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Monthly Report

March 2010

Last day to register!
VSNJ 32nd Annual Scientific Meeting
March 3, 2010
Nanina's In The Park, Belleville

Speakers include:

Paul Haser, MD of UMDNJ-Robert Wood Johnson Medical School
Joseph V. Lombardi, MD of Cooper University Hospital
Michael Marin, MD of Mount Sinai Medical Center
Clifford Sales, MD, MBA of the Cardiovascular Care Group

download form at

www.vascularsocietynj.org

From the Statehouse

Beverly J. Lynch

The Senate Health, Human Services and Senior Citizens Committee debated and released a new measure (S-377, sponsored by Committee Chairwoman Senator Loretta Weinberg, D-Teaneck), that makes various changes to the membership and duties of the State Board of Medical Examiners (BME).

Specifically, the bill:

- Provides that the three public members of the BME include one person who represents a senior citizen advocacy group, one who represents a child advocacy group, and one who represents a Statewide consumer advocacy group.
- Specifies that at least one of the 12 physician members of the BME shall be a pediatrician.
- Specifies that a member of the BME is eligible for reappointment for one additional term of office, but no member shall serve more than two consecutive terms of office.
- To ensure that the BME takes timely disciplinary action to protect the public, when appropriate, the bill provides that:

· the Medical Practitioner Review Panel of the BME is required to investigate notices or complaints it receives from health care facilities and health maintenance organizations regarding a licensee in order to make a recommendation to the BME, and to make its recommendation within 90 days after receipt of the complaint, rather than to investigate "promptly," as the law currently provides. If the review panel requires additional time due to extenuating circumstances, it shall so notify the board, indicating the reason and the amount of additional time required to make its recommendation, and transmit a copy of the notice to the Attorney General and the complainant.

· within 60 days upon receipt of notification from a physician of any action taken against the physician's medical license by any other state licensing board or any action affecting the physician's privileges to practice medicine by any out-of-State hospital, health care facility, health maintenance organization or other employer, the BME shall investigate the information received and obtain any additional information that may be necessary in order to make a determination whether to initiate disciplinary action against the physician.

Some in the physician community argued that specifying the representation of three public members and a pediatrician would restrain the work of the Board. The bill can now be considered by the full Senate, at the discretion of the Senate President.

For information on these or any legislative measures, please contact me at BLYNCH@BLYNCHASSOCIATES.COM or 609-392-7553.

Legal Report

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CMS Issues Proposed Rule Outlining How Eligible Parties May Receive Incentive Payments for EHR

On January 13, 2010, the Centers for Medicare & Medicaid Services ("CMS") published its interim final rule ("IFR") to implement the electronic health record ("EHR") incentive programs enacted under the American Recovery and Reinvestment Act of 2009 (the "Act"). Under the Act, eligible providers and hospitals may receive payments for implementing EHR systems. The IFR went into effect on February 12, 2010, with an opportunity for public comment and refinement until March 15, 2010. The Office of the National Coordinator for Health Information Technology also published an IFR on January 13, 2010, relating to the initial set of standards, implementation specifications, and certification criteria for EHR technology.

The IFR issued by CMS outlines proposed provisions of the EHR incentive programs and includes a definition of "meaningful use" of EHR technology. Demonstrating meaningful use is a prerequisite for receiving Medicare incentive payments. Under the IFR, a "meaningful EHR user" is defined as an eligible professional or eligible hospital that, during the specified reporting period, demonstrates meaningful use of certified EHR technology in a form and manner consistent with certain objectives and measures in the IFR. The objectives and measures would include use of certified EHR technology in a manner that improves quality, safety, and efficiency in health care delivery, reduces health care disparities, engages patients and families, improves care coordination, improves population and public health, and ensures adequate privacy and security protections for personal health information.

The definition of "meaningful use" in the IFR contains the minimum standards for eligible professionals and eligible hospitals to participate in the Medicare EHR incentive program. Demonstration of "meaningful use" will be phased in

over three stages. More exact criteria for stages two and three will be developed over time and before their implementation, which is currently anticipated to be 2013 and 2015. In stage one, meaningful use criteria will focus on capturing health information in a coded format, using that information to track key clinical conditions and communicating that information for care coordination purposes, implementing clinical decision support tools to facilitate disease and medication management, and reporting quality measures and public health information.

In stage two, the meaningful use criteria would expand on the stage one criteria to encourage the use of health information technology for continuous quality improvement at the point of care and the exchange of information in the most structured format possible, such as the electronic transmission of orders and test results. In stage three, the goals will be to focus on promoting improvements in quality, safety and efficiency, focusing on decision support for national high priority conditions, patient access to self management tools, access to comprehensive patient data and improving population health.

The stage one criteria will be the meaningful use criteria for all payment years until updated by future rulemaking. CMS will start to pay incentives to eligible hospitals on October 1, 2010, and eligible professionals on January 1, 2011. Eligible professionals may receive up to \$44,000 over a five year period under the Medicare program and Medicaid incentives may reach \$63,750 per eligible professional. Eligible hospitals may receive several million dollars depending on their discharge volume and other criteria. CMS will penalize eligible professionals and eligible hospitals that are not meaningful users of health information technology by 2015 through reduced payments for Medicare services.

Bill Requiring Managed Care Plans to Pay Health Care Claims Based on Assignment of Benefits Passed Into Law

On January 16, 2010, a bill which requires managed care plans to pay health care claims based on assignment of benefits was signed into law by Acting Governor Stephen M. Sweeney (the "Law"). The Law applies to insurance carriers that offer managed care plans with both in-network and out-of-network benefits. As originally introduced, the Law would require that, in instances where a covered insured assigns his or her rights to benefits to an out-of-network provider, the insurance carrier must remit payment for reimbursement directly to the out-of-network provider. However, prior to its passage by the Assembly, the Law was amended to provide that the payment must be in the form of a check payable to the provider or a check payable to the provider and the covered person as joint payees, with a signature line for each of the payees. This amendment undermines to some extent the impact of the Law.

The Law does provide however, that any payment made only to the covered insured, rather than the health care provider or both parties, will be considered unpaid, and unless the payment is remitted to the health care provider within the statutory time frames for payment of claims, the payment will be considered overdue and will be subject to the statutory charge of interest.

The requirements of the Law will become effective on the 365th day next following the enactment date, i.e., January 17, 2011, and will apply to any health benefit plan in which the carrier has reserved the right to change the premium and which is in effect on or after the effective date.