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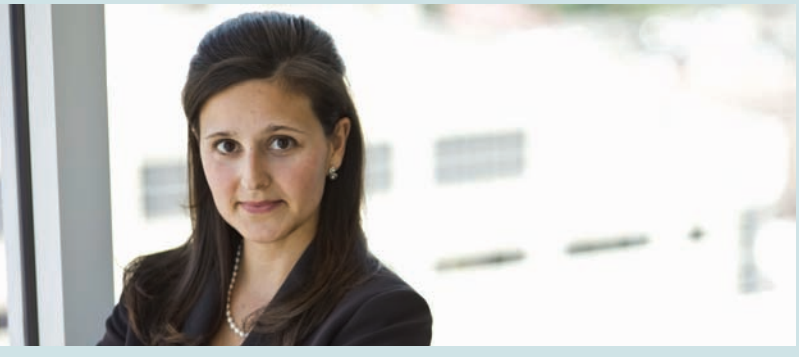
News for North Carolina Hospitals
from the Health Law Attorneys of Poyner Spruill LLP

Value-Based Reimbursement: CMS Ups the Ante for Hospitals with Proposed Rulemaking

By Jessica M. Lewis



Among the many reforms mandated by the Affordable Care Act (ACA), hospitals will be subject to a Hospital Value-Based Purchasing Program (Hospital VBP Program) applicable to Medicare payments for inpatient stays under the Inpatient Prospective Payment System (IPPS). To that end, the Centers for Medicare & Medicaid Services (CMS) has recently issued a proposed rule implementing this program. 76 Fed. Reg. 2454 (January 13, 2011). This rule represents a natural continuum in the line of quality-based health care initiatives from CMS, including the quality reporting programs for hospital inpatient services, hospital outpatient services, physicians and other related health care professionals, home health agencies, and skilled nursing facilities.

To evaluate a hospital's quality of care under the Hospital VBP Program, the ACA requires CMS to use measures from the Hospital Inpatient Quality Reporting Program (Hospital IQR Program). The Hospital IQR Program, a voluntary system through which hospitals report data related to certain quality measures which is in turn reflected on the Hospital Compare website, presently includes 27 process-of-care measures. Among these are acute myocardial infarction, heart failure, pneumonia, and surgical care; 15 claims-based measures related to mortality and readmission rates; three structural measures regarding cardiac surgery, stroke care, and nursing care; and the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. CMS proposes to use measures identified by the Secretary of the Department of Health and Human Services, initially touching on the following conditions/topics:

- Acute myocardial infarction (AMI)
- Heart failure (HF)
- Pneumonia (PN)
- Surgeries (as measured by the Surgical Care Improvement Project (SCIP))
- Health care-associated infections (HAI)
- The HCAHPS survey, a survey posed to discharged patients to gather information regarding critical aspects of their hospital stays

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CMS Ante...
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Based on the above conditions/topics, CMS proposes 17 process-of-care measures and eight survey measures as the initial set of measures against which to evaluate hospitals. Initial clinical process-of-care measures include AMI-related measures such as fibrinolytic therapy received within 30 minutes of hospital arrival, HF-related measures such as evaluation of left ventricular systolic function, and HCA-related measures such as receipt of a prophylactic antibiotic within one hour of surgical incision. The initially selected HCAHPS survey measures include:

- Communication with nurses
- Communication with doctors
- Responsiveness of hospital staff
- Pain management
- Communication about medications
- Cleanliness and quietness of hospital environment
- Discharge information
- Overall rating of hospital

A detailed list of these measures can be found at 76 Fed. Reg. 2462, Table 2. Note that a selected measure will not apply to a hospital that does not provide services "appropriate to" the selected measure.

CMS intends to add new measures to the program after such measures have been included in the Hospital IQR Program and have been listed on Hospital Compare for one year. While CMS's initial focus will be process of care, CMS intends to expand its quality analysis to include outcome measures, efficiency measures, and patients' experience of care measures.

Effective July 1, 2011, CMS proposes to begin evaluating hospitals through these initial measures. As a result of CMS's review of these measures, beginning in fiscal year 2013, hospitals will receive incentive payments for CMS-identified quality care for discharges occurring on or after October 1, 2012 and/or for improvements in quality performance over a previous period (to be determined by CMS). The incentive payments will be funded by a 1% reduction to base operating diagnosis-related group (DRG) payments for each discharge in fiscal year 2013, and up to a 2% reduction by fiscal year 2017. Conversely, hospitals that fail to meet CMS-proposed quality measures or to improve performance will be penalized by receiving a reduction in DRG payments of up to 1%. CMS estimates that no hospital will receive more than a net 1% increase or decrease in payments.

The monetary incentives and penalties associated with quality of care continue to rise for hospitals with the proposed adoption of this rule implementing the Hospital VBP Program. Hospitals face scrutiny under the existing audit landscape from entities such as the recovery audit contractors (RACs), who are incentivized to find quality issues and whose focus, to date, has primarily been on hospitals. The quality measures recently proposed by CMS in the Hospital VBP Program rule focus on many of the same conditions/issues identified under the RAC Program as allegedly preventable – or at least mitigable – culprits in rising health care costs. This proposed rule underscores the need for hospitals to focus on the measurable aspects of delivery of quality care by implementing internal auditing procedures that are thorough, timely, properly focused, and responsive so as to ensure that the most accurate and complete data exist, are properly maintained, and are made available to the appropriate entities in a timely manner.

CMS is accepting comments on the proposed rule through March 11, 2011.

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Summary of North Carolina Senate Bill 33's Medical Malpractice Reform

By Kim Licata

Medical malpractice reform entered the North Carolina General Assembly through Senators Apodaca, Brown and Rucho's sponsorship of Senate Bill 33: "Medical Liability Reforms" (the "Bill"). These malpractice reform measures would apply to nursing homes, hospitals, physicians, and other persons defined as "health care providers" under N.C. Gen. Stat. § 90-21.11. Medical malpractice actions are defined by statute to include lawsuits based on personal injury or death arising out of the furnishing of or failure to furnish professional services by a health care provider. The Bill proposes to reform medical malpractice actions in the following ways:

- **Limiting the Liability of Emergency Services Providers:** The Bill makes it harder for a plaintiff to recover for damages resulting from emergency care by raising the level of misconduct and intent required of a health care provider of emergency services before malpractice is found. The Bill requires a plaintiff to prove more likely than not that a health care provider failed to meet the standard of care (as judged by providers of the same profession with similar training and experience in the same or similar communities) and that this failure amounted to gross negligence, wanton conduct, or intentional wrongdoing before a plaintiff can win damages. Currently, a plaintiff must only show that more likely than not a health care provider did not meet the standards of practice among members of the same health care profession with similar training and experience in the same or similar communities. "Emergency services" is defined by statute to mean that medical care needed to screen for or treat an emergency medical condition, including services in an emergency department.

- **$250,000 Cap on Noneconomic Damages:** A plaintiff's recovery for noneconomic damages is capped at $250,000. Noneconomic damages include pain, suffering, emotional distress, loss of consortium, inconvenience, physical impairment, disfigurement, or other similar damages. A court will reduce any award of more than $250,000 noneconomic damages to the capped level.

- **Periodic Payment versus Lump Sum Awards for Future Economic Damages over $75,000:** Today, medical malpractice awards, even for future expenses related to medical care or lost future earnings, are due and payable in a lump sum amount. The Bill changes current practice by permitting either party in a medical malpractice lawsuit to ask the judge to permit the payment of future economic damages in whole or in part by regular periodic payments versus a lump sum amount. This will require judgments to specify what amount is awarded for future economic damages as opposed to other types of damages for which a plaintiff sued. The Bill requires that these periodic payments be made by a trust fund or annuity approved by the court and that the judgment specify the person to receive the payments and the amount of each payment, such that these payments will fully satisfy the defendant's judgment as to future economic damages. Under this proposal, the general rule would be that the periodic payments not yet paid or due end with the death of the plaintiff. The Bill permits the court that entered the malpractice award to modify the judgment to provide that upon the plaintiff's death, the periodic payments are to continue and are to be paid to persons surviving the plaintiff.

- **New Form for Medical Malpractice Verdicts and Awards:** The Bill requires any malpractice award to specify the amount for (a) noneconomic damages (pain and suffering, emotional distress, and other damages noted above), (b) present economic damages (medical care, lost wages, or other damages to the plaintiff that have occurred up to the date of malpractice award), and (c) future economic damages (medical care, lost wages, and other damages to the plaintiff that will occur in the future).

- **Appeal Bonds:** The Bill sets a new bond requirement for health care providers appealing a medical malpractice award at the lesser of the amount of the judgment or the amount of the provider's medical malpractice insurance coverage.

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ICE Targets Large Employers: How to Be Prepared

By Jennifer Parser

On January 20, 2011, John Morton, chief of U.S. Immigration and Customs Enforcement (ICE), announced the creation of an Employment Compliance Inspection Center (ECIC), and the news should put all large employers on notice. The ECIC will be staffed for the exclusive purpose of examining the hundreds or even thousands of I-9s of larger companies targeted for an ICE audit.

ICE has reported that last fiscal year it conducted 2,740 audits and recorded $7 million in fines, considerably more than the $1 million levied in 2009 and the $700,000 levied in 2008. For the most part, smaller employers were targeted. The new ECIC has been created to support regional immigration offices that may have avoided auditing large employers because of the logistics of conducting an audit. "We wouldn't be limited by the size of a company," Morton said. Termed a "silent raid," an ICE audit with the enhanced ability to handle a large volume of I-9s implements a promise in 2009 by the Obama administration to move away from the Bush administration's practice of conducting surprise raids that resulted in massive worker arrests and eventual deportations. The ICE focus is now on finding the employers who employ undocumented workers instead of targeting the undocumented workers themselves.

Corrections to I-9s

Late last year, ICE provided some insight into how it will treat deficient I-9s. So-called good faith violations are viewed dimly if corrections are made after ICE sends a "Notice of Inspection" - the first step in an audit. ICE indicated that only technical violations should be corrected after a Notice of Inspection. Armed with this knowledge, employers need to proactively perform internal audits on a regular basis and make corrections before receiving a Notice of Inspection.

Document All I-9 Corrections Carefully

ICE will examine whether the employers' actions in correcting any defective I-9s are reasonable by examining what happened, when it happened, and why it happened through a contemporaneous record. Therefore, corrections should be conspicuously corrected in a different color ink with date and name of person correcting, as well as an explanatory note for the correction, either in the margin or, if using an electronic I-9 system, through recorded notations. An electronic I-9 provider must have adequate safeguards to ensure that the I-9 is complete and updated if needed. The $1 million plus Abercrombie & Fitch settlement for I-9 violations, albeit made in good faith, was the result of Abercrombie & Fitch designing its own electronic I-9 system that turned out to be defective rather than choosing a well-designed system by an outside provider.

Section 1 Must Be Corrected by the Employee

ICE has also indicated that it is uncomfortable with an employer making changes to Section 1 of the I-9, as the potential for fraud exists. It is prudent to allow the employee to make any corrections to Section 1 of the I-9.

ICE Auditors' Instructions

If an employer is audited by ICE, it should get any follow-up instructions from the auditor in writing, as ICE has confirmed that its auditors do not operate in a standardized fashion. With the creation of the ECIC, it is to be hoped that review of larger employers' I-9s will receive the same standard of review, but for the time being, it is best to carefully document in writing any instructions received from an auditor as proof that his or her instructions were being followed, in the event of any ICE follow-up or subsequent audit.

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You Can't Say That! The Dangers of Overbroad Social Media Policies

By Kim Licata

Social media use is exploding, and the prevailing attitude of users seems to be "post now, think later." In this climate, employers undoubtedly should develop and implement policies to protect their reputation and brand in the marketplace. But, like their employees posting online, if employers go too far in their statements, they may face unforeseen consequences.

In December of last year, our firm alerted you to one such unforeseen consequence: an unfair labor practice charge from the National Labor Relations Board (NLRB). This alert provides an update on the status of that case and identifies a new case that may yield even more interesting precedent.

Earlier-Reported NLRB Case Settles

In our earlier alert, we reported that American Medical Response (AMR) allegedly fired an employee for her disparaging Facebook posts about a supervisor, to which several of her Facebook "friends" who were also co-workers added their comments. AMR's decision to fire the employee was based on a violation of its company handbook, which reportedly contained a policy on blogging and Internet posting that prohibited employees from making "disparaging, discriminatory or defamatory comments when discussing the company or the employee's superiors, co-workers and/or competitors." The NLRB filed a complaint against AMR, asserting that AMR's policies and disciplinary actions were unfair labor practices, based on its theory that employees have a protected right to discuss their wages, hours, and working conditions while not at work. On the eve of a scheduled administrative hearing to address the NLRB charges, a National Labor Relations Authority regional director approved an undisclosed settlement pursuant to which AMR reportedly will revise its policies. AMR previously reached a settlement with the employee involved.

New NLRB Case Filed

If, like us, you were looking to this case to provide some judicial guidance on how labor laws will apply in social media cases, don't despair. The NLRB has already filed another unfair labor practice charge against Student Transportation of America (NLRB Reg. 34, No. 34-CA-12906, union charge filed 2/4/11) for maintaining and enforcing policies in its company handbook that infringe on employees' rights, including its broad social media policy that prohibited "the use of electronic communication and/or social media in a manner that may target, offend, disparage, or harm customers, passengers, or employees; or in a manner that violates any other company policy." Unlike the AMR case, the complaint against Student Transportation of America contains no allegation that an employer improperly disciplined any specific employee. As such, the case presents a more limited question: Are employers effectively barred from restricting certain employee speech in social media, even when no disciplinary measures are taken to enforce the policy?

What Should You Do?

While social media policies often include broad provisions to limit negative, offensive, or disparaging statements or images relating to employment, employers should take the time now to review their policies for overbroad statements regarding employee speech. This review should include (1) the company handbook; (2) any policies on confidentiality or nondisclosure, workplace ethics, company loyalty, computer or information systems use, or social media use; and (3) any other company statements that bear on employee conduct and that could run afoul of the NLRB's current enforcement approach. Employers should bear in mind that having appropriate policies and offering employee training on social media use can increase the likelihood that employee time spent on social media will be a positive experience rather than a source of liability. Employers can also consider other tips on social media pitfalls that we provided in an earlier alert, http://www.poynerspruill.com/publications/Pages/ToFriendorNottoFriend.aspx.

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Health Information Exchanges: Ready or Not Here They Come!

By Kim Licata

p.s. **Poyner Spruill** publishes this newsletter to provide general information about significant legal developments. Because the facts in each situation may vary, the legal precedents noted herein may not be applicable to individual circumstances.

Health information exchanges (HIEs) are being created by states, professional associations, and many others even as you read this very article. Marketplace incentives and health care reform are encouraging the creation of HIEs, including those in North Carolina, this past year. What does this all mean, and how can a provider get ready?

Providers should familiarize themselves with the legal and operational issues associated with HIEs. Participation in a HIE raises issues of information privacy and security, patient access and rights, professional liability, and data property rights. Likewise, incentives for providers adopting electronic medical records also raise tax and fraud and abuse considerations. In the near future, a HIE, as a keeper of all electronic health information, may become the most powerful player in health care delivery and you want to know what you are or will be dealing with now as opposed to later. Providers, either by themselves or through a professional association, need to take on an active role in forming HIEs to be part of the decision-making process and the policy setting. In brief, providers should consider how they will manage risks and obligations associated with HIE, including the following:

Privacy and Security of Health Information. Providers participating in HIEs must consider how this participation affects the confidentiality of patient information, the medical record (from documentation to designated record sets), as well as the privacy and security of patient information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH). Participants in HIEs will need to be able to navigate federal and state law and regulations on consent, confidentiality by type of provider or type of health information, and restrictions on the use and security of such information. Getting information into and out of a HIE are critical threshold issues.

Patient Access and Patient Rights. Providers will need to have systems in place to permit patient access and to protect patient rights when participating in a HIE. As records become increasingly electronic, providers and patients will encounter new software and media hurdles in this process, as well as cost and implementation issues.

Provider Liability. HIEs introduce significant new liability for providers. First, HIEs are vulnerable to privacy and security threats like health care providers, but HIEs represent an additional access point to a provider's information and opportunity for a potential data breach of the providers by others not under the provider's control. HIEs will likely set specific breach notification timeframes (potentially as short as 1 hour), liability for intrusions "through" a provider's link to the HIE (potentially unlimited), and other requirements either through contract or policies of which providers need to be informed and on alert. The importance of a provider's privacy and security policies and procedures cannot be overstated because missteps can mean significant breach notification expenses, loss of business revenue, civil liability, and even in extreme cases, criminal liability. Second, HIEs represent an additional exposure for professional liability if information is inaccurate, incomplete, or not timely entered. Third, mistakenly transmitting health information of patients who have opted out of the HIE is yet another potential grounds for provider liability. It is a delicate balance between a patient's right to control his or her health information and a health care provider's need to have complete health information to provide quality health care services. These represent new twists on provider liability.

Property Rights in the Information. Health information is an asset for providers, patients, marketers, and a host of others. Thus, who owns the data in the HIE (and what rights the owner has) is a key issue to resolve.

Fraud and Abuse and Tax Issues. To the extent that providers are considering donating technology or electronic medical records systems, these donations implicate fraud and abuse laws and the tax exempt status of a provider. While donating technology as part of a provider's development of a health information infrastructure with affiliated or associated practitioners may make good business sense, there are a number of legal restrictions to consider before such donations begin.

Summary. Providers should assess how their current policies and procedures, existing contractual obligations, and insurance coverage may be implicated (and need to be changed or updated) by participation in a HIE. Engage legal advisors in this review process, as well as key employees from information technology, privacy and security, and other key departments. Doing your homework now means less heartache later when implementation and participation will consume much of the applicable information technology budget. The ultimate value in a HIE is the exchange of accurate information in a timely manner to provide quality care, but achieving this requires advance work and consideration of these many issues to reduce the associated risks of participation.