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SHORTS ON LONG TERM CARE

Poyner Spruill LLP's International Award-Winning Newsletter for the North Carolina LTC Community

Nursing Facility Survey Trends:
Directed Plans of Correction, Privacy Violations and FTag 520 Quality Assurance Committee Citations

by Ken Burgess

Directed Plans of Correction, or DPOCs, have long been part of the arsenal of enforcement sanctions available to the Centers for Medicare & Medicaid Services for survey deficiencies, just like civil money penalties (CMPs); denial of payment for new admissions and termination. However, over the years, we've rarely seen CMS or the Division of Health Service Regulation (DHSR) use them, but that appears to be changing.

In several recent surveys we've reviewed or appealed, CMS has imposed a DPOC as a remedy. Every SNF provider knows what a POC is—four elements you must address to explain 1) how you corrected an alleged deficiency for the affected resident(s); 2) how you identified other residents who may be at risk from the same deficient practice; 3) systemic changes you implemented to avoid harm or the risk of harm to those residents; and 4) what system of internal monitoring you've developed to ensure that those "fixes" actually work and stick. In a DPOC, the CMS does all that for you, by telling you how to fix the problem, prevent its recurrence and monitor your improvements. In the ones we've seen so far, the DPOCs come directly from CMS in the facility's Notice of Imposition (along with other remedies such as civil money penalties), not from DHSR.

In the recent DPOCs we've seen, both in North Carolina and other Region IV states, CMS goes way beyond the normal four elements of a normal POC. In at least two cases we've seen or heard about, CMS (not DHSR, mind you) has required a facility to develop a "root cause analysis" not just of the deficiencies cited during the survey, but also of prior deficiencies cited at other facilities operated by the same owner or management company. In at least one such case, the facility's deficiency history wasn't egregious. Said differently, this wasn't a "poor-performing facility" by any definition CMS has ever developed and released. In another, CMS required the facility operator to retain an outside expert to assist with analyzing the suspected cause of a deficiency and to provide specified training.

DPOCs and HIPAA. Our latest experience with DPOCs involved an alleged HIPAA violation in which a resident's protected health information (lab results) was allegedly texted to a physician, specifically at the doctor's request. No unauthorized third party ever saw the information, and no allegation to that effect was included in the survey report. For this, the facility received an "E"-level deficiency (no actual harm but potential for more than minimal harm) at FTag 164, a privacy rule that makes no mention at all of HIPAA or state or federal privacy laws. Nonetheless, CMS imposed a 10-point directed plan of correction that included:

- The hiring of an outside independent contractor, who had to be preapproved by CMS and not related to the facility's owners, operations or management, to train staff, the governing body and all primary care physicians who provided care to any resident during an "on-site, in-person, face-to-face" training session;
- Revised HIPAA policies and procedures, including training on identity theft, which was not an issue in the cited deficiency;
- Designation of a facility HIPAA compliance officer;
- In-service training for all staff;
- A letter to all residents and families informing them of the alleged HIPAA violation and steps being taken to remedy it and prevent its recurrence, among multiple other steps the facility was required to take.

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COBRA Meets ACA – Time to Update COBRA Notices *by Kelsey Mayo*

The Affordable Care Act created a new option to obtain health insurance for employees who are losing job-based coverage—the Health Insurance Marketplace (commonly referred to as the Exchange). Because this new coverage option might be relevant to an employee who is deciding whether to take COBRA coverage, the Department of Labor (DOL) issued new model COBRA notices that include information about the Exchange. These model notices cover both the initial COBRA notice due upon commencement of employer coverage and the COBRA election notice that is due when certain qualifying events occur. The models are available on the DOL website.

Although employers are not required to use the new model notices, the models will be considered good faith compliance with COBRA notice content requirements. Employers should either begin using the new model notices, or update current COBRA notices, as appropriate, to reflect the new content and language sanctioned by the DOL.

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NLRB Reconsiders Employee Use of E-mail Systems *By Danielle Wilson*

Under current law, employees have no statutory right to use their employer-provided email for Section 7 purposes. However, on April 30, 2014, the National Labor Relations Board (NLRB or the Board) released a Notice and Invitation to File Briefs asking advocates to submit their position as to whether the Board should overturn its decision in *Register Guard*, 351 NLRB 1110 (2007) which held that employees do not have the statutory right to use their employer's email system for non-business purposes, including Section 7 activity.

The NLRB released the invitation in response to an Administrative Law Judge's decision in *Purple Communications, Inc.*, where the judge dismissed an allegation that the employer violated Section 8(a)(1) of the National Labor Relations Act (NLRA) by maintaining policy prohibiting personal use of its electronic equipment and systems. In response, the General Counsel of the NLRB and the AFL-CIO asked the Board to overrule its decision in *Register Guard* and adopt a rule that employees who are permitted to use their employer's email for work purposes also have the right to use it for Section 7 activity, subject only to the need to maintain production and discipline.

The Board has given interested parties the opportunity to weigh in on several questions, including: (1) should the Board reconsider its conclusion that employees do not have a statutory right to use their employer's email system (or other electronic communications systems) for Section 7 purposes and (2) if the Board overrules its decision, what standard(s) of employee access to the employer's electronic communications systems should be established?

If the Board's decision in *Register Guard* is overruled, employees would be allowed to use their employer-provided email accounts and electronic systems to engage in a wide range of Section 7 activities including, but not limited to: (1) organizing a strike or picketing to improve working conditions, (2) forming or attempting to form a union among the employees of a company, and (3) joining a union whether the union is recognized by the employer or not.

Overruling the decision will also present the question of whether employers who provide email access to employees for work purposes would be obligated to provide access to company email during non-work time. Interested parties have until June 16, 2014 to file briefs with the Board in Washington, D.C.

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Nursing Facility Survey... continued from page 1

The facility was given 15 days to implement this expansive set of "remedies" before a discretionary denial of payment for new admissions would take effect. The facility was also required to address how it planned to handle "the loss of PHI" through employees who no longer worked at the facility." Neither of these elements was included in CMS's DPOC, nor was there ever any allegation in the CMS 2567 that any PHI was "lost," only that it was communicated in isolated instances between a facility nurse and an attending physician, both of whom were authorized to received such information under HIPAA.

So, what's up with these DPOCs? We're not really sure. We've heard some rumors that CMS Region IV is "experimenting" with DPOCs. They certainly have the right to use them under applicable statutes and regulations governing the survey process. But, why now, all of a sudden? And why now in facilities that haven't demonstrated a pattern of being unable to develop and successfully implement their own effective POCs? And why is CMS using them, at least in many cases, for isolated deficiencies at low scope and severity levels in facilities with relatively good survey histories?

Honestly, we haven't seen enough of these to call it a strong trend. But we've seen enough to recognize that this is something different. We've also heard reports from other providers and long term care attorneys in Region IV of the same sorts of DPOCs. And we've brought this issue to the attention of leaders at the American Health Care Association along with other providers and counsel in Region IV. We also know from our contacts in other Region IV states and across the country that CMS is focusing on HIPAA and privacy issues. Stay tuned; there's definitely more to come on both of these issues.

Ken Burgess and Elizabeth Johnson of Poyner Spruill will be speaking at the NCHCFA Summer Symposium and, among other topics, will address HIPAA risks and risk management tips and provide more information on DPOCs and F520 deficiency avoidance and correction.

F520 Quality assurance committee deficiencies. Finally, on the survey side, here's a head's up—we are starting to see frequent deficiency citations by the Division of Health Service Regulation under FTag 520 governing Quality Assurance Committees. Our recent experience reflects that when DHSR cites a facility for a deficiency at a scope and severity level of "G" or higher, the facility may also receive a corresponding deficiency at the same scope and severity level as the underlying deficiency if the facility did not self-identify the issue and take it to the QA Committee and then have a robust and thorough treatment of the issue by the QA Committee. We've rarely seen F520 tags in Region IV surveys or in North Carolina until recently, but we're starting to see them now. We also understand from conversations with DHSR personnel that F520 tags can also result from repeat deficiencies that indicate ongoing systems issues or uncorrected problems.

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Hospitals File Lawsuit Over Medicare ALJ Hearings Delays

by Chris Brewer

Over 460,000 appeals requesting hearings before an administrative law judge (ALJ) were pending in the Office of Medicare Hearings and Appeals (OMHA) at the end of 2013, with 15,000 new appeals being submitted each week. At the beginning of 2014, OMHA suspended any further assignments of appeal requests by providers for a period of up to 28 months. The suspension applies to cases received by OMHA after July 15, 2013. The tremendous increase in appeals is directly related to the expanded number of Medicare contractors reviewing claims and the expanded volume of claims reviews.

The moratorium by OMHA prompted the American Hospital Association (AHA) to sue the U.S. Department of Health and Human Services (HHS) on May 22, 2014, to force the secretary of HHS to meet deadlines required by statute for reviewing denials of Medicare claims. In its lawsuit, AHA asserts that providers may wait up to five years to complete four levels of administrative appeals. Federal regulations require the ALJ hearing appeals to be completed within 90 days following the date the request is received by OMHA. If this timetable is not met, the only remedy available is escalation to the Departmental Appeals Board (DAB) where similar delays are common. If the DAB does not decide the appeal within 180 days, escalation is allowed to the federal district court. These remedies are of little practical value to providers.

The delays have hurt providers in many ways. ALJ reviews have consistently led to high rates of reversals of claim denials. In addition, Medicare providers are impacted by the recoupment of alleged overpayments during the expected 30 months they must wait for an appeal to be assigned and heard by an ALJ.

HHS and OMHA have taken steps to address the problem. Provider reviews by recovery auditors were suspended at the end of February 2014. When the RA audit program resumes with new contractors, new guidelines will be in place that are designed to reduce the number of claims reviewed and to facilitate resolution of audit findings at the contractor level. It is hoped this will result in the filing of fewer administrative appeals. Initiatives by OMHA to assist providers impacted by the delays are described on its website (http://www.hhs.gov/omha), including "best practice" guideline tips for providers filing hearing requests.

Notwithstanding these measures, the moratorium on assigning cases for hearing remains in place and the backlog continues to grow. As AHA alleges in its lawsuit "OMHA has admitted that it is not meeting statutory deadlines and will not be able to do so any time the near future." ■

Medicare Part C Update: Co-Insurance Payments For Dual Eligible Residents

by Chris Brewer

Prior to the implementation of NC Tracks, the North Carolina Medicaid program would pay co-insurance for correctly filed claims for dual eligible residents (Medicare and Medicaid) who were covered primarily by Medicare Part C plans. This was consistent with Medicaid policies and guidelines set forth in the May 2013 Medicaid bulletin. On or after July 1, 2013, when NC Tracks began processing Medicaid claims and payments, NC Tracks instead began applying the same policy used for "straight" Medicare Part A crossover claims. Under this current reimbursement policy, NC Tracks does not allow co-insurance to be paid unless the daily rate billed on the Medicare claim is less than the facility's Medicaid rate. As a practical matter, this results in almost no co-insurance payments to providers by Medicaid for these claims.

During 2011, Medicaid audit contractor Health Management Systems (HMS) conducted post-payment reviews of North Carolina long term care facilities for Medicaid payments received from 2005 through 2010. In its audit findings, HMS identified Part C co-payments as overpayments received by facilities. Subsequently, the Medicaid program asked HMS to hold the recovery of alleged overpayments in abeyance until Medicaid could conduct an evaluation of the policy. To date, there has been no further action regarding that aspect of the HMS audits.

Because of the audit findings and continued uncertainty regarding past and future Medicaid policy, many facilities have held these payments and billed receivables in reserve accounts pending policy clarification by the Medicaid program. Providers and advocates on their behalf have requested that the Division of Medical Assistance review these issues and resolve them favorably to providers by restating and reinstituting the policy allowing Medicaid to pay co-insurance applicable to Part C claims.

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From the Marketing Department: Firm Honored by Chambers USA® in Six Practice Areas in 2014

Chambers USA: America's Leading Lawyers for Business has ranked six practice areas and 11 Poyner Spruill attorneys as leaders in their respective fields. The firm received rankings, that identify the firm as a leader in North Carolina for outstanding work in health law (Band 2), banking (Band 2), bankruptcy (Band 2), environment (Band 3), general commercial litigation (Band 4), and real estate (Band 3). One comment from a source that was contacted about the firm's attorneys and health law practice area was "The team is business-friendly, easy to work with and offers excellent value."

We are also thrilled that three of our health law attorneys were recognized as well—Ken Burgess, Wilson Hayman and Steve Shaber (all Band 2). Also recognized were Brian Corbett (Up & Coming, banking), Glenn Dunn (Band 2 environmental), Susie Gibbons (Band 3, employment), Brad Herring (Band 4, banking), Keith Johnson and Rick Kane (Band 4, environmental), Dave Krosner (Band 4, corp./M&A), and Lisa Sumner (Band 2, bankruptcy). Chambers USA was launched in 2003 as a means of ranking attorneys and practice groups in tiers that serve as an annual comparison with other firms across the state. Interviews with thousands of peers and clients are conducted across the country each year to compile the rankings.

Advance Directives Update:
North Carolina's MOST Form Gets a Makeover

by Ken Burgess

North Carolina's Medical Order For Scope of Treatment, or "MOST" form is currently undergoing some changes. Don't panic if you're thinking "We just figured out how to use this thing." Most of the changes are minor, and one that long term care providers have asked for and will like is deletion of the one-year automatic renewal requirement contained in the original MOST form approved by the Department of Health and Human Services. Under the original form, the MOST had to be renewed at least annually or it expired, even if the resident had experienced no change in condition and no other "required review" criteria had been triggered. One of the proposed revisions would eliminate this requirement and would limit the required renewal of the MOST form to only events that would "require" a review and renewal of or modification to the form—a resident's change of condition or a change in the expressed care choices of a resident.

The revised MOST form is working its way through the regulatory approval process. We'll keep our readers posted on the status of these changes and let you know when they are finalized. In the interim, the MOST form as it was originally crafted remains in effect, including the requirement that it be renewed annually to remain effective. ■

More on End of Life: NCHCFA Presented All-Day Training on End-of-Life Issues and Advance Directives

by Ken Burgess

Back by popular demand, the NCHCFA presented a day-long training and refresher course on end-of-life issues and advance directives at the Embassy Suites in Greensboro on July 15, 2014. Speakers included Ken Burgess from Poyner Spruill; Cindy DePorter from the Division of Health Service Regulation, and Deborah Love and Dee Leahman from the Novant organization. The program focused on North Carolina and federal law governing advance directives and residents' rights to have their end-of-life choices honored in long term care facilities. They also examine regulatory challenges for long term care providers, including the specific expectations of the Division of Health Service Regulation and the Centers for Medicare & Medicaid Services when conducting or reviewing surveys of end-of-life issues. They discussed real-life, recent surveys involving end-of-life deficiency citations and offered tips for compliance. Finally, they examined ethical issues implicated by end-of-life issues and shared methods for having effective conversations with residents and families about end-of-life issues. If you would like a copy of Ken's presentation, please contact Jackie Spivey in our marketing department at jspivey@poyners.com. ■

Business Is Booming in North Carolina:
Options for Long Term Care Growth

by Todd Hemphill

Currently, North Carolina's State Medical Facilities Plan does not identify a need for many new additional nursing home or adult care home beds. The 2014 SMFP identifies no need for nursing home beds, and for only 30 assisted living beds each in Jones and Pamlico Counties. At the State Health Coordinating Council's recent meeting, where it's drafting the 2015 SMFP, the SHCC identified no need for nursing home beds and a need for 20 adult care home beds in Jones County, 10 adult care home beds in Washington County, and 330 adult care home beds in Brunswick County. Otherwise, there are no new long term care beds identified in North Carolina in the next 18 months.

Many nursing home and assisted living providers may believe that developing new beds under the SHCC need-determination methodology provides the only opportunity for growth. However, there are several other options. The CON law permits the acquisition of an existing licensed health service facility without filing a new CON application. Even if a facility is closed, it can still be acquired, as long as the beds are still licensed.

In order to obtain the exemption, the purchaser must send a letter to the CON section advising of its intent to enter into a purchase agreement with the existing facility owner. While these letters typically do not require a CON application, they do require the assistance of counsel to ensure compliance with the law. Negotiation and preparation of the asset transfer documents also typically require consultation with an attorney.

Further, if the purchaser wishes to relocate the beds to a new site, that can be achieved through filing a CON application to relocate the beds. Nursing home and adult care home beds may be relocated within the same county through the CON process regardless of the SMFP need-determination. In addition, a provider may file a CON application to relocate beds to a contiguous county, as long as the proposal would not result in a deficit of licensed beds in the county that would be losing the beds or a surplus of beds in the county gaining the beds, as reflected in the SMFP.

In addition, many hospitals have been getting out of the nursing home business in recent years, transferring their beds to existing nursing home providers in their counties. Regulatory approval for this type of transfer can be obtained through a combination of an exemption determination and a CON application. However, this process is complicated, and advice of counsel is particularly recommended if you are exploring this option.

North Carolina is now the 10th largest state in the U.S. and one of the fastest-growing states in the over-65 population category. Despite the absence of "new" beds in the annual SMFP, the state's nursing facility and assisted living industries are expanding, merging, moving and reconfiguring using all these devices. In short, business is booming.

Please feel free to contact our health law team if you are considering expansion, merger, relocation, or selling a long term care company or facility. We have a great deal of experience in this area and are happy to help.

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Health Care Law Firm Bode Hemphill Joins Poyner Spruill

On June 1, 2014, the boutique health care law firm Bode Hemphill, LLP joined Poyner Spruill, bringing our health law team to 14 members.

Ken Burgess, health law practice group leader, said, "We are extremely pleased to have Todd Hemphill, Matt Fisher, David Broyles, as well as their assistant, Janet Plummer join our law firm. Todd and his team have ably served their clients and are recognized as leaders in their field. Merging their significant skills and talents with the health law professionals of Poyner Spruill will enable us together to expand the array of legal services available to our health care clients."

S. Todd Hemphill joined our team as a Partner. He received his undergraduate degree from Dartmouth College and his JD and MBA degrees from the UNC. Todd has been practicing law in Raleigh since 1982. Since joining Bode Hemphill in 1986, his practice has been focused on health law, including health care strategic planning issues, assisting clients in developing health care development strategies under the Certificate of Need law, negotiating health care transactions, and litigating Certificate of Need awards and denials. Todd is a member of the N.C. Bar Association's Health Law Council, and a board member of PineCone, the Piedmont Council of Traditional Music. Hemphill said, "I have worked with the health law attorneys at Poyner Spruill for many years and am excited that we will be joining such an accomplished group of attorneys. The time was also right to be able to broaden our services to existing clients, and Poyner Spruill is the perfect fit." He may be reached at 919.783.2958 or themphill@poynerspruill.com.

Matthew A. Fisher also joined the team as a Partner. He received his undergraduate degree from the University of Tennessee and his JD degree from UNC. For the past eight years, he has been with Bode Hemphill, litigating Certificate of Need cases and other health care matters, including appeals challenging certification and licensure survey decisions and penalties and issues pertaining to DMA provider payment denial. Prior to joining Bode Hemphill, he defended and litigated commercial, business, medical malpractice, insurance coverage, and general liability tort cases at a large North Carolina insurance defense firm. Matt is a member of the board of directors of the N.C. Society of Health Care Attorneys. He may be reached at 919.783.2924 or mfisher@poynerspruill.com

David R. Broyles joined us as an Associate. He received his undergraduate degree from ECU and his JD degree from Campbell University. His practice centers on advising health care clients on state and federal regulatory compliance, operational and strategic planning issues, and a multitude of revenue issues, including third-party insurance payers, commercial managed care payments, Medicare, and Medicaid. David also represents health care providers in litigation related to Certificate of Need awards and denials, Medicaid reimbursement, and health care facility licensure and certification. He is Secretary/Treasurer and a member of the board of directors of the N.C. Society of Health Care Attorneys and a board member of the NC Museum of History Young Associates. He may be reached at 919.783.2923 or dbroyles@poynerspruill.com.

Once Todd, Matt, David, and Janet (legal assistant to Todd, Matt and David) get settled into their new digs in Downtown Raleigh, we plan on visiting as many clients and friends as time will allow in order to introduce them to you personally. They will also be with us at most of the trade shows this year—stop by our exhibit and say hello!