2018 Healthcare Hot Topics

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SEXUAL HARASSMENT

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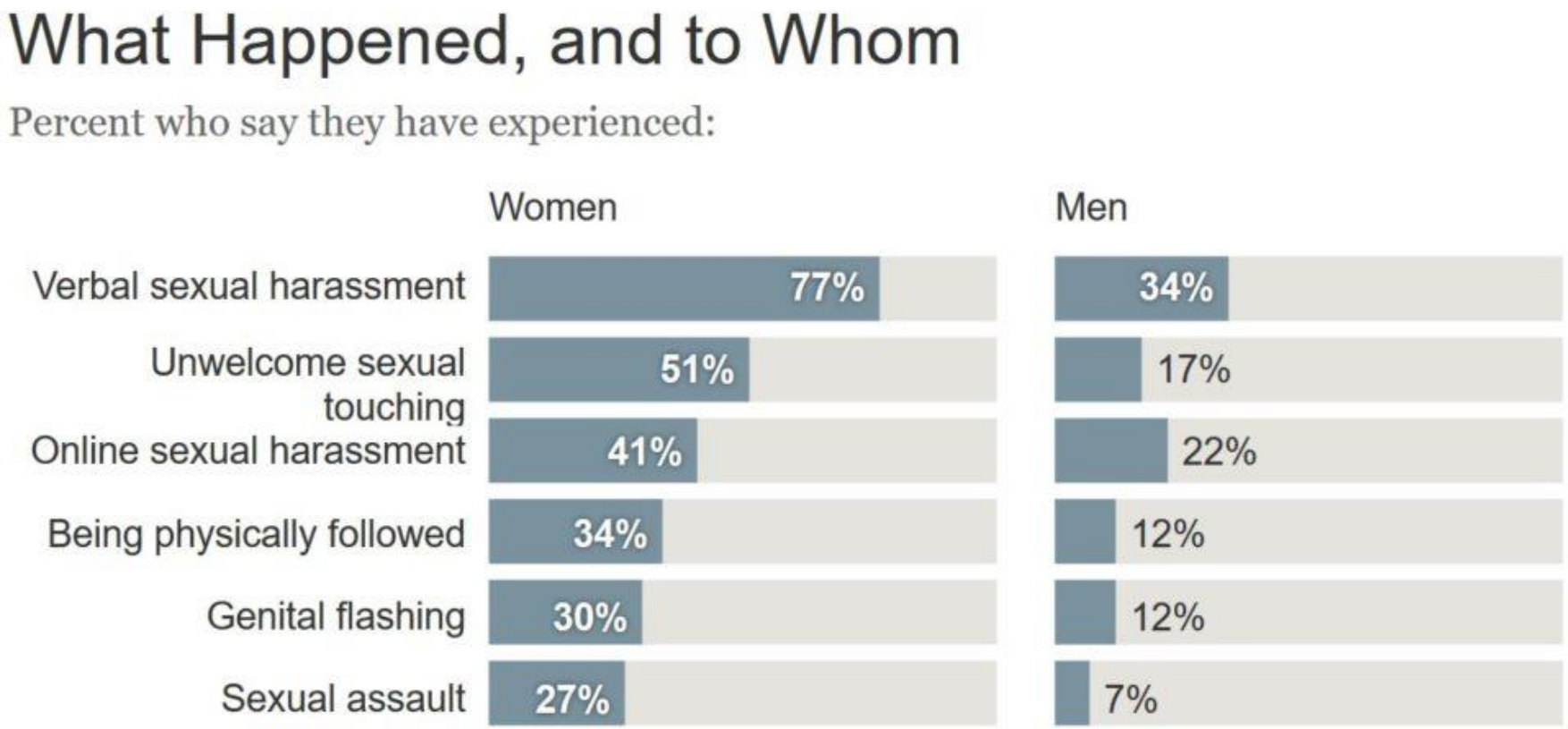


SEXUAL HARASSMENT

- #MeToo in Medicine
- For nurses, sexual harassment from patients is ‘par for the course’

SEXUAL HARASSMENT

- Sexual harassment statute of limitations/continuing violation in harassment cases -

  -what to do about old/stale allegations

SEXUAL HARASSMENT

Can I Immediately Fire a manager/supervisor Based on Sexual Harassment Allegations?

SEXUAL HARASSMENT

- Reporting Process
  - -source of allegations

- Investigations

SEXUAL HARASSMENT

- Supervisor training – especially important because: 1) supervisors can subject your hospital to strict liability; 2) failure to properly deal with alleged co-worker harassment frequently leads to liability
- Fraternization policy

FMLA

- what constitutes a request for FMLA leave?
  further inquiry
- using proper FMLA forms
- WC leave

Guns In Hospitals

- Signage
- Penal Code -v- Gov't. Code
- "A hospital licensed under Chapter 241, Health and Safety Code, or a nursing home licensed under Chapter 242, Health and Safety Code, shall prominently display at each entrance to the hospital or nursing home, as appropriate, a sign that... give(s) notice in both English and Spanish that it is unlawful for a person licensed under this subchapter to carry a handgun on the premises."

  Tex. Gov't Code Sections 411.204(b)-(c).

Guns in Hospitals (Continued)

- Written permission
- Rights of Employers
- Government entity clinics/board meetings

Do Not Resuscitate

- The new law defines DNR as an Order instructing health care professionals not to attempt cardiopulmonary resuscitation (CPR) on a patient whose circulatory or respiratory function ceased.
- The new requirements for a valid DNR only apply to Orders issued in a health care facility or hospital and do not apply to an out-of-hospital DNR.

Do Not Resuscitate

- In order for a DNR to be valid in a hospital setting, it must be dated and issued by the patient's attending physician. It must also:
- comply with a competent patient's written and dated directions; or
- comply with a competent patient's oral directions delivered to or observed by two competent adult witnesses (at least one of whom cannot be an employee of the attending physician or the facility); or
- be issued pursuant to the patient's directions set forth in a properly executed advance directive; or
- be issued pursuant to the directions of a patient's legal guardian or an agent who has been given medical power of attorney over the patient; or
- be issued pursuant to a treatment decision that follows the procedures under state law for when a person has not executed or issued a directive and is incompetent or incapable of communication; or
- be medically appropriate and not contrary to the directions given by a competent patient whose death is imminent, regardless of CPR.

Do Not Resuscitate

- The DNR Order can take effect immediately as long as the Order is placed in the patient's chart as soon as practicable.
- The DNR cannot be placed in the chart under scenario (f) above until a competent patient is notified of the Order. In the case of an incompetent patient, there must be a "reasonably diligent" effort to notify a person known to be the incompetent patient's healthcare agent, the patient's guardian, spouse, adult children or parents (in that order) of the existence of a DNR.
- Liability protections for healthcare providers who attempt, in good faith, to comply with the statute (this protection is ONLY available if the healthcare provider documents his/her attempts to comply with the notice provision in the patient's medical record).
- WEBINAR OPPORTUNITIES – THT on March 19 & THA on March 21.

Balance Billing: SB 507

- As of January 1st, patients may pursue mediation through the Texas Department of Insurance for a broader range of disputed bills.
- Prior to SB 507 becoming law, mediation was limited to bills resulting from care provided by health care providers at a hospital.
- Now out-of-network facility bills for **emergency care** are subject to mediation.
- Mediation now applies to ASCs, birthing centers, chapter 241 hospitals, and FECs (independent and hospital-owned).
- Codified in Chapter 1467 of the Texas Insurance Code

Balance Billing: SB 507
Application

- Applies if a patient receives a bill for a service provided on or after Jan. 1, 2018 based on an out-of-network claim requiring the patient to pay more than $500, after copayments, deductibles and coinsurance, and the claim is for:

1. Out-of-Network Emergency Care (**facility's bill or provider's bill**); OR
2. Any health care, medical service or supply provided at an in-network facility by an out-of-network physician, health care practitioner or other health care provider (the provider's bill).

Balance Billing: SB 507
Rights and Obligations

1. The patient may request mediation for that bill from TDI. TDI will notify the provider or facility if a patient requests mediation. The mediator's fees will be split evenly and paid by the insurer or administrator and the facility-based provider or emergency care provider.
2. Each bill or explanation of benefits sent to the patient for that claim must contain a notice in at least **10-point boldface type** with a conspicuous, plain-language explanation of the mediation process, information on how to request mediation, and the underlined statement in the next slide (or something similar):

Balance Billing: SB 507
Sample Statement to Include with a Bill or EOB

Certain out-of-network services provided on or after January 1, 2018 requiring payment of over $500 are eligible for mediation through the Texas Department of Insurance. You may be able to reduce some of your out-of-pocket costs for an out-of-network medical or health care claim that is eligible for mediation by contacting the Texas Department of Insurance at www.tdi.texas.gov/consumer/cpmmediation.html or (800) 252-3439.

If you are eligible, you may request mediation by completing and submitting the Health Insurance Mediation and Authorization Request Form and sending it to the Texas Department of Insurance by Mail: Consumer Protection, Mail Code 111-1A, Texas Department of Insurance, P.O. Box 149091, Austin, TX 78714-9091; Fax: (512) 490-1007; or Email: ConsumerProtection@tdi.texas.gov.

Balance Billing: SB 507
Rights and Obligations (2 of 2)

3. If a patient contacts the insurer, administrator, facility-based provider or emergency care provider, the entity is encouraged to inform the enrollee about mediation and provide the enrollee with TDI's telephone number and website address.
4. *Mediation Exception:* For non-emergency care only, patients have the right to ask about network status and for an estimate of charges from an out-of-network facility-based provider before providing care. If a patient received an estimate and signed it, the facility-based provider is not required to mediate if the amount billed is less than, or equal to, the maximum amount projected in the estimate.

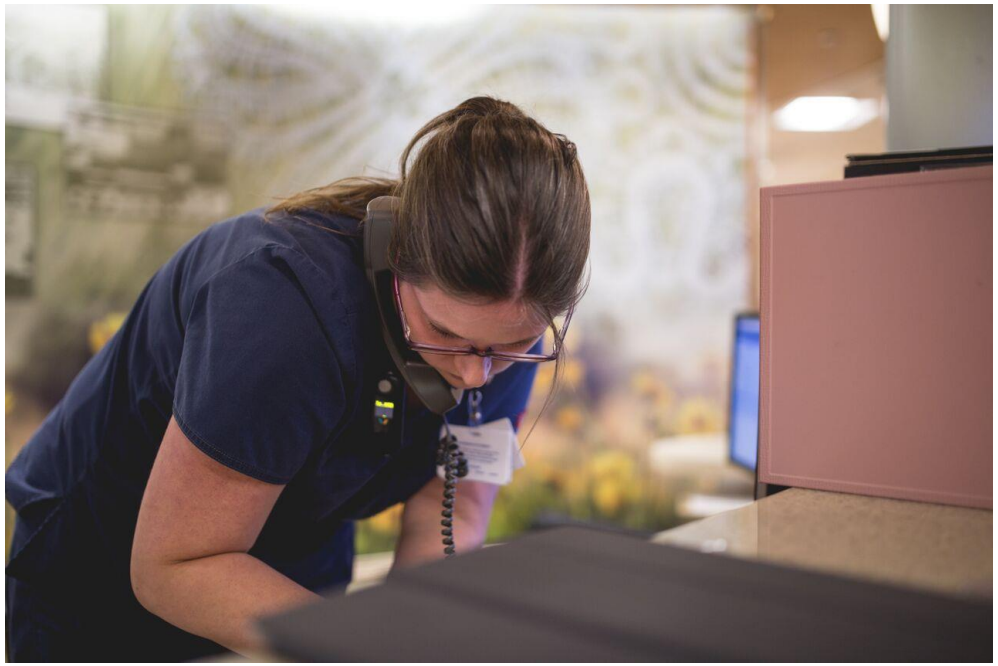
Balance Billing: SB 507
Definitions

1. Emergency Care: "health care services provided in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize a medical condition of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in: (1) placing the person's health in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of a bodily organ or part; (4) serious disfigurement; or (5) in the case of a pregnant woman, serious jeopardy to the health of the fetus."
2. Facility-Based Provider: "a physician, health care practitioner, or other health care provider who provides health care or medical services to patients of a facility (Facility means ambulatory surgical center, birthing center, hospital licensed under Chapter 241 Health & Safety Code, or freestanding emergency medical care facility, whether independent or owned or operated by a hospital)."
3. Emergency Care Provider: "a physician, health care practitioner, facility, or other health care provider who provides and bills an enrollee, administrator, or health benefit plan for emergency care."

Tex. Ins. Code Section 1467.001

Telemedicine: SB 1107

- Sets forth new parameters for telemedicine services in Texas
- Does not apply to mental health services
- Practitioners are subject to the same standard of care applicable to an in-person visit.



Telemedicine: SB 1107

- Telemedicine services now conditioned on establishing a valid patient-provider relationship:
  - Preexisting practitioner-patient relationship
  - Pursuant to a call-coverage agreement, in accordance with TMB rules
  - Practitioner provides guidance on follow-up care, provides a record to the patient's primary care physician within 72 hours of the visit (and with patient's consent), and the telemedicine service is provided in one of the following:
    - Synchronous audiovisual interaction
    - Asynchronous store and forward technology, if the practitioner uses relevant images or medical records
    - Another form of telemedicine which allows the practitioner to comply with the standard of care

Telemedicine: SB 1107

- There is no practitioner-patient relationship if an abortifacient, or any other drug or device that terminates a pregnancy, is prescribed.

- Medicaid reimbursement criteria is relaxed; HHSC cannot:
  - Require an approval process for telehealth reimbursement
  - Require a tele-presenter; or
  - Set forth situations where a face-to-face visit is required.

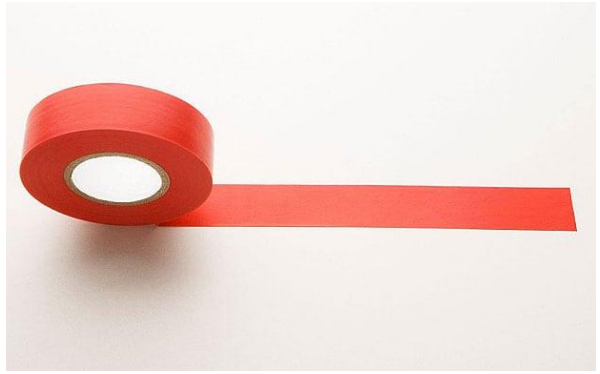
Telemedicine: SB 1107

- Insurance plans must post their telemedicine polices online and cannot:
  - Exclude from coverage because a visit is not in-person; or
  - Charge higher deductibles, copayments, or coinsurance for in-network, covered telemedicine visits.

- Note: A valid license to practice medicine in Texas is required to treat a patient, located in Texas, via telemedicine.

1115 Waiver

- On December 21, 2017 CMS approved a new 5-year Medicaid 1115 Waiver, through Sept. 2022.
- Worth approximately $25 billion for Texas.
- While maintaining significant funding for uncompensated care payments and Delivery System Reform Incentive Payments, the Waiver implements two major changes:
    1. Transitioning from use of the current "UC Tool" to a modified S-10 Worksheet to calculate and distribute UC payments based on hospital charity care costs alone. Medicaid shortfall and bad debt costs no longer will be allowed.
    2. Winds down DSRIP projects and funding.



1115 Waiver

- Level funding for Uncompensated Care for 2018 and 2019, then "resized" based on S-10 data for the following 3 years
- Level funding for Delivery System Reform Incentive Payment Program for 2018 and 2019 with decreased funding in 2020 and 2021, and no funding in 2022
- DSRIP program will transition to one focused on "health system performance measurement and improvement."
- Variety of terms and conditions associated with renewal.
- Visit https://www.tha.org/waiver for additional details.

Mental Health Parity: HB 10

- Requires health plans to provide benefits and coverage for mental health conditions and substance use disorders under the same terms and conditions as their medical and surgical benefits and coverage.
- An ombudsman is established to help with access
- A workforce to help agencies enforce the rules is created, TDI and HHSC must conduct a study and prepare a report on benefits as they compare to each other
- HB 10 mirrors existing federal regulations.

Mental Health Parity: HB 10

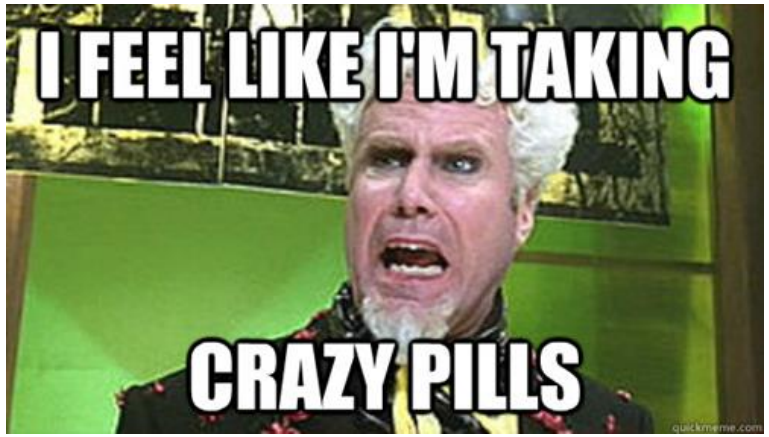
- Quantitative and non-quantitative treatment limitations will be evaluated
  - "Quantitative" – limitations based on days of coverage or number of visits; can include a deductible, copayment, co-insurance, or other expense, requirement, or limit.
  - "Non-quantitative" – a limit on scope or duration that is not expressed numerically. Ex: preauthorization, formulary design, network tier design, step therapy, geographic restrictions, etc.
- Applies to plans offering both physical and mental and substance use treatment benefits.
- TDI will review quantitative and non-quantitative limitations related to in- and out-of-network in- and outpatient care, emergency care, and prescription drugs.

340B Drug Pricing Program
Background

- 1992 program allowing certain hospitals and other health care providers to obtain discounted prices on covered outpatient drugs from drug manufacturers.
- Manufacturers must offer 340B discounts to covered entities to have their drugs covered under Medicaid.
- Applies to disproportionate share (DSH) hospitals, critical access hospitals (CAHs), rural referral centers, sole community hospitals, children's hospitals, and freestanding cancer hospitals.
- Each eligible hospital must be government-owned, a public or nonprofit hospital that is formally delegated governmental powers by a state or local government, or a nonprofit hospital under contract with government to provide services to low-income patients who are not eligible for Medicare or Medicaid.
- Each eligible hospital, except for CAHs, must have a minimum DSH adjustment percentage (which is based on the share of a hospital's inpatients who are Medicaid and low-income Medicare patients).

340B Drug Pricing Program
How it Worked in 2017

- Estimated that the minimum discount to covered entities is 22.5% off ASP (average sales price). So, assuming a prescription drug normally costs $100, the covered entity should be paying $77.50 (or less) for it.
- Despite whatever savings the covered entity receives under 340B, Medicare generally REIMBURSES ASP+6% for a prescription drug. So, again assuming the covered entity pays $77.50 for a normally $100 prescription drug, Medicare will still reimburse $106.
- The covered entity can then keep the difference between the reimbursed and actual amounts.



340B Drug Pricing Program
Change for 2018

- CMS changed the reimbursement figure from ASP+6 to ASP-22.5 in a Rule effective January 1, 2018
- The American Hospital Association filed suit in *AHA v. Hargan* claiming
  - CMS did not have the authority to reduce the reimbursement figure; and
  - The reduction defeats 340B's purpose because covered entities can't retain the spread to provide additional services to the community.
- On 12/29/17 the court dismissed the 340B case as moot because
  - the plaintiffs had not submitted a claim for reimbursement; and
  - they had not appealed the rule properly.
- AHA appealed and filed a motion to expedite, which was granted on January 30th.

340B Drug Pricing Program
H.R. 4392

- On 11/14/17 U.S. Reps. David McKinley (R-WV) and Mike Thompson (D-CA) introduced HR 4392 to stop the Centers for Medicare & Medicaid Services from implementing or enforcing the 340B reimbursement reduction.

- THA supports HR 4392, which is continuing to gain sponsors .

Maintenance of Certification
SB 1148

- Effective January 1, 2018

- "Maintenance of certification" – periodic **recertification** requirements prescribed by a certifying board (such as the American Board of Medical Specialties) for the upkeep of an initial certification.

- Prior to SB 1148's enactment, a hospital or health plan had discretion to mandate a physician's compliance with ongoing maintenance of certification requirements as a prerequisite to privileging or inclusion in a network. Ongoing maintenance of certification is considered evidence that a physician is up-to-date on training and education in their specialty.

Maintenance of Certification
SB 1148

- A managed care plan may differentiate between physicians based on a physician's maintenance of certification if the physician's maintenance of certification is required for accreditation or certification.
  - Example: Guidelines for a neonatal designation require certain physicians to successfully complete an applicable maintenance of certification program; the plan could require such completion of the maintenance of certification program.
- Where maintenance of certification is not required for accreditation or certification, a managed care plan *may not* differentiate between physicians – based on maintenance of certification – for payment, reimbursement, or contracting purposes.

Maintenance of Certification
SB 1148

- A hospital licensed by the State of Texas may differentiate between physicians based on a physician's maintenance of certification if the physician's maintenance of certification is required for designation, accreditation, or certification.
  - Example: Guidelines for a hospital's trauma designation require certain physicians to successfully complete an applicable maintenance of certification program; the hospital may require the relevant physician(s) to complete the applicable maintenance of certification.
  - These guidelines may be promulgated by CMS, the American College of Surgeons, or other, similar body.

Maintenance of Certification
SB 1148

- A hospital licensed by the State of Texas may differentiate between physicians, based on a physician's maintenance of certification if the voting physician members of the organized medical staff authorize such differentiation.
  - Example: A hospital's medical staff votes to amend its bylaws to require maintenance of certification for all privileged physicians; this maintenance of certification requirement is permissible.
    - The medical staff has discretion to:
      - limit this requirement to certain specialties, if so desired;
      - apply grandfathering provisions (in connection with applicable grandfathering provisions enacted by a certifying board);
      - Rescind any maintenance of certification requirement, by vote
  - Maintenance of certification requirements enacted by a hospital's medical staff may not conflict with requirements for designation, certification, or accreditation.
    - Example: A medical staff may not vote to rescind maintenance of certification requirements for certain physicians when the hospital's designation requires those physicians to complete an applicable maintenance of certification program.
  - A hospital's governing body or administration may not take part in the medical staff's vote on any maintenance of certification requirements.

Maintenance of Certification
SB 1148

- Where maintenance of certification is not required for a hospital's designation, accrediting, or certification, and the hospital's medical staff has not voted to require maintenance of certification, the hospital *may not* differentiate between physicians based on maintenance of certification.

  - This restriction does not apply to a medical school licensed by the State of Texas, or a comprehensive cancer center designated by the National Cancer Institute.

Maintenance of Certification
SB 1148

TAKEAWAYS:

- A hospital seeking or maintaining a designation, certification, or accreditation must determine what maintenance of certification requirements apply. Any requirements must be documented and applicable physicians should be advised, in writing, of those requirements.

- If the hospital's medical staff desires to require maintenance of certification, the medical staff must enact such requirements through a duly authorized and valid vote. The hospital's governing body should not take part in any such vote.

- If neither of the above apply, the hospital should review any maintenance of certification policies for conflict with HB 1148.