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# Health Law UPDATE

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## FEDERAL UPDATE

### CMS Finalizes 2018 Physician Fee Schedule

The Centers for Medicare & Medicaid Services (CMS) recently published the final Calendar Year (CY) 2018 Medicare Physician Fee Schedule (MPFS). Under the CY 2018 MPFS, overall physician payment rates will increase by 0.41 percent in CY 2018 as compared to CY 2017. The new MPFS sets the CY 2018 MPFS conversion factor at $35.9996 and the CY 2018 national average anesthesia conversion factor at $22.1887. The new MPFS also adds several codes to the list of telehealth services that are covered by Medicare, including certain services related to chronic care management. In addition, the new MPFS reduces rates to certain off-campus physician services operated by hospitals as required by the Bipartisan Budget Act of 2015.

Under the CY 2018 MPFS, the Medicare Diabetes Prevention program that was previously adopted as a limited demonstration program will be available nationwide as a Medicare Part B service. Also effective for CY 2018, newly approved biosimilar biological products with a common reference product will no longer be grouped into the same billing code. CMS also decided to further delay implementation of the Imaging Appropriate Use Criteria Program that was mandated by the Protecting Access to Medicare Act of 2014, but whose implementation has been delayed several times by CMS. CMS has also made adjustments to the reimbursement for several imaging services.

Under the new rule, CMS will require the use of Level II modifiers on claims to indicate patient relationship categories. For CY 2018, CMS has made certain modifications to the Physician Quality Reporting System, including reducing the number of reporting requirements to six measures. For solo practitioners and groups, CMS has also reduced the penalties for not meeting minimum quality reporting requirements. CMS has also adopted modifications to the Medicare Shared Savings Program, including revising the assignment methodology for ACOs with rural health clinics and federally qualified health center participants; adding new chronic care management and behavioral health integration codes to the definition of primary care services; and reducing the required amount of submission materials for program applications. The new MPFS is effective as of January 1, 2018.

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### New Jersey Spearheading a National Attempt to Increase Access to Opioid Use Disorder Treatment

On January 6, 2017, New Jersey requested a waiver from the traditional Medicaid program, requesting permission to expand services available for substance use disorder treatment and rehabilitation, and on January 23, 2017, New Jersey requested that the President and Congress allow federal reimbursement for certain rehabilitation and treatment programs for individuals with substance use disorder by either repealing the Medicaid Institutions for Mental Diseases (IMD) exclusion or excluding substance use disorder from the definition of mental disease.

Since the inception of Medicaid in 1965, federal law has excluded financing for most care delivered in IMDs, commonly referred to as the IMD exclusion. The IMD exclusion prohibits payments for Medicaid-covered individuals, between the ages of 21 and 64, who are patients in an IMD with a capacity above 16 beds.

On November 1, 2017, the Centers for Medicare & Medicaid Services (CMS) announced a new policy to allow states to design demonstration projects that increase access to treatment for opioid use disorder (OUD) and other substance use disorders (SUD), and granted immediate approval of both New Jersey and Utah's demonstration waivers under the new policy. Through these updated policies, New Jersey will be able to pay for a fuller continuum of care to treat New Jersey residents with mental disabilities and SUDs, including critical treatment in residential treatment facilities that Medicaid is unable to pay for without a waiver.

New Jersey will provide a comprehensive and coordinated SUD benefit to adults and children while also allowing for the continuum of SUD services provided to Medicaid beneficiaries who reside in residential treatment facilities and institutions for mental diseases. The services covered as part of the SUD benefit will include residential treatment, withdrawal management, medication-assisted treatment, peer supports, and targeted case management.

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### CMS Issues Final Rule to the Quality Payment Program for 2018

Centers for Medicare & Medicaid Services (CMS) recently issued a final rule that made changes to the Quality Payment Program for 2018. This program is mandated by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

The final rule includes the following provisions:

- Physicians and other eligible clinicians will generally be rewarded for performance improvement under the Merit-Based Incentive Payment System (MIPS) through changes to the scoring method
- The low-volume threshold, which used to exclude individuals or groups from the program with less than or equal to $30,000 in Medicare Part B allowed charges or less than or equal to 100 Medicare Part B patients, has increased to exclude individuals or groups with less than or equal to $90,000 in Medicare Part B allowed charges or less than or equal to 200 Medicare Part B patients. This will cause more clinicians in small practices to be exempt from participation
- Eligible clinicians will be able to continue their use of 2014 and/or 2015 Certified Electronic Health Record Technology (CEHRT), and those that choose to use only 2015 CEHRT will receive bonus points
- Solo practitioners and small practices will have the choice to form or join a Virtual Group to participate with other practices. A Virtual Group is a combination of two or more Taxpayer Identification Numbers, made up of solo practitioners and groups of ten or fewer eligible clinicians who come together "virtually" (regardless of specialty or location) to participate in MIPS for a performance period of one year
- Five bonus points will be added to the final scores of small practices
- Up to five bonus points will be added to the final scores of eligible clinicians caring for complex patients
- CMS provides additional detail on how eligible clinicians in Alternative Payment Models (APMs) will be assessed under the APM scoring standard
- Clinicians are allowed to become qualifying APM participants through a combination of Medicare participation in Advanced APMs and participation in Other Payer Advanced APMs
- It is easier for clinicians to qualify for incentive payments by participating in Advanced APMs that begin or end in the middle of a year.

This final rule can be found at *http://bit.ly/2gXW7KN.*

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### Pharmacists to Pay $5 Million as Community Restitution for Opioid Dispensing Abuse

Husband and wife pharmacist-owners of a Georgia pharmacy were ordered by the federal Department of Justice (DOJ) to pay $5 million in what the DOJ has called a first-of-its kind "community restitution" to combat the opioid crisis. The pharmacists were convicted in March 2017 on federal drug and money laundering charges for illegally dispensing controlled narcotic substances to customers of what has been coined a "pill mill" that had one location across the street from the pharmacy. They were both convicted of a drug trafficking conspiracy, three counts of illegally dispensing controlled substances without a legitimate medical purpose and outside the usual course of professional practice, and a money laundering conspiracy. In addition, the husband was convicted of five counts of concealment money laundering and laundering more than $10,000 of criminally derived property.

In addition to serving lengthy prison sentences, each of the husband and wife must pay $2.5 million in restitution, which will be distributed to two Georgia state agencies responsible for substance use disorder treatment and victim assistance. U.S. Attorney Byung J. "BJay" Pak stated, "These pharmacists fed opiate addictions among so many as a means to sustain their lifestyles. Now, they will begin to serve lengthy prison sentences and pay back the State of Georgia to account for some of the harm they caused to the community. The money will go to help the individuals whose lives have been scarred by addiction." *http://bit.ly/2yTVnx2* This use of community restitution is yet another signal that the DOJ and other federal agencies are determined to utilize all tools at their disposal to penalize those who are helping to fuel our nation's opioid epidemic.

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## STATE UPDATE

### New Jersey Dentists May Bill for Diabetes Screening

As of January 1, 2018, New Jersey dentists can bill for performing chair-side diabetes screenings for at-risk patients. The screening is a finger-stick capillary HbA1c glucose test procedure that can be used to rapidly identify high-risk patients.

In January 2015, the New Jersey Board of Dentistry ruled that administering blood sugar screenings was within a dentist's scope of practice. The Board also held that such screenings are not, however, presumed to be the standard of care. In response to the Board's ruling, Delta Dental of New Jersey launched a pilot program to enable network providers to screen for diabetes and encourage appropriate referrals. New Jersey is at the forefront of a movement to use dentists as part of a coordinated effort to diagnose and treat diabetes.

Effective as of 2018, the American Dental Association (ADA) developed a new dental procedure billing code to address the testing, which opens the door for reimbursement requests. D0411 is defined as "HbA1c in-office point of service testing." The ADA also published guidance on point of care for diabetes testing and reporting that includes the following:

- When a screening test should be recommended
- How the procedure is delivered
- How to analyze the results
- What to do with the test results.

Dentists interested in providing the testing must ensure they have the appropriate lab licensing and related safeguards in place. In addition, the Board has held that if the screening is provided, then the results should be provided to the patient and appropriate referrals made.

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## New Jersey Legislative Update

***Proposed Amendments to Rules Governing Delegation of Injections*** — On November 6, 2017, the Board of Medical Examiners (BME) proposed amendments to the rules governing the delegation to certified medical assistants the administration of subcutaneous and intramuscular injections and the performance of venipuncture. The BME proposes to amend N.J.A.C. 13:35-6.4 to reduce the required clock hours for certified medical assistant education from 600 to 330, to require that certified medical assistants complete training in the administration of injections, to amend the definition of certified medical assistant to recognize new entities that may certify medical assistants, and to recognize that certified medical assistants can perform venipuncture. In order to direct a certified medical assistant to perform injections or venipuncture, a physician must determine that the assistant has completed the required education and training. Comments on the proposed amendments must be submitted by January 5, 2018.

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***State Board of Dentistry Denies Petition to Recognize ABDS Specialties*** — On November 6, 2017, the State Board of Dentistry (BOD) denied a petition on behalf of the American Board of Dental Specialties (ABDS) requesting that the BOD amend existing regulations to formally recognize the ABDS-recognized certifying boards/areas of practice as specialties, and any future ABDS-recognized specialties. This would allow diplomates of ABDS-recognized certifying boards to advertise as specialists. While the BOD agreed that its existing specialty advertising rules should be amended, the BOD did not believe that the petition as written would fully address the concerns raised by the ABDS. Accordingly, the BOD determined to deny the petition for rulemaking.

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***Proposed Legislation to Require Physical Exam for Eighth Grade Students*** — On November 9, 2017, S3552 was introduced to require every student enrolled in grade eight, in a public or nonpublic school, to undergo a physical examination using the "Preparticipation Physical Evaluation" (PPE) form, which includes a cardiac component. Current law requires that prior to the participation of any student enrolled in grades six through 12 on a school-sponsored interscholastic or intramural athletic team, the student must have a physical examination using the PPE form.

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# Brach Eichler In The News

On November 30, 2017, **John D. Fanburg** presented the Burton L. Eichler award at the Jersey Choice Top Doctors reception hosted by *New Jersey Monthly* at the Mountain Ridge Country Club. Brach Eichler sponsored the event honoring the top doctors across the state as chosen by their peers. Dr. Kenneth S. Miller, an ophthalmologist, was recognized for his commitment helping those less fortunate in his community, and around the world, improve their sight.

Brach Eichler's health law practice group released its outlook for 2018, citing top trends to look for in the new year that will drive change and continue to shape the health care landscape in the state of New Jersey. Included in those trends are continued consolidation, private equity deals, access to capital markets, narrowing of physician networks and an increase in data breaches. See *http://bit.ly/2AOLL9t.*

# HIPAA CORNER

Early this month, the National Institute of Standards and Technology (NIST) released its second draft of its *Framework for Improving Critical Infrastructure Cybersecurity Version 1.1* (Framework). NIST also released the companion to the Framework document, titled *Roadmap for Improving Critical Infrastructure Cybersecurity Version 1.1* (Roadmap), as well as a *Fact Sheet* to assist in understanding the Framework and Roadmap.

NIST stated in the Fact Sheet, "[t]his draft is intended to provide a flexible, voluntary, and effective tool to help organizations better manage their cybersecurity risks. Like the earlier proposed update, this draft is fully compatible with Version 1.0 and can be used as the basis for communication between organizations." Among other things, the update:

- Declares applicability of Cybersecurity Framework for "technology," including at least information technology, operational technology, cyber-physical systems, and the Internet of Things
- Enhances guidance for applying the Cybersecurity Framework to supply chain risk management
- Summarizes the relevance and utility of Cybersecurity Framework measurement for organizational self-assessment
- Better accounts for authorization, authentication, and identity proofing
- Administratively updates the Informative References.

Public comments on the documents are due to NIST by 11:59 p.m. on January 19, 2018 via *cyberframework@nist.gov*. NIST anticipates finalizing the Framework in Spring 2018.

Although focused on national security, the documents provide useful information relating to cybersecurity risks that may be helpful to health care providers and other HIPAA-covered entities and business associates in enhancing information security measures in compliance with the HIPAA Security Rule and in fighting the battle against ever-increasing cybersecurity threats.

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