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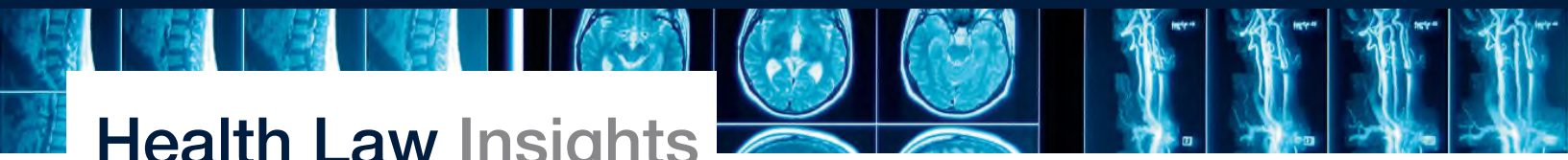

Health Law Insights

In this issue:

Federal Updates

State Updates

HIPAA Updates

Two-Midnight Rule Deadline Extension

The Centers for Medicare & Medicaid Services (CMS) has extended the deadline for compliance with the two-midnight rule through September 30, 2014. The rule provides that if an inpatient stay crosses two midnights, the admission will be presumed reasonable and necessary, so long as it is also medically necessary. Therefore, any inpatient admission that spans two midnights from the time of admission will not be reviewed, absent evidence of gaming or abuse. Conversely, inpatient stays that do not last two midnights are considered to be more suitable as outpatient observation, a classification under which Medicare reimburses at a substantially lower rate.

During the extension, recovery audit contractors (RACs) will not be permitted to review inpatient stays that last one day or less. However, Medicare administrative contractors (MACs) will be permitted to review small samples of claims for compliance and to aid in education and guidance. These sample claims will not be accessible by RACs during the transition period, nor will they be eligible for look-back review.

Deadlines for Electronic Health Record (EHR) Meaningful Use

Providers will now have until March 31, 2014, to submit data attesting to meaningful use of EHRs. CMS announced that this extra month will give physicians the opportunity to demonstrate their meaningful use of an EHR system in 2013. The deadline for hospital compliance was December 1, 2013; however, CMS stated that hospitals may retroactively submit their attestation data by March 15, 2014. These extensions come in lieu of the fact that payment adjustments in 2015 will be based on 2013 data.

This year also marks the beginning of Stage 2 for eligible entities that have completed two years of Stage 1. For entities that qualified for the incentive payment before 2013, a demonstration of meaningful use during the entire fiscal year must be provided. However, entities and individuals establishing meaningful use for the first time in 2013 will only be subject to a three-month reporting period.

District Court Upholds Federal Trade Commission's (FTC's) Antitrust Challenge to a Hospital System's Acquisition

The U.S. District Court for the District of Idaho recently deemed an acquisition between a physician practice group and a health system anticompetitive. Saltzer Medical Group, a large multispecialty physician practice group, was acquired by St. Luke's Health System. However, after the acquisition, federal and state consumer-protection agencies, concerned about the acquisition's anticompetitive nature, brought claims under the Clayton Act and the Idaho Competition Act. The court, after calculating market concentration numbers, found that the deal gave Saltzer Medical Group and St. Luke's nearly 80 percent of the primary-care market in Nampa, Idaho. The District Court agreed with the concerns, ruling that the acquisition would lead to higher expenses for insurers and health care consumers. Therefore, the court found that the arrangement violated federal and state law.

Protections for EHR Donations Extended

The United States Department of Health and Human Services (HHS) has extended legal protections for donated EHR products. The protections provided by the safe harbor under the federal Anti-Kickback Statute and the exception to the federal physician self-referral law, commonly known as the "Stark Law" were due to expire on December 31, 2013, but have been extended to December 31, 2021. The extension will allow physicians to accept donated EHR products for the duration of CMS's meaningful use incentive program. Newly excluded, however, are donations made by laboratory companies.

HHS has extended to 2021 legal protections against kickback claims arising from donation of Electronic Health Record products. Newly excluded, however, are donations from laboratory companies.

HHS Suspends Medicare Appeals

HHS has issued a moratorium on Medicare appeals for at least two years. Appeals rose 184% from 2010 to 2013, and administrative law judges (ALJs) have a large backlog. The current estimated timeline includes 18 to 24 weeks for each appeal to be docketed, along with 24 to 28 months for the appeal to be assigned to an ALJ. The appeals that will be tabled are those initiated by Medicare providers and suppliers and Medicaid state agencies. Appeals filed directly by Medicare beneficiaries will continue to be assigned during the suspension.

CMS Provides Presumptive Eligibility Criteria

CMS has issued a bulletin providing assistance for hospitals in making presumptive eligibility determinations for uninsured individuals seeking medical treatment. This bulletin is intended to aid states in implementing hospital determinations processes, for which a plan must be submitted by March 31. Based on the relevant criteria, if the patient is presumed to be eligible, the individual is temporarily enrolled and the health care provider will receive payment for the services provided.

Court Finds Medical Clinic Is Not Liable for Employee Disclosure

The Second Circuit Court of Appeals ruled that a New York medical clinic will not be liable for its employee's disclosure of personal health information. The clinic's nurse recognized the patient as her sister-in-law's boyfriend and immediately disclosed to her relative what the patient was being treated for. The court found that the clinic was not liable for the employee's behavior under *respondeat superior* or vicarious liability, as it was not foreseeable and was outside the scope of her employment.

House and Senate Agree to Doc Pay Overhaul Deal

A final agreement has been reached by lawmakers in the House and Senate in an effort to repair the Medicare physician reimbursement system. The nearly 200-page bill would overhaul Medicare's sustainable growth rate formula by phasing in new payment models. The bill effectively combines three former bills approved by the House Ways and Means Committee, the Senate Finance Committee, and the House Energy and Commerce Committee. Physicians will receive a .5% payment increase for five years (2014-2018) and, in 2018, physicians who receive a large share of revenue through alternative payment models, such as accountable care organizations, will be provided 5% bonuses. The bill also requires HHS to provide medical professionals' utilization and payment data on the Physician Compare website.

Physician Compare Website Based on Specific Quality Measures

CMS announced that its Physician Compare website will rate physicians using quality measures specific to particular conditions based on the Physician Quality Reporting System. Reporting under this system will include care coordination, patient safety, clinical effectiveness and the population to which the treatment is provided.

Proposed Rule for EHR Certification

The Office of the National Coordinator for Health Information Technology (ONC) recently released a proposed rule updating the EHR certification program, marking the first instance of ONC issuing separate certification criteria from CMS's meaningful use regulations. The proposed rule will include additional criteria for certification, compliance with which will be voluntary. The additional criteria will reflect the requirements for certification set to take effect in 2017 at the completion of the meaningful use program. ONC's intention is for EHR programmers to incorporate the 2017 standards early in order for products to be tested and developed ahead of the program deadlines. The proposed rule is set to take effect in 2015 and is expected to be published this summer.

New Jersey Legislature Passes Lithotripsy Exception to Codey Law

The New Jersey self-referral law, commonly known as the Codey Law, prohibits health care practitioners from referring patients to health care services in which the practitioner has a financial interest, but the law provides a number of exceptions from the prohibition. On December 19, 2013, both houses of the New Jersey legislature passed a new exception for lithotripsy services.

Currently, a practitioner is permitted to refer patients to a health care service in which the practitioner has a financial interest if the practitioner held a financial interest in the health care service prior to the effective date of the Codey Law. However, if the new exception is signed into law by the Governor, referrals will be permitted by practitioners who invest in a licensed facility that provides lithotripsy services even if the practitioner obtained their financial interest in the facility after the effective date of the Codey Law.

Expansion of the Definition of "Health Care Service Firm"

A recent bill in the New Jersey Senate expands the definition of health care service firms to include firms that place, or arrange for the placement of, personnel to provide companion services. The bill defines "companion services" as "nonmedical basic supervision and socialization services which do not include direct physical contact with the individual and which are provided in the individual's home." Because of the expanded definition, health care service firms that provide companion services must obtain accreditation and comply with annual auditing requirements. The previous definition included only firms that placed or arranged for the placement of personnel to provide health care or personal care services.

Nursing Home Patients Have Private Right of Action not Provided to Those in Assisted Living

According to the U.S. District Court for the District of New Jersey, the private right of action against facilities that fail to protect specific rights provided to nursing home residents by the New Jersey Nursing Home Responsibilities & Rights of Residents Act (NHRRRA) does not equally apply to residents of assisted-living facilities. Although the definition of "nursing home" within the NHRRRA is broad, the Court found that the NHRRRA does suggest a distinction between nursing homes and assisted-living facilities. While individuals in assisted living are afforded protections by means of a different New Jersey law, a private right of action for a constitutional violation is not among them.

Private rights of action for constitutional violations are not available to NJ's assisted-living residents, though they are to their nursing home counterparts. Other state laws protect those in assisted living.

New Rules Adopted for Out-of-State Hospital Medicaid Reimbursement

Effective July 1, 2014, new amendments to New Jersey Administrative Code (N.J.A.C.) 10:52-4.5 by the Division of Medical Assistance and Health Services provide significant changes to current out-of-state hospital Medicaid reimbursement. Under the amendments, inpatient services provided by participating hospitals shall be reimbursed by the lesser of either the New Jersey Diagnosis-Related Group (DRG) payment rate, 100 percent of the out-of-state Medicaid agency's claim-specific reimbursement methodology, or total charges. Inpatient services provided in a non-participating hospital shall be reimbursed by either the lesser of the negotiated rate, the New Jersey DRG payment rate, or total charges. Similarly, outpatient services from a participating hospital shall be reimbursed by the lesser of the average cost-to-charge ratio or fee schedule rate of New Jersey, 100 percent of the out-of-state Medicaid agency's claim-specific reimbursement methodology, or total charges. Lastly, outpatient services from a non-participating hospital shall be reimbursed by either the lesser of the average cost-to-charge ratio of New Jersey, the fee schedule rate of New Jersey, or total charges.

Dermatology Practice Settles in First-of-Kind Breach

HHS has reached a settlement of $150,000 with a Massachusetts-based dermatology practice. The settlement comes after the practice failed to issue and enforce sufficient policies and procedures in order to avoid and mitigate Health Information Technology for Economic and Clinical Health Act breaches. The practice reported a breach in October 2011 when a flash drive was stolen from an employee's car. The drive contained unencrypted protected health information (PHI) of 2,200 individuals. However, the practice

did not properly analyze the risks of confidentiality in electronic PHI until one year later. Additionally, the practice did not issue policies and procedures, as required by the Health Insurance Portability and Accountability Act (HIPAA), to properly train employees until February 2012.

Proposed Rule for Gun Background Checks

HHS has proposed a rule that will allow HIPAA-covered entities to permissibly disclose information to the National Instant Criminal Background Check System and identify individuals barred from possessing firearms. The individuals subject to this disclosure would be those who are disqualified from receiving, possessing, shipping, or transporting firearms based on the federal mental health prohibition. Comments on this rulemaking are due March 10, 2014. The Department of Justice has also proposed a regulation to clarify the types of individuals and mental illnesses the prohibition and disclosures apply to.

HIPAA Mental Health Guidance

The Department of Health and Human Services Office of Civil Rights has recently issued guidance that clarifies a provider's ability to share mental health records with a patient's family and friends. The guidance illuminates provider responsibility under HIPAA's privacy rule.

Direct Patient Access to Lab Results

CMS has released a final rule that will allow patients to have direct access to laboratory test results. In order to facilitate the access, the rule will modify the Clinical Laboratory Improvement Amendments of 1988 and HIPAA. The rule will preempt any adverse state laws and will take effect April 7, 2014. HIPAA-covered laboratories will have six months to come into compliance with the rule, which requires that they provide patients or their representatives with results within 30 days of a request.

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