NEWS

Making a Difference
Long Term Care Newsletter

BAKER DONELSON
EXPAND YOUR EXPECTATIONS℠

Issue 3, 2015

DOL Creates Long-Term Headache for Long Term Care: Higher Wages, More Overtime and Greater Overhead

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Last month, the U.S. Department of Labor (DOL) proposed new regulations under the Fair Labor Standards Act (FLSA) that will dramatically increase the number of employees who must be paid overtime for all hours worked beyond 40 per week.

Under the current regulations, employees who earn more than $455 per week (or $23,660 per year) could qualify as exempt and are therefore ineligible for overtime.

Under the newly proposed regulations, the minimum salary to qualify as exempt has been dramatically increased to $970 per week (or $50,440 per year). The DOL is also considering whether non-discretionary bonuses and incentive payments should be included when determining an employee's weekly or yearly salary.

To prevent the new minimum salary from becoming outdated, the DOL proposes tying it to an automatic annual update; for example, (i) a fixed percentile of hourly wages, or (ii) the Consumer Price Index for urban consumers.

In its statement accompanying the proposed regulations, the DOL made clear that the purpose of the new regulations is to "transfer income from employers to employees in the form of higher earnings."

Will the new regulations apply to the long term care industry? Absolutely. Under the new regulations, any employee making less than $970 per week (or $50,440 per year) will now likely be classified as non-exempt (subject to a few exceptions). This means these employees must be paid overtime for all hours worked over 40, and time keeping records for all hours worked must be maintained for each employee.

Is your facility covered by the new regulations? Yes, most likely. A facility need only have two or more employees to be covered – but that isn't all. The facility (by itself or as part of a larger company or group) must also have annual gross income equal to or more than $500,000, and the facility must be engaged in interstate commerce, which most facilities are.

What positions are most likely impacted? While it will vary for each facility, the positions most likely to be impacted include: directors and assistant directors of nursing, maintenance managers and directors, housekeeping managers and directors, RN unit managers and directors, HR specialists, marketing and sales employees, administrators, dietary managers, RNs (if paid hourly) and MDS coordinators.

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Will your facility's employment practices liability insurance (EPLI) cover lawsuits triggered by the new regulations? No, not likely. While EPLI policies vary, they typically do not cover claims or lawsuits brought under the FLSA. So if a facility is sued under the FLSA, the facility, not an insurance company, will pay all defense costs and attorneys' fees, as well as any judgment entered against a facility. The new regulations do not change this in any way, and they do not have any impact on EPLI policies in general.

How much time will your facility have to implement the new regulations? Likely less than 90 days. Typically the DOL provides a 180-day "grace period" for implementation of new regulations. In this case, however, because the Obama administration is pushing for the new regulations to be in place before the 2016 presidential election, we anticipate the DOL will shorten the "grace period" to less than 90 days. In other words, if a facility waits until the DOL orders the new regulations, which we anticipate will occur in late 2015 or early 2016, it will then have just 12 weeks to implement the new regulations and make all necessary changes.

What can a facility do to lessen any impact? We highly recommend facilities audit at-risk positions. Our FLSA Audit Team will work with your facility to determine whether current classifications remain lawful under the proposed regulations. We also offer training sessions for impacted employees, covering topics such as the importance of clocking in and out, after-hours email practices and working remotely.

How do you set up an audit or training? What if you need more information? Contact your regular Baker Donelson attorney, or you can contact a member of our FLSA Audit Team. When you do, ask about our flat fee pricing for certain types of audits. We offer three levels of flat fee pricing for salary audits: silver, gold and platinum. Each level includes review and analysis of positions that will be affected by the new regulations, such as directors and assistant directors of nursing, or RN unit managers and directors. At the gold and silver levels, we go further and collect information directly from employees. We then use this information to identify trends in work performed outside of normal business hours and/or away from the facility. This allows a facility to better estimate future overtime costs under the new regulations.

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What is the TCPA and Why is it of Concern to Long Term Care Facilities?

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The Telephone Consumer Protection Act (TCPA) was enacted in 1991 to protect consumers, especially cell phone consumers, from unwanted robocalls and texts. The Act applies to virtually any company that utilizes auto-dialing technology. You may be aware of the Act because the Federal Communications Commission (FCC) amended its rules under the TCPA to implement the national Do-Not-Call list.

There once existed a split among courts as to whether the Act even applied to health care providers. The FCC recently issued a ruling, however, which made it clear that the health care exemption applies *only to health care-related calls* (such as post-discharge follow-up, appointment notifications, etc.) and **not account-related communications and payment matters** – i.e., collections calls.

Because of this new ruling, many long term care facilities (LTCFs) are behind the curve with respect to their policies on collections calls. According to some experts, the FCC ruling not only requires that LTCFs obtain the specific consent of the resident for their billing/collection services to contact them by cell phone, but also that the consent contain a number of detailed elements and disclosures.

In light of this ruling and the general rise in consumer class actions alleging violations of the TCPA, it is wise for LTCFs to review their internal collection policies and practices. The aforementioned FCC ruling will inevitably lead to more litigation. Many of the suits filed under the TCPA seek millions of dollars, with statutory damages at $500 to $1,500 *per unlawful call or text message*. Clearly, the dollars have the potential to add up quickly, and plaintiffs' lawyers around the country are taking note, even going to the airwaves to solicit claims under the TCPA.

The TCPA requires a consumer's *express written consent*, demonstrating that the consumer received "clear and conspicuous disclosure" that the consumer authorizes the use of his or her phone number to receive future calls that deliver prerecorded or autodialed messages by or on behalf of a specific provider and/or its authorized agent(s).

With all that being said, what should LTCFs do in response to this ruling? Is it a simple addition to the resident admission/intake form, authorizing contact by cell phone, or something much more substantial required in a separate consent document? We suggest the following as a checklist of requirements for written consent:

1. Identify the provider and its agents to whom consent is being provided.
2. Identify the consumer's telephone number.
3. Indicate a clear and affirmative agreement (i.e., "I agree/consent").

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What is the TCPA and Why is it of Concern to Long Term Care Facilities?, *continued*

4. Disclose that the consumer is authorizing the provider and its agents to contact the consumer at the phone number(s) provided *for all matters*, including but not limited to payment.
5. Disclose that the calls may be made using automated technology.
6. Disclose that the consumer is **not** required to provide consent as a condition of receiving services.
7. Obtain the consumer's signature (either electronically through E-SIGN or handwritten).

Note that the FCC has ruled that an individual gives express consent to receive autodialed or prerecorded collection calls from creditors or third-party collectors by providing his/her cell phone number in connection with an existing debt if the number was provided by the consumer to the creditor *during the transaction that resulted in the debt owed*. As such, utilization of the above suggested language, in the resident admission/intake form, and the resident/financial representative's consent thereto, would pass muster under the TCPA.

We believe that LTCFs should revise their current resident admission/intake forms to add this consent. As is clear from the regulation and subsequent FCC ruling, it would be helpful if the consent were executed simultaneously with the form signed by the customer that outlines the resident's financial responsibilities. It needn't be an entirely separate document, but the consent should be clear and unambiguous and should reflect that the consumer is giving his/her consent for receipt of all calls, ***including but not limited to*** those seeking collection of a debt.

Our team is eager to provide assistance in drafting or revising your resident admission/intake forms to ensure compliance with the TCPA, its regulations and subsequent FCC rules.

Preparing for the Inevitable: Legal Holds

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Litigation is an unfortunate inevitability in the long term care industry. How well your company weathers that storm often depends on your preparation, and one of the most vital parts of your litigation response plan is your company's legal hold. But when is a legal hold necessary and how do you approach its four common phases – reporting, scoping, communicating and releasing?

The Importance of a Legal Hold

A legal hold – a directive (usually written) that advises company personnel that documents and electronically-stored information (ESI) relating to litigation must be preserved as potentially relevant evidence – is an essential first step in any litigation matter. Not only must a legal hold be implemented for all active litigation matters, but it also must be considered when a company receives notice that litigation is a "reasonable possibility." When determining what constitutes that reasonable possibility,

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Preparing for the Inevitable: Legal Holds, *continued*

a court typically has the benefit of hindsight. Therefore, a company must be extremely cautious about preserving potential evidence after receiving any notice, no matter how informal, of the likelihood of litigation.

The goal of a legal hold is to alert company personnel that anything relating to the claims in the potential lawsuit must be retained until the matter's conclusion. One common retention pitfall is ESI, which may be deleted by the routine operation of the information technology (IT) systems. For example, when a nurse leaves a facility for other employment, policies and procedures may cause email or information stored on a local hard drive to be deleted. To protect against this, we recommend taking affirmative steps to ensure that ESI is preserved, including suspension of routine deletion policies.

Failure to comply with a legal hold can result in serious consequences. Should information be destroyed after a company has notice that the information was potentially relevant to a dispute, the opposing party may claim destruction of evidence – ***spoliation*** – and argue for damaging relief, such as evidentiary sanctions, monetary fines or default judgment. These court-imposed spoliation sanctions can be detrimental to even the strongest defense on the merits. For this reason, an effective legal hold is a crucial litigation response.

Your legal hold should have four steps: (1) reporting the hold; (2) scoping the hold; (3) communicating with employees; and (4) releasing the hold.

1. Report

A legal hold begins when the triggering event is ***reported***. By its nature, a legal hold must be implemented for known litigation (or regulatory event). But equally as important is a legal hold triggered by reasonably foreseeable or anticipated litigation, such as when:

- The opposing party (or their counsel) has shown a tendency to pursue legal actions and has requested information;
- The communications from the potential claimant threaten to sue; or
- The communications from the potential claimant request that the receiving party retain records and information relating to the potential claim.

When factors such as these make litigation a reasonable likelihood, the company, its inside and outside counsel, and its frontline business personnel must be aware of the legal hold responsibility. Organizations should provide proper training and communication channels for reporting and escalating litigation events.

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Preparing for the Inevitable: Legal Holds, *continued*

2. Scope

A legal hold must then be ***scoped*** and tailored to a specific company's profile. This process depends in large part on the company's IT architecture and information governance (IG) practices – for instance, whether emails are retained for a short period of time or indefinitely. Scoping may require forensic imaging, smartphone captures or other technical implementations of the hold. IT and records management should review the litigation hold to determine what information must be retained, where relevant information may be stored and how the company's normal operating procedures must be altered during the hold.

3. Communicate

The legal hold should then be ***communicated*** to the "custodians," employees or record-keepers who have potential evidence in their possession or care. This includes employees actually involved in the case (e.g., potential witnesses or key players) as well as those who may have access to relevant evidence. For example, the IT department or records management personnel may need to start suspension of any information governance that would result in evidence disposal.

The communication must be clear and comprehensive. A legal hold notice should give instructions and enough background on the matter such that the frontline employee will have an understanding of what should be identified and preserved. Moreover, the method of communication must reflect the realities of the IT/IG practices of the organization as well as the business climate: sometimes a legal hold notice "cascades" from a supervisor, and other times it is sent by outside counsel to the custodians for verification. Regardless of the method of communication, the legal hold must be reasonably matched to the business environment and the severity of the event.

4. Release

After the litigation event has concluded, the company may ***release*** the hold. This process requires periodic review and tracking of outstanding holds and a mechanism to release information subject to stale holds. Keep in mind that although documents may no longer be needed for litigation, your company may still need to preserve them in order to comply with industry regulations or applicable laws. The company should give a final notice to custodians detailing what information can be deleted and what information should be preserved.

Conclusion

While a litigation hold takes time and effort to implement successfully, it can help your company preserve positive evidence, avoid harmful sanctions and alleviate an already stressful situation. Creating processes for employing an effective litigation hold is the first step toward preparing for the inevitable.

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CMS Proposes Rules Requiring LTC Facilities to Implement Compliance and Ethics Programs

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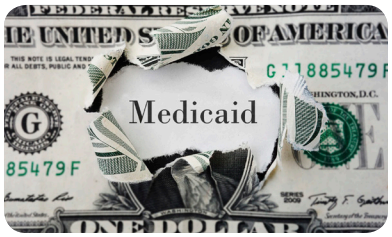

Under proposed rules issued by the Centers for Medicare and Medicaid Services (CMS), long term care (LTC) facility operators would be required to develop, implement and maintain a comprehensive compliance and ethics program in order to participate in the Medicare and Medicaid programs.[1] If finalized, these new rules would create a burdensome and expensive, but ultimately necessary, set of regulatory requirements for LTC operators.

Historically, the federal regulatory agencies with oversight responsibility for Medicare and Medicaid providers have emphasized the need for a robust compliance program as a "best practice" for providers and suppliers. For example, the Department of Health and Human Services Office of Inspector General (OIG) issued compliance program guidance (CPG) for nursing facilities in 2000 and 2008 that established the OIG's seven basic compliance program elements and identified particular areas of significant risk for LTC providers.[2] Other examples of the OIG's emphasis on developing a "culture of compliance" can be found throughout the relevant advisory opinions, settlement agreements and public policy statements.

Until recently, the OIG's recommendations for maintaining a corporate compliance program were simply that – recommendations. Section 6102 of the Affordable Care Act (ACA) changed that paradigm, however, by requiring all skilled nursing facilities (SNFs) to develop and implement an effective compliance and ethics program within three years of the ACA's enactment.[3] The ACA also required the Secretary of the Department of Health and Human Services (DHHS) to work with the OIG to promulgate regulations for implementing that statutory mandate. Although slightly overdue, the proposed requirement to develop and maintain an effective compliance and ethics program represents the agency's initial attempt at implementing the ACA requirements.

Again, CMS's proposed revisions to the conditions for participation in Medicare and Medicaid would require every LTC facility operator to have a compliance and ethics program in place one year after adoption of the final rule. In addition, every facility's compliance and ethics program would have to include certain specified components drawn largely from the OIG's existing CPG. These program components include:

- The development and distribution of written standards of conduct, as well as written policies, procedures and protocols that cover topics such as reporting suspected violations.
- The assignment of high-level personnel to oversee the compliance and ethics program.
- Communication of the written compliance standards, policies and procedures to the facility's staff, contractors and volunteers.

[1] See generally CMS, Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities; Proposed Rule, 80 Fed. Reg. 42168 (Jul. 16, 2015).

[2] See OIG, Supplemental Compliance Program Guidance for Nursing Facilities, 73 Fed. Reg. 56832 (Sept. 30, 2008), available at http://oig.hhs.gov/compliance/compliance-guidance/index.asp (last visited Oct. 22, 2015); OIG, Compliance Program Guidance for Nursing Facilities, 65 Fed. Reg. 14289 (Mar. 16, 2000), available at http://oig.hhs.gov/compliance/compliance-guidance/index.asp (last visited Oct. 22, 2015).

[3] See 42 U.S.C. § 1320a-7j(b).

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CMS Proposes Rules Requiring LTC Facilities to Implement Compliance and Ethics Programs, *continued*

- Enforcement of the standards, policies and procedures through consistent disciplinary mechanisms.
- Performance of an annual program review in order to update as indicated by changes in applicable laws and regulations.

In addition, operators that have five or more LTC facilities would be required to:

- Conduct a mandatory compliance and ethics training program on an annual basis.
- Designate a compliance officer for whom the compliance and ethics program is a "major responsibility."
- Designate a compliance liaison at each of the operator's facilities.

The costs to implement the proposed rule are expected to be significant. Not only would larger operators be required to prepare an extensive, formal compliance program and designate a compliance officer and compliance liaisons at each facility, but CMS estimates that the new program requirements will cost LTC facilities (collectively) well over $100 million per year.

Comments to the proposed rule were due to CMS by October 14. Baker Donelson's Long Term Care Industry Service Team will be monitoring these developments closely in the weeks and months ahead.

What Happens to LTC Arbitration Agreements if the Proposed CMS Rules are Implemented?

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By now, most industry members are aware that Centers for Medicare and Medicaid Services (CMS) recently published a proposed set of new rules for regulating long term care (LTC) facilities. During the review period, CMS received more than 8,000 comments from stakeholders about the proposed changes. Since this was CMS's first attempt since 1991 to make widespread changes to its rules, the agency's proposal has sparked significant debate. CMS's proposed rule for the use of arbitration agreements is particularly controversial as the signing of arbitration agreements has become commonplace in the admission process at LTC facilities.

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What Happens to LTC Arbitration Agreements if the Proposed CMS Rules are Implemented?, *continued*

Practical Effect of Proposed Rule

The most significant change proposed by CMS is a prohibition on making the signing of arbitration agreements a prerequisite for admission to a LTC facility. This change would effectively make arbitration agreements unenforceable in many jurisdictions. For example, in Mississippi, arbitration agreements generally are not enforceable unless the resident personally signs the arbitration agreement or has provided a durable power of attorney to the resident's responsible party. One exception to that rule is if the prospective resident lacks capacity to make her own decisions and the person admitting the resident to the facility is a qualified surrogate under the Mississippi Health Care Surrogate Act. However, the signing of an arbitration agreement is not a "health care decision" under the Act unless executing the arbitration agreement is required at admission. Consequently, CMS's proposal to prohibit mandatory arbitration agreements would make arbitration agreements unenforceable in Mississippi in most instances, since a resident's family member often executes the admission paperwork due to the prospective resident's lack of capacity.

CMS's Regulatory Authority

Until now, CMS's only position on arbitration agreements was that a facility could not threaten to discharge a current resident for refusing to execute an arbitration agreement after admission (see January 9, 2003 Letter, Ref: S&C-03-10). CMS had said that it was not weighing in on the use of arbitration agreements prior to a resident's admission to the facility. CMS is reversing that position and declaring its belief that requiring prospective residents to sign arbitration agreements is an unfair practice.

CMS's rulemaking authority comes from Title XVIII of the Social Security Act and the corresponding subsections of that Act providing for the regulation of the Medicare system and long term care facilities. Nowhere within the Act is there any provision for CMS's authority to regulate arbitration agreements as proposed by CMS's new rules. This fact is particularly important because the Federal Arbitration Act (FAA) prohibits the treating of arbitration agreements differently from any other contract. As the United States Supreme Court has stated, the FAA reflects an "emphatic federal policy in favor of arbitral dispute resolution" (*KPMG LLP v. Cocchi*). Without specific authority from Congress, CMS likely lacks the authority to regulate preadmission arbitration agreements.

By way of comparison, the Consumer Financial Protection Bureau (CFPB) is preparing new rules governing the use of arbitration agreements in the financial services industry. Unlike CMS, Congress vested the CFPB with authority to draft new rules to regulate arbitration agreements under the Dodd-Frank Act. Without similar authority from Congress, CMS's new rule prohibiting binding arbitration agreements may not survive judicial scrutiny if implemented.

Potential Outright Ban on Pre-dispute Arbitration Agreements

CMS also has requested feedback on whether the use of arbitration agreements should be completely prohibited in the long term care setting. Some politicians have publicly supported CMS's proposed rule changes and encouraged CMS to move toward an outright ban of preadmission arbitration agreements For example, on September 23, 2015, 34 Democratic United States Senators issued a public statement

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What Happens to LTC Arbitration Agreements if the Proposed CMS Rules are Implemented?, *continued*

encouraging CMS to ban completely the use of mandatory arbitration agreements by long term care providers and only allow facilities to enter into arbitration agreements after an incident has occurred. Noticeably absent from the Senators' position statement is any reference to CMS's legislative authority to regulate preadmission arbitration agreements. That is likely because no such authority exists.

CMS's intent to limit the use of preadmission arbitration agreements seemingly conflicts with the policy objectives of the FAA. If CMS implements its proposal to regulate arbitration agreements, it should expect lawsuits challenging its authority to implement such regulations.

In the Trenches

Jackson litigators have obtained two defense verdicts in back-to-back trials in Hinds County Circuit Court with Judges Kidd and Green over the last two weeks:

- Brad Smith, La'Verne Edney, Adria Jetton and Kate Allen (all Jackson) recently obtained a defense verdict in Hinds County Circuit Court. In the case, filed against a nursing and rehab center, the plaintiff alleged that the nursing home's failure to assess a resident resulted in her death. The case was tried before Judge Winston Kidd.
- Davis Frye, La'Verne Edney, Brad Moody and Christy Milton (all Jackson) recently obtained a defense verdict in Hinds County Circuit Court. In the case, filed against a nursing and rehab center (different from above), the plaintiff alleged that the nursing home's failure to assess a resident resulted in her death. The case was tried before Judge Tommie Green.

Jason Edgecombe and Ted Lotchin's articles "'Extrapolation' demonstrates False Claims Act liability in rehab" and "False Claims Act liability for poor quality of care" were published in *McKnight's Long-Term Care News*.

On August 26, Rich Faulkner (Chattanooga) participated in the webinar "Buying and Selling Long Term Care Facilities: Overcoming Complex Regulatory and Business Challenges" as mentioned on the Baker Donelson website found here.

Christy Crider (Nashville) was a panelist at the program "Responding to Unusual Events in Your Facility" at the 2015 Tennessee Health Care Association Annual Convention on August 30 in Nashville. The panel discussion offered tips on how to investigate an unusual event, conduct interviews and develop an action plan. It also covered handling internal and external communications, from talking to family members and the media to reporting up the chain of command.

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Join Us For Our Monthly Long Term Care Webinar Series*

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

11.10.2015: **Proper and Improper Use of Background Checks and Arrest Records**
presented by Angie Davis

12.15.2015: **Fraud and Abuse Compliance Program 101: Do You Have a Plan?**
presented by Gina Greenwood

* This schedule is subject to change.

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