



New Jersey Health Law

Bulletin

A summary of recent developments provided by the health care law firm Garfunkel Wild, P.C.

Implementation of Medicaid Recovery Audit Contractor Program

The Patient Protection and Affordable Care Act ("PPACA"), enacted in March 2010, provided for the extension of the Medicare Recovery Audit Contractor ("RAC") program to State Medicaid programs. Medicare RACs are private sub-contractors that are authorized to perform audits of Medicare payments to health care providers. As an incentive for proper auditing, and to ensure that overpayments to providers are identified and recovered, subcontractors are paid certain percentages of such recoveries of overpayments.

Despite the fact that the New Jersey Department of Health and Senior Services has yet to issue regulations governing the extension of the RAC program to state Medicaid programs, the State has entered into a Medicaid RAC contract with Health Management Systems ("HMS"), effective August 1, 2011. HMS will serve as the subcontractor and will conduct audits of Medicaid payments to long-term care facilities, home health agencies, hospices, adult day health facilities, laboratories, and individual providers. The Medicaid Fraud Division ("MFD") of the State Comptroller's Office will coordinate the efforts of HMS, and HMS will report its audit findings to the MFD.

HMS will conduct two types of audits. When HMS determines that improper payments can be ascertained clearly and unambiguously and without extensive

document review, HMS will conduct an Automated Review. HMS will issue an Improper Payment Notification Letter (the "Letter") to the respective provider detailing the perceived payment error. The provider will then have the opportunity to submit additional information in response to the Letter. HMS will issue a final determination after a re-evaluation of the new information. Alternatively, HMS may perform a Complex Review when it has detected potentially improper payments, but cannot automatically validate such determination. In such cases, claims are flagged as potentially improper, and HMS will contact the provider to request medical records to validate the claims. HMS may review such records for a period up to three years from the date of request, and may elect to extrapolate the results of the review to the entire patient population. HMS will then make its final determination regarding improper payment following its review.

Providers may appeal a final determination to the Office of Administrative Law within twenty (20) days from the final determination letter. ■

Adoption of Patient Safe Handling and Violence Prevention Rules

Originally proposed in January 2011, two sets of rules designed to protect the physical well-being of both health care workers and patients (the "Rules") were recently adopted. Accordingly, the New Jersey Department of Health and Senior Services must implement the terms and establish the respective programs.

Pursuant to the Rules, all hospitals and nursing homes (the "Facilities") must establish a violence prevention program (the "Prevention Program") in order to ensure that health care workers are protected from violence. The Facilities must also establish a violence prevention committee (the "Prevention Committee"), which meets at least quarterly to assess violence prevention and develop a written Prevention Program in accordance with the Rules. The Prevention Program must, at a minimum,

(Continued on page 2)

Enactment of Medicaid ACO Demonstration Program

On March 31, 2011, the Centers for Medicare and Medicaid Services ("CMS") proposed new regulations (the

"Regulations") under the Patient Protection and Affordable Care Act ("PPACA") to help health care providers coordinate care for Medicare patients in a more efficient manner

(Continued on page 2)

New Jersey Health Law Bulletin is written and edited by Jeffrey S. Brown, Andrew E. Blustein, Steven R. Antico, Alan H. Perzley, Kimberly Kempton-Serra and Matthew Colford of Garfunkel Wild, P.C., Hackensack, NJ. Reader questions are welcomed; the editors can be contacted at 201-883-1030.

Implementation of Universal Transfer Form

By the end of October 2011, all health care facilities licensed in New Jersey must put into operation the Universal Transfer Form (the "Form") for patients being discharged or transferred from one health care facility to another. Over 1900 New Jersey health care facilities—including hospitals, skilled nursing facilities, home health care agencies, and ambulatory surgery centers, among others—will be required to use the Form starting October 30, 2011. Emergency departments are exempted from mandatory use of the Form. First proposed by the New Jersey Department of Health

and Senior Services in July 2010, the Form is comprised of a comprehensive checklist of patient medical and personal information, including all information required by federal transfer regulations. Individual facilities are tasked with developing written facility policies and procedures for the correct use of the Form. The Form is intended to significantly improve patient care across multiple facilities by ensuring accurate transfer of pertinent clinical information.

The Form is currently available through the Department of Health and Senior Services' website. ■

ACO Demonstration Program

(Continued from page 1)

through Accountable Care Organizations ("ACOs"). The PPACA requires CMS to establish a shared savings program (the "Program") that will facilitate coordination among providers in order to improve the quality of care for Medicare fee-for-service beneficiaries and reduce unnecessary costs. ACOs will serve as the mechanism to achieve the goals of the Program, as they create incentives for providers to work together to treat individual Medicare patients across various health care settings. The Program will reward ACOs that lower costs while meeting performance standards on quality of care. However, the Program will also penalize those ACOs that fail to provide efficient, cost-effective care.

A New Jersey law, enacted on August 18, 2011, extends this federal concept to the State. The law establishes the Medicaid ACO Demonstration Project (the "Demonstration Project"), which will enable providers to continue to receive Medicaid reimbursement directly from the Medicaid program while participating in certified Medicaid ACOs. The three-year Demonstration Project seeks to address a variety of access, coordination and

service utilization problems that lead to increased health care costs. Pursuant to the Demonstration Project, Medicaid ACOs may organize as nonprofit corporations and apply to the New Jersey Department of Human Services ("DHS") for certification. The Department may certify a Medicaid ACO, notwithstanding the fact that such ACO also participates in a federal Medicare ACO project. A Medicaid ACO must establish a plan to receive and distribute gainsharing payments from DHS and must submit such plan to DHS for approval. A gainsharing plan submitted to DHS must contain an assessment of the shared savings and the impact on revenues of hospitals that agree to participate. DHS will only approve such plans that promote care coordination, collaboration between providers, and increased medication adherence.

If, after three years, the Demonstration Project successfully reduces costs and improves the quality of care for Medicaid patients, the certified Medicaid ACOs may be established on a permanent basis. ■

Adoption of Patient Safe Handling and Violence Prevention Rules

(Continued from page 1)

set forth the procedures for recordkeeping, violent incident reporting, investigation and evaluation, and follow-up care. In addition, the Prevention Committee must conduct analyses to improve security procedures and controls based upon potential risk factors for violent incidents.

The Rules also require the Facilities to minimize unassisted patient handling in order to decrease the number of job-related injuries suffered by health care workers and improve the quality of care for patients. Pursuant to the Rules, the Facilities must establish a safe patient handling committee (the "Safe Handling Committee") to create a safe patient handling program (the "Safe Handling Program") designed to increase the use of patient handling aids, such as mechanized lateral transfer aids, sliding boards, and full body slings. The Safe Handling Program must be in writing and must, at a minimum, set forth a uniform system of protocols to be used consistently by health care workers when handling patients during assessments. Importantly, a patient's need for assisted handling must be assessed prior to handling, and handling aids must be used unless the assessment dictates that such assistance is not needed. The Safe Handling Program must state that patients have the right to refuse the use of assisted patient handling. ■

LEGISLATIVE & REGULATORY UPDATE

Required Disclosures by Health Care Professionals

Assembly bill A-4185, enacted on June 27, 2011, requires certain health care professionals working in an office to disclose to patients their name, type of license, and highest level of academic degree. This information must be either in a display in their office or in a writing to a patient on that patient's first office visit. The bill also requires a person licensed to practice medicine or surgery who is certified in a medical specialty to disclose the name of the certifying board or association. Additionally, health care professionals must include their names, type of license, and highest level of academic degree in all advertisements.

Provision of Influenza Vaccination to Health Care Workers

Senate bill S-2984, introduced on June 29, 2011, requires that all general or specialized hospitals and nursing homes provide annual influenza vaccinations to all of their workers who provide direct patient care or otherwise have contact with patients.

Reuse of Prescription Drugs

Senate bill S-2987, introduced on June 29, 2011, provides that unopened, unexpired prescription drugs that were previously dispensed to, but not used by, a patient within a licensed health care facility may be reused at the facility after consultation with the New Jersey State Board of Pharmacy.

Practice of Respiratory Care

Adopted on August 15, 2011, these Rules limit the tasks that a respiratory care practitioner can delegate to assistants to routine tasks, such as cleaning and sterilizing equipment, maintaining and handling oxygen, and setting up

equipment. In addition, new requirements were set forth for continuing education programs, courses, and related credits. A licensee may now obtain continuing education credit for completion of Board-approved, performance-based competency assessments. Finally, failure to complete continuing education requirements may now result in the imposition of penalties and/or license suspension.

Infection Reporting for Ambulatory Surgery Facilities

The New Jersey Department of Health and Senior Services (the "Department") has proposed amendments to the current requirement that health care facilities report all healthcare-associated infection ("HAI") data to the Department. The regulations require that health care facilities make HAI data available on a quarterly basis, and that the information is available to the public. The amendments require that ambulatory surgery facilities abide by the reporting standards as set forth above. However, the data that each ambulatory surgery facility must report has yet to be determined by the Department. The purpose of the amendments is to provide the Department with a measurable means of assisting ambulatory surgery facilities in improving patient outcomes.

MRSA Infection Prevention Programs

Introduced on September 19, 2011, Senate bill S-3037 would require hospitals to implement a Methicillin-Resistant Staphylococcus Aureus ("MRSA") infection prevention program in all areas of the hospital, with the possible exception of inpatient psychiatric units. Under the program, hospitals would need to screen patients for MRSA upon admission, take patient cultures upon discharge or transfer, create a written infection prevention

policy, and implement contact precautions for infected patients. Additionally, hospitals would be required to report the number of cases of facility-acquired MRSA infections to the New Jersey Department of Health and Senior Services (the "Department"). Only general hospitals licensed by the Department will be immediately subject to the requirements of the bill.

Proposed Amendments to Health Maintenance Organizations and Health Care Quality Act Rules

In order to comply with Federal regulations promulgated under the Patient Protection and Affordable Care Act ("PPACA"), the New Jersey Department of Banking and Insurance ("DOBI") proposed amendments on September 19, 2011 to DOBI's Health Maintenance Organization ("HMO") rules and Health Care Quality Act ("HCQA") rules regarding internal and external review and appeals processes for benefits determinations. Determinations of the appropriateness of a member's healthcare benefits, formerly known as utilization management decisions, are now labeled adverse benefit determinations, consistent with the Federal regulations. The proposed amendments set forth a number of changes, including, without limitation: (1) a requirement that HMOs provide for an appeal and review system in connection with adverse benefit determinations, (2) a provision ensuring the right of any covered person or provider to appeal a final internal adverse benefit determination to a DOBI-administered Independent Utilization Review Organization ("IURO") (with some categorical exceptions), (3) a requirement that makes final adverse benefit determinations of IUROs binding on both the HMO and member, to the extent that other State or Federal remedies are not available, and (4) certain modifications to the time periods concerning such appeals and reviews of adverse benefit determinations. ■

New Jersey Health Law Bulletin is the property of Garfunkel Wild, P.C. With approval of the editors and proper credit given to the firm, it may be reproduced or excerpted. This newsletter is provided only as an educational source to highlight important issues in health care. It is not intended as a source for legal advice; readers requiring legal assistance should seek competent counsel.

Office of Inspector General Advisory Opinion: *Arrangement Between Medical Equipment Supplier and Skilled Nursing Facility May Violate Anti-Kickback Statute*

The Office of the Inspector General (“OIG”) recently issued an opinion advising a supplier of medical supplies and equipment (the “Supplier”) on the Anti-Kickback Statute (“AKS”) implications of two proposed arrangements between the Supplier and a skilled nursing facility (the “Facility”) for items furnished exclusively by the Supplier to the Facility. The arrangements concern the provision of equipment and supplies covered by the Medicare program (“Covered Items”), which the Supplier bills to Medicare directly, and those that are not covered by Medicare (“Non-Covered Items”), which the Supplier bills to the Facility. Both arrangements potentially violate the AKS and would be subject to sanctions.

In the first proposed arrangement (“Arrangement A”), the Supplier would furnish the Facility with all Covered and Non-Covered Items and related services. The Supplier’s cost of Covered items and related services would be adequately covered by payments from Medicare. However, the rate at which the Supplier would offer Non-Covered Items and related services to the Facility would be lower than the Supplier’s actual cost. Supplier’s payments from Medicare would be sufficient to offset any losses from the below-cost pricing of Non-Covered Items and services. Under the second proposed arrangement (“Arrangement B”), the Supplier’s owners would form a new supplier company. Supplier would provide all Cov-

ered Items and related services, and the new company would provide all Non-Covered Items and related services. Arrangement B is otherwise identical to Arrangement A.

The OIG concluded that each scenario may result in AKS violations by both parties because of the potential impact that the Supplier’s below-cost rates for Non-Covered Items could have on the Facility’s referrals of other Medicare business, such as business in connection with the Covered Items, to the Supplier. Rates that are not commercially reasonable—below Supplier’s costs for providing items and services—create an inference that the Supplier is offering improper discounts in exchange for referrals for the Facility’s other Medicare business, in violation of the AKS. The OIG determined that there is also a strong possibility that the Facility would be soliciting improper rates on business for which it bears risk in exchange for referrals of Medicare business (on which it does not bear risk). In Arrangement B, replacing the Supplier with a separate, but commonly-owned, company does not change the analysis for either the Supplier or the Facility.

Please note that the OIG’s opinion only applies to the specific facts at issue and should not be relied upon without consulting legal counsel. ■

About Garfunkel Wild, P.C.

Garfunkel Wild, P.C. (GW) is among the most active health care specialty law firms in the country, with offices in New Jersey, New York and Connecticut. It serves numerous New Jersey hospitals, licensed health facilities, medical practices, physicians and other health care practitioners, and health care related companies.

The firm specializes in addressing the complex legal, regulatory, business and financial needs of its clients: it helps clients negotiate favorable reimbursement rates from insurers and government; gain regulatory approval for facilities expansion or new services; merge, acquire or network with other organizations; and purchase or lease new technology and equipment. GW also assists numerous health care providers and others to comply with complicated, costly, and often onerous state and federal regulations.

For more information, please contact:

- ◆ *Jeffrey Brown (jbrown@garfunkelwild.com)*
- ◆ *Andrew Blustein (ablustein@garfunkelwild.com)*
- ◆ *Steven Antico (santico@garfunkelwild.com)*
- ◆ *Alan Perzley (aperzley@garfunkelwild.com)*

at 201-883-1030 or visit the firm’s website at www.garfunkelwild.com

THIS MATERIAL IS INTENDED AS INFORMATIONAL ONLY AND THE CONTENT SHOULD NOT BE CONSTRUED AS LEGAL ADVICE. READERS SHOULD NOT ACT UPON INFORMATION IN THIS MATERIAL WITHOUT FIRST SEEKING PROFESSIONAL ADVICE.

PLEASE BE ADVISED THAT PURSUANT TO NEW JERSEY RULE OF PROFESSIONAL CONDUCT 7.3(B)(5), WE ARE REQUIRED TO PROVIDE THE FOLLOWING NOTICES:

NOTICE: BEFORE MAKING YOUR CHOICE OF ATTORNEY, YOU SHOULD GIVE THIS MATTER CAREFUL THOUGHT. THE SELECTION OF ANY ATTORNEY IS AN IMPORTANT DECISION.

NOTICE: If this letter is inaccurate or misleading, report same to the Committee on Attorney Advertising, Hughes Justice Complex, P.O. Box 037, Trenton, New Jersey 08625.

© 2011 Garfunkel Wild, P.C.

Garfunkel Wild, P.C.
411 Hackensack Avenue
Hackensack, NJ 07601