Health Care Practice Group

Cinde Warmington
Chair
cwarmington@
shaheengordon.com

William E. Christie
wchristie@
shaheengordon.com

Steven M. Gordon
sgordon@
shaheengordon.com

Lucy J. Karl
lkarl@
shaheengordon.com

Donald Crandlemire
dcrandlemire@
shaheengordon.com

Benjamin Siracusa Hillman
bsiracusahillman@
shaheengordon.com

www.shaheengordon.com

Tenacity, Creativity and Results are the three words that best describe Shaheen & Gordon's approach to addressing complex legal issues. Our health care team closely monitors the rapidly changing legal environment so that our clients are prepared to meet the challenges of today as well as tomorrow. Relying on a wealth of experience, we offer practical advice and assist in implementing recommendations tailored specifically to meet the needs of both large and small health care clients.

FEDERAL DEVELOPMENTS

Affordable Care Act Implementation

Federal Court Permits Lawsuit Against the Administration to Proceed

On September 9, the federal court in Washington, D.C. granted in part and denied in part the Administration's attempt to dismiss a lawsuit brought by the House of Representatives. The lawsuit alleged that the Administration acted beyond constitutional boundaries in using public funds to fund cost-sharing reductions without appropriation, and in delaying the employer mandate. The Court held that the House has standing to challenge the expenditure of funds without an appropriation by Congress, but does not otherwise have standing to challenge the Administration's implementation of the statute itself. Accordingly, the Court allowed the claim challenging the expenditure of funds for cost-sharing reductions to proceed, but dismissed the claim that Secretary of Treasury Jacob Lew surpassed his constitutional powers by delaying enforcement of the ACA's employer mandate without first seeking an amendment to the statute itself.

Administration Reports Gains in Health Insurance Coverage Under the ACA

On September 8, CMS announced that as of June 30, 2015, 9.9 million people were enrolled in ACA marketplace plans, a slightly smaller number than the 10.2 million who were enrolled when the first enrollment count for 2015 was released on June 2. Of those enrolled on June 30, about 84% were receiving an advance premium tax credit. The majority (7.2 million people) are enrolled in the 37 Federally-run exchanges, while 2.7 million are enrolled on state-run exchanges. Additionally, as of June 30, CMS said the marketplace had ended the coverage of about 423,000 individuals due to their failure to produce sufficient documentation of their citizenship or immigration status.

On September 22, the U.S. Department of Health and Human Services reported that about 17.6 million uninsured individuals have gained coverage since the implementation of the ACA, up from the previous March estimate of 16.4 million. Coverage gains through Medicaid and the health insurance marketplaces has accounted for 15.3 million of the total in the two years since open enrollment began in October 2013. The remaining 2.3 million people are young adults who gained coverage between 2010 and 2013 under the provision allowing young adults to remain on their parents' insurance until age 26.

States that expanded their Medicaid programs saw an average 8.1% drop in uninsured individuals, while states that did not expand their Medicaid programs still saw an average drop of 7.3%. The third open enrollment period is set to begin on November 1. The Department of Health and Human

Services intends to focus its efforts on reaching the 10.5 million Americans eligible for marketplace coverage who remain uninsured.

OIG Says CMS Did Not Accurately Account for Marketplace Contract Costs

On September 18, the Office of Inspector General for the U.S. Department of Health and Human Services issued a report concluding that CMS could not deliver an accurate accounting of the cost of contracting in the Federal marketplace to stakeholders. The OIG reviewed 62 contracts awarded in connection with the marketplace. In six of these contracts, CMS recorded more than $24 million in obligations and $23 million in expenditures without project codes associated with Federal marketplace costs. The OIG recommended that CMS properly identify all relevant contract costs related to the design, development and operation of the Federal marketplace.

Other Federal Developments

CMS ONC Issues EHR Meaningful Use Final Rule

On October 6, the Centers for Medicare and Medicaid Services Office of the National Coordinator for Health Information Technology issued a final rule establishing new criteria for Electronic Health Records vendors as well as easing the meaningful use requirements surrounding EHR utilization by providers. CMS has set up a 60-day comment period, seeking specific feedback to inform future EHR incentive programs and to assist in the implementation of Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The rule contains the following changes to EHR meaningful use:

- The new Stage 3 meaningful use requirements will be compulsory on January 1, 2018, as opposed to January 1, 2017.
- "Check box" measures have been removed and additional focus has been added for clinical decision support, electronic prescribing, as well as provider-provider and provider-patient information exchange.
- Flexibility and simplicity has been significantly enhanced, primarily through the reduction of reporting objectives from 20 to less than 10, and the ability to tailor reportable objectives to the specificities of a given practice.
- The reporting period for 2015 has been reduced to 90 days. Providers that are new to the EHR Incentives Program will also have a 90 day reporting for 2016 and 2017.

The ONC also issued its final EHR interoperability roadmap. The roadmap focuses on three broad components that aim to achieve effective interoperability between providers: alignment of incentives, necessary technical standards and implementation specifications, and appropriate governance structures.

House Lawmakers Seek to Delay Stage 3 Meaningful Use Final Rule

On September 29, Senators Lamar Alexander, Chairman of the Senate Health, Education, Labor, and Pensions Committee, and John Thurne, Chairman of the Senate Commerce, Science, and Transportation Committee, sent a letter to the Secretary of the U.S. Department of Health and Human Services urging the administration to expeditiously adopt modifications to the Stage 2 EHR Meaningful Use program and to delay finalizing Stage 3 until January 1, 2017 at the earliest. The Senators were not alone, with 116 House Representatives having sent a similar letter to Secretary Burwell just a day earlier. The legislators are responding to concerns voiced by providers about the difficulty of complying with the complex Stage 2 requirements which is evidenced by the fact that only 12 percent of eligible providers and 40 percent of eligible hospitals are in compliance. Legislators maintain that finalizing of the Stage 3 rules should be delayed so that the lessons learned from implementing modifications to Stage 2 can be incorporated. Both

the American Hospital Association and the American Medical Association have urged CMS to delay the final ruling of Stage 3 as well citing similar concerns.

OIG Wants DHHS OCR to Improve Oversight of HIPAA Privacy Rule Compliance

In two reports released on September 29, the U.S. Department of Health and Human Services Office of the Inspector General (OIG) said that the Office of Civil Rights (OCR) needs to improve its oversight of covered entities' compliance with the HIPAA Privacy Rule and its breach notification protocols. In its first of the two reports, the OIG noted that while the OCR is responsible for enforcement of the HIPAA Privacy Rule, its oversight has been primarily reactive with 98% of all closed privacy cases originating from complaints. Although compulsory audits were established by the Health Information Technology for Economic and Clinical Health Act (HITECH) in February 2010, the OIG found that the OCR has not fully implemented an auditing program for assessing Privacy Rule compliance. Additionally, the OIG reported that the OCR did not document corrective action for 26% of closed privacy investigations. The OIG report made several recommendations for the OCR to improve its oversight activities such as fully implementing an auditing program, maintaining complete records of corrective action taken, developing an efficient method for tracking cases and expanding outreach and education efforts.

In the second of the two reports, the OIG found that the OCR did not have complete documentation of corrective action for 23% of its closed large breach cases, and had no mechanism for tracking small breaches reported by covered entities. The OIG noted that the lack of such tracking limits the ability to track and identify covered entities with multiple small breaches. The complete reports may be found at: http://oig.hhs.gov/oei/reports/oei-09-10-00510.pdf and http://oig.hhs.gov/oei/reports/oei-09-10-00511.pdf

CMS Announces Medication Therapy Management Model

On September 25, the Centers for Medicare and Medicaid Services' Center for Medicare and Medicaid Innovation (CMMI) announced a medication therapy management model for Medicare Part D intended to improve health care quality and outcomes. The model, named the Medicare Part D Enhanced Medication Management Model will assess whether providing prescription drugs plans with additional incentives and flexibilities to design and implement innovative programs will improve outcomes and potentially lower cost. The five year model is slated to come into effect on January 1, 2017.

Government Accountability Office Finds Hospital Value-Based Purchasing Program had Little Effect on Care Quality

In a report issued on October 1, the Government Accountability Office (GAO) said Medicare's Hospital Value-Based Purchasing program (HVBP) has had very little effect on quality of care. In each of the program's first three years, between 74% and 93% of hospitals received a bonus or penalty of 0.5% of applicable Medicare payments. The GAO found no significant changes in hospital performance on quality measures included in the HVBP program, but noted there is potential for improvement as the program matures. The GAO did note improved performance by hospitals in response to incentives related to hospital readmissions, which is not included in the HVBP but does serve as an indicator that such incentive programs can be effective in improving the quality of care. The complete report may be found at: http://www.gao.gov/products/GAO-16-9

CMS Issues Financial Incentives to Reduce Hospital-Acquired Conditions and Readmissions

On September 25, the Centers for Medicare and Medicaid Services awarded $110 million to 17 national, regional, or state hospital associations and health system organizations to continue efforts to reduce preventable hospital-acquired conditions and readmissions. The second round of the Hospital

Engagement Networks contracts are part of the Partnership for Patients initiative, which is a nationwide public-private collaboration that began in 2011 with the intent of reducing hospital-acquired conditions by 40% and 30-day readmissions by 20%. The U.S. Department of Health and Human Services estimates that 50,000 fewer patients died and $12 Billion was saved between 2010 and 2013 due to the reduction in hospital-acquired conditions. Those selected awardees are required to conduct intensive training programs to hospitals, provide technical assistance to achieve quality goals, and implement and improve tracking systems to monitor hospital progress. The CMS press release with the list of the 17 selected organizations may be found at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-09-25.html

CMS Proposal Revises Medicare Payment for Clinical Lab Tests

On September 25, the Centers for Medicare and Medicaid Services proposed revisions to the Medicare payment system for clinical lab tests under the Clinical Laboratory Fee Schedule (CFLS). The proposed changes, made to comply with the Protecting Access to Medicare Act of 2014 (PAMA) would result in $360 million less in Medicare Part B payments for clinical lab tests paid under the fee schedule in FY 2017, with a 10-year estimated impact of $5.14 billion less in program payments. The proposal is intended to make the amount paid by Medicare under the fee schedule equal to amount paid by private payers. Under the proposal, laboratories would be required to report volume data as well as private payer rates if they receive at least $50,000 per year in Medicare revenues from lab services and more than 50% of their Medicare revenues from payments under the CLFS or the Physician Fee Schedule. For an entity that is composed of multiple facilities, including at least one CLIA certified laboratory, the eligibility for reporting will be made based on the Medicare payments received across the entire entity. Based on this criteria, CMS does not expect hospital laboratories will be required to report. It also estimates that more than 50 % of independent laboratories and 90% of physician offices will not be required to report. The new rates will be effective on January 1, 2017. The proposal may be found in the October 1 Federal Register at 80 Fed. Reg. 59386.

CMS Seeks Input on Physician Payments Models

On September 28, the Centers for Medicare and Medicaid Services issued a Request for Information (RFI) seeking comment on the new Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) for physicians participating in Medicare. This RFI was anticipated after CMS stated in its 2016 Physician Fee Schedule proposal in July that it planned to seek further input in order to better implement the new physician payment models authorized under Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which repealed the Sustainable Growth Rate.

The RFI seeks specific comment on MIPS eligible professionals (EPs) identifiers and exclusions; parameters for Virtual Groups, which allow a group's performance to be tied together even when EPs in the same group do not share the same Tax Identifier Number; the performance categories for assessment; development of performance standards; performance scoring and performance thresholds; public reporting; feedback reports; and other measures. It seeks specific comment on how APMs should be defined and paid, as well as on physician-focused payment models (PFPMs). Comments are due to CMS by November 2. The RFI, which was published in the October 1 Federal Register may be found at 80 Fed. Reg. 59102.

CMS Issues "Action Plan" to reduce Health Disparities in Medicare

On September 8, the Centers for Medicare and Medicaid Services Office of Minority Health (OMH) released its action plan aimed at reducing health disparities in America, *The CMS Equity Plan for Improving Quality of Medicare*. The purpose of the plan is to reduce health disparities that are present in minority and

underserved Medicare populations who typically have a higher burden of disease, higher barriers to access care, lower quality of care, and higher instances of chronic disease. The plan focuses on "increasing awareness and understanding of disparities, creating and finding solutions and accelerating the implementation of effective actions." Details can be found in the complete report at: https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH_Dwnld-CMS_EquityPlanforMedicare_090615.pdf

DOJ Underscores Focus on Individual Accountability in Corporate Wrongdoing

In a memorandum issued on September 9, the U.S. Department of Justice (DOJ) outlined steps for Federal prosecutors to follow in order to ensure that individuals responsible for illegal conduct are held accountable during corporate wrongdoing investigations. The memorandum set forth the following six key measures for Federal prosecutors and civil litigators to apply in corporate wrongdoing investigations:

- Corporations must provide to the DOJ all relevant facts relating to the individuals responsible for the misconduct, "regardless of their position, status, or seniority in the company," to qualify for DOJ cooperation credit.
- Both criminal and civil corporate investigations should focus on individuals from the outset.
- Criminal and civil attorneys at the DOJ conducting corporate investigations should communicate regularly.
- Absent extraordinary circumstances, a corporate resolution will not provide protection from criminal or civil liability for any individuals.
- DOJ attorneys should not resolve matters with a corporation without a clear plan to resolve related individual cases.
- Civil attorneys should focus on individuals as well as the company and decide whether to bring suit against an individual based on considerations beyond the individual's ability to pay.

These guidelines will be applicable to all investigations moving forward as well as currently pending investigations to the extent they can be applied. The memorandum can be found at: http://www.justice.gov/dag/file/769036/download

American Hospital Association Reports High Success Rate in Overturning RAC Appeals

On September 10, the AHA released its RACTrac second quarter survey results, which indicated that, based on the responses of 819 hospitals, 49% of Recovery Audit Contractor (RAC) denials were appealed with a 69% success rate. Some 41% of the denials were reversed in the discussion period, but for those proceeding to the ALJ, the process was protracted. More than 89% of appeals to the Administrative Law Judge, the judge took longer than the 90-day statutory limit to provide a determination. The average dollar amount for an automated denial was $918 and the average dollar amount of a complex denial was $5543, with the most common complex denials being inpatient coding and discharge status denials.

Senate Bill Delays Enforcement of Direct Supervision for Outpatient Therapy

On September 11, the Senate passed a bill that delays through 2015 the enforcement of the Centers for Medicare and Medicaid Services direct supervision requirement for outpatient therapeutic services provided in hospitals. There was a prior enforcement delay already in effect. Citing the difficulty of small and rural hospitals to comply with the stringent requirements and a clarification enacted under the Protecting Access to Rural Therapy Services allowing general rather than direct supervision, the Senate sought a further delay in enforcement. The Bill now moves to the House for consideration.

US District Court Validates Two-Midnight Rule But, In A Victory for Hospitals, Remands the Rule for Further Rulemaking

On September 21, The U.S. District Court for the District of Columbia ruled that the Secretary of the DHHS had the authority to authorize an across-the-board rate cut for Medicare inpatient payments as part of the agency's new "two-midnight" policy, but the failure to explain the methodology to calculate the 0.2% reduction amounted to more than harmless error. The court found that the FY 2014 IPPS proposed rule neglected to describe how the agency arrived at the reduced rate, depriving plaintiff hospitals the opportunity for meaningful comment on the rule before it became final, a violation of the Administrative Procedure Act. Instead of vacating the rule, the Court, citing the potential for serious disruptions, ordered the Secretary of the DHHS to submit a timetable for re-promulgating the rule and considering stakeholder comments.

You can read the court's findings here: http://law.justia.com/cases/federal/district-courts/district-of-columbia/dcdce/1:2014cv00263/164649/50/

Five-Year Health IT Strategic Plan is Finalized

On September 21, the U.S. Department of Health and Human Services' Office of the National Coordinator for Health Information Technology (ONC) released the final Federal Health IT Strategic Plan 2015-2020. In December 2014, the ONC issued a draft of the strategic plan, receiving over 400 comments on it from stakeholders between then and the comment deadline in February of this year. The plan "explains how the federal government intends to apply the effective use of information and technology to help the nation achieve high-quality care, lower costs, a healthy population, and engaged individuals." It highlights four strategic goals to:

- Advance person-centered health and self-management
- Transform healthcare delivery and community health
- Foster research, scientific knowledge, and innovation
- Enhance the nation's health IT infrastructure

The plan may be found at: https://www.healthit.gov/sites/default/files/federal-healthIT-strategic-plan-2014.pdf

The Office of the Inspector General Reports that States Improve on Medicaid Managed Care Rebate Collection

On September 17, the U.S. Department of Health and Human Services Office of the Inspector General reported that States are doing a better job at collecting drug rebates through Medicaid Managed Care Organizations as required by the ACA. The report is a follow up to a 2012 report that found that ten States did not collect rebates for medications dispensed to Medicaid MCO beneficiaries. The current report found that 35 out of 37 States collected rebates, however, 9 of those 35 could not collect rebates for all rebate-eligible drugs paid through MCOs, mainly because they could not reliably obtain National Drug Codes from claims. The full report here: http://oig.hhs.gov/oei/reports/oei-05-14-00431.asp

OIG Finds Billing for Certain Ophthalmology Services Questionable

In a September 16 report, the US Department of Health and Human Services Office of the Inspector General found certain billing practices related to the diagnosis and treatment of wet, age-related macular degeneration (wet AMD) and cataracts by providers to be questionable. In conducting its review, the OIG developed nine measures designed to capture suspected fraud, waste and abuse. The measures identified providers with unusually high billing for procedures to treat wet AMD, complex cataract surgeries, tests to

diagnose wet AMD and ophthalmology claims using modifiers. The OIG reported that 4 percent of providers billing ophthalmology services demonstrated at least one of the nine measures. The OIG report recognized that there may be legitimate reasons why some providers had increased billing of these measures but urged that further scrutiny is warranted. CMS concurred with OIG recommendations that it 1) increase monitoring of billing for ophthalmology services, including by using the measures identified by the OIG, and 2) review and take appropriate action regarding the 4 percent of providers identified in the OIG's evaluation. A copy of the OIG report may be found at: http://oig.hhs.gov/oei/reports/oei-04-12-00280.asp

OCR Launches Website to Help "APP" Developers Navigate HIPAA

On October 6, the U.S. Department of Health and Human Services Office of Civil Rights (OCR) launched a new website aimed at helping health information technology developers, specifically those who develop mobile applications, navigate the complexities of HIPAA when creating products. The site addresses HIPAA and breach notification rules while also providing developers with access to OCR representatives for guidance on creating new "apps" and programs. The website is part of DHHS' initiative to close the gap between industry stakeholders and complicated regulations.

ONC Launches Online EHR Complaint Form

The U.S. Department of Health and Human Services Office of the National Coordinator for Health Information Technology (ONC) recently launched an online form which can be used to file complaints concerning specific certified EHR products. The ONC has stated that although it might not be able to address every single complaint, the new online form will allow the ONC to better understand specific issues and the extent to which they affect providers. The form specifically targets the following areas:

- ONC Health IT Certification
- Information Blocking
- Health IT Safety
- Usability
- Privacy and Security
- Clinical Quality Measures

The form may be found at: https://www.healthit.gov/healthitcomplaints

CMS Issues Guidance on Switching EHR Vendors

On September 23, the Centers for Medicare and Medicaid Services issued two FAQs that provided additional guidance to providers seeking to change their EHR vendor. The first FAQ addresses provider eligibility for a hardship exception when switching to a new EHR vendor. CMS states that if a provider switches vendors and is unable to demonstrate meaningful use, that provider is able to apply for a hardship exception to a payment adjustment. The second FAQ addresses the options a provider has if the EHR vendor it uses is decertified by CMS. If a provider's EHR vendor is decertified after the reporting period has ended, the provider may use that EHR to demonstrate meaningful use. However, if the vendor is decertified before the reporting period has ended, then the provider may apply for a hardship exception. Also, a provider may contact the hardship coordinator if the hardship exception period has already closed to apply for special hardship exception in order to avoid a payment adjustment. The FAQs may be found at: https://questions.cms.gov/faq.php?id=5005&faqId=12653 and https://questions.cms.gov/faq.php?id=5005&faqId=12657 .

OIG Issues Policy Reminder About Information Blocking

On October 6, the Office of the Inspector General (OIG) issued a policy reminder regarding how

information blocking may affect safe harbor protection under the Federal anti-kickback statute. The anti-kickback statute prohibits a person or entity from knowingly and willing offering, paying, soliciting, or receiving remuneration to induce or reward referral for items or services reimbursable under a Federal health care program. There are exceptions to the prohibition known as safe harbors, including the electronic health records (EHR) safe harbor. One of requirements of the EHR safe harbor is that the donor of the EHR technology does not take any action that would limit or restrict the use, compatibility or interoperability of the EHR system. In its policy reminder, the OIG cautioned that certain arrangements which would preclude or inhibit any competitor from interfacing with the system or arrangements under which technology vendors and donors agree to charge high interface fees to non-recipient providers or to competitors may fail to satisfy the anti-kickback requirements. The anti-kickback EHR safe harbor corresponds closely with a similar exception under Stark and, accordingly, donors and providers should consider the implications of information blocking under Stark as well.

CMS Finds Errors in the 2014 PQRS Data Reports

Centers for Medicare and Medicaid Services (CMS) recently discovered errors in the PQRS reporting data submitted in 2014 by vendors reporting on behalf of providers who reported via EHR or through the qualified clinical data registry (QCDR). As a result, the data cannot be used for the PQRS portion of the 2016 value-based payment modifier (VBPM). Impacted providers can expect their VBPMs to reflect only claims-based outcome measures and CAHPS for PQRS survey data if utilized in 2014. CMS importantly notes that PQRS and meaningful use participation is not affected by these data inconsistencies because the program requirements are met by completion of reporting. CMS recommends all providers review their Quality and Resource Use Reports (QRURs) to see if they were affected by these data inconsistencies.

State Developments

Republican Legislators and Governor Hassan Reach Agreement on State Budget

On September 16, Republican legislators and Governor Hassan reached agreement on the State budget that will, among other things lower business taxes, fund a pay raise for state employees, and enhance and expand opioid addiction treatment and prevention, among other things. The budget passed the Senate by a vote of 24-0 and in the House by 291-73. Despite some opposition from conservatives, many Republicans and Democrats praised the bill for its bipartisanship and fiscal responsibility.

Legislators Delay State Retiree's Coverage Cost Increases

In a hearing on September 25, NH legislators delayed a decision to raise prescription drug copayments and premiums for retired State employees. The State's retiree health benefit plan is currently operating at a $10.6 million deficit. The Chair of the Joint Legislative Fiscal Committee, Representative Neal Kurk, indicated that legislators needed more time to understand, scrutinize, and discuss a proposal set forth by the Department of Administrative Services to reduce the deficit in the health plan by increasing premium contributions for all retired State workers under the age of 65 while increasing drug copays for everyone covered by the plan. In addition to this, the Department of Administrative Services proposed utilizing $3.8 million of its $5.6 million budget surplus to help reduce the deficit. It noted that if a decision is not reached by October 20, changes to the plan will not be effective until 2017 and, thus, any financial benefit to the State will be delayed. Beneficiaries expressed concerns about rate increases.

Three NH Hospitals Partner with Harvard Pilgrim in Joint Venture

Harvard Pilgrim Health Care is partnering with Elliot Health System, Dartmouth-Hitchcock and Frisbie Memorial Hospital in a joint venture aimed at slowing the growth rate of health care costs while

simultaneously improving quality of care and health outcomes. The program intends to use clinical, financial and operational data to provide analytical information to clinicians to further improve the quality and efficiency of patient care. The company, called Benevera Health, will commence operations on January 1, 2016, and is the process of hiring 40 staff members most of who will function as patient care advocates working with its partner hospitals.

New Hampshire Department of Health and Human Services Announces Enrollment Period for Remaining Population in Medicaid Care Management

On October 8, the NH Department of Health and Human Services (DHHS) announced that Medicaid recipients who had previously been permitted to opt out of Medicaid Care Management will be required to enroll in a Medicaid Managed Care Organization. Enrollment will begin on November 1 with coverage effective February 1, 2016. The affected population includes children in Foster Care, Medicare Dual Eligibles, Home Care for Children with Severe Disabilities, Children with special health care needs enrolled in Special Medical Services/Partners in Health and Children with Supplemental Security Income. Individuals required to enroll in the program will receive letters from DHHS informing them about the enrollment process.

Legislative Updates

2016 Legislative Service Requests

Legislators have so far filed 661 legislative service requests (LSRs) to be considered in the upcoming session of the legislature. An LSR is a request to have a bill drafted. We will be tracking those related to health care through the months ahead. Those we have flagged for tracking thus far are as follows:

LSR 2012 - extending the New Hampshire health protection program
LSR 2035 - relative to the wellness and primary prevention council
LSR 2037 - relative to medical benefits under motor vehicle insurance
LSR 2051 - relative to the use of the Family and Medical Leave Act time as it applies to workmen's compensation
LSR 2086 - relative to consultations under the telemedicine law
LSR 2087 - relative to prescriptions under the telemedicine act
LSR 2105 - relative to transportation companies under the Medicaid managed care program
LSR 2106 - relative to brokers arranging transportation for Medicaid patients
LSR 2107 - requiring vendors under the Medicaid managed care program to provide certain reports
LSR 2120 - requiring the department of health and human services to report on the effectiveness of mental health treatment programs
LSR 2201 - relative to the health care premium contribution for retired public employees who are not Medicare eligible
LSR 2202 - relative to the health care premium contribution for retired public employees who are Medicare eligible
LSR 2235 - relative to sales by pharmacists under the controlled drug act
LSR 2258 - extending the prospective repeal of the certificate of need program
LSR 2259 - extending the New Hampshire health care quality assurance commission
LSR 2266 - requiring a medical care provider to inform a woman who is discovered to have dense breast tissue
LSR 2286 - relative to health insurance fraud and abuse reporting
LSR 2338 - adding post-traumatic stress disorder to qualifying medical conditions under therapeutic use

of cannabis
LSR 2345 - establishing a commission to study health care for all in New Hampshire
LSR 2363 - relative to child support paid through the department of health and human services
LSR 2368 - relative to hospital rates for self-pay patients
LSR 2393 - extending the suspension of prior authorization requirements for a community mental health program on drugs used to treat mental illness
LSR 2395 - relative to membership of the oversight committee on health and human services
LSR 2430 - relative to administration of pharmaceuticals by optometrists
LSR 2431 - relative to emergency medical services
LSR 2439 - repealing the law governing access to reproductive health care facilities
LSR 2468 - relative to disclosure of costs for out-of-network health care services
LSR 2469 - relative to qualifying medical conditions for purposes of therapeutic cannabis
LSR 2486 - relative to life, accident, and health insurance
LSR 2513 - repealing medical injury damage caps
LSR 2554 - establishing an office of health services planning and review within the department of health and human services
LSR 2593 - adding 2 alternative treatment centers under the law governing use of cannabis for therapeutic purposes
LSR 2594 - establishing a study committee to study the New Hampshire health protection act
LSR 2615 - relative to insurance incentives to lower costs of health care
LSR 2628 - relative to qualifying medical conditions for the use of cannabis
LSR 2675 - relative to repayment of LCHIP funding
LSR 2677 - relative to the controlled drug prescription health and safety program
LSR 2679 - establishing a committee to study the membership of a subcommittee of the board of medicine
LSR 2680 - establishing a committee to clarify compact licensing guidelines for physicians
LSR 2692 – relative to collaborative practice between pharmacists and health care providers

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Cinde Warmington and Benjamin Siracusa Hillman contributed to this month's Legal Update.

BIOS

CINDE WARMINGTON
Cinde, a partner at Shaheen & Gordon, leads the Health Care Practice Group and focuses her practice entirely on representing health care clients. Her prior clinical and administrative experience makes her uniquely qualified to assist providers in facing a rapidly changing regulatory environment.

BENJAMIN SIRACUSA HILLMAN
Ben assists individual practitioners, group practices, and hospitals with a variety of health related business, regulatory, and litigation issues, and advises small businesses on compliance with the Affordable Care Act. Ben also practices in the areas of civil litigation, elder law, estate planning and probate.