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Health Care News

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## Public Health Preparedness: Pandemic Influenza

On December 5, 2005, Mike Leavitt, Secretary of the U.S. Department of Health and Human Services (HHS) announced that HHS plans to meet with officials in every state over the next 120 days to prepare for a possible influenza pandemic. The meetings, "pandemic-planning summits", will engage medical, emergency response, political, economic, school and community leadership in the planning process. Secretary Leavitt stated "[t]here have been ten pandemics of influenza in the last three hundred years. There have been three in the last century. There is no rational basis to believe that the early years of the 21st century will be different. When it comes to a pandemic we are overdue and under prepared". HHS is advising state leaders to adopt plans to i) delineate the roles and responsibilities of state and local agencies; ii) build on existing preparedness and response plans for bioterrorism and infectious disease emergencies; and iii) address legal issues, such as those impacting hospital staffing, patient care and quarantine (both state and federal law authorize the use of quarantine). For more information regarding the federal influenza plan go to: http://pandemicflu.gov/ Relevant New York State Department of Health information is available at: http://www.health.state.ny.us/diseases/communicable/influenza/index.htm In addition to government initiatives, large private businesses are being advised to plan for serious disease outbreak. See the Centers for Disease Control and Prevention's December 6, 2005, checklist for private industry: http://www.cdc.gov/flu/pandemic/

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## CMS Establishes New Process to Waive Penalties Caused by Bad CMS Advice

The Centers for Medicare and Medicaid Services ("CMS") has announced a new process whereby providers and suppliers, including physicians, hospitals, nursing home, home health agencies, etc., can apply to be relieved from penalties related to violations of Medicare rules and regulations if the underlying violation resulted from erroneous advice given by CMS or its contractors. CMS Manual System, Pub. 100-04 Medicare Claims Processing, Transmittal 739, November 1, 2005. To be eligible to request a waiver of penalties, all of the following requirements must be met: (1) the advice relied upon must have been provided after July 24, 2003 but before the provider or supplier filed any claims related to the matter covered by the advice; (2) the advice given must have been wrong; (3) the advice must have been given in writing; (4) the advice must have been issued by CMS or a CMS contractor acting within its scope of contacted authority; (5) all of the applicable facts must have been fully disclosed; (6) the provider or supplier must have followed the erroneous advice; and (7) the provider or supplier's reliance upon the erroneous advice must have been "reasonable". CMS indicates that "reasonability" will be assessed based on such factors as whether or not the written advice from CMS included "speculations, disclaimers, or other equivocal language" or indicated that further information is necessary; whether the advice appears accurate on its face; whether it contradicts a current official program issuance; whether the advice was superseded by a new policy; and/or whether a claim filed in reliance on the advice was rejected. The implementation date for the new process is January 19, 2006. Retrospective requests will be considered, but on a relatively tight timeframe.

## N.Y. Court of Appeals Requires Hearing Before NYS Department of Health Can Recoup Medicaid Payments

The Court of Appeals has ruled that a home health care agency is entitled to notice and an opportunity to be heard before the Department of Health can recover Medicaid payments it claims were improperly paid to the agency. Matter of Visiting Nurse Service of New York Home Care v. New York State Department of Health (Nov. 2005). In dispute were Medicaid payments for which the agency was not able to receive compensation from Medicare or other payors, a so called "provider liability" claim. State and federal regulations make Medicaid the "payor of last resort" because other potential sources of payment, including Medicare, must be exhausted before claims are paid by Medicaid. The Visiting Nurse Service ("VNS") argued that it was not obligated to repay Medicaid unless it had actually received payment from Medicare for the services provided. It also contested Department of Health's recoupment procedures, arguing that no administrative hearing had been available to contest Department of Health's actions. The court below had agreed with Department of Health's contention that recoupment was permissible in those instances where VNS failed to engage in reasonable efforts to ascertain whether the services were Medicaid eligible. On appeal, the Court of Appeals concluded that a hearing must be held on the issue of whether VNS, in fact, took reasonable measures to ensure proper designation and processing of claims. The Court also addressed whether the Department of Health was properly ordered by the Court below to cease recoupment pending such administrative hearing. In view of the Department's failure to comply with its own regulation requiring a response to a request for a hearing within 90 days, it was barred from continuing to withhold Medicaid payments pending the hearing.

## Compliance Corner

### OIG Proposes Hospital Exclusion

The Office of Inspector General (OIG) has taken the extraordinary step of seeking to exclude South Shore Hospital and Medical Center (South Shore) in Miami, Florida from participation in all Federal health care programs for failing to comply with the terms and conditions of its 2002 corporate integrity agreement (CIA). A CIA is an OIG structured and approved compliance program that is often required to resolve a fraud and abuse case. In its December 7, 2005 press release, the OIG explains: "South Shore's repeated and egregious failure in this case to abide by the terms of its CIA requires OIG for the first time to seek exclusion for such a violation." The OIG states that South Shore failed to timely do its annual reports, implement certain CIA requirements and advise the OIG of its sale in May 2003 to new owners, who also were subject to a CIA. According to the press release, the OIG analyzed the potential impact upon beneficiaries if South Shore were no longer a participating hospital and concluded the impact would not be adverse because there were enough other hospitals in the area. South Shore still has thirty days to cure the deficiencies. If after that time, the OIG still proceeds with the exclusion, South Shore can appeal the decision.

Whistleblower Snags Another -

Yet another hospital falls prey to a whistleblower lawsuit involving paying for referrals of Medicaid beneficiaries for substance abuse treatment services. Cabrini Medical Center in New York City was added as a defendant in the civil fraud case involving Applied Consulting Inc. The Complaint alleges that Cabrini paid Applied for the referral of patients pursuant to an illegal Administrative Services Agreement.

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