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This is an advertisement.

Ransomware Attack Highlights Importance of Preparation

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Hollywood Presbyterian Medical Center in Los Angeles recently paid a $17,000 ransom in bitcoins to a malware hacker who seized control of the hospital's computer systems and demanded money ransom as a condition to returning access, the hospital's chief executive said. The cyber-attack occurred February 5, when hackers using malware infected the institution's computers, preventing hospital staff from being able to communicate from those devices. The malware locked key systems by encrypting files, rendering them unusable by staff. Without the decryption key from the hackers, the hospital had no access to its own systems. According to the CEO, "[t]he quickest and most efficient way to restore our systems and administrative functions was to pay the ransom and obtain the decryption key." The hospital said it alerted authorities and was able to restore its computer systems with the assistance of technology experts, but the episode lasted ten days. Reports currently indicate there was no evidence that any patient or employee information was subject to unauthorized access. However, the event disrupted operations and forced the hospital to return to pen and paper for its record-keeping.

This leaves all organizations with the question – what should we do to protect ourselves? Here are a few high level suggestions:

1. Be ready for a ransomware attack by having a plan in place. Make sure your company's documented Data Incident Policy and Procedure is current and contains the information needed to respond effectively and quickly. It should include details regarding who employees are to contact – day or night – including the emergency phone numbers and email addresses for critical team members, federal authorities and outside vendors such as technical forensic investigators and experienced breach-response legal counsel. Include decision trees for potential events including a ransomware attack, a distributed denial-of-service (DDoS) attack or a breach of personal information. While it appears the hospital was able to quickly react and turn off the systems to reduce the potential for a breach of personal information, would your organization be able to do the same as quickly?

2. Organizations must test their policies and procedures to ensure that they are appropriate and that all executives understand the implications of the decisions made. We strongly recommend a "bench test" exercise of your Data Incident Policy and Procedure to make sure the plan works for your organization and that employees understand the policies and procedures well enough to respond appropriately. Don't wait until trouble strikes.

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3. Ensure the organization's security program includes a detailed disaster recovery and business continuity program (DR/BC Program). These DR/BC Programs are not limited to planning for situations such as fires, earthquakes, floods and hurricanes – they should include the potential for a ransomware or DDoS attack. Organizations should have a good understanding of the latency for back up files and the ability to switch to another hot site or third party location. The recovery points and objectives for the recovery should be known in advance. Important data should be backed up regularly and saved via unconnected storage solutions. When data is backed up appropriately, ransomware demands become less effective.

4. All organizations must continue to update operating system and security software on a regular and consistent basis. Investing in the right tools and protocols can be costly, however those costs should be evaluated with the new paradigm in mind – one in which your organization could be paralyzed at the whim of a criminal.

5. Have a good understanding of information governance and its role in your comprehensive security program. Unfortunately, we have worked with clients who have a security program in place, but one that is missing key and critical pieces that could have been identified easily with a small investment in the development of an information governance program. Be vigilant and you will be ready if your organization is the next target of a malicious malware ransom attack.

For more information on how this issue may affect your business or related matters, contact Alisa Chestler, CIPP/US and Sam Felker, or any members of Baker Donelson's Privacy and Information Security Team.

CMS Therapy Payment Model Under Review: What to Expect in 2016

Joy Boyd Longnecker, 615.726.5632, jlongnecker@bakerdonelson.com

In 2015, the Medicare payment system for therapy services provided by Skilled Nursing Facilities (SNFs) saw intense media and governmental scrutiny. Several news articles and reports were published on the need for reform, many of which highlighted increased billing by SNFs for therapy services at the "ultra-high" (*i.e.* highest) reimbursement level despite allegedly static beneficiary characteristics.[1]

[1] *See, e.g.*, "The Medicare Payment System for Skilled Nursing Facilities Needs To Be Reevaluated," Department of Health and Human Services, Office of Inspector General Report, Sept. 2015, OEI-02-13-00610; "How Medicare Rewards Copious Nursing-Home Therapy," *Wall Street Journal*, Aug. 16, 2015; "Nursing Homes Bill for More Therapy Than Patients Need, U.S. Says," *The New York Times*, Sept. 30, 2015; and "The Need to Reform Medicare's Payments to Skilled Nursing Facilities Is As Strong As Ever," Medicare Payment Advisory Commission and Urban Institute, Joint Report, Jan. 2015.

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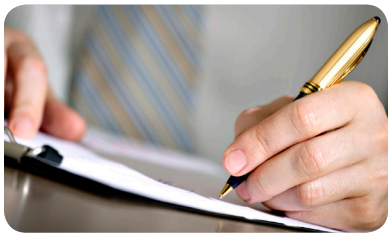
CMS Therapy Payment Model Under Review: What to Expect in 2016, *continued*



At this point, it appears that the current reimbursement model for therapy will almost certainly change. The only real question is how. Medicare's present payment model establishes a daily reimbursement rate for three different categories: (1) nursing and non-therapy ancillary services; (2) therapy care; and (3) room and board. Since its inception in 1998, the therapy billing model, which classifies patients into different resource utilization groups (RUGs) based on their care needs, has been criticized for encouraging SNFs to provide "unnecessary" rehabilitation therapy services in order to maximize reimbursement rates.[2]

The reimbursement rate for therapy services is based on the patients' rehabilitation needs and depends, in part, on the RUG to which a patient is assigned. There are five general RUG levels for rehabilitation therapy patients: (1) Rehab Ultra High (RU); (2) Rehab Very High (RV); (3) Rehab High (RH); (4) Rehab Medium (RM); and Rehab Low (RL). The highest daily rate Medicare will pay an SNF is reserved for patients who require "Ultra High" levels of skilled therapy, or a minimum of 720 minutes of therapy per week from at least two therapy disciplines (*e.g.*, physical, speech, and/or occupational), and one therapy discipline must be provided at least five days per week. Under the current payment model, a patient's assigned rehabilitation RUG level depends on the number of skilled therapy minutes and number of therapy disciplines the patient received during a seven-day assessment period, referred to as the "look back period."

Recent criticism of the therapy reimbursement model centers on the steady increase in Medicare reimbursements for ultra-high therapy. According to the Office of Inspector General's September 30, 2015 report, SNFs received an average of $66 per day more than their therapy costs for ultra-high therapy, versus an average margin of just $11 per day when billing for low therapy. The OIG report also challenges an industry-wide claim that the increase in ultra-high billing is mainly the result of greater patient sophistication, demand, and/or acuity. The OIG's data from FYs 2011 to 2013 shows that ultra-high therapy billing rose, even though key patient characteristics, like age and condition, generally remained static. Significantly, the OIG report attributes roughly 80 percent of the $1.1 billion increase in Medicare payments to the overall uptick in ultra-high therapy billing among SNFs.

The Centers for Medicare and Medicaid Services (CMS) acknowledges that therapy reimbursements are currently "based primarily on the amount of therapy provided to a patient, regardless of the specific patient characteristics and care needs." In an effort to address this apparent disconnect between reimbursement and care needs, CMS initiated the SNF Therapy Payment Research project and contracted with a third party (Acumen, LLC) in an effort to "identify potential alternatives to the existing methodology used to pay for services." Phase one of the project involved the contractor's review of past research and policy issues concerning the therapy payment model, as well as options for "improving or replacing the current system." The contractor's conclusions from this phase were published in a report in April 2014. This report identified four potential payment system options:

1. Resident Characteristics Model – uses resident information (*e.g.*, medical, functional or cognitive

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[2] Medicare Payment Advisory Commission and Urban Institute, Joint Report, Jan. 2015, at p. 2.

CMS Therapy Payment Model Under Review: What to Expect in 2016, *continued*

status) to group residents with similar clinical characteristics and expected cost of care to determine reimbursement

2. Hybrid Model – combines case-mix classification system[3] with resource-based pricing adjustment; similar to current therapy payment model's inclusion of resource use into payment calculus

3. Fee Schedule – payment amounts are based on resident's actual therapy use, not expected resource use

4. Competitive Bidding – market-based pricing of therapy services through a competitive bidding process

Of the four options described above, the CMS contractor recommended using the resident characteristics and hybrid model concepts to "inform the specific models that will be developed and tested in the next phase of the project."

Currently, CMS's project is in its second phase, where the contractor is using its above findings to "identify potential models suitable for further analysis." This process is ongoing, and comments/feedback on therapy payment methodology may be submitted any time to SNFTherapyPayments@cms.hhs.gov.

Long term care providers who offer therapy services can expect to see the current scrutiny of therapy billing by CMS to continue in 2016. In conjunction with CMS's exploration of alternative therapy billing models, federal and state governments have stepped up their efforts to detect perceived abuses in therapy billing and have paid particularly close attention to long term care providers who seek what they deem to be "excessive" ultra-high therapy reimbursements. Civil Investigative Demands and other subpoenas requesting company-wide therapy billing records, patient charts and other data are on the rise. In view of the increased attention being paid to therapy reimbursements, it is critical that all long term care providers review their therapy billing records and, if appropriate, conduct an internal audit to verify that the therapy services being provided are necessary, patient-specific and properly documented. Over the past year, Baker Donelson has conducted multiple investigations into therapy billing, supervised internal audits and assisted several clients with responding to state and federal subpoenas.

[3] Case-mix groups are comprised of residents "expected to receive a similar amount of therapy." These residents could be grouped according to: (1) resource-based options; (2) resident characteristic-based options; and (3) outcomes-based options. In a resource-based payment system, reimbursement would be based on "resource utilization, such as the number of minutes of therapy or the frequency of therapy sessions." The resident-characteristic-based option would group residents based on certain characteristics. The outcomes-based option would "group residents with similar clinical profiles and expected outcomes from therapy."

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Field Trips, Resident Safety and Liability: Considerations for Long Term Care Facilities

Michael Goodin, 901.577.2208, mgoodin@bakerdonelson.com

In virtually any skilled nursing or assisted living facility, activities for senior residents are an integral part of the facility's operations. Many facilities tout or advertise the activities that their facility offers to residents, for good reason. Facilities usually employ an activity director or activity coordinator, whose job duties include planning activities for residents, with the goal of enhancing residents' psychological and emotional well-being. Recreational activities can and should be an important part of residents' lives.

Activities can include arts and crafts, group games such as bingo and music or dancing. Another common group activity which facilities offer residents is off-site field trips to places such as a zoo, museum or even to a shopping mall. Unfortunately, any off-site activity raises safety and liability issues not present for activities performed at the facility. Relatively minimal pre-trip assessment and planning, however, can ensure resident safety, therefore minimizing liability, and should be done before every field trip.

Off-Site Safety Concerns on Field Trips

Any problem that can occur at the facility can occur during a field trip. Unlike problems that occur at the facility, however, issues that arise off-site present an additional layer of difficulty. Off-site locations are often not equipped to meet the needs of a resident, especially if problems occur. For field trips, the two most common sources of injuries to residents are falls and wandering/elopement.

Outside the controlled environment of the facility it becomes impossible to ensure that residents' paths are clear and level. Handrails may not be present and assistive devices such as walkers or wheelchairs may become difficult, if not impossible, to use. Similarly, interventions such as a Wander Guard become useless outside the facility. As with all care and services provided to residents, the facility must ensure resident safety while providing the highest possible level of emotional and psychological well-being for its residents. A facility can do both, while minimizing potential liability, by taking a few simple precautions before a field trip.

Ensuring Safety and Minimizing Liability

Ensuring safety and minimizing liability for a field trip comes down to two questions: 1) is the resident's condition suitable for this field trip; and 2) can the facility provide adequate staff to ensure the safety of every resident on the field trip? An off-site environment is not a controlled environment, and what may be adequate staffing at the facility will not be adequate staffing on a field trip.

1. **Assessing Resident Condition**

   The first step to ensure safety and minimize liability on a field trip is to ensure that a resident is a good candidate for the field trip in the first place. Halfway through a walking field trip to the zoo is too late to realize that a particular resident was not strong enough to make the trip. Pre-trip assessment of the resident's condition is critical and resident safety should always trump a resident's desire to participate in a field trip.

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Field Trips, Resident Safety and Liability: Considerations for Long Term Care Facilities, *continued*

Any resident at high risk for a condition requiring acute medical treatment is probably not good candidate for a field trip. A resident with symptomatic congestive heart failure is likely not appropriate for a field trip to walk around the mall. Although exercise may be appropriate for that resident, the exercise should occur in a controlled environment such as the facility.

Similarly, even relatively healthy residents must be assessed for their suitability for a particular activity. Is the resident a high-fall risk with unsteady gait? If so, then the resident should likely not participate in a field trip to an area with uneven terrain. Is a resident wheelchair bound? If so, then the resident is not a good candidate for a field-trip to a location that is not wheelchair friendly. Furthermore, although many places such as museums or zoos may provide wheelchairs or assistive devices, many do not. The logistics of transporting wheelchairs, walkers, etc., must also be considered, even if the field trip location is wheelchair friendly.

The facility must also consider the resident's wander/elopement risk. This assessment will often require some tough decision-making, as residents with the highest wander/elopement risk are often the very residents who are most able and desirous to participate in field trips and off-site activities. Residents who are high risk for wander/elopement can be great candidates for a field trip, but only if the facility can provide adequate safety for the resident while on the field trip.

2. **Staffing for Field Trips**

Even residents who are fall risks, are wheelchair bound or are elopement risks may be able to participate in a field trip, if there are adequate staff available to meet the off-site needs of the resident. For example, if the facility can provide stand-by assistance for a resident who is a fall risk, that resident may be able to participate in the field trip. If the facility can provide the appropriate wheelchair and staff to assist the resident, then a wheelchair-bound resident can be an appropriate candidate for a field trip. Even residents who are high-risk for elopement can be appropriate for field trips, if the facility can provide adequate staffing to keep eyes on these residents at all times.

Of course, providing sufficient staffing is never easy, even at the facility. Furthermore, providing sufficient staffing for a field trip may mean pulling staff away from the facility while leaving the highest need residents at the facility. However, the facility may find that its employees are much more willing to spend a few overtime hours on a trip to the zoo than at the facility.

It is also important to consider the role that residents' families can play in providing assistance on field trips. Although the facility may determine that there is insufficient staffing to take a particular high-risk resident on the field trip, that resident's family may wish to accompany the resident or provide a sitter to accompany the resident on the trip. Additionally, the families of low-risk residents may also wish to accompany their loved one on a field trip. These additional family members can allow staff to focus on high-risk residents and improve overall safety on the trip.

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Field Trips, Resident Safety and Liability: Considerations for Long Term Care Facilities, *continued*

Conclusion

An off-site field trip will always pose challenges and potential risks greater than those posed by an activity at the facility. Field trips can, however, be tremendously beneficial to residents and field trips can and should be part of the activities that a facility offers to its residents, if possible. A facility can offer field trips, ensure resident safety and minimize potential liability by ensuring that a resident is a good candidate for a particular trip and providing sufficient staff to account for the challenges of an off-site environment.

Whether You Know It or Not, There Are or Will Be a Granny Cam in Your Center: What Are You Going to Do About It?

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You are the exception if you haven't had a family member put a video camera in a resident's room. Sometimes they do it secretly, like in a digital photo frame, and sometimes they put them in plain view. This raises major issues – from privacy issues to demoralizing our caregivers. So what can you do? Let us help.

What Does the Law Say About It?

The law varies from state to state. There is no federal law prohibiting the use of such cameras or mandating that nursing homes allow their use. While multiple states are currently considering proposed legislation that would forbid long term care (LTC) centers from prohibiting the installation of granny cams in residents' rooms, only four states, New Mexico, Oklahoma, Texas and Washington, have enacted such legislation. In Maryland, granny cams may be installed in a nursing home resident's room, but only if the resident's facility allows them. The Tennessee legislature is one of many that has failed in attempting to pass legislation allowing the permissive use of granny cams. These facts taken together strongly support the proposition that states are free to decide for themselves whether nursing homes may prohibit the installation of granny cams in residents' rooms. So, unless you are in one of those four states, you can prohibit them if you want to.

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Whether You Know It or Not, There Are or Will Be a Granny Cam in Your Center: What Are You Going to Do About It?, *continued*

Why Should You Prohibit Granny Cams?

First, granny cams in residents' rooms may violate the privacy rights of various individuals. At a minimum, a LTC resident and their roommate have a right to privacy in their room, and their consent to the installation of a granny cam is required. Beyond this, a LTC facility's obligations under HIPAA may be implicated by the installation of granny cams in residents' rooms. Also, certain granny cam interceptions can violate wiretapping and electronic surveillance statutes. Finally, it is demoralizing to caregivers and hurts the morale of the team. There are few people who could relax and perform well at their jobs with a camera pointed at them all day with a video feed to someone looking to scrutinize their every move.

Best Practices

Family members are understandably concerned about care. Cameras usually stem from a fundamental lack of trust and a communication deficit. When forbidding granny cams, LTC facilities should up their game in great communication. LTC facilities should encourage residents and their family members to go directly to facility management with their concerns and foster an environment in which open communication is not only encouraged, but also actively facilitated. Examples are enabling residents to video chat with family members, creating shared calendars that family members may view and investing in software that allows family members to securely text staff, request resident pictures and updates, or even view a resident's activity though digital records that staff members create.

Regardless of whether your center plans to allow or prohibit cameras, you should have a clear policy addressing it. Even in states with statutes specifically allowing cameras, certain conditions limit the installation and use of granny cams. For example, the Texas statute requires permission from roommates, providing that roommates may stipulate other conditions, such as the camera never being pointed at them, and that conspicuous notices be posted throughout the facility informing residents, staff and visitors of the presence of video cameras. If, however, you decide to ban granny cams in your facility, make sure you have a good written policy on it before the issue comes up. It will save you a lot of trouble on the back end.

In the Trenches

Jason Edgecombe and Ted Lotchin's article "The best defense is a good offense when mitigating False Claims Act liability," was published in *McKnight's Long-Term Care News*.

In December, Baker Donelson represented two health care lending groups, one based in New York and the other in Ohio, in four loans for health care facilities totaling more than $44 million. The New York-based group loans included: (i) an $18.5 million loan for the acquisition of a skilled nursing facility in Buffalo, New York; (ii) a $1.54 million mezzanine loan behind a $12.08 million senior loan for the acquisition of skilled nursing facilities in New Jersey and Massachusetts; and (iii) an $8.1 million loan for the acquisition of a skilled nursing facility in Gaffney, South Carolina. The Ohio-based loan was a

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In the Trenches, *continued*

$16.5 million loan to refinance existing debt and fund an equity buy-out of the borrowers in connection with two skilled nursing facilities in Ohio. All four of these loans are bridge loans that the two companies, both industry leaders in HUD financing, plan to subsequently finance under the HUD Section 232 program. Mary O'Kelley led the team of Baker Donelson attorneys and paralegals, which included Rich Faulkner, Jim Levine, Ross Schram, Rebecca Delong and Marie Walker.

Davis Frye, La'Verne Edney, Brad Smith, Adria Jetton, Brad Moody and Clay Gunn led our Mississippi trial team to success by obtaining three defense verdicts for the nursing homes supported by our client, a major nursing home administrative support services company.

1. A jury in Hinds County returned a defense verdict in favor of a nursing and rehab center in a case where the plaintiff claimed that a nursing home resident died as a result of the facility's alleged failure to assess the resident properly.

2. The following week, our team obtained a defense verdict for a Jackson, Mississippi nursing and rehab center in a case that alleged the nursing home failed to provide appropriate fluid to the resident, resulting in her dehydration and death.

3. A Hinds County Circuit Court granted a directed verdict in favor of another skilled nursing facility in Jackson, Mississippi, in a case that claimed the nursing home failed to assess a resident's condition, resulting in her hospitalization and death.

Craig Conley led the Memphis litigation team to success in multiple high-risk cases for nursing homes supported by our client, a major nursing home administrative support services company. Following a brief trial in Shelby County, Tennessee, the jury returned a favorable verdict in a case involving a nursing and rehab center in Memphis. Following arbitration, we received a favorable verdict for another Memphis nursing facility, for which the team capped off the year by obtaining two dismissals based on plaintiffs' failures to comply with the Tennessee Healthcare Liability Act.

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4.12.16: **10 Things You Wish You Didn't Have to Know About HIPAA/Data Breaches**
presented by Gina Greenwood

5.10.16: **Bankruptcy Implications**
presented by Tim Lupinacci

6.14.16: **What Every Provider Needs to Know About Therapy Billing**
presented by Christy Crider and Joy Boyd Longnecker

7.12.16: **Value-Based Purchasing and Other ACA Initiatives – What It Means to Your Nursing Home!**
presented by Danielle Trostorff

8.9.16: **Audits and Appeals in the LTC Space**
presented by Donna Thiel and Tracy Weir

9.13.16: **What Every Provider Needs to Know About Granny Cams**
presented by Christy Crider and Charles McLaurin

10.11.16: **Race, Sexual Orientation and Social Media Discussions in the Workplace**
presented by Zachary Busey and Gina Greenwood

11.15.16: **Buying and Selling Your HUD-Financed Facility**
presented by Andrea Barach

12.13.16: **Are You Protecting Your QA Documents?**
presented by Christy Crider and Caldwell Collins

To receive information about the webinar series or to register, email rsvp@bakerdonelson.com.

* This schedule is subject to change.

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