

# **NEW JERSEY ASSOCIATION OF AMBULATORY SURGERY CENTERS**

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**LEGAL REPORT**

**PRESENTED BY**

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## **I. NEW JERSEY DEVELOPMENTS**

### **A. New Jersey Legislature Approves Out-of-Network Bill**

On April 12, 2018, the New Jersey Senate and the New Jersey Assembly passed the “Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act” (the Bill) after an amended version of the Bill was approved by various Senate and Assembly committees the previous week. Governor Phil Murphy is expected to sign the bill into law shortly. The intent of the Bill is to increase transparency to consumers with regard to in-network and out-of-network health care services, enhance consumer protections, create an arbitration system to resolve certain health care billing disputes between insurers and providers, and contain rising costs associated with out-of-network health care services. Some key aspects of the Bill include the following:

- Prior to scheduling an appointment with a covered person for a non-emergency or elective procedure, a health care facility will be required to:
  - (1) Disclose to the covered person whether the health care facility is in-network or out-of-network with respect to the covered person’s health benefits plan;
  - (2) Advise the covered person to check with the physician arranging the facility services to determine whether or not that physician is in-network or out-of-network and provide information about how to determine the health plans participated in by any physician who is reasonably anticipated to provide services to the covered person;
  - (3) Advise the covered person that at a health care facility that is in-network:

(a) the covered person will have a financial responsibility applicable to an in-network procedure and not in excess of the covered person's copayment, deductible, or coinsurance;

(b) Unless the covered person, at the time of the disclosure, has knowingly, voluntarily, and specifically selected an out-of-network provider to provide services, the covered person will not incur any out-of-pocket costs in excess of the charges applicable to an in-network procedure; and

(c) Any bills, charges or attempts to collect by the facility, or any health care professional involved in the procedure, in excess of the covered person's copayment, deductible, or coinsurance should be reported to the covered person's carrier and the relevant regulatory entity.

(4) Advise the covered person that at a health care facility that is out-of-network:

(a) Certain health care services may be provided on an out-of-network basis, including those health care services associated with the health care facility;

(b) The covered person may have a financial responsibility applicable to health care services provided at an out-of-network facility, in excess of the covered person's copayment, deductible, or coinsurance, and the covered person may be responsible for any costs in excess of those allowed by their health benefits plan; and

(c) The covered person should contact the covered person's carrier for further consultation on those costs.

- A health care facility will be required to make available to the public a list of its standard charges for items and services.
- A health care facility will be required to post on the facility's website:

(1) The health benefits plans in which the facility is a participating provider;

(2) A statement that:

(1) Physician services provided in the facility are not included in the facility's charges;

(2) Physicians who provide services in the facility may or may not participate with the same health benefits plans as the facility; and

(3) The covered person should check with the physician arranging for the facility services to determine the health benefits plans in which the physician participates; and

(4) The covered person should contact their carrier for further consultation on those costs.

(3) The name, mailing address, and telephone number of the hospital-based physician groups that the facility has contracted with to provide services including, but not limited to, anesthesiology, pathology, and radiology; and

(4) The name, mailing address, and telephone number of physicians employed by the facility and whose services may be provided at the facility, and the health benefits plans in which they participate.

- A health care professional will be required to disclose to a covered person in writing or through an internet website the health benefits plans in which the health care professional is a participating provider and the facilities with which the health care professional is affiliated prior to the provision of non-emergency services, and verbally or in writing, at the time of an appointment. If a health care professional does not participate in the network of the covered person's health benefits plan, the health care professional shall, in terms the covered person typically understands:

(1) Inform the covered person that the professional is out-of-network and that the amount or estimated amount the professional will bill the covered person for the services is available upon request;

(2) Upon receipt of a request from a covered person, disclose to the covered person in writing the amount or estimated amount that the professional will bill the covered person absent unforeseen medical circumstances that may arise when the health care service is provided;

(3) Inform the covered person that the covered person will have a financial responsibility applicable to health care services provided by an out-of-network professional; and

(4) Inform the covered person to contact the covered person's carrier for further consultation on those costs.

- If a covered person receives: inadvertent out-of-network services; or medically necessary services at an in-network or out-of-network health care facility on an emergency or urgent basis, the health care professional performing those services shall:

(1) In the case of inadvertent out-of-network services, not bill the covered person in excess of any deductible, copayment, or coinsurance amount;

(2) In the case of emergency and urgent services, not bill the covered person in excess of any deductible, copayment, or coinsurance amount.

“Inadvertent out-of-network services” is defined as health care services that are: covered under a managed care health benefits plan that provides a network; and provided by an out-of-network health care provider in the event that a covered person utilizes an in-

network health care facility for covered health care services and, due to any reason, in-network health care services are unavailable in that facility.

- If attempts to negotiate reimbursement for services provided by an out-of-network provider do not result in a resolution of the payment dispute, and the difference between the carrier's and the provider's final offers is not less than \$1,000, the carrier or out-of-network provider may initiate binding arbitration to determine payment for the services. The arbitrator's decision shall be one of the two amounts submitted by the parties as their final offers and shall be binding on both parties. In making a determination, the arbitrator will be required to consider:

(1) The level of training, education, and experience of the health care professional;

(2) The health care provider's usual charge for comparable services provided in-network and out-of-network with respect to any health benefits plans;

(3) The circumstances and complexity of the particular case, including the time and place of the service;

(4) Individual patient characteristics; and

(5) As certified by an independent actuary: (a) the average in-network amount paid for the service by that carrier; and (b) the average amount paid for that service to other out-of-network providers by that carrier.

## **II. FEDERAL DEVELOPMENTS**

### **A. 2019 Budget Proposal Adds \$7 Billion to Combat Opioid Epidemic**

The Trump administration's proposed 2019 budget requests an additional \$7 billion for fiscal year 2019 to address the ongoing opioid epidemic. The amount would be in addition to the \$3 billion for fiscal year 2018 and \$3 billion for fiscal year 2019 already approved by Congress in the recent budget deal passed on February 9th. The Department of Health and Human Services' budget summary provides that the allocated funds will go toward "improved access to prevention, treatment and recovery services; more availability and distribution of overdose reversing drugs; better public health data and reporting; research on pain and addiction; and better pain management practices." Experts and lawmakers have called for clarity as to how the funds will be appropriated and are wary that these new funds will actually be used for criminal justice efforts related to opioids rather than health care treatment. Advocates of the proposal believe that even more funding is critically necessary.

### **B. February Budget Deal Relaxes Medicare Telemedicine Rules**

The Bipartisan Budget Act of 2018, passed on February 9, 2018, expands Medicare's coverage of telemedicine services by expanding the Creating High-Quality Results and Outcomes Necessary to Improve Chronic Care (CHRONIC) Act passed by Congress in 2017. Beginning on January 1, 2019, end-stage renal disease patients may receive monthly clinical assessments via telehealth from a freestanding dialysis facility or their home, rather than

telehealth being limited to certain origination sites and geographic areas. Similarly, patients with acute stroke symptoms may receive telehealth services which were previously limited to only patients in rural health areas or areas with provider shortages. The Act also allows additional types of Accountable Care Organizations (ACOs) to obtain a Next Generation ACO telehealth waiver which will waive geographic restrictions and allow for a patient's home to be the originating site as well as allow tele-dermatology and tele-ophthalmology. The Act also seeks to expand access to telehealth services by Medicare Advantage enrollees beginning in 2020, but leaves it to the Centers for Medicare and Medicaid Services (CMS) to determine what types of services should be included. CMS expects to open the public commentary period regarding these services by November 30, 2018.

**C. Health IT Vendor Faces Class Action after Ransomware Attack**

Electronic health records software giant Allscripts Healthcare Solutions Inc. has been named in a putative class action in Illinois federal court, alleging that a ransomware attack on the company disrupted service to tens of thousands of doctors and hospitals, and put patients' lives at risk. Allscripts' data centers in Raleigh and Charlotte, North Carolina, were hit with a strain of ransomware known as "SamSam" on January 18, 2017, which shut down access to electronic health records for health care providers nationwide.

The complaint, brought by Palm Beach, Florida-area health care provider Surfside Non-Surgical Orthopedics, alleges that it and other medical providers could not access patients' records or electronically prescribe medications, forcing Surfside and other class members to cancel appointments. The complaint further alleges that Allscripts should have known to protect itself and, by extension, its many clients and their patients, as ransomware attacks are a known threat. Surfside's complaint further points out that Allscripts itself had acknowledged in its 2016 annual report that it was a candidate for a security breach or other cyberattack. Surfside is demanding certification of a nationwide class and is asking the court to force Allscripts to change its policies and practices to prevent another such attack. The complaint also demands restitution and disgorgement of the revenues wrongfully retained as a result of Allscripts' wrongful conduct and asks for actual and compensatory damages.

The action should serve as a warning and reminder to covered entities and their business associates of the importance of performing periodic risk analyses as required under the HIPAA Security Rule. Such risk analyses are intended to identify security risks, threats, and vulnerabilities which must be addressed through the development and implementation of a risk management plan.

**D. HIPAA Obligations Don't End When a Business Closes its Doors**

A receiver appointed to liquidate the assets of Filefax, Inc., an entity located in Northbrook, Illinois that advertised itself as providing for storage, maintenance, and delivery of medical records for covered entities, has agreed to pay \$100,000 to the U.S. Department of Health and Human Services, Office for Civil Rights (OCR) in order to settle potential violations of the HIPAA Privacy Rule.

On February 10, 2015, the OCR received an anonymous complaint alleging that an individual associated with Filefax was selling medical records. An investigation was opened, and it was confirmed that between January 28 and February 14, 2015, Filefax impermissibly disclosed the Protected Health Information (PHI) of 2,150 individuals by leaving the PHI in an unlocked truck in the Filefax parking lot, or by granting permission to an unauthorized person to remove the PHI from Filefax, and leaving the PHI unsecured outside the Filefax facility.

In addition to the \$100,000 monetary settlement, the receiver has agreed, on behalf of Filefax, to properly store and dispose of the remaining medical records found at Filefax's facility in compliance with HIPAA.

The case demonstrates that HIPAA obligations may extend even after a business closes its doors, and that fines and penalties may extend to receivers liquidating assets of defunct businesses.