Making a Difference

Baker Donelson Long Term Care Newsletter

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A Harsh Reminder To Always Sign Arbitration Agreements

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The Mississippi Supreme Court recently held that the failure of a nursing home to sign its own arbitration agreement was fatal to the enforcement of the agreement. The court's ruling provides a harsh reminder to all long term care providers of the importance of signing their own arbitration agreements.

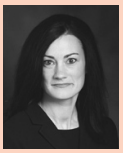
In *Byrd v. Simmons*, 5 So. 3d 384 (Miss. 2009), the plaintiff admitted his mother to a nursing home in Mississippi. At the time of admission, the plaintiff signed on behalf of his mother an admission agreement and the facility's standard arbitration agreement. The facility signed the admission agreement but failed to sign the arbitration agreement. After the death of the plaintiff's mother, the plaintiff's attorney recognized the facility's mistake and wrote a letter to the facility stating that the plaintiff revoked his offer to accept the agreement to arbitrate. The plaintiff subsequently filed a medical malpractice lawsuit against the nursing home. The defendant facility filed a motion to require the plaintiff to arbitrate his claims. However, the defendant's motion was denied by the trial court. *Byrd*, 5 So. 3d at 386-87.

On appeal, the Mississippi Supreme Court focused on the fact that no representative of the nursing home signed the arbitration agreement. The court first noted that the facility did not require the plaintiff to agree to arbitrate as a prerequisite to admit the plaintiff's mother to the facility. Based on this finding, the court determined that the admission agreement and the arbitration agreement were stand-alone documents, and the nursing home's execution of the admission agreement was insufficient to require arbitration. According to the Mississippi Supreme Court, there was no mutual agreement between the plaintiff and the facility to arbitrate because the nursing home failed to sign the agreement to arbitrate. The court therefore affirmed the trial court's denial of the motion to compel arbitration. *Byrd*, 5 So. 3d at 389.

The *Byrd* opinion serves as a reminder to all facilities that they should not overlook the perfunctory act of signing arbitration agreements. Given the importance of arbitration agreements in many jurisdictions, long term care providers who utilize arbitration agreements should review their admission procedures to ensure all necessary details for securing valid arbitration agreements are in place. Providers should also review their admission records to make certain that all arbitration agreements have been signed by a representative of the facility.

In the Trenches

Jill Steinberg, a shareholder in the Memphis office, spoke at the Mid-Year Meeting of the International Association of Defense Counsel (IADC) on "Effectively Compelling Arbitration."



Christy Crider, a shareholder in the Nashville office, and **Sonya Smith**, an associate in the Nashville office, are completing the arbitration of a nursing home wrongful death arbitration in Tennessee.

Craig Conley, a shareholder in the Memphis office, and Christy Crider won a Motion to Dismiss an Administrator from a nursing home wrongful death case.

Davis Frye, a shareholder in the Jackson office, was successful on compelling a nursing home wrongful death case to arbitration.

Alison Shaw and **Richard Faulkner Jr.**, both of counsel in the Chattanooga office, recently trained long term care providers on labor and employment issues specifically related to the long term care industry.

New Medicare Mandatory Reporting Imposes Significant Obligations on Long Term Care Facilities

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Long term care facilities: heed the good news – we have a three-month implementation delay in the Mandatory Reporting Requirements for Medicare. This is even more important to those of you who are unaware of the reporting requirements. Two years ago Congress passed the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), which added new and significant mandatory reporting requirements for group health plans (GHP), liability insurance (including self-insurance), no-fault insurance and workers' compensation benefits, where they have made a payment to a Medicare beneficiary.

With 78 million American baby-boomers about to age into the system, the intent of the law is to preserve Medicare funds where other insurers are primary to Medicare. The new reporting requirements are being implemented by the Centers for Medicare & Medicaid Services (CMS). All mandatory reporters must register with CMS no later than September 30, 2009; the original deadline was June 30, 2009.

Many long term care facilities will be responsible for reporting under the law, in that they are self-insured for their liability coverage or are considered self-insured under the law based upon the deductible in place for their insurance. While under current law Medicare has been the secondary payer to other insurance for many years, the process has largely been "pay and chase" but with little front-end information to identify the potential sources of such funds. Settlements that covered medical expenses were difficult to identify and track, and beneficiaries were often unable to repay Medicare when the Medicare Secondary Payer (MSP) issue was identified months or years later.

The penalties for non-compliance with these new obligations are significant – **over $1,000 per day, per claim**. And since the reporting is quarterly and an employer might not realize it missed a deadline until the next reporting

date, it is conceivable that one missed deadline could result in a liability of $90,000 or more. Furthermore, 42 CFR 411.24(i) permits Medicare to recover from the primary payer even if the primary payer has reimbursed the beneficiary or other party if it was aware or should have been aware that Medicare made a conditional primary payment.

The following are frequently asked questions to assist facilities in determining their responsibilities under the law.

What are the new obligations for facilities?

MMSEA imposes *registration* and *reporting* requirements.

Long term care facilities that meet the definition of a *Responsible Reporting Entity* (RRE) are now required to register with Medicare and to report settlements and payouts. RREs (other than GHPs) must register with CMS between May 1 and September 30, 2009.

As of January 1, 2009, GHPs were required to comply with the reporting requirements. All GHPs were required to register not later than April 30, 2009 and recently began testing with CMS.

CMS has been very careful in how it discusses the new mandatory reporting requirements. At almost every opportunity they have explained that the new MSP provisions do not eliminate CMS's existing processes if a Medicare beneficiary (or his/her representative) wishes to obtain interim conditional payment amount information prior to a settlement, judgment, award or other payment.

Who is required to register under the new requirements?

Every facility (or their corporate parent) should engage in a simple process to determine whether or not it qualifies as an RRE and therefore needs to register with CMS to report under the new MSP requirements.

First, the facility must inventory its insurance coverage to determine if it is an "applicable plan." Applicable plans include liability insurers (including self-insurance), no-fault insurance

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New Medicare Mandatory Reporting Imposes Significant Obligations on Long Term Care Facilities, *continued*

and workers' compensation. As every state has different workers' compensation statutes, companies may be faced with an obligation in one state and no obligation in another.

The analysis of whether a company is an RRE is complex. Examples of liability insurance include, but are not limited to, product liability, auto liability and malpractice liability coverage. Examples of no-fault coverage include medical payment and medical expense coverage as well as any personal injury protection. Companies which have a deductible for their insurance coverage or do not have liability coverage at all must pay close attention: the definition of self-insured may include your company based on the deductible structure; and if you pay for any claims directly (i.e. no liability insurance), you will have to report a settlementwith a Medicare beneficiary for anything which has triggered or could trigger a Medicare payment obligation.

When is the registration deadline?

Once a company makes the determination that it is an RRE, and determines which applicable plans it will need to report, the registration process must begin. Registration must be completed by September 30, 2009.

What does a registered plan need to report?

Reporting is divided into two categories (1) Total Payment Obligations to Claimants (TPOCs) and (2) Ongoing Responsibility for Medicals (ORMs). For TPOCs, the obligation is essentially upon the settlement of the case. For an ORM, the RRE will generally have two reports. The first report is made when the ORM is assumed and the second is made when the ORM is terminated. There are exceptions to reporting: for both liability and no-fault insurance, if the date of incident is prior to December 5, 1980, no report is required. Most illuminating about this date is the realization that CMS has anticipated that a report could be filed for a claim in which the date of the incident occurred almost 30 years ago. There are also *de minimus* thresholds for reporting, but they are quite low.

The reporting requirements apply to settlements, judgments and awards made after July 1, 2009 for ORMs and January 1, 2010 for TPOCs. This means that RREs should begin to gather the data they will need to report as they work with any current claims.

When will reporting begin?

CMS expects to test reporting with each RRE beginning July 1, 2009. The RRE will then be assigned a quarterly reporting schedule. Each RRE will report once a quarter with all the applicable claims which have occurred in the last 135 days prior to the report. Production reports will be accepted on January 1, 2010, with initial submissions due between April 1 and June 30, 2010, depending upon when the RRE has registered and been assigned a reporting schedule.

This means that RREs need to perform their own due diligence on open cases and any obligations which may exist as of today, and to ensure that any settlements include language recognizing Medicare's interests.

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.

For more information about our **Long Term Care Industry Service Team**, please contact Christy Crider, team leader and a shareholder in our Nashville office, at 615.726.5608 or ccrider@bakerdonelson.com.