Schenck Price
SCHENCK PRICE SMITH & KING, LLP
www.spsk.com

HEALTH LAW DISPATCH

December 2020

Medicaid Reimbursement

Medicaid MCO's Improper Use of Triage Fee

By Brian M. Foley, Esq.

We discovered recently that at least one, and possibly more Medicaid Managed Care Organizations ("MCOs") under contract with the State of New Jersey, have been misapplying Emergency Room Triage Fees to reduce payments for Emergency Room services.

In 2018, the State introduced the concept of the Emergency Room Triage Fee as part of original Medicaid. According to the policy, the Emergency Room Triage Fee of $140, will be paid in lieu of the normal fees for Emergency Room services, for certain low acuity care provided in the Emergency Room. (The policy was adopted by the State for original Medicaid only, but some of the Medicaid MCOs have also started using it. This should be addressed in contract language going forward.) The Emergency Room Triage Fee is to be paid only under very specific circumstances. According to the policy, claims that are submitted that meet all the following criteria will be paid the Emergency Room Triage Fee.

- Revenue Code 45X is present on the claim,
- Procedure code 99281, 99282, 99283, 99284, or 99285 are present on the claim, and
- All of the first three diagnosis codes on the claim are on the current approved non-emergent diagnosis code list published on the NJMMIS website.

There are a number of exemptions to this policy, including pregnant women, children ages 6 or younger, seniors ages 65 or older, or inclusion of a certification of emergency form attachment.

We are seeing that at least one Medicaid MCO (and possibly others) may be inappropriately paying the Triage Fee in lieu of the normal Emergency Room rate, where the first three diagnosis codes contain one or more emergent codes. A list of diagnosis codes that constitute non-emergent codes is published by NJMMIS on its website. Those non-emergent codes must appear in each of the first three diagnosis positions, for the payer to pay the Triage Fee. Otherwise, they should pay the normal Emergency Room rates, as per the contract. Despite the presence of emergent codes in one or more of the first three positions, the payer is paying only the Triage Fee. In some cases, the payer paid the claim correctly, but then came back and recouped the original payment and issued payment of the Triage Fee of $140. We brought this issue to the attention of one of the Medicaid MCOs, who immediately ceased the practice and made full restitution to the hospital.

Hopefully, your hospital has not experienced this issue, but it is worth reviewing to make sure that the Medicaid MCOs are not paying inappropriately for your Emergency Room services.

For more information, contact Brian M. Foley, Esq., at bmf@spsk.com or (973) 540-7326.

Fraud and Abuse Regulations

OIG and CMS Pave the Way for Value-Based Arrangements

By Meghan V. Hoppe, Esq.

Last December, Schenck Price issued a Special Edition of the Health Law Dispatch dedicated to proposed regulations aimed at reforming the federal Anti-Kickback statute (the "AKS") and the federal Physician Self-Referral Law (the "Stark Law"). The

long-awaited final rules, which largely adopt the proposed regulations, were published concurrently by the Office of Inspector General of the Department of Health and Human Services ("OIG") and the Centers for Medicare & Medicaid Services ("CMS") on December 2, 2020. The final rules pave the way for value-based health care by, among other things, creating new safe harbors under the AKS and exceptions under the Stark Law for certain value-based compensation arrangements.

The new exceptions and safe harbors rely on a set of shared terminology. They protect "value based arrangements" involving at least one "value based activity" for a target population. The value based arrangement must involve a "value based enterprise" or "VBE," which is two or more participants that: (1) are collaborating to achieve at least one value-based purpose; (2) are each a party to a value-based arrangement with the other (or at least one other participant in the same VBE); (3) have an accountable body or person responsible for financial and operational oversight of the VBE; and (4) have a governing document describing the VBE and how its participants intend to achieve the VBE's value-based purpose(s).

The new Stark Law and AKS rules both include protections for arrangements with *full financial risk*. An AKS safe harbor also covers *substantial downside financial risk*, and a Stark Law exception protects arrangements with meaningful *downside financial risk*. The value-based exceptions and safe harbors provide flexibility in structuring relationships among providers proportional to their assumption of financial risk. Therefore, arrangements involving greater risk are subject to fewer regulatory requirements.

Notably, the value-based exceptions and safe harbors do not include a requirement that the arrangements reflect fair market value (FMV), which is a traditional fraud and abuse safeguard found in many of the existing Stark Law exceptions and AKS safe harbors that has created significant barriers to value-based compensation arrangements in the past. While the new AKS safe harbors and Stark Law exceptions include many similarities intended to protect value-based arrangements, the requirements for compliance are not identical. For example, pharmaceutical manufacturers, pharmacy benefit managers (PBMs), medical device companies, lab companies, compounding pharmacies and durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) are excluded from the value-based AKS safe harbors. The new Stark Law exceptions do not exclude any specific entities from eligibility

The new rules take effect on January 19, 2021, other than certain revisions to the Stark Law relating to group practices that will be effective January 1, 2022, and apply only prospectively. Thus, arrangements entered into prior to January 20, 2021 are still subject to current regulations.

For more information, contact Meghan V. Hoppe, Esq. at mvh@spsk.com or (973) 540-7351.

Hospital Mergers

Federal Courts Reject Challenges to Pennsylvania Hospital Merger

By Daniel O. Carroll, Esq.

On December 8, 2020, a federal district court in the Eastern District of Pennsylvania denied a request from the Federal Trade Commission ("FTC") and Pennsylvania attorney general to preliminarily enjoin a proposed merger between Thomas Jefferson University and Albert Einstein Healthcare Network. See FTC, et al., v. Thomas Jefferson Univ., et al., 2020 U.S. Dist. LEXIS 229735 (E.D. Pa., Dec. 8, 2020). Seeking a preliminary injunction to prevent the merger, the initial administrative complaint filed in March alleged that the proposed merger between the two healthcare systems (with 17 hospitals) would reduce competition and increase prices in two Pennsylvania counties (Philadelphia and Montgomery). Judge Gerald Pappert rejected these arguments holding that the government failed to meet its burden of proof.

Judge Pappert found that the government's expert's econometric calculations did not show that its geographic markets correspond to the commercial realities of southeastern Pennsylvania's competitive healthcare industry. Furthermore, testimony primarily from two (of the region's four) major commercial insurers is not unanimous and is not supported by the record as a whole. Rather, the Court found that the insurers' conclusory assertions that they would have to agree to price increases with the hospitals were not credible. Evidence of the aspirations of the health systems to become "more indispensable" to insurers by virtue of the merger does not change the record to show that, from the insurers' perspective, insurers would in fact pay a price increase for hospital services

in the geographic markets instead of looking to hospitals outside those markets. Failing to establish its prima facie case that the insurers would not avoid a price increase by looking to hospitals outside those markets, the government did not show "that there is a credible threat of harm to competition during the time between the denial of this preliminary injunction and the final adjudication of" the merits.

On December 21, 2020, the Third Circuit Court of Appeals issued a one-page order denying the government's appeal of the Court's decision.

Recently, the FTC appears to be more active in its attempts challenge hospital mergers. Hospitals and health systems considering merger should take heed with respect to this increased antitrust scrutiny but should also take note of the favorable factors in the Court's analysis of this case.

For more information, contact Daniel O. Carroll, Esq. at doc@spsk.com or (973) 631-7842.

HIPAA

OCR Proposes Modifications to HIPAA Privacy Rule

By Deborah A. Cmielewski, Esq.

The U.S. Department of Health and Human Services ("HHS") Office for Civil Rights ("OCR") has proposed modifications to the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule. The Notice of Proposed Rulemaking ("NPRM"), which promotes health information sharing and coordination of patient care, represents another vital step in HHS Deputy Secretary Eric D. Hargan's Regulatory Sprint to Coordinated Care. A complete copy of the NPRM is available here.

Key components of the NPRM include the following:

- The NPRM seeks to expand a covered entity's ability to disclose protected health information ("PHI") in the case of certain health emergencies by allowing a covered entity to share information based on a "good faith" belief that the disclosure would be in the patient's best interests, rather than the covered entity's "professional judgment."
- The NPRM seeks to expand a covered entity's ability to disclose PHI to avert a threat to health or safety when harm is "serious and reasonably foreseeable," rather than the existing standard, which requires a "serious and imminent" threat to health or safety.
- The NPRM seeks to modify the definition of "health care operations" to clarify that the term includes care coordination and case management for individuals.
- The NPRM proposes to specifically permit covered entities to share PHI with social services agencies, community-based organizations, home and community-based service providers or other third parties that provide or coordinate health-related services necessary for an individual's care coordination and case management.
- The NPRM contains several modifications that facilitate an individual's right of access to his or her own health information.
- The NPRM proposes to eliminate a covered entity's obligation to (i) obtain a patient's written acknowledgement of receiving a Notice of Privacy Practices and (ii) retain copies of the acknowledgements for six (6) years.
- The NPRM proposes to allow disclosure of patient information to Telecommunications Relay Services ("TRS") and to specifically exclude TRS providers from the definition of "business associates."

Public comments will be due 60 days after publication of the NPRM in the Federal Register.

For more information regarding the NPRM, contact Deborah A. Cmielewski, Esq. at dac@spsk.com or (973) 540-7327.

Information Blocking

ONC Extends Deadlines for Applicability of Information Blocking Rules

By Divya Srivastav-Seth, Esq.

Due to the ongoing pandemic, the Office of the National Coordinator for Health Information Technology ("ONC") has is-

sued an interim final rule and extended the deadline for applicability of its earlier final rule related to electronic health information blocking from November 2, 2020 until April 5, 2021. See 85 Fed. Reg. 70,064 (Nov. 4, 2020). The ONC's Final Rule, 85 Fed. Reg. 25,642, May 1, 2020, ("Final Rule"), implemented the 21st Century Cures Act's, Public Law No:114-255 (December 13, 2016), prohibition against information blocking which broadly includes any practice of a covered actor, i.e., a health care provider, health IT developer of certified health IT, health information network or health information exchange, that is known or could be reasonably understood to likely interfere with the access, exchange, or use of electronic health information ("EHI") unless required by law or covered by an ONC regulatory exception.

ONC has included regulatory exceptions in the Final Rule for reasonable and necessary activities that subject to certain conditions will not constitute information blocking. These exceptions include practices that are reasonable and necessary to prevent harm, protect privacy and security of EHI, involve the inability of an actor to fulfill a request due to infeasibility or the temporary unavailability of EHI access. Other exceptions include procedures involving limitations as to content and manner or charging of fees or license requirements. The content and manner exception would allow the definition of EHI to be narrower in scope for the eighteen months after the applicability of the Final Rule so that actors could respond with a minimum of EHI identified by the data elements represented in the United States Core Data for Interoperability ("USCDI") standard. After these eighteen months expired, the EHI would revert to the broader definition found in the rule which references the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA") Privacy Rule (45 CFR §160.103) subject to exceptions for psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding), regardless of whether the group of records are used or maintained by or for a covered entity as defined under HIPAA. The interim final rule extends this use of the USCDI standard to October 6, 2022.

A practice that does not meet the conditions of an exception would not automatically constitute information blocking and would be evaluated on a case-by-case basis to determine whether information blocking has occurred.

The Office of the Inspector General has issued a proposed rule regarding the applicability of the civil monetary penalty framework for violations of the information blocking rules but these rules have not become final yet and further rulemaking is anticipated.

For more information, contact Divya Srivastav-Seth, Esq. at dss@spsk.com or (973) 631-7855.

Medical Malpractice

Damages Apportionment Among Successive Tortfeasors, Just In Time for the Holidays

By Benjamin A. Hooper, Esq.

A recent appellate case, Glassman v. Friedel, 2020 N.J. Super. Lexis 241 (App. Div. 2020) seeks to resolve whether the allocation scheme created by the Contributory Negligence Act ("CNA"), N.J.S.A. 2A:5-5.1 to 5.8 may be applied to situations involving successive independent tortfeasors, i.e., distinct accidents resulting in separate or enhanced injury to the plaintiff.

First, to appreciate the impact of the Glassman opinion it is necessary to review the development of the statutory scheme governing the apportionment of damages among joint tortfeasors. Joint tortfeasors are two or more persons who are responsible for the same injury. The Joint Tortfeasors Contribution Law ("JTCL"), N.J.S.A. 2A:53A-1 to 5, was enacted in 1952 to ameliorate the injustice of the common law which permitted a plaintiff to place the burden of fault on a single defendant and collect the entirety of the damages from a single tortfeasor, despite the negligence of multiple actors. The JTCL apportioned any damages awarded on a *pro rata* basis by dividing the total verdict award by the numbers of liable tortfeasors.

The fairness of a *pro rata* apportionment was rightfully criticized. Two decades later the CNA was enacted, and when applied in combination with the JTCL created a more equitable approach to apportioning damages between joint defendants. The effect of the CNA was to replace the former *pro rata* liability of the JTCL with the obligation of each tortfeasor

to pay damages in accordance with its own adjudicated percentage of fault. Pursuant to the CNA a jury must allocate a percentage of fault to each defendant, including any defendants settling out before trial. The damages attributable to each defendant are then calculated by the court based on their assigned percentage of fault. The CNA process applies equally to settling defendants and non-settling defendants and did away with the old system where the non-settling defendants who proceeded to trial were entitled to a "*pro tanto*" credit for the settlement proceeds paid by any parties who settled in advance of trial and whose liability was not adjudicated at trial. For example, if a jury awards $1 million to a plaintiff and finds each of the three defendants equally responsible for the injury each defendant would be responsible to pay plaintiff one third of the $1 million award. If, however, one the three defendants settled out in advance of trial for $500,000 the plaintiff would receive the benefit of a good bargain by settling for more than the share of responsibility allotted to the settling party by the jury, and the amount paid by the other two non-settling defendants would remain one third of the award.

In Glassman, a suit involving successive tortfeasors, the Estate of Jennifer Collum-Glassman sued the restaurant where Jennifer fell and fractured her ankle. As a result of the injury Jennifer came under the care of the medical defendants who performed surgery on the fractured ankle, which allegedly resulted in sensory impairments and ultimately her death at age 40. The restaurant settled before trial for $1.15 million. The medical defendants contended that as successive tortfeasors the CNA's elimination of pro tanto credits among joint tortfeasors was not applicable and that at trial they were entitled to a $1.15 million credit toward any recovery against them to protect themselves from having to pay more than their fair share of the total damages, and prevent the plaintiff from receiving a financial windfall at trial.

The Appellate Division ruled that the CNA applies to all negligence actions, inclusive of situations involving successive tortfeasors, but not in the same way it applies to joint tortfeasors. In the context of successive torts, the CNA helps to achieve the legislative objective of comparative responsibility by requiring juries to apportion damages between successive events and to apportion fault among the parties responsible for each event. Accordingly, a successive tortfeasor, like the medical defendants, may seek an apportionment of the damages between those caused by its negligence and the damages caused by the initial tortfeasor (the restaurant), regardless of whether the initial tortfeasor was adjudged negligent or whether the initial tortfeasor settled out of the case. Accordingly, the medical defendants could not be held liable for Jennifer's fractured ankle, the resulting pain and suffering, and the need for surgery. Furthermore, the CNA's apportionment system eliminated the use of *pro tanto* credits based on a plaintiff's settlement with another party, and the adjudicated tortfeasor was entitled only to a reduction in any award of damages by application of the adjudicated percentage responsibility of other tortfeasors.

The Glassman opinion guarantees that the relative fault of the party causing the initial injuries is irrelevant and the damages apportionment scheme makes certain a defendant is not obliged to pay for injuries they did not proximately cause.

For more information, Benjamin A. Hooper, Esq. at bah@spsk.com or (973) 631-7847.

Recent Health Law Legal Alerts

Office of Inspector General Issues Special Fraud Alert Warning About Company Sponsored Speaker Programs

By Divya Srivastav-Seth, Esq.

September Brings Stern Reminders for HIPAA Compliance

By Meghan V. Hoppe, Esq.

HHS Extends Deadline and Expands Eligibility Requirements for Provider Relief Fund Applications

By Divya Srivastav-Seth, Esq.