NEWS

Making a Difference
Long Term Care Newsletter

BAKER DONELSON
EXPAND YOUR EXPECTATIONS℠

Issue 2, 2014

Managing Regulatory Risk in Nursing Home-Hospice Arrangements

Thomas William Baker, 404.221.6510, tbaker@bakerdonelson.com

Challenges of Nursing Home-Hospice Arrangements. As a nursing home resident's life expectation sunsets, transfer of the resident from the restorative care of a skilled nursing facility (SNF) to the palliative care of a hospice may be the best and most humane choice in the health care continuum. However, coordination of benefits is challenging when a hospice patient resides in a SNF, and the unwary may be exposed to regulatory risk.

Regulatory Risk Fundamentals. Virtually all regulatory compliance issues arise from two broad areas: (1) correct submission of claims for payment; and (2) financial arrangements with referral sources. Both must be considered in managing regulatory risk arising from nursing home-hospice arrangements, and each has its peculiar complexities.

Nursing Home-Hospice Conditions of Participation. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), published a final rule in 2013 on "Requirements for Long Term Care Facilities; Hospice Services," which provides the foundation for regulation of SNF-hospice arrangements. These requirements dovetail with the Hospice Conditions of Participation to promote coordinating care in a manner that prevents duplication of services and payments.

The regulations permit SNFs to arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices, provided that the SNF and the hospice enter into a written agreement that satisfies specific regulatory requirements. Each written agreement must include the following:

- A description of the services that the hospice will provide
- The hospice's responsibilities for determining the plan of care as described in the hospice regulations
- The services the SNF will continue to provide, based on each resident's plan of care
- A communication process, including how communication between the SNF and the hospice will be documented to ensure that the needs of the patient are met 24 hours per day
- A provision that the SNF immediately notifies the hospice of any significant change in the patient's physical, mental, social or emotional status; clinical complications that suggest a need to alter the plan of care; a need to transfer the resident from the SNF for any condition; or the patient's death

Continue on next page

Table of Contents

Managing Regulatory Risk in Nursing Home-Hospice Arrangements, *continued*

- A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided
- An agreement that it is the SNF's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative and ensure that the level of care provided is appropriately based on the individual resident's needs
- A delineation of the hospice's responsibilities, including, but not limited to: providing medical direction and management of the patient; nursing counseling (including spiritual, dietary and bereavement); social work; medical supplies, durable medical equipment and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions
- A provision that when SNF personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the SNF personnel may administer the therapies when permitted by state law and as specified by the SNF
- A provision stating that the SNF must report all alleged violations including mistreatment, neglect, or verbal, mental, sexual and physical abuse, including injuries of unknown source and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the SNF becomes aware of the alleged violation
- A delineation of the responsibilities of the hospice and SNF to provide bereavement services to the SNF staff

The regulation also requires that the SNF must notify the hospice immediately regarding the need to transfer a resident from the SNF for any condition, not just for a condition related to the terminal condition, and that the SNF representative designated to work with the hospice must have a clinical background.

Challenges in Coordinating Room and Board Benefits and Payments. There are peculiar rules related to payment for room and board. For a SNF-hospice resident who is either covered by Medicare or is a "private pay" resident, the SNF must provide the room and board and bill for it separately. However, if a SNF resident who qualifies for hospice coverage is a Medicaid beneficiary, the hospice must bill the applicable Medicaid program for the per diem and then pay the SNF for the room and board provided to the resident receiving hospice care. Accordingly, the accounts for SNF residents who qualify for the hospice benefit need to be carefully managed.

Continue on next page

Managing Regulatory Risk in Nursing Home-Hospice Arrangements, *continued*

Challenges in Coordinating Medicare Part D Drug Benefits with the Hospice Benefit. The most recently recognized challenge to coordination of benefits in a SNF-hospice arrangement arises from coordinating benefits under Medicare Part D with the hospice benefit. The manner in which Part D must be coordinated with the hospice benefit for SNF residents who elect hospice coverage is quite complex and involves the SNF. Therefore, it must be addressed in the SNF-hospice agreement.

When a SNF resident elects the hospice benefit, it might no longer be medically necessary to prescribe certain drugs as the individual shifts from restorative to palliative care. However, some drugs not covered by the hospice benefit may continue to be prescribed, and the individual resident who elects the hospice benefit may be responsible for full payment of the drugs.

Fraud and Abuse Statutes, Regulations and Rules Governing Hospice-SNF Relationships. SNF-hospice arrangements must also comply with the fraud and abuse laws governing relationships between referral sources.

Anti-Kickback Statute Analysis. The federal Anti-Kickback Statute is very broad and imposes sanctions on individuals or entities that knowingly and willfully offer, pay, solicit or receive any remuneration (which means virtually anything of value, whether direct or indirect, overt or covert, in cash or in kind) in return for or to induce or arrange for the referral of items or services reimbursable by Medicare, Medicaid or any other federal governmental reimbursement program. The Anti-Kickback Statute is implicated when referrals for items or services payable by a governmental reimbursement program run in one direction and remuneration runs in the opposite direction. In this situation, the Statute is implicated because the SNFs will enter into agreements with hospice providers for the provision of hospice services on the SNF premises.

Most SNF-hospice arrangements do not fall within a safe harbor regulation under the Anti-Kickback Statute. While this does not necessarily mean that the arrangement is illegal, it does mean that the SNF needs to manage the regulatory risk arising from the arrangement through appropriate compliance with the Standards of Conduct.

OIG Compliance Guidance. The Department of Health and Human Services, Office of the Inspector General (OIG) has expressed concerns about violation of the Anti-Kickback Statute in hospice-nursing home relationships for many years. A 1998 Fraud Alert identified the following potential violations:

- Hospice provision of free nursing services to non-hospice patients
- Hospice payments to nursing homes for Medicaid-covered room and board payments that are in excess of what the nursing home would have been paid under the Medicaid program or for goods and services that are actually components of room and board (Medicaid pays 95 percent of daily nursing home rate)

Continue on next page

Issue 2, 2014

Managing Regulatory Risk in Nursing Home-Hospice Arrangements, *continued*

- Inflated payments by a hospice to a SNF for provision of services to hospice patients that are not components of room and board

- Cross-referral arrangements (i.e., "You refer to my hospice if I refer to your SNF")

Compliance Guidelines. The key to any nursing home corporate compliance and ethics plan should be compliance with the SNF Compliance Guidelines promulgated in 2008, which include the following Standards of Conduct:

- No hospice will be permitted to pay any nursing home more than a Medicaid- covered patient would have paid for room and board.

- Any additional non-core services that the nursing home provides to the hospice must be provided at fair market value.

- No party shall provide the other party with free goods or services of any nature, including, without limitation, nursing services provided by the hospice to the nursing home for non-covered services.

- The hospice shall take substantive precautions to ensure that the hospice patient qualifies for the hospice benefit.

- The hospice shall have procedures for reviewing its claims for payment to ensure that the hospice provides all items and services described in the plan of care.

The adage that "an ounce of prevention is worth a pound of cure" is particularly applicable when health care providers address management of regulatory risk, and every SNF and hospice needs to be sure that its arrangements and compliance and ethics plans reflect current statutory and regulatory requirements.

NEWS

Making a Difference
Long Term Care Newsletter

BAKER DONELSON
EXPAND YOUR EXPECTATIONS℠

Issue 2, 2014

Long Term Care Providers Take Note: The Top Five Employment Law Mistakes to Avoid

Russell W. Gray, 423.209.4218, rgray@bakerdonelson.com

Americans love top ten lists. In that love-for-lists spirit, and in an effort to be informative, we list below the top five employment law mistakes that long term care employers need to avoid.

1. Implementing a No-Fault Attendance Policy Without Regard to the Americans with Disabilities Act (ADA). No-fault attendance policies are fairly common among long term care employers. Recently, the EEOC has pursued employers that implement no-fault attendance policies without considering if an absence counted under that policy may constitute a disability that the employer must reasonably accommodate under the ADA. An employer that has reason to know that an employee is missing work due to a medical condition needs to consider whether such medical condition may constitute a disability. Then, the employer must consider possible reasonable accommodations for such disability rather than simply counting the employee's absences under a no-fault attendance policy.

2. Not Recognizing Retaliation Issues. The long term care industry presents a potentially ripe environment for unlawful retaliation claims. Employees, for instance, may engage in protected activities by complaining either internally or externally (even if ultimately without global revision merit) about resident care issues, alleged billing irregularities or alleged discrimination. Long term care employers must ensure that they take adverse employment action against an employee only for legitimate, nondiscriminatory reasons and that they can support such termination through sufficiently documented evidence. Such measures will significantly reduce the risks associated with retaliation claims.

3. Failing to Provide Proper Notices and Information under the Family and Medical Leave Act (FMLA). The FMLA sets forth specific requirements for providing certain notices to employees about their FMLA rights and how employers must designate leave as FMLA leave. Despite specific instructions from the Department of Labor (DOL) in that regard, long term care employers all too often fail to meet those requirements at times because of untrained employees at the facility level. Long term care employers need to ensure that their managers understand the FMLA and its notice requirements. The training should include how to provide proper FMLA notices and information, such as the DOL form WH-381 and WH-382, to their employees.

4. Failing to Count Workers' Compensation Leave as FMLA Leave. The FMLA regulations make clear that leave for a workers' compensation injury and FMLA leave can run concurrently if the workers' compensation injury constitutes a "serious health condition." Long term care employers, however, at times fail to designate workers' compensation leave as FMLA leave. Such failure can result in an employee returning from a lengthy workers' compensation leave and then immediately taking FMLA leave for another reason or claiming that the employer did not reinstate him or her, properly maintain his or her benefits or otherwise meet the requirements of the FMLA as applied to the workers' compensation leave. Long term care employers should implement procedures and provide proper training to ensure that they are properly designating workers' compensation leave as FMLA leave.

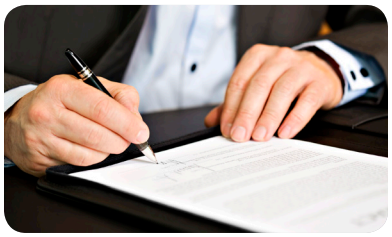
Continue on next page

Long Term Care Providers Take Note: The Top Five Employment Law Mistakes to Avoid, *continued*

5. Engaging in Improper Pay Practices for Meal Periods. The DOL takes the position that nonexempt employees must be "completely relieved from duty" during meal periods. According to the DOL, if an employee is interrupted for work during his or her meal period, the employer must pay the employee for the entire meal period. Certified nursing assistants may be particularly vulnerable to meal period interruptions due to the nature of their job duties and meal practices. Long term care employers must take an active role to ensure that nonexempt employees are not performing work duties during an unpaid meal period.

HUD Helps Clear Confusion in Loans to the Long Term Care Industry

Andrea C. Barach, 615.726.7321, abarach@bakerdonelson.com



Overview – New Guidance from HUD. By now, long term care project owners are very aware of the advantages of HUD-insured financing. However, HUD's program policies continue to challenge some providers who own and/or operate multiple facilities.

On April 25, 2014, HUD helped clear up some confusion with its new Mortgagee Letter, which offered additional guidance on some questions raised by lenders and borrowers in connection with portfolio health care financing. To read the entire Mortgagee Letter, click here.

HUD's Rationale for Master Leases Restated and Explained. HUD clarified its reasons for its long-standing policy that requires master leases for groups of projects under common ownership or operation – to tie together multiple facilities with the same ownership so that revenue from each facility is available to support the other facilities within the portfolio.

HUD expressly acknowledges its purpose is to prevent defaults under the mortgages it insures. Thus, HUD agrees, and in this Mortgagee Letter has clarified, that project owners need a reasonable time to correct deficiencies and cure defaults before mortgage defaults are triggered. This offers comfort to some borrowers who may otherwise be reluctant to enter into the master lease.

In addition, HUD now expressly recognizes that future projects may be added to or removed from a master lease, and the new guidance states that the loan documents should contemplate amendments to add future HUD-financed facilities or remove facilities. This is a significant clarification and an endorsement of lenders' inclusion of provisions similar to partial release provisions in conventional financing.

Continue on next page

HUD Helps Clear Confusion in Loans to the Long Term Care Industry, *continued*

The new guidance from HUD additionally reminds the long term care financing community that despite inclusion of multiple projects within the same master lease, each project stands alone, as a single underwritten loan, and must qualify, standing alone, for Section 232 financing. A poor project that would otherwise not qualify may not be financed under Section 232 by adding it into a portfolio of other very strong projects. This is not new, but it bears remembering.

Master Leases – HUD Guidance on Structural Issues. What may be most interesting is that HUD has finally weighed in on some significant structural issues that have caused many practitioners much anguish and confusion. In this author's opinion, we should view these new guidelines as very productive first steps, but not necessarily the final conclusion in every respect.

- **Multiple Minority Owners**. Here, a portfolio of facilities with common majority ownership has different minority investors in each project (For example, Investor A owns 5 percent of Project A but no interest in Project B, and Investor B owns 10 percent of Project B and no interest in Project A.) HUD recognizes that it is unfair to expect that Investor A's interest in cash from Project A would be usable to support losses at Project B. HUD's guidance will now permit the minority interest to be free from the pledge so long as the majority owner's profits from each project are available to support all projects under the master lease. While simple in principle, negotiation of the actual detailed transaction structure may be challenging, and HUD recognizes that it will need to be creative to address situations with multiple minority owners.

- **Multiple Operators**. This is the situation facing some real estate investment trusts (REITs). A REIT may acquire health care projects from different owners and thus have projects leased and operated by multiple unrelated operators, while the ownership interests remain aligned within the same REIT-affiliated group. Standard HUD policy requires that projects under common ownership be financed within the same master lease portfolio. However, if the operators are not affiliated with one another, a cross guaranty of sublease obligations, which is the heart of a HUD master lease, is not going to be palatable to them. With the new guidance, HUD recognizes that a single master lease is not feasible and will allow separate leases/master leases for each operator or affiliated operator group so long as the majority ownership group pledges profits from each master lease to support all of the projects. HUD suggests a "master landlord" structure would be used to create this overall pledge across the master leases. Borrowers and lenders will need to work together with HUD in order to craft a structure; however, this author retains some doubt as to the practicality of a master landlord concept. There may be alternatives to a master landlord that will fit into the program requirements, such as a pledge by the affiliated owner of surplus cash or the establishment of a reserve from surplus cash that will give HUD the protection of financial responsibility across the portfolio.

Continue on next page

HUD Helps Clear Confusion in Loans to the Long Term Care Industry, *continued*

- **Multiple Lenders**. HUD recognizes that a borrower may need or want to select different lenders for projects in its portfolio. Before the current letter, it was unclear whether future projects financed by a new FHA lender must be added to the owner's pre-existing master lease portfolio with its prior lender. HUD now acknowledges that the borrower can use separate master leases for each lender, so long as an uncured default under one master lease will trigger a default under all master leases. This could be very problematic for lenders. While a pledge of surplus cash accounts may be a workable solution, it is clear that borrowers and lenders will need to work with HUD to create a solution that works for all parties.

Conclusion. With this most recent guidance we have received some much-needed help in sorting through the challenging issues in the HUD master lease portfolios, but questions still remain, and the negotiation of actual documents may prove interesting in the days ahead.

In The Trenches

Andrea Barach, Jim Levine and Rob Wollfarth represented a large nonprofit senior housing provider in transactions to replace the investor limited partner in two projects: modification of existing HUD insured mortgage financing; and removal of co-general partner and negotiated payoff of subordinate debt.

Andrea Barach also represented a nonprofit nursing home company in the acquisition of a minority interest in its management company, including renegotiation of management agreements in connection with the acquisition.

Davis Frye, La'Verne Edney and Brad Moody obtained a directed verdict in a nursing home negligence case in Mississippi which the plaintiff alleged that a nursing home resident developed a decubitus ulcer on her foot that required amputation and ultimately resulted in the death of the nursing home resident.

On March 18, the *Nashville Post* reported that Andrea Barach was named to the Nashville Bar Foundation 2014 Fellows class.

On March 20, *The Chattanoogan* noted that Rich Faulkner served as a panelist at the 2014 American Health Lawyers Association Long Term Care and the Law Program, which was held in Las Vegas. Rich participated in the panel discussion, "Transfers of Distressed Long Term Care Facilities."

Christy Crider presented "Ten Tips to Keep Your Litigation Costs Under Control" during the Kentucky Association of Health Care Facilities Quality Summit in Bowling Green, Kentucky, April 29 – 30.

In The Trenches, *continued*

On May 19, 2014, Jim Levine served on the faculty of HUD's "Closing School," an internal seminar for all HUD closing attorneys throughout the nation. Jim spoke about issues and challenges arising in HUD loans in which the operator of a long term care facility has different ownership than the owner of the real estate. Jim also spoke about matters relating to changes of operators of long term care facilities subject to HUD loans.

In June, Russell W. Gray and Kathlyn Perez presented "Understanding New Department of Labor Regulations Relating to Home Health Worker Pay" as part of the Baker Donelson Long Term Care webinar series.

Articles co-authored by Davis Frye and Brad Smith ("Top 10 Ways to Avoid Litigation") and Angie Davis and Steven Fulgham ("Top 10 Best Practices for Social Media in LTC") were published in *McKnight's Long-Term Care News* in April and June 2014, respectively.

On May 19, Andrea Barach and Jim Levine co-authored the article "HUD Weighs in on Questions in Long Term Care Finance" in *National Mortgage News*.

Andrea Barach and Jim Levine co-authored the Baker Donelson Client Alert, "HUD Issues New Handbook for Long Term Care Financing Under Section 232."

NEWS

Making a Difference

Long Term Care Newsletter

BAKER DONELSON

EXPAND YOUR EXPECTATIONS℠

Issue 2, 2014

Join Us For Our Monthly Long Term Care Webinar Series

7.8.2014: **Discussion of Apology Laws and Setting Realistic Expectations**
presented by Summer McMillan and Joshua Powers

8.12.2014: **REITs and Long Term Care Facilities**
presented by Ken Beckman and Rich Faulkner with special guest panelists

9.9.2014: **Are You Compensating Your LTC Employees Correctly?**
presented by Whitney Harmon

10.14.2014: **Nurse Practitioners and Physician Assistants: Opportunities for LTC Facilities**
presented by Rich Faulkner and Dr. Randy Heisser

12.9.2014: **What's New in Federal Guidelines Governing LTC Corporate Compliance and Ethics Plans**, presented by Tom Baker and Alisa Chestler

1.13.2015: **Navigating the Bermuda Triangle of FMLA, ADA and Workers' Compensation**
presented by Jenna Bedsole

To view recordings of past presentations in our webinar series, click here.

Making a Difference Editors:

Craig C. Conley
Shareholder
Memphis
cconley@bakerdonelson.com

Amy W. Mahone
Of Counsel
Chattanooga
amahone@bakerdonelson.com