Riker Danzig Health Care Update September 29, 2017

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New Jersey State: Selected Proposed and Adopted Legislation

- A. 5144 – Introduced – Requires health insurers to provide coverage for prescription drugs through entire course of treatment as determined by prescriber.
- A. 320 – Amended/Substituted – Establishes minimum Medicaid reimbursement rate for personal care services.
- P.L. 2017, c. 220 – Adopted – Requires health insurance carriers, SHBP, and SEHBP to inform covered persons about organ and tissue donation.
- P.L. 2017, c. 230 – Adopted – Eliminates the unemployment insurance exemption for interns employed by hospitals.

New Jersey State: Selected Proposed Regulation

- 49 N.J.R. 2729(a) – Proposed – This proposed rule would amend certain provisions of the Health Claims Authorization, Processing and Payment Act and add new provisions related to a health carrier's ability to seek reimbursement of overpaid or underpaid claims.
- 49 N.J.R. 2738(a) – Proposed – The State Board of Medical Examiners is proposing to amend its rules related to physician assistants to create an expanded, physician-delegated scope of practice for physician assistants, while also eliminating the temporary licensure of persons who have not yet passed the national certifying examination.
- 49 N.J.R. 2745(a) – Proposed – This proposed rule would repeal N.J.A.C. 13:35-5.1, N.J.A.C. 13:35-5.2 and N.J.A.C. 13:35-6.8, which concern standards for eye examinations, standard and tolerances for optical lenses,

and standards for the prescription or dispensing of amygdalin.

- 49 N.J.R. 2746(a) – Proposed – This proposed rule would add new regulations pertaining to licensed pharmacists abilities' to administer influenza vaccines to persons under the age of 18.
- 49 N.J.R. 2880(a) – Proposed – This proposed rule would reinforce the existing rights of a covered person to request from their insurer to request services from an out-of-network provider, but pay network level cost sharing when the network associated with the covered person's plan does not contain an available provider to perform the needed services.

Federal: Selected Proposed Legislation

- H.R. 3338 – Introduced – Requires that health plans provide coverage for a minimum hospital stay for mastectomies, lumpectomies, and lymph node dissection for the treatment of breast cancer
- H.R. 3360 – Introduced – Promotes and expands the application of telehealth under Medicare and other federal health care programs.
- H.R. 3451 – Introduced – Amends Title III of the Public Health Service Act to expand the program for payments to teaching health centers with GME programs.
- H.R. 3536 – Introduced – Requires persons who undertake federally funded research and development of drugs to enter into reasonable pricing agreements with the Secretary of Health and Human Services.
- H.R. 3611 – Introduced – Amends Title XVIII of the Social Security Act to create incentives for healthcare providers to promote quality healthcare outcomes.

Federal: Selected Proposed and Adopted Regulations

- 82 FR 36238-01 – Adopted – This final rule updates the prospective payment rates for inpatient rehabilitation facilities (IRFs) for federal fiscal year 2018.
- 82 FR 36530-01 – Adopted – This final rule updates the payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs) for fiscal year 2018. It also adds a new cost category for Installation, Maintenance, and Repair services.
- 82 FR 36638-01 – Adopted – This final rule will update the hospice wage index, payment rates, and cap amount for fiscal year 2018. Additionally, this rule includes new quality measures and provides an update on the hospice quality reporting program.
- 82 FR 37990-01 – Adopted – CMS is revising the Medicare hospital inpatient prospective payment systems for operating and capital-related costs of acute care hospitals to implement changes arising from their continuing experience with those systems for fiscal year 2018.
- 82 FR 39310-01 – Proposed – This rule would cancel the Episode Payment Models and Cardiac Rehabilitation incentive payment model and rescind the regulations governing those models. It would also

revise certain aspects of the Comprehensive Care for Joint Replacement model.

- 82 FR 39553-01 – Proposed – The Department of Health and Human Services is soliciting comments on delaying the effective date of the January 5, 2017 final rule that sets forth the calculation of the ceiling price that applies to all drug manufacturers that are required to make their drugs available to covered entities under the 340B program.

State Litigation

- A cardiac surgery group in New Jersey, Mid-Atlantic Surgical Associates P.C., recently filed a putative class action against UnitedHealthcare in the District Court for the District of New Jersey, alleging that UnitedHealthcare has systematically underpaid out-of-network providers for emergency medical services. For more information on the case, see, Mid-Atlantic Surgical Associates PC v. UnitedHealthcare Services Inc., case number 2:17-cv-06270, in the U.S. District Court for the District of New Jersey.
- A New Jersey district court judge recently ruled to toss an antitrust suit brought against Humana Inc., by a rival specialty pharmacy, Prime Aid Pharmacy Corp. The pharmacy argued that Humana forced patients to accept mail-order delivery through its own specialty pharmacy, which Prime Aid alleged was an intentional and deliberate attempt to monopolize a captive market for locked-in patients needing specialty medications. For more information on the suit, see, Prime Aid Pharmacy Corp. v. Humana Inc. et al., case number 2:16-cv-02104 in the U.S. District Court for the District of New Jersey.

Federal/Other State Litigation

- The Third Circuit recently overturned a lower court's award of $1,000,000 to a university student who was dismissed from a Pennsylvania hospital clinic program after she refused to take a drug test. The Third Circuit found that the agreement between the student's university and the medical facility made clear that the medical facility could unilaterally exclude a student from participating in clinical training if they did not comply with hospital policy. For more information on the case, see, Angela Borrell v. Bloomsburg University et al., case number 15-2823, in the U.S. Court of Appeals for the Third Circuit.
- A split Seventh Circuit recently aligned with a split Sixth Circuit panel on the issue of the validity of forum selection clauses in ERISA plans. The Seventh Circuit said that while ERISA suggests that benefits suits should be brought where the plan is administered, where the breach took place, or where a defendant resides, nothing in ERISA specifically mandates that suits must be brought in those locations. As such, two circuits have now approved forum selection clauses in ERISA plans. For more information on this case, see, In Re: George W. Mathias, case number 16-3808, in the U.S. Court of Appeals for the Seventh Circuit.
- A Southern District of New York judge recently held that the test espoused in the United States Supreme Court's decision in Universal Health Services v. Escobar is mandatory in False Claims Act (FCA) cases.

Specifically, that decision held that FCA cases involving "implied false certification" can be viable when two conditions exist: (1) There are "specific representations" about services provided, and (2) undisclosed noncompliance makes the representations misleading. For more information on this case, see, U.S. ex rel. Vincent Forcier v. Computer Sciences Corp., case number 12-cv-01750, in the U.S. District Court for the Southern District of New York.

- The D.C. Circuit recently ruled that a lower court judge acted too quickly in ordering that the Department of Health and Human Services clear Medicare's enormous backlog of hospital billing appeals by 2021. Specifically, a split D.C. Circuit panel remanded the question to the district court judge to take a deeper look at whether the Department of Health and Human Services can clear the backlog of roughly 600,000 appeals by 2021 while still protecting taxpayer dollars. For more information on the case, see, American Hospital Association et al. v. Thomas Price, case number 17-5018, in the U.S. Court of Appeals for the District of Columbia Circuit.
- A Kentucky Appellate Court recently ruled that under the United States Supreme Court's decision in Kindred Nursing Centers LP v. Clark et al., the family of a deceased nursing home patient could not escape arbitration of their negligence claims against the facility. For more information on the suit, see, Diversicare Healthcare Services et al. v. Michael Riley, case number 2015-CA-000651-MR, in the Commonwealth of Kentucky Court of Appeals.
- A U.S. Court of Federal Claims judge recently ruled that Molina Healthcare was owed more than $52 million from the federal government in Affordable Care Act payments. Specifically, the judge ruled that the government was liable for "risk corridor" payments under the ACA because the program created an implied-in-fact contract between insurers and the government that required the government to pay insurers if they lost money during the first three years of the ACA's implementation. For more information on the suit, see, Molina Healthcare v. U.S., case number 17-97C, in the U.S. Court of Federal Claims. This decision comes on the heels of another decision by the same court just weeks prior that had held that the federal government does not need to subsidize insurers with "risk corridor" payments, because Congress overrode that obligation when it approved spending bills in 2014 and 2015 that blocked taxpayer funding for the risk corridors program. For more information on this suit, see, Maine Community Health Options v. U.S., case number 1:16-cv-00967, in the U.S. Court of Federal Claims.
- A Connecticut federal judge recently ruled to certify a class of certain Medicare beneficiaries. Specifically, the case concerns due process claims over Medicare beneficiaries' ability to appeal being hospitalized under "outpatient observation status," a classification that doesn't require patients to be admitted. The status is covered under Medicare Part B, not Part A, which carries lower reimbursement rates. Advocates argued that this could cost patients thousands of dollars more in out-of-pocket costs and yet they have no administrative recourse to appeal this status. For more information on the case, see, Alexander et al. v. Price,

case number 3:11-cv-01703, in the U.S. District Court for the District of Connecticut.

The list above does not include every proposed or adopted legislation, litigation or guidance document that may impact the health care industry. Instead, it includes only a select few chosen by the authors, and any information in this Update is not intended to provide legal advice. If you are concerned that a proposed or adopted legislation, litigation or guidance document may impact your practice, then you should seek legal advice. Nothing in this Update should be relied upon as legal advice in any particular matter.

If you have any questions about the issues discussed in this Update, please contact the following Riker Danzig attorneys:

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