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CMS Authorizes a Streamlined Credentialing and Privileging Process for Telemedicine

By: Monica A. Frois, Esq.

On May 2, 2011, the Centers for Medicare and Medicaid Services (CMS) issued its final rule on the credentialing and privileging of practitioners who provide telemedicine services. The final rule and regulations become effective July 5, 2011. The purpose of the rule is to revise the Conditions of Participation (CoPs) for both hospitals and critical access hospitals (CAH) to provide a less onerous credentialing and privileging process for clinical providers who provide telemedicine services. CMS has defined telemedicine as the “provision of clinical services to patients by practitioners from a distance via electronic communications.” The major change is that the revised CoPs allow hospitals and CAH to rely on a distant-site hospital’s credentialing information without performing an independent internal review.

CMS’ intention through the final rule was to provide the following:

- 1) Enable patients to receive medically necessary interventions in a more timely manner;
- 2) Enhance patient follow-up in the management of chronic disease conditions;
- 3) Provide more flexibility to small hospitals and critical access hospitals in those regions with a limited supply of primary care and specialty providers;
- 4) Create a more cost effective alternative to traditional service delivery approaches; and
- 5) Improve patient outcomes and satisfaction.

This rule changed the Medicare conditions of participation that previously required the governing body of a hospital to make privilege determinations based on the recommendation of the appropriate hospital medical staff committees after the committees had reviewed and analyzed the credentialing information of each practitioner applying for clinical privileges. Similarly, each CAH was required to base privilege decisions on internal review. Under the old rule, these requirements applied whether the services were provided on site at the hospital or through a telecommunications system.

The American Hospital Association advocated for these changes, because so many hospitals contract with non-hospital entities for the provision of telemedicine services. The new rule has been said to ease what many hospitals viewed as a “credentialing burden” for telemedicine services. Under the final rule, hospitals are not prohibited from using the traditional credentialing and privileging process.

The final rule provides that a hospital receiving telemedicine services may rely upon credentialing and privileging information from a “distant-site facility.” A distant-site facility is defined as the location of the provider of the telemedicine services. Certain conditions must be met, and these include a written agreement with the distant-site facility.

The final rule also provides for a form of “proxy credentialing” with Medicare-certified hospitals and other telemedicine entities regardless of whether they are a Medicare-certified hospital.



Steps for Credentialing for Practitioners from Distant-Site Hospitals

- 1) A written telemedicine services agreement;
- 2) The distant-site hospital must be a Medicare participating hospital;
- 3) The distant-site practitioner must be privileged at the distant-site hospital. The privilege status must be confirmed by the distant-site hospital through the production of a current delineation of the practitioner's privileges;
- 4) The distant-site practitioner must hold a license issued or recognized by the state in which the hospital or CAH is providing telemedicine services; and
- 5) The hospital or CAH that credentials and privileges the distant-site practitioner must share the practitioner's performance review information with the distant-site hospital to ensure accountability.

Steps to Credentialing Practitioners from Distant-Site Telemedicine Entities

- 1) A written telemedicine services agreement;
- 2) The distant-site telemedicine entity must have in place credentialing and privileging procedures for accessing the qualifications and furnishing services that meet the standards set forth in the CoPs;
- 3) The distant-site practitioner must have the experience and expertise as represented by the distant-site telemedicine entity;
- 4) The distant-site practitioner must hold a license issued or recognized by the state in which the hospital or CAH is providing telemedicine services; and
- 5) The hospital or CAH that credentials and privileges the distant-site practitioner must share the practitioner's performance review information with the distant-site telemedicine entity to ensure accountability.

Hospitals will also need to update medical staff bylaws and associated policies to include criteria for privileging distant-site practitioners requesting privileges to provide telemedicine services under a written agreement. Hospitals will need to maintain evidence of an internal review of the distant-site practitioner's performance and send the distant-site hospital or telemedicine entity information to use in the periodic appraisal of the distant-site practitioner. At a minimum, the rule requires that the information include the following:

- 1) All adverse events that result from telemedicine services provided; and
- 2) All complaints received about a practitioner.

Hospitals should ensure that in drafting the agreements and policies that they comply with all applicable state and federal confidentiality and privacy laws including the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinic Health Act to make sure that patient information and the confidentiality of physician peer review is maintained.

CMS received numerous comments regarding the legal issues and exposure associated with the more streamlined credentialing approach. CMS commented that "these issues are beyond the scope of this rule, and that any relevant legal issues must be worked out entering into the agreements in accordance with other laws and regulations governing such contracts or agreements."

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Federal Government Asserts Jurisdiction over Healthcare Providers for Purpose of Affirmative Action Compliance

By Cecile Gordon and Alex Glaser

This article details, in question and answer format, recent efforts by the federal government's Office of Contract Compliance Programs (OFCCP) to assert jurisdiction over hospitals and other healthcare providers.

What is the OFCCP?

The OFCCP is a unit within the Department of Labor (DOL) that imposes specified rules and regulations on companies doing business with the federal government. The OFCCP requires employers that contract or subcontract with the federal government to supply goods or non-personal services to abide by certain affirmative action rules in the employment context. Providing insurance is a “non-personal service” under OFCCP regulations. Therefore, any entity that contracts with the federal government to provide insurance services is a government contractor subject to OFCCP jurisdiction. Moreover, any entity that subcontracts with a main contractor covered by the regulations is subject to the same jurisdiction. The OFCCP has used this broad definition of “non-personal services” to assert jurisdiction over hospitals that contract with insurers to provide medical care.

An employer that falls under OFCCP jurisdiction must have an affirmative action plan with regard to hiring minorities, women, disabled individuals, and veterans. Failure to follow the affirmative action rules may result in fines, sanctions, and/or the loss of the government contract.

What kinds of medical service provider contracts fall under OFCCP jurisdiction?

Two recent cases demonstrate the broad jurisdiction that the OFCCP believes can be asserted over healthcare services contracts.

- *OFCCP v. UPMC Braddock*, ARB Case No. 08-048 (May 29, 2009)

In May 2009, the OFCCP successfully asserted jurisdiction over three hospitals that contracted with an HMO to provide medical services to federal government employees. In this case, the hospitals had provider agreements with the HMO, which had a contract to provide medical supplies and services to patients insured by the Federal Employee Health Benefits Program (FEHBP). The DOL Administrative Review Board ruled that the provider agreements were covered subcontracts within the meaning of the OFCCP regulations. Therefore, the hospitals, as federal government subcontractors, had to abide by the OFCCP affirmative action rules. The Board distinguished the HMO arrangement from a traditional insurance reimbursement arrangement, which has historically not been considered a covered arrangement under the OFCCP regulations. This case is currently on appeal to the U.S. District Court for the District of Columbia.

- *OFCCP v. Florida Hospital of Orlando*. ALJ Case No. 2009-OFC-00002 (Oct. 18, 2010)

In October 2010, the OFCCP scored another victory over hospitals when an administrative law judge ruled that Florida Hospital of Orlando was a covered subcontractor under the OFCCP regulations. In this case, the hospital contracted with Humana Military Healthcare Services to join its network and provide healthcare services to military service members insured by the TRICARE program. Humana had a contract with TRICARE to establish provider networks. The judge ruled that the Humana/Florida Hospital arrangement created a subcontract over which the OFCCP had jurisdiction despite Department of Defense regulations that provide that TRICARE is a federal financial assistance program and healthcare providers under network agreements are not subcontractors. This case is on appeal to an Administrative Review Board.

What is OFCCP Directive 293?

Bolstered by the *Braddock* and *Florida Hospital* decisions, the OFCCP issued Directive 293 on December 16, 2010. The Directive outlines the OFCCP’s objectives for asserting jurisdiction over hospitals and other healthcare entities.

The main principles of the directive are as follows:

- Traditional fee-for-service reimbursement arrangements under Medicare Parts A and/or B or Medicaid are “federal financial assistance” and will not be considered covered contracts under the OFCCP’s jurisdiction. However, arrangements under Medicare Parts C (Medicare Advantage) and D (prescription drug coverage) may rise to the level of a federal government contract or subcontract. For example, the directive provides that an organization with a contract to establish a Medicare Advantage PPO will be a covered contract. If the organization subcontracts with others to provide healthcare, prescription drugs, or claims processing, all of the subcontracts will be considered federal contracts as well.

- The OFCCP may have jurisdiction over a healthcare provider receiving Medicare Part A and/or B reimbursement if the provider also holds a separate covered contract (i.e., a Medicare Advantage or Medicare Part D contract).
- The OFCCP will distinguish between traditional reimbursement arrangements with insurance companies and arrangements with other types of health plans and HMOs. Following the reasoning in *Braddock*, a hospital providing services through a managed care company that contracts with a federal contracting agency will probably be considered a subcontractor for OFCCP purposes. The directive points out that traditional insurance reimbursement arrangements do not provide direct healthcare services and therefore are exempt from OFCCP regulation.
- The OFCCP reserves the right to determine whether an arrangement is a covered contract on a case-by-case basis. Notably, the OFCCP will apply broad definitions of the terms “contractor” and “subcontractor” without regard to the use of the same or similar terms in other government regulations.
- A contractor or subcontractor may not defeat OFCCP jurisdiction by including language to the contrary in its contract.
- OFCCP jurisdiction will probably attach to a healthcare provider that provides services to TRICARE or FEHBP beneficiaries.
- Medical device providers and suppliers may be covered under the directive.
- Grants provided by federal healthcare programs will not in and of themselves create covered contracts.

Directive 293 can be found [online](#).

I’m a healthcare provider that may be covered under the directive. What should I do?

- Review the terms of the OFCCP’s directive carefully.
- Carefully review the terms of your provider agreements to determine if they are subject to the directive.
- Determine if HMOs and other entities with which you have contractual arrangements have agreed to provide healthcare services to government employees.
- Track the appeals and developments of the *Braddock* and *Florida Hospital* cases.
- If the directive applies, create or update affirmative action plans to comply with OFCCP regulations.
- Monitor the OFCCP’s developments in Directive 293 and its application.

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