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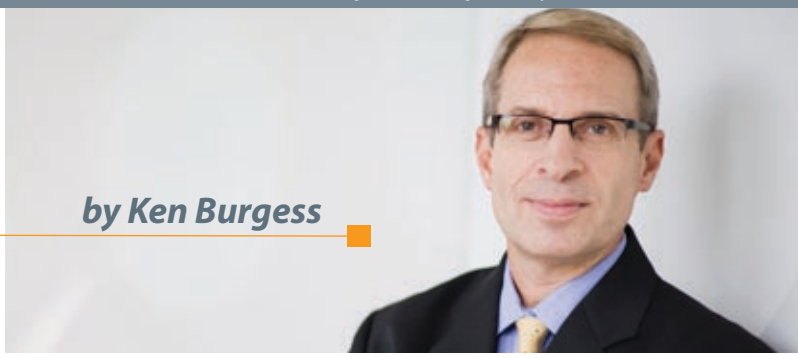
SHORTS ON LONG TERM CARE

for the North Carolina LTC Community from Poyner Spruill LLP

Beautiful Sadness – A Tribute to Debbie Mathis



by Ken Burgess

I suppose all of us deal with grief and loss in different ways. For me, for some reason I've never understood, snippets of songs come into my crazy head in times of loss. It happened when my father died in 2002, and it's happened over and over again throughout the years. So perhaps it's no surprise that on Saturday, June 4th when Polly Welsh called to tell me that Debbie Mathis had passed after her long battle with cancer, it happened again. The words of a song I hadn't thought of in years hit me, and I smiled.

The song is called "Beautiful Sadness," and it goes like this:

You're lovely to remember
And looking back I'm feeling
Like I'm walking very slowly, through a soft and misty rain
And a beautiful sadness comes over me

I first knew Debbie when she worked for Brian Center, back in the day, as they say, and more recently and much better when she joined the Lutheran Services for Aging (LSA) family. We all remember people differently I suppose, based on how we knew them. I knew Debbie as a loyal client, good friend, and lovely woman in every sense of the words.

But what I remember most about her is her passion for end-of-life issues. Debbie and I talked often about advance directives, dignity in dying, and end-of-life care. Just a few weeks before her passing, Debbie called to ask if I'd teach an end-of-life care session for the LSA family from across the state. "Of course," I said, "anything you want." I didn't even know at the time that Debbie was facing her own end-of-life journey, and, typical for Debbie in her selfless way, she never mentioned it. Perhaps it's ironic, and very telling about Debbie's generosity and graciousness, that two days before the scheduled session, my "church mother" from my teen years passed away, and her funeral was scheduled for the same day as the training. I called Debbie and began to explain what had happened, how important my church mother had been to me at a tough time in my life, and how I was so conflicted about the funeral being on the same day as the training session. As I nervously blathered on and on, Debbie, sweetly, cut me off and said, "There's no decision here to fret about. You have to go to that funeral, and we'll just reschedule the session." We never got to do that, but Debbie, we are holding that session this fall in your honor and your memory.

I also remember Debbie from years of association conventions. She would ALWAYS find me, no matter how crowded the hotel or how busy she was, and she'd always update me on how our latest LSA project together was going. She never attended even one of my boring lectures without finding me to say how much she enjoyed it and how much she had learned. And she had that smile I can still see.

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OIG Issues New Advisory Opinion on Hospital to Post-Acute Care Settings Referral Arrangements

By Ken Burgess

On May 20, 2011, the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services issued an Advisory Opinion (AO) in which it concluded that a referral arrangement operated by a for-profit company that many SNFs reportedly use could violate the anti-kickback statute and expose the parties to the arrangement to civil money fines and other sanctions, including exclusion from federal government programs, because it could create an undue risk of overutilization of or overbilling for services covered by Medicare or Medicaid.

The federal anti-kickback statute makes it a crime to knowingly and willfully offer, pay, solicit, or receive any remuneration (i.e., anything of value) to induce or reward referrals of items or services reimbursable by a federal health care program. The law ascribes criminal liability to parties on both sides of an illegal transaction, and it covers arrangements where even one purpose of the arrangement is to induce referrals by exchanging items of value.

The arrangement at issue in the May 20th AO involved a for-profit company that makes referrals from hospitals to post-acute care settings, including SNFs, home health providers and others. The company used an online referral service that provided hospitals with a nationwide list of all licensed post-acute care providers, with the names coming from state licensure databases.

When hospitals needed to discharge a patient, they would provide the patient's information, including medical records, to the online referral service and receive back a list of providers in the area with the requisite level of care. Both the hospital and the post-acute providers would pay a fee for access to the online service. Other post-acute care providers could also participate in the service without paying a fee but had to fax their information to the referral company, which, according to the referral service, seriously impaired their ability to obtain referrals because of the time involved in faxes going back and forth, as opposed to the more rapid exchange of information online. The referrals were normally made on a first-come, first-served basis, so a rapid response to a referral inquiry was important.

The company also conceded that while the fees charged to participants in the system were not based on the volume or value of referrals made or received, those costs did exceed what it actually cost to operate the system. Some post-acute providers reported that their profit margins are so slim, they cannot afford to pay the required fees.

Over the years, the OIG has created by regulation certain "safe harbors" that provide protection from criminal liability if the arrangement at issue meets all elements of the regulatory safe harbor. Specifically, the OIG has created a safe harbor for referral services and agencies. However, under that safe harbor, any fees must be uniformly charged to all participants, fees must be based only on the costs of operating the service, and fees must not vary with the volume or value of referrals of federal health care program business.

The OIG concluded that the arrangement at issue in the May 20th AO did not meet all elements of the referral services safe harbor, including the requirement that fees be uniformly assessed against all participants in the referral arrangement and be based only on the cost of operating the system. The OIG specifically noted the following problems with the arrangement. One, only providers paying the referral fees would have access to the more rapid online referrals, effectively eliminating providers who would not or could not pay the fees and thus had to rely on the system of faxing information to receive a referral. Two, the system would operate to penalize post-acute providers that did not pay the company's referral fee. Three, providers that could not afford to pay the fee would be at a serious competitive disadvantage, and even those that did pay the fee might feel pressure to recoup their costs by prolonging patient stays, providing separately billable unnecessary services, or upcoding RUG assignments.

While every AO is technically limited to the facts presented by the requestor and is limited only to the parties involved, providers and health care lawyers look to these AOs for guidance on how similar or identical arrangements would be viewed by the OIG. Interestingly, one or more national companies that either use or are considering using a system like that addressed in the AO have claimed that a competing referral service intentionally sought a negative AO from the OIG, presumably as a competitive maneuver.

Several national organizations representing SNFs and other post-acute providers are studying the AO and considering responses that would potentially permit such referral arrangements, or examining how they might be structured to be acceptable to the OIG. We will continue to monitor these developments and report on them in future issues of *Shorts*.

ASSISTED LIVING COMMUNITIES

Turning Your Facility and Staff into Detectives

Complying with the Elder Justice Act Crime Reporting Requirements

by Kim Licata

On June 17, 2011, the Centers for Medicare and Medicaid Services (CMS) issued much-needed guidance to state survey agency directors on what CMS expects from a long term care (LTC) facility that is obligated to report a "reasonable suspicion of a crime" committed against a resident of that facility. This vexing provision of the Elder Justice Act (EJA) found in last year's massive health care reform law triggers an almost impossibly short reporting obligation, not only for the facility, but also for certain individuals.

What facilities and individuals are affected by this obligation? Nursing facilities, skilled nursing facilities, hospices providing services in an LTC facility, and Intermediate Care Facilities for the Mentally Retarded. Individuals who are obligated to make reports include a facility's owner, operator, employee, manager, agent, or contractor. You may be asking, who doesn't have to make a report as an individual? Also the fact that one individual makes a report doesn't relieve another individual from his or her own obligation to make a report. In fact, information about who reported an event and who knew of the event (and did not report) will be documented by the survey agency. Sound duplicative? It is, but you cannot limit any individual's responsibility to report under this provision.

To whom must a report be made? To at least one law enforcement agency and the state survey agency.

What obligations does an LTC facility have? First, facilities must determine if they received at least $10,000 in federal funds in the prior year; if not, read no further (but that's probably not too many of you). Second, facilities must notify covered individuals of their reporting obligations under the EJA (think training). Third, facilities must post yet another notice, in an appropriate location, for employees about the EJA, including an employee's right to file complaints under the EJA (including with the state survey agency). Fourth, facilities should make sure their anti-retaliation policy covers reports under the EJA (it probably does if the policy was broadly written).

What else does CMS think a facility ought to do? CMS states that covered facilities "effectively" implementing the EJA's reporting obligation will also: (a) coordinate with law enforcement, (b) review adherence to existing CMS policies, and (c) develop policies and procedures specific to the EJA requirements. While these are not stated as "requirements," you should assume they are.

When must the facility make a report? Reporting time frames are dependent on whether the resident experiences serious bodily injury; if so, report immediately, but not later than within two hours of the event. If there is no serious bodily injury to a resident (e.g., financial crimes against the resident), then report within twenty-four hours of the event.

What do you need to document when you make a report? Follow your policies and procedures and document appropriately your investigation, your findings, your response, and your report. Include dates, time and names of individuals involved. Involve legal counsel as soon as possible. Be prepared to discuss the event with your survey agency.

While it is good to have some guidance on the EJA's reporting requirements, reading the guidance won't answer all your questions about your obligation. For example, the guidance does not clarify what is a "crime" (the EJA says that's a matter of state or local law) or what a facility is supposed to do when an already overworked local law enforcement agency does not or cannot respond to the report. CMS and survey agencies are watching you as you bounce between the health care world to the world of detectives and back again.

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A Beautiful Sadness (continued from page 1)

Ted Goins tells me that nearly 550 people packed the church for Debbie's funeral service. I'm not surprised. He also said that the Debbie I knew as calm, sweet, and passionate about the elderly was also "a rock." "She was always here," he said, "calm and unflustered and always had her eye on the mission of LSA. She worked and really didn't miss a beat during her three-year battle with cancer, until the very end. One week before she passed, she was sitting in her bed lamenting how many emails she had that needed answering." That sounds just like Debbie.

Ted also said that he would gladly have made Debbie his health care and financial power of attorney and would have trusted any decision she made. I know, given Debbie's passion for end-of-life issues, that she would have considered that the highest of compliments and honors.

The outpouring of sadness, respect and affection for Debbie has come from across the state and nation to her family and the LSA family. She leaves a legacy of family, friends and thousands of seniors whose lives she touched and will continue to touch long after we are all gone. She championed LSA's New Pathways culture change initiative, and she pushed for LSA to rebuild the old Lutheran Home-Winston Salem in a socioeconomically depressed area of town because she thought those folks, nearly all indigent, deserved a better place to live. LSA broke ground on that new facility the same week Debbie passed. And, Ted says, "Her fingerprints are all over the beautiful new neighborhood design facility called Trinity Grove, in Wilmington." They are also all over the lives of those of us who were blessed to have known her.

Another song that comes to me now, as I sit and write this tribute to my good friend, goes like this: "I wanna know, the things they told us way back then are really so. I wanna make a little mark before I go. I wanna fly."

My dearest Debbie, rest assured you made a mark before you went. In the words of our Lord, "Well done, my good and faithful servant, well done." Now you are flying.

Ken Burgess advises clients on a wide range of legal planning issues arising in the SNF setting, assisted living setting and other aspects of long term care. He may be reached at 919.783.2917 or kburgess@poynerspruill.com.

Ken's Quote of the Month

"For what avail the plough or sail,
Or land or life, if freedom fail?"

~Ralph Waldo Emerson

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