STATLAW® New York

Volume XXIV Number IX – September 15, 2016
Single Issue Price: $5.00

Late breaking news on medical-legal development affecting physicians and health care professionals

CMS Announces MACRA Refinements: Although final regulations have yet to be promulgated under the Medicare Access and CHIP Reauthorization Act ("MACRA"), and are not scheduled to be issued until November, 2016, in a recent blog post, Andrew Slavitt, the Acting Administrator of the Centers for Medicare and Medicaid Services ("CMS"), announced options which physicians could select in order to comply with the Merit-based Incentive Payment System ("MIPS"). MIPS will replace meaningful use, the physician quality reporting system ("PQRS") and the value-based modified programs. Although MIPS does not go into effect until 2019, reporting is set to begin on January 1, 2017. The proposed rule requires providers to report and participate in the entire program for the whole year, beginning on January 1, 2017, which could allow the provider to receive a "modest positive payment adjustment." However, the blog post advances two additional options. First, according to the blog post, a provider will be required to submit only "some data," and as long as "some data [is submitted] to the Quality Payment Program, including data from after January 1, 2017, you will avoid a negative payment adjustment." The other option is reporting for a reduced number of days, where providers could report for an unspecified shorter period during calendar year 2017 and still receive "a small positive payment adjustment." Physicians who qualify for participation in an Advanced Alternative Payment Model ("APM") will be exempt from MIPS; however, it is estimated that very few providers will qualify for this option.

Department of Health and Human Services (HHS) Increases Civil Monetary Penalties: Penalties imposed by the Department of Health and Human Services (HHS) have long been criticized by healthcare providers as being excessive, punitive and draconian in light of the constant changes and implementation of new regulations. Healthcare organizations and advocates have called to reduce, if not completely revamp, the civil penalty system. Critics argue that it is easy for a physician to inadvertently violate one of the plethora of rules and regulations that carry with it potentially crippling monetary penalties that far exceed the actual loss suffered by the government. For instance, the U.S. Supreme Court recently issued a unanimous decision, which allowed the federal government to pursue more False Claims Act cases against healthcare providers under the legal theory of "implied certification." Implied certification can impose liability if a contractor has engaged in a lie by omission, such as failing to disclose its noncompliance. On the heels of that decision, which should bring about increased civil suits, HHS issued an interim final rule where several civil monetary penalties will nearly double. HHS reasoned that the monetary penalties needed to be updated as they failed to account for multiple years of inflation. The increases apply to civil monetary penalties that are as little as $2,000 as well as other penalties that start at $1 million before the adjustments. The new maximum penalties will touch every part of healthcare that works with the federal government. Dozens of other updated penalties affect both Medicare and Medicaid managed-care companies. HHS also updated its civil fraud penalties to reflect that those penalties and other fines will now be adjusted annually to account for inflation. The rule noted the new maximum penalties apply to any fines assessed after Aug. 1, 2016, as well as all penalties stemming from violations that took place after Nov. 2, 2015.

Reminder – New CDS Law Went into Effect on July 22, 2016: Reminder: Effective July 22, 2016, pursuant to an amendment to a statute regulating controlled substance prescriptions (amendments to Public Health Law 3331), a prescriber may not prescribe more than a seven day supply of any schedule II, III or IV opioid upon the initial consultation or treatment of a patient for acute pain. Upon any subsequent consultations for the same pain, the prescriber may issue, in accordance with existing rules and regulations, any appropriate renewal, refill or new prescription for the opioid or any other drug. For the purposes of the law, the term "acute pain" means "pain, whether resulting from disease, accidental or intentional trauma, or other cause, that the practitioner reasonably expects to last only a short period of time." The term does not include chronic pain, pain treated as part of cancer care, hospice or other end-of-life care, or pain being treated as part of palliative care services. Amendments have also been made to various provisions of the Insurance law to provide that coverage for prescription drugs subject to a copayment for a limited initial prescription of an opioid drug must be either: (i) proportional between the copayment for a 30-day supply and the amount of drugs that the patient was prescribed; or (ii) equivalent to the copayment for a full 30-day supply for the opioid drug, provided that no additional copayments may be charged for any additional prescriptions for the remainder of the 30-day supply. The NYS Department of Health website has a Frequently Asked Questions section regarding the new law, which can be viewed at the following link: www.health.ny.gov/professionals/narcotic/laws_and_regulations/docs/combat_heroin_legislation_faq.pdf