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MEDICAID COVERAGE FOR HOSPITAL EMERGENCY ROOM OBSERVATION SERVICES

As reported in the May 2011 issue of the New York State Medicaid Update, hospitals may be eligible to receive separate payment for hospital observation services from Medicaid, including Medicaid Managed Care and Family Health Plus plans. Services must be provided in a distinct observation unit and patients must be seen, evaluated and admitted to the unit from the emergency department. Patients must be in observation status for a minimum of eight hours and a hospital may bill for up to 24 hours of observation, after which the patient is expected to be admitted or discharged.

Until the New York State Department of Health (DOH) adopts regulations addressing observation units, hospitals must receive a waiver from the DOH in order to bill for observation services. In order to qualify for the waiver, a hospital will need to submit an application detailing the hospital's goals for the unit; the clinical criteria/indicators for assignment to and discharge from the unit; a clear statement regarding oversight of and accountability for the unit; a detailed description of the physical space; a defined staffing plan; and a summary of quality review/improvement activities for the unit.

For more details regarding the application and the billing, see the May 2011 Medicaid Update, which can be accessed at http://www.health.state.ny.us/health_care/medicaid/program/update/2011/2011-05.htm#eme/
OCR ISSUES PROPOSED RULE ADDRESSING EXPANDED RIGHT OF A PATIENT TO AN ACCOUNTING OF PHI DISCLOSURES

The Office of Civil Rights (OCR) has issued a notice of proposed rulemaking that addresses the expanded right of patients to get an accounting of disclosures of their protected health information (PHI). The implications and challenges for health care providers would be significant if the proposed rule is adopted. Although patients have had a right to an accounting of disclosures pursuant to the HIPAA Privacy Rule, such right did not extend to disclosures for treatment, payment or health care operations purposes. The Health Information Technology for Economic and Clinical Health Act (HITECH) requires that “covered entities” and their “business associates” must account for disclosures of PHI to carry out treatment, payment and health care operations if such disclosures are through an electronic health record (EHR). This new requirement will pose a challenge for health care providers and their EHR vendors. Although such systems are expected to create and maintain access logs, they are not required to have the capability to account for treatment, payment and health care operations disclosures. In the proposed rule, OCR acknowledges that to provide a full accounting for disclosures of paper as well as electronic PHI, which will also need to include disclosures to and by its business associates, it will be an expensive, manual and time-consuming process for covered entities.

In addition to the expanded accounting of disclosures, OCR is proposing that patients be entitled to request an access report indicating who has accessed their electronic PHI. The access report would identify workforce members as well as persons outside the covered entity who have accessed an individual's electronic PHI. According to OCR: “The intent of the access report is to allow individuals to learn if specific persons have accessed their electronic designated record set information.” The access report would cover the three-year period prior to the date of the request for such report but would not identify the purpose for which the information was accessed. The report would be expected to include the date and time of access; the name of the person who accessed the information, if available; a description of what information was accessed, if available; and a description of the action by the user, if available (e.g., create, modify, access or delete). The right to an access report would be effective January 1, 2013, for electronic designated record set systems acquired after January 1, 2009, and January 1, 2014, for systems acquired before January 1, 2009.

OCR has also proposed modifications to the existing accounting requirements, including reducing the timeframe to respond to requests for an accounting from 60 to 30 days. A covered entity would also be required to act on requests for an access report no later than 30 days after receipt of the request. In the event that the accounting or access report cannot be provided within 30 days of the request, the covered entity may extend the time to act by no more than 30 days so long as the covered entity provides the individual with a written statement of the reasons for the delay and the date by which the accounting or report will be provided. The proposed regulation states that a covered entity may have only one extension of time to act.

More information about the proposed rule can be found at [http://www.hhs.gov/ocr/privacy/](http://www.hhs.gov/ocr/privacy/).
CMS PROPOSES TO EXPAND ACCESS TO SEASONAL INFLUENZA IMMUNIZATION

In the May 4, 2011, Federal Register, the Centers for Medicare & Medicaid Services (CMS) proposed new requirements for Medicare-certified providers designed to expand access to seasonal influenza vaccination. This notice of proposed rulemaking would update the conditions of participation and conditions for coverage for a number of provider types.

The proposed rules would require covered Medicare providers and suppliers to offer all persons an annual influenza vaccination during flu season, unless medically contraindicated. As always, any person would retain the right to decline any vaccination. CMS put forth these proposed rules in an effort to increase access to the vaccine, increase the number of patients receiving annual vaccination against seasonal influenza, and decrease flu-linked morbidity and mortality. These influenza vaccinations would offer both direct protection to the persons receiving vaccination and indirect benefits to others through decreased exposure to infected persons.

This proposed requirement would extend to Medicare-certified:

- Short-term, acute care, psychiatric, rehabilitation, long-term care, children’s, and cancer hospitals
- Critical access hospitals (CAHs)
- Rural health clinics (RHCs)
- Federally qualified health centers (FQHCs)
- End-stage renal disease (ESRD) facilities that offer dialysis services.

The proposed rule does allow for situations in which vaccine supplies may be unavailable or in short supply, and recognizes that providers and suppliers would not be held accountable for providing vaccine for all patients in such circumstances. Additionally, the proposed rule would require the included providers and suppliers to develop policies and procedures that would allow them to offer vaccinations for pandemic influenza, in case of a future pandemic influenza event for which a vaccine is developed.

The proposed rule is available online from the Federal Register at http://www.federalregister.gov/articles/2011/05/04/2011-10646/medicare-and-medicaidprograms-influenza-vaccination-standard-for-certain-participating-providers/

CMS will accept public comments on the proposed rule until July 5, 2011, and will respond to comments in a final rule to be published in the coming months. To submit comments, search for rule CMS-3213-P at http://www.regulations.gov/

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In a recent court decision, a federal court in New York State dismissed a lawsuit that was brought by federally qualified health centers (FQHCs) and their trade association to challenge New York’s methodology for paying FQHCs under the federal Medicaid law. In *Community Healthcare Association v. New York State Department of Health*, the FQHCs and the association alleged in their complaint that New York was violating a federal Medicaid law that requires states to fully reimburse FQHCs for their costs. The plaintiffs asked the court to declare that the state’s conduct was unlawful under the federal Medicaid law and to issue an injunction prohibiting the state from continuing to violate the federal law.

The court did not, however, reach the merits of the plaintiffs’ claims. Instead, the court dismissed the case based on sovereign immunity grounds. Specifically, the court ruled that the Eleventh Amendment of the United States Constitution barred the plaintiffs from suing the State of New York in federal court. The Eleventh Amendment provides, in brief, that a federal court’s jurisdiction “shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by Citizens of another State, or by Citizens or Subjects of any Foreign State.”

In arguing that their claims fell within an exception to the Eleventh Amendment that applies to claims that the federal government may assert against a state, the plaintiffs contended that the FQHCs were acting as trustees of federal funds to which they were entitled under federal law and thus “standing in the shoes” of the federal government. The court summarily rejected that argument as there was no indication that the federal government authorized the FQHCs to stand in its shoes. The court also rejected the plaintiffs’ position that the federal Medicaid law authorized FQHCs to sue states. The court explained that, even if that were true, the federal Medicaid statute could not abrogate a constitutional provision. Finally, the plaintiffs argued that despite sovereign immunity, persons may sue states for illegally seized property. The court disposed of that point, too, since it found that the dispute in the case involved the adequacy of the state’s reimbursement formula and not the return of property that was actually seized by the state.
CHANGES TO CONDITIONS OF PARTICIPATION IMPACTING CREDENTIALING OF PHYSICIANS AND PRACTITIONERS PROVIDING TELEMEDICINE SERVICES

Effective July 5, 2011, Medicare participating hospitals and critical access hospitals (CAHs) will be able to use an expedited credentialing and privileging process for physicians and practitioners who solely provide telemedicine services and are already credentialed by another authorized entity. Under revised conditions of participation adopted by the Centers for Medicare and Medicaid Services (CMS), participating hospitals and CAHs may now rely on the prior credentialing and privileging determinations of a “distant-site hospital” or “distant-site telemedicine entity” when granting privileges to a physician or practitioner providing solely telemedicine services. Presently, participating hospitals must fully evaluate the credentials of every physician or practitioner who provides services prior to granting privileges at the hospital irrespective of whether such services are telemedicine services.

In order to qualify for the expedited credentialing process, the physician or practitioner in question must have been granted privileges by a distant-site hospital or telemedicine entity that has entered into a written agreement with the participating hospital or CAH for telemedicine services.

The written agreement must ensure that the following conditions are met:

- The individual distant-site physician or practitioner is privileged by the distant-site hospital or telemedicine entity, which provides a current list of physicians and practitioners granted privileges to the participating hospital or CAH.
- The individual distant-site physician or practitioner holds an appropriate license recognized by the state in which the participating hospital or CAH whose patients are receiving telemedicine services is located.
- The hospital or CAH keeps evidence of the performance of all telemedicine services provided by each distant-site physician or practitioner granted privileges under the agreement and sends the distant-site hospital or telemedicine entity the information for use in the periodic evaluation of each physician or practitioner. At a minimum, the performance information must include adverse events and complaints related to the telemedicine services provided by the physician or practitioner.

The written agreement must also ensure that the distant-site hospital is a Medicare participating provider. While a distant-site telemedicine entity need not participate in the Medicare program, the written agreement must ensure that, at a minimum, the entity’s medical staff credentialing and privileging process meets the standards applicable to a Medicare participating hospital. A copy of the final rule adopting the changes to the Medicare conditions of participation may be found at http://www.gpo.gov/fdsys/pkg/FR-2011-05-05/html/2011-10875.htm

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OMIG REVIEWS IMPENDING VERIFICATION REQUIREMENTS FOR CERTAIN HOME HEALTH AGENCIES

The New York Office of Medicaid Inspector General (OMIG) held a webinar on May 25 to review recently enacted requirements for use of third-party verification organizations for certain home health services. One of the proposals put forth by the New York Medicaid Redesign Team was a long-term effort to improve Medicaid integrity by requiring select home health and personal care providers to comply with pre-claim verification requirements. The Legislature subsequently enacted this proposal in a new section 363-e of the Social Services Law.

The requirements under section 363-e apply to certified home health agencies, long-term home health agencies and personal care providers with total Medicaid reimbursement exceeding $15 million per calendar year. While licensed home care services agencies (LHCSAs) are not subject to the new requirements, OMIG made a point of emphasizing that the entities subcontracting with LHCSAs remain liable for all services billed by such agencies. OMIG considers it in the best interests of agencies subject to section 363-e to have adequate systems in place to monitor subcontractors and to insist that subcontractors have robust compliance initiatives.

The centerpiece of the new system is the requirement to have claims verified by a “verification organization,” a third-party entity that will use electronic means, including contemporaneous telephone or other electronic data, to verify whether a service or item was provided to an eligible Medicaid recipient. The verification organizations are required under the statute to capture (1) the identity of the individual providing services or items; (2) the identity of the Medicaid recipient; and (3) the date, time, duration, location and type of service or item. The contemporaneous electronic systems are meant to overcome the susceptibility of manual caregiver time entries to fraud or mistake. The system will also enable electronic cross-checking of claims to ensure a caregiver is not charging two agencies for the same time.

Section 323-e also requires the verification organization to compile exception and conflict reports and supply them to the providers. An exception report will be an electronic report generated before a claim is submitted, detailing for the home health or personal care agency conflicts between services or items on the basis of the identity of the caregiver or item; the identity of the Medicaid recipient; and/or the time, date, duration or location of the service. For example, an exception report would note if a caregiver fails to comply with the scheduled time for electronic verification or fails to call in altogether. A conflict report, by contrast, occurs when a second claim submitted by another agency identifies an inconsistency in the schedule or location of the service or item. Because one claim will have already been paid, the conflict report will trigger the 60-day timeframe to repay the overpayment imposed under section 6402 of the Patient Protection and Affordable Care Act.

OMIG indicated that it would not mandate that agencies subject to section 323-e comply with the requirements in the 2011–2012 fiscal year. Rather, OMIG will use experience with existing exception and conflict reports to hone its auditing procedures and issue compliance guidance in anticipation of implementation in 2012.

The webinar can be found at http://www.omig.ny.gov/data/content/view/204/294
NEW FUNDING OPPORTUNITIES UNDER THE DOCTORS ACROSS NEW YORK INITIATIVE

The New York State Department of Health (DOH) has posted on its website new funding opportunities related to the Doctors Across New York Initiative. The new funding opportunities are described below.

Physician Loan Repayment Program – Cycle II

Starting July 27, 2011, and continuously thereafter until March 30, 2012, DOH will be accepting applications for the second cycle of the Doctors Across New York Physician Loan Repayment Program. The Physician Loan Repayment Program provides up to $150,000 toward loan repayment for physicians in exchange for a five-year service obligation in an underserved area. Eligible applicants are teaching hospitals, hospitals, other health facilities licensed by DOH, facilities licensed or operated by a municipality or county government, private physician practice organizations and individual physicians. For this fiscal year, $3.4 million has been appropriated for the program.

More information can be found on the DOH website at http://www.health.state.ny.us/funding/rfa/1104181147/index.htm

Ambulatory Care Training Program

DOH is requesting applications by August 12, 2011, at 3:00 p.m. for the Doctors Across New York Ambulatory Care Training Program. The Ambulatory Care Training Program provides funds to sponsoring institutions to defray the costs of training residents in freestanding ambulatory care sites which include diagnostic and treatment centers or physician practices that satisfy the requirements of the request for applications. For this fiscal year, $4.3 million has been appropriated for the program.

Additional information may be found on the DOH website at http://www.health.state.ny.us/funding/rfa/1001051045/index.htm

Physician Practice Support Program

DOH started accepting applications for the Physician Practice Support Program on June 14, 2011. Applications will be accepted and processed on a continuous basis until March 30, 2012, at 4:00 p.m., or until funding runs out. The Physician Practice Support Program provides up to $100,000 (maximum $50,000 per year) to physicians in exchange for a two-year service obligation in an underserved area. Funding is to be used for eligible practice costs and/or repayment of education loans. Eligible applicants include physicians, physician groups, general hospitals and other healthcare providers. Up to $7.2 million in funding is available for qualified applicants.

Additional information may be found on the DOH website at http://www.health.state.ny.us/funding/rfa/1103141142/index.htm

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