Making a Difference

Baker Donelson Long Term Care Newsletter

BAKER DONELSON
BEARMAN, CALDWELL & BERKOWITZ, PC

Volume 2011, Issue 1

Spotlight on Alabama

Baker Donelson is proud to welcome Dennis Nabors and David Belser in our new Montgomery, Alabama office.

Dennis Nabors, shareholder in the Montgomery office, focuses his practice in health care law and related public policy issues. Mr. Nabors is well versed in Alabama's political arena as the former Chief of Staff to Governor Guy Hunt, the former Assistant Attorney General for the State of Alabama White Collar Crime and Civil Rights, the former City Attorney for Montgomery and the former Executive Vice President and Chief Lobbyist for the Alabama Hospital Association.

Dennis Nabors

David E. Belser

Mr. Nabors helps health care clients such as hospital systems, long term care companies, home health agencies, hospice agencies, Medicaid billing agencies and physician groups navigate through the many government health care agencies and regulations to achieve their business goals. Because he regularly works with local and national government health care agencies, Mr. Nabors has a great understanding of and strong relationships with the local and national health care payors, the Alabama Certificate of Need Review Board, the Alabama State Health Planning and Development Agency, the Alabama Department of Mental Health, the Alabama Department of Public Health and the Alabama Board of Nursing.

Mr. Nabors represented the largest U.S. comprehensive home health care provider and one of the largest providers of outpatient hospice services in numerous matters concerning dramatic new changes in legislation affecting the industry.

David E. Belser, of counsel in the Firm's Montgomery office, concentrates his practice in health care regulatory law. Mr. Belser has extensive experience assisting hospitals, ambulatory surgery centers, long term care facilities, substance abuse facilities, home health agencies and hospice agencies in navigating the complex regulations governing the health care industry in Alabama. Mr. Belser assisted the Alabama State Health Planning and Development Agency and the Statewide Health Coordinating Council in drafting and implementing the new health care regulations governing the regulation of hospice agencies in Alabama.

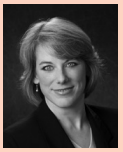
Our Montgomery office is located at 614 South Hull Street, Montgomery, Alabama 36104. To reach either attorney, call 334.262.2000.

In This Issue:

In the Trenches

Long Term Care Symposium: Baker Donelson hosted its first Long Term Care Symposium in Nashville last fall. The event brought together 50 thought leaders representing 25 long term care companies from seven states to learn about how to deal with the greatest challenges in the industry from more than 30 Baker Donelson attorneys.

CMS Victory: Heidi Hoffecker and Donna Thiel won an absolute victory against CMS in a case where CMS had significantly delayed Medicare certification for a skilled nursing facility. As a result of the appeal filed by Ms. Hoffecker and Ms. Thiel, CMS agreed to move the certification date back nine months, which was the date the skilled nursing facility met all the Conditions of Participation.



Hoffecker

Thiel

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Good Cause Payment Suspension

Heidi Hoffecker, 423.209.4161, hhoffecker@bakerdonelson.com

Centers for Medicare and Medicaid Services (CMS) recently issued guidance on when a state can continue to make payments to an individual or entity participating in Medicaid despite a pending investigation of a credible allegation of fraud.

The Affordable Care Act[1] earlier amended the Medicaid program integrity provisions to prohibit Federal Financial Participation (FFP) where an individual or entity was under investigation for fraud, unless the state determined there was good cause not to suspend such payments.[2]

In February 2011, CMS published the final rule, which became effective March 25, 2011. On that same date, the Director of the Center for Program Integrity issued an information bulletin providing guidance on good cause exceptions to the rule requiring payment suspension.

The good cause exceptions generally include the following:

1. Specific requests by law enforcement that state officials not suspend payment;
2. A determination by a state that other available remedies implemented by the state could protect Medicaid funds more effectively or quickly than a payment suspension;
3. Provision of written evidence by the affected provider that persuades the state that a payment suspension should be terminated or imposed only in part;
4. A determination by the state agency that certain specific criteria are satisfied by which recipient access to items or services would otherwise be jeopardized;
5. A decision by law enforcement not to certify that a matter continues to be under investigation;
6. A determination by the state agency that payment suspension (in whole or in part) is not in the best interests of the Medicaid program; and
7. The credible allegation of fraud focuses solely on a specific type of claim or arises from only a specific business unit of a provider and the state determines that a suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid.

The information bulletin also included five additional pages of guidance in the form of Frequently Asked Questions (FAQs).

The final rule added the definition of "credible allegation of fraud":

> A credible allegation of fraud may be an allegation, which has been verified by the state, from any source, including but not limited to the following:
> (1) Fraud hotline complaints
> (2) Claims data mining
> (3) Patterns identified through provider audits, civil false claims cases and law enforcement investigation
>
> Allegations are considered credible when they have indicia of reliability and the state Medicaid agency has reviewed all allegations, facts and evidence carefully and acts judiciously on a case-by-case basis.[3]

Once a state verifies an allegation of fraud, it must refer the suspected fraud

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In the Trenches, *continued*

Tennessee Health Care Association: The Tennessee Health Care Association/Tennessee Center for Assisted Living Annual Convention and Trade Show is August 29-30, 2011 at Gaylord Opryland Resort & Convention Center in Nashville. Join Baker Donelson shareholder Christy Crider and associate Carrie McCutcheon for their panel, "Big Survey Fines: Appeal or Pay?" on Sunday, August 28, 2011 at 2:00 p.m. Directly following, join Ms. Crider, fellow Baker Donelson shareholder Donna Thiel and Tennessee Health Management Chief Operating Officer Mark Davis for their panel, "Get Paid for Care: Fighting Medicare Program Audits" at 3:00 p.m.


Crider


McCutcheon


Thiel

Baker Donelson was a proud sponsor of the 2011 Tennessee Health Care Association/Tennessee Center for Assisted Living Legislative Conference themed "Partners in Progress" held March 29-30, 2011, in Nashville.

Good Cause Payment Suspension, *continued*

to the Medicaid Fraud Control Unit (MFCU) or other law enforcement agency for further investigation. The state must also suspend payments unless a good cause exception exists.

The FAQs state that payment suspension is not triggered by an investigation regarding the validity of an allegation of fraud, but only where a state determines that an allegation of fraud is credible and refers the matter to its MFCU or other law enforcement agency for investigation.

If the MFCU declines to accept a referral from a state, even if the declination is due to lack of resources and not a determination that the allegation of fraud lacks credibility, a state may refer the matter to another law enforcement agency that has capacity to accept the referral from the state agency. If the second referral is made, the payment suspension should continue. If a second referral is not made, the payment suspension should be ended.

Once payment is suspended, the states must have a quarterly certification from the MFCU or other law enforcement agency that the matter continues to be under investigation in order for the states to continue the payment suspension.

CMS is in the process of creating a web-based portal for the states to report payment suspensions, and expects that the portal will be functional prior to April 1, 2012. CMS anticipates that states will report payment suspensions imposed on providers during the third and fourth quarters of fiscal year 2011.

Heidi Hoffecker is an attorney in the Chattanooga office.

1. Patient Protection and Affordable Care Act, Pub. L. 111-148 as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152.
2. The good cause exception is codified at 42 C.F.R. § 447.90.
3. 42 C.F.R. § 455.2.

Victory for Mississippi Nursing Home

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In February 2011, Baker Donelson attorneys Barry Ford, Davis Frye and Brad Moody defended a nursing home client in a jury trial in Jackson, Mississippi. The plaintiff sued on behalf of his mother, a long-term resident of the nursing home.

Like many residents, at the time of her admission to the nursing home, the plaintiff's mother had serious medical conditions that significantly compromised the nursing home's ability to improve her physical and mental condition. Her end-stage dementia affected her ability to eat, drink and communicate. Her swallowing became more and more impaired, decreasing her ability to ingest necessary protein to help her body repair itself. In addition, perhaps predictably, as her condition deteriorated, her skin began to break down. She developed pressure sores on her buttocks and her heels, which became infected. As a result, a wound care physician recommended a below knee amputation to her family. However, before the decision was made to proceed with the procedure, the resident died at age 92 from pneumonia.

Although the plaintiff criticized almost every facet of his mother's care, the trial team focused on the quality care provided to the resident by the facility team. From the director of nursing and the treatment nurses to the therapists and certified nursing assistants, the interdisciplinary team at the nursing home provided loving care and treatment to the resident. Physician orders were followed; medications were administered; treatments were performed; and the resident was regularly turned and repositioned.

While the plaintiff argued that the resident's condition was caused by a lack of care, the trial team successfully proved that the resident's condition deteriorated notwithstanding the excellent care that she received. Even the plaintiff's nurse expert conceded that there was nothing in the nursing home records that indicated that the staff was not trying their very best to provide quality care to the resident.

The jury listened closely to the evidence presented during

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Victory for Mississippi Nursing Home, *continued*

the week-long trial and, in the end, determined that the nursing home was not negligent and did not cause the resident's death. By returning a verdict for the nursing home, the jury determined that the plaintiff was entitled to no monetary damages whatsoever.

This case is representative of most of the nursing home cases that we litigate. Certainly, no chart is perfect, and caregivers make mistakes at times that may necessitate a resolution before trial. However, we have found in our practice that nursing home staff members feel called to their profession. They are typically made up of good, quality health care professionals who believe in what they do and who work diligently to provide excellent care to their residents. By introducing a jury to these individuals and by educating a jury about the reality of commonly-experienced conditions like pressure sores, infections, and dehydration, we have been able to tell the nursing home's story persuasively, even when there are negative medical outcomes. It is this story that lead to the positive outcome at our recent trial.

Best Trial Practices:

1. Focus on the individuals who care for the residents – the story the jury hears should be just as much about the caregivers as it is about the one receiving the care.
2. Teach the jury about the many things the caregivers do everyday to make a resident's life better, including those things caregivers don't think to chart – the quick tidying of the room, the friendly banter with the resident, - those things that good caregivers do to serve the person they're caring for.
3. Educate the jury about the reality of the aging process. Through expert witnesses, describe the physiological processes that occur as the human body naturally declines.
4. Demonstrate compassion for the family through questioning techniques and demonstrate the compassion that the caregivers had for the resident.

Davis Frye is an attorney in the Jackson office.

Self-Reporting Violations May Lower Civil Money Penalties under Final Rule

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The Final Rule "Civil Money Penalties for Nursing Homes" was published in the Federal Register (76 Fed. Reg. 15106) on March 18, 2011. Section 6111 of the Affordable Care Act amended the Social Security Act to incorporate new provisions governing the imposition and collection of civil money penalties when nursing homes are not in compliance with federal participation requirements. By this Final Rule, the Centers for Medicare and Medicaid Services (CMS) revised and expanded Medicare and Medicaid regulations as required in accordance with Section 6111 of the Affordable Care Act of 2010. According to CMS, Congress enacted Section 6111 to improve efficiency and effectiveness of the nursing home enforcement process by reducing delays between the identification of problems with noncompliance and the effect of penalties that are intended to motivate a nursing home to maintain continuous compliance with basic expectations regarding the provision of quality of care. Section 6111 sought to eliminate a facility's ability to defer the financial effect of a civil money penalty until after a formal appeal and litigation.

Provisions of the Final Rule include:

Opportunity for Independent Informal Dispute Resolution. Although CMS retains ultimate authority for survey findings and imposition of civil money penalties, a facility has the opportunity for independent informal dispute resolution within 30 days' notice that a civil money penalty has been imposed. CMS clarified that a facility can elect either the current informal dispute resolution process conducted by the state or a new Independent Informal Dispute Resolution (IIDR) process to be conducted by an independent entity approved by CMS. The facility must request the IIDR within 10 days of receipt of CMS's offer of IIDR and the IIDR must be completed within 60 days of the facility's timely request.

Escrow Account for Civil Monetary Penalties (CMPs). CMS is authorized to collect and place CMPs imposed by CMS into an escrow account pending the resolution of any formal appeal by the facility. A CMP can be collected by CMS upon the earlier of (i) completion of an IIDR, or (ii) 90 days after notice of the imposition of the CMP. Per day,

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Self-Reporting Violations May Lower Civil Money Penalties under Final Rule, *continued*

CMPs would be effective and continue to accrue but would not be collected during the time that a CMP is subject to the IIDR process. When a facility is successful on appeal, the applicable portion of any CMP amount held in escrow would be returned to the facility with interest.

Authority to Reduce CMP if Facility Self-Reports. The Secretary of Health and Human Services can reduce CMPs by as much as 50 percent in situations where the facility self-reports a compliance violation and quickly corrects it. For a facility to receive this 50 percent reduction, CMS must determine that the facility self-reported and corrected the noncompliance within 10 days of identifying it and before it was identified by CMS or the state. Noncompliance constituting immediate jeopardy, a pattern of harm, widespread harm or resulting in a resident's death is not eligible for CMP reduction. A facility that receives the 50 percent reduction may not also receive the 35 percent reduction currently available to a facility for waiving its right to a hearing.

Use of Escrowed CMP. Ninety percent of the escrowed CMP attributable to Medicare may be used for the protection or benefit of nursing home residents, with the remaining 10 percent being conveyed to the U.S. Treasury.

Effective Date. In order for CMS to phase in the provision implementing the

availability of an IIDR process, the effective date for the Final Rule is January 1, 2012. CMS intends to issue additional guidance on the use of CMP funds and the new IIDR process through survey and certification memoranda.

The Final Rule made several changes to the proposed rule based on the comments that CMS received, including:

- The Rule clarified that a facility may choose to elect either the current IIDR process or the new independent IIDR process.
- The requirement for a user fee was removed.
- CMS may adjust the timing of CMP payments to account for a facility's financial hardship.
- When a facility does not pay the applicable CMPs into an escrow account within 30 calendar days from the notice of collection, the collection process will be the same process for state-imposed CMPs under 42 C.F.R. §488.432.
- Finally, the self-reporting and correction time frame was changed and the eligibility for a 50 percent reduction was clarified.

Jonell Beeler is an attorney in the Jackson office.

Upcoming Events
Please check out the events page on the Baker Donelson website for a comprehensive list of events on a variety of topics that may be of interest to you: **www.bakerdonelson.com**.

Making a Difference is edited by Heidi Hoffecker, an attorney in our Chattanooga office, who can be reached at 423.209.4161 or hhoffecker@bakerdonelson.com. For more information about our **Long Term Care Industry Service Team**, please contact Christy Crider, team leader and an attorney in our Nashville office, at 615.726.5608 or ccrider@bakerdonelson.com.