newark | 1.46% |
| • Saint Clare's Hospital, Denville | 1.42% |

OIG Conducts Study of Physician Owned Distributors

The Department of Health & Human Services Office of Inspector General ("OIG") recently conducted a study to determine the extent of overlap between physician owned hospitals and physician owned distributors ("PODs") of spinal devices. The goal of the study was to determine the extent to which spinal devices used in physician-owned hospitals were purchased from PODs that had common physician ownership with the hospital. In conducting the study, the OIG used publicly available data and provider data compiled by the Centers for Medicare & Medicaid Services.

While the study only found one physician who had an ownership interest in both a hospital and a POD that supplied spinal devices to that hospital, the OIG acknowledged that information regarding physician ownership of PODs is limited, and it is therefore likely that a greater overlap between physician owned hospitals and PODs exists. The OIG also noted that transparency of ownership of PODs is important to ensure that providers do not violate anti-referral laws in purchasing medical equipment, in that physician ownership of PODs might affect clinical decision-making by influencing providers to perform unnecessary procedures in order to profit from a device supplier in which the provider has a financial interest.

60 Day Overpayment Rule: Federal District Court Enforces Strict Standard

In the first court case to interpret the Affordable Care Act's ("ACA's") 60 day overpayment rule, the United States District Court, Southern District of New York, adopted a strict interpretation of the rule. In the case of U.S. ex rel. Kane v. Continuum Health Partners, Inc. et al., the Court rejected the defendant's motion to dismiss the suit alleging failure to return Medicaid overpayments in a timely manner. The Court concluded that overpayments were "identified" and the 60 day clock to repay the overpayments started running when the defendant became aware that the overpayments likely existed, as opposed to when the overpayments were conclusively confirmed. The decision is the first to interpret the ACA's 60 day overpayment rule, which requires providers to return any Medicare or Medicaid overpayment within 60 days of the overpayment being identified. If an overpayment is not returned within 60 days of identification, a provider is subject to liability under the False Claims Act.

Since the 60 day rule was adopted, there have been questions regarding the interpretation of when an overpayment has been "identified". The Centers for Medicare & Medicaid Services issued a proposed rule on the topic in 2012, providing that an overpayment has been identified when a provider has actual

knowledge of the overpayment or has acted in reckless disregard or deliberate ignorance of the existence of the overpayment. However, due to widespread opposition to the proposed rule, it was never adopted. In this case, Continuum, an operator of non-profit hospitals in New York, was made aware of the likely existence of Medicaid overpayments in February 2011. However, the Government alleges that Continuum took more than two years to repay the overpayments. In its motion to dismiss, Continuum argued that although it was made aware of the possibility of the overpayments in February 2011, the 60 day clock should not have started running until it conclusively established each erroneous claim and the specific amount of the overpayments.

The Court agreed with the Government's interpretation in concluding that to allow Continuum to evade liability because it had not conclusively established each erroneous claim and the specific amount of each overpayment would contradict Congress's intention in adopting the 60 day rule. Furthermore, the Court rejected Continuum's argument that this would impose an unworkable burden on providers because not starting the 60 day clock running until the specific amounts of the overpayments were established would create a perverse incentive for providers to delay identifying and calculating overpayment amounts. The Court did provide that an overpayment obligation arising pursuant to the 60 day rule does not in and of itself establish False Claims Act liability. False Claims Act liability arises when an obligation is knowingly concealed or knowingly and improperly avoided or decreased.