NEW JERSEY STATE SOCIETY OF ANESTHESIOLOGISTS

THE NJSSA PULSE

JULY-AUGUST 2013

FROM THE STATEHOUSE

Advocacy and Management Group
Beverly Lynch

CHRISTIE SIGNS $33 BILLION FY14 BUDGET

On June 28, Governor Christie signed into law a $33 billion state budget. After many close door discussions, Christie's budget secured the support of nearly two-thirds of the Democratically controlled legislature in both the Senate and the Assembly. The budget is four percent, or $1.3 billion, larger than last year's budget.

Fiscal Year 2014's budget includes slightly more funding for education, nursing homes and programs for disabled residents. The budget also expands the state's Medicaid program, which will make New Jersey eligible for $227 million in federal funding through the President's Affordable Care Act. An estimated 104,000 New Jerseyans will become eligible through the expansion of Medicaid in the Garden State.

Christie's budget includes $40 million in contingency funds for Hurricane Sandy recovery efforts that are not covered by the federal government. However, the signed budget does not include a tax cut, as requested by Republicans, nor does it include the additional $7.5 million for family planning centers requested by Democrats.

RACE FOR NEW JERSEY'S US SENATE SEAT

The race for New Jersey's U.S. Senate seat heats up as the August primary quickly approaches. Newark Mayor Corey Booker leads Democratic rivals with 49 percent support according to a recent Monmouth University poll. Booker is faced by Democratic contenders U.S Congressman Frank Pallone, U.S. Congressman Rush Holt, and New Jersey State Assembly Speaker Sheila Oliver.

Republican front-runner and conservative activist Steve Lonegan faces New Jersey physician Dr. Alieta Eck (internal medicine) in this summer's primary election. Primary elections for the U.S. Senate seat will take place on August 13, with special general elections on October 16. Elections for New Jersey's Governor and State Legislature will take place on November 5, 2013.

ASSEMBLY BUDGET COMMITTEE APPROVES LOCAL HOSPITAL FEE PILOT PROGRAM

In June, the Assembly Budget Committee passed legislation that could establish a local hospital fee pilot program. The program is primarily focused on increasing financial resources through Medicaid to support local hospitals and ensure necessary services to low-income citizens. The pilot program will impose a local health care related fee on select hospitals and provide participating cities and counties with new fiscal resources. Revenues generated from the fee will allow New Jersey to qualify for further federal funding. No more than five cities and four counties will be able to participate in the pilot program. These cities and counties have not yet been determined. The legislation now awaits consideration by the full Assembly.

SAVE THE DATE!

NJSSA's 55th Annual Spring Meeting

Saturday, March 15, 2014

Hyatt Regency, New Brunswick

NOTE NEW LOCATION

Christie Administration releases Annual Hospital Performance Report:

Report shows improvements in hospital quality

The Department of Health (DOH) today released New Jersey's annual Hospital Performance Report, which demonstrates that hospital quality continues to improve in the state. The report includes two new measures and also identifies opportunities for hospitals to continue to enhance their performance.

The report scores hospitals in three general categories: Recommended Care, Patient Safety, and Healthcare-Associated Infections.

- Recommended Care Measures show how often each hospital provides the recommended treatment eligible patients with four common conditions: heart attack, pneumonia, heart failure and patients having surgery.
- Patient Safety Indicators (PSIs) help hospitals identify potentially preventable adverse events or serious medical errors and implement corrective steps.
- Healthcare-Associated Infections show how well hospitals are providing safe care by comparing hospital Healthcare-Associated Infection experience with the national experience and giving hospitals information to reduce these preventable infections and improve patient safety.

The department also added two measures to this year's report. Under Recommended Care Measures, Perioperative Temperature Management was included to illustrate the percent of patients whose body temperature was normal before or after anesthesia. This information is important because temperatures that fall below normal present a risk for patients undergoing surgery. Another measure, added under Healthcare-Associated Infections, was Surgical Site Infection following knee replacement surgery.

In addition to quality data, the report also offers consumer advice on taking an active role in healthcare, including how to manage medications and questions to ask health care providers.

Recommended Care Measures for Specific Health Conditions

This section scores hospitals on how often they provide certain patients with a specific treatment that is nationally recognized as a best practice. Heart attack, heart failure, pneumonia and care of surgical patients are scored on 26 measures. These include practices such as giving heart attack patients aspirin on arrival at the hospital to help reduce the severity of the attack. Here are some report highlights:

- Of the 26 recommended care measures, New Jersey exceeded national scores on 17 measures compared to 15 last year.
- New Jersey hospital performance was equal to national norms on eight measures.
- Only one measure, PCI received within 90 minutes for heart attack patients – a procedure to open blocked blood vessels - fell below national average (91 vs. 94). However, hospital performance on this measure improved 2.2 percent, rising to 91 percent in 2011 from 89 percent in 2010.

Patient Safety

The report also compares hospitals on 12 measures called Patient Safety Indicators (PSI). This section shows how well each hospital is providing safe patient care by examining the number of medical complications that occur during hospitalization, medical procedures and child birth.

Highlights include:

- New Jersey performed better or the same in 11 of the 12 PSI indicators in 2011 compared to 2010.
- On seven of the comparable 10 PSIs New Jersey outperformed the nation.
- New Jersey lagged the national average on three indicators: post-operative bleeding or blood clot, post-operative bloodstream infections and hip fractures following surgery.

Healthcare-Associated Infections (HAIs)

HAIs are infections patients get while in a hospital or healthcare facility. The goal of reporting HAIs is to provide consumers with information and to encourage hospitals to prevent these serious infections. Nationally, HAIs account for approximately 1.7 million infections and almost 100,000 deaths annually. The estimated financial impact of these infections is between $28 billion and $33 billion a year.

The results for these HAIs are as follows:

- Central Line-Associated Bloodstream Infections were lower than central-line infections seen nationally with 27 percent infections fewer than expected.

- Coronary Artery Bypass Graft infections, Abdominal Hysterectomy infections, Knee replacement infections and Catheter-Associated Urinary Tract infections were similar to the rates of these infections seen nationally
- The greatest reduction among HAIs was in abdominal hysterectomy infections, which had 33 percent reduction in infections in one year.

New Jersey hospitals performed better than last year's report on all measures except for Coronary Artery Bypass Graft infections. The report is available at www.nj.gov/health/hpr.

What's happening in our neighboring states...

The NJSSA website now includes links to the newsletters from Pennsylvania and New York. Check it out here...

http://www.njssahq.org/news.htm

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LEGAL REPORT

JOHN FANBURG, ESQ.
PARTNER, BRACH EICHLER LLC

FEDERAL UPDATE

Physician Payments Sunshine Act Becomes Effective Next Month

The Physician Payments Sunshine Act ("PPSA"), which is part of the Affordable Care Act, will become effective August 1, 2013. The PPSA requires manufacturers of medical devices, drugs, biological materials, or medical supplies, that participate in federal health care programs, to report to the Centers for Medicare & Medicaid Services ("CMS") any transfers of value of $10.00 or more that are provided to a physician or teaching hospital. Reportable items include consulting fees, honoraria, gifts, entertainment, and charitable contributions. The PPSA also requires reporting of ownership or investment interests held by certain physicians and immediate family members in the applicable manufacturers or in group purchasing organizations.

A series of exemptions are carved out in the statute, including product samples, buffet food and drink available at large scale conferences or similar large scale events, educational materials that directly benefit patient use (excluding textbooks), short term medical device loans to permit evaluation of a device, certified and accredited CME, and a transfer of value to a physician when the physician is a patient and not acting within his or her professional capacity.

Some third party transfers and indirect transfers are also required to be reported whether or not the physician actually receives the payment or transfer. The legislation is aimed at creating greater transparency, with the majority of the information from the manufacturers' annual reports to CMS being available to the public on a searchable website. Physicians will have the right to challenge the reports pertaining to them within a specified time period.

NJ Doctor Wins Significant Victory in United States Supreme Court

In a rare 9-0 decision, the U.S. Supreme Court gave a boost to the medical profession's efforts to address deceptive policies of large health insurers that are overwhelmingly bad for patients and physicians. *Oxford Health Plans LLC v. Sutter* (decided June 10, 2013) presented the question of whether physicians may arbitrate as a class when the agreement requires all disputes be submitted to arbitration.

Dr. Sutter entered into a fee-for-service arrangement with Oxford Health Plans (OHP). He agreed to provide medical care to members of OHP's network, and OHP agreed to pay for those services at prescribed rates. Several years

later, Dr. Sutter filed suit against OHP on behalf of himself and a proposed class of other physicians under contract with OHP. He alleged that OHP failed to make full and prompt payment to the doctors in violation of their contracts. OHP moved to compel arbitration; the state court granted OHP's motion and referred the suit to arbitration. The parties agreed the arbitrator should decide whether their contract authorized class arbitration, and he determined that it did. OHP filed a motion in federal court to vacate the arbitrator's decision on the grounds that he had exceeded his authority under the Federal Arbitration Act. The district court denied the motion and the Court of Appeals for the Third Circuit affirmed.

The Supreme Court upheld the Third Circuit finding that the language in the arbitration agreement permitted the arbitrator to decide whether or not the agreement authorized a class action. Indeed, what makes this case so important is the number of agreements out there that have arbitration agreements with a prohibition on class actions. Now, as long as one person is willing to step up, that person may have the opportunity to address the status of all similarly situated physicians. Predictably, some businesses have already started adding "no class action" clauses in their agreements and more are likely to do so in the future. However, there are actions filed by physicians across the country that have been on hold waiting for this decision. The plaintiffs in those cases will likely benefit greatly from this decision.

Pilot Program for Patient Reporting of Medical Errors

The U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality (AHRQ), announced that it is seeking approval for its patient information collection project: "A Prototype Consumer Reporting System for Patient Safety Events." Under the project, consumers would be able to submit reports describing medical errors that resulted in harm or injury. AHRQ hopes that the reporting system will reduce the number of adverse medical events by promoting patient reporting. The project includes a proposed form to collect information reported by patients, consumers, family members and other caregivers by telephone or online. AHRQ thinks that patient reports could complement and enhance reports from providers to create a more complete understanding about adverse medical events.

In an initial round of comments, physicians and other providers expressed concerns about consumers' inability to distinguish preventable errors from unavoidable complications of care. In addition, there are concerns about an increase in medical malpractice claims.

STATE UPDATE

New Jersey Supreme Court Strictly Enforces the Specialty Requirement in Medical Malpractice Case

The New Jersey Supreme Court recently unanimously held that a plaintiff's medical malpractice expert should have been barred from offering testimony regarding the standard of care required of a board certified emergency room physician and a physician certified in family medicine, because the expert did not have the appropriate credentials in those areas of medicine. The plaintiff alleged he became ill while operating a gas-powered saw in an enclosed basement. He arrived at a hospital emergency room where the physician defendants, one board-certified in emergency medicine and the other in family medicine, suspected carbon monoxide poisoning and directed treatment. The plaintiff suffered brain damage and filed a malpractice action.

Pursuant to the Affidavit of Merit Statute, N.J.S.A. 2A:53A-41, a plaintiff is required to file with the court an Affidavit of Merit from a physician in the same specialty or sub-specialty as a condition of filing a medical malpractice lawsuit. The plaintiff retained an expert who was board certified in preventative medicine with a sub-specialty in undersea and hyperbaric medicine, and who had clinical experience in evaluating and treating patients with acute carbon monoxide poisoning. However, under a plain textual reading of the Affidavit of Merit Statute, the New Jersey Supreme Court ruled that the plaintiff did not present an Affidavit of Merit or expert testimony from an appropriately credentialed expert. While the Court found that plaintiff's expert was qualified

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as an expert under New Jersey Rules of Evidence, he was not qualified under the Affidavit of Merit Statute to render an opinion on the standard of care required of a board certified emergency room physician and a physician certified in family medicine because he was not appropriately credentialed in those specialties.

New Jersey Bills May Impact Health Care Providers

A4144 (identical to S2820), an act concerning medical records, was reported from the Senate's Health, Human Services and Senior Citizens Committee on June 13, 2013 after being introduced in the Assembly and referred to the Assembly's Health and Senior Services Committee on June 6, 2013. The bill would revise current regulations related to the fees that can be charged for replication of medical records.

S2756 (identical to A3586), an act concerning declarations of death upon the basis of neurological criteria, was reported with amendments from the Senate's Health, Human Services and Senior Citizens Committee on June 13, 2013. The bill would require that a declaration of death on the basis of neurological criteria be made by a licensed physician qualified by specialty or expertise, based upon the exercise of the physician's best medical judgment and in accordance with currently accepted medical standards.

News from the Carrier Advisory Committee

Peter Goldzweig, DO,
NJSSA Vice President & CAC Representative

Medicaid Agrees to Retroactive Payment to January 1

Medicaid has agreed to pay certain resubmitted claims retroactive to January 1. In January 2013, the Medicaid program required that all physicians who order, refer, or attend Medicaid beneficiaries, but do not bill for their services, enroll in the program as non-billing providers. The program confirmed that enrolling will not cause a physician to become a participating provider, but it will allow participating providers to be paid and will bring the program into compliance with the Affordable Care Act.

The Medical Society of New Jersey, in response to complaints from Medicaid participating providers who are not being paid due to the ordering/referring physician's failure to enroll as a non-billing provider. In April MSNJ requested that the Medicaid program "consider making an exception that allows for resubmission of claims for payment once the non-billing provider has enrolled." The program recently advised that the treating physician may resubmit denied claims after the ordering/referring physician enrolls as a non-billing provider.

In 2013, non-billing provider enrollment will be retroactive to January 1, 2013. In 2014 and going forward, non-billing provider enrollment will be retroactive to one year prior to receipt of the enrollment application. For instance, a non-billing provider who submits an enrollment application on March 15, 2014 will be retroactively enrolled back to March 15, 2013. This is to allow participating physicians enough time to resubmit claims within the timely filing limit (up to one year).