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News for North Carolina Hospitals
from the Health Law Attorneys of Poyner Spruill LLP

Here Comes the Patient Protection and Affordable Care Act: What Does It Mean for Hospitals?

by Kim Licata

President Obama's signing of the Patient Protection and Affordable Care Act of 2010 (the Act) into law this past month was welcomed as a historic change to our nation's health care system. The 2,400-page reform bill (H.R. 3590) cleared Congress on March 21, 2010, after a heated and mostly partisan vote. Naturally, hospitals and other health care providers benefit (financially) from the Act's insurance market and coverage reform to the extent these measures increase the number of patients with insurance coverage (an estimated 32 million newly insured individuals) and reduce self-pay and charity care cases. In the event that you haven't had time to digest the voluminous text of the Act, we have identified 10 aspects of the new Act of likely interest to hospitals.

Tracking Hospital Readmission Rates. First, acute care hospitals will be able to participate in a program under Medicare to incentivize improved quality outcomes by tracking hospital readmission rates and offering financial incentives to reduce preventable readmissions. This program authorized by Section 3025 of the Act will track excess readmissions and provide public reports of hospital readmission rates. The Centers for Medicare & Medicaid Services (CMS) will oversee this program, which is anticipated to be established in 2012.

Medicare Pilot Program for Bundling of Hospital and Physician Services. Second, Section 3023 of the Act authorizes another new Medicare nationwide pilot program aimed at the integration of medical care that will affect hospitals starting in 2013. This program will bundle payments to physicians, hospitals and others involved in a patient's treatment during an episode of care involving hospitalization to encourage the coordination, efficiency and quality of specified services among providers. The services subject to the new pilot program identified in the Act include:

- Acute care inpatient services;
- Outpatient hospital services (includes emergency department services);
- Post-acute care services (includes home health, skilled nursing, inpatient rehabilitation, and inpatient hospital services by a long term care hospital);
- Physician services in and outside the acute care setting; and
- Any other service identified by regulation.

The Act details that the pilot program would be limited (at least initially) to beneficiaries having one of eight "applicable conditions" to be identified by the Department of Health and Human Services (HHS) as such conditions that involve six common characteristics including being amenable to a bundled payment and involving an opportunity for providers and suppliers of services to improve the quality of care while reducing expenses.

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Is Your I-9 Policy Vulnerable to Immigration and Customs Enforcement Sanctions? *A Review*

by Jennifer Parser

As you probably know, Form I-9 is a mandatory employment eligibility verification form. Completion of the I-9 by both employer and employee must occur within three days of hire for every employee hired after November 6, 1986, regardless of nationality or immigration status.

I-9 violations can occur even if your entire workforce is legal. A paperwork violation can be something as simple as failing to date or sign the I-9 Form. Fines can range from $110 to $1,100 per paperwork violation, but increase exponentially for knowing violations. For instance, employers convicted of having knowingly hired illegal aliens or continuing to employ aliens who are or became unauthorized to work may face fines of up to $3,000 per employee and/or six months' imprisonment.

The Obama administration has made it clear that Immigration and Customs Enforcement (ICE) of the Department of Homeland Security will be seeking out and sanctioning employers in an effort to stop the employment of illegal aliens. To make good on that promise, ICE issued over 650 notices to inspect I-9s on a single day in 2009, which was more than it issued in all of 2008. Although hospitals have not to date been a specific target for enforcement action by ICE, there has been a tremendous increase in enforcement actions over the past several years. Consequently, hospital employers must evaluate their current I-9 policies.

What about Independent Contractors' Workers' I-9s?

Using an independent contractor or subcontractor whose illegal workforce is working on your premises is a vulnerable point for ICE sanctions against your hospital. ICE can deem these workers to be your employees under two circumstances: (1) by indications of there being an employer/employee relationship, extremely broadly defined by the amount of control your managers exercise over these workers, or (2) by your having actual or "constructive knowledge" of the independent contractor's workforce being illegal.

Let us look at the two most common types of independent contractors found in the hospital setting and apply them to the above. The first is independent contractor companies such as cleaning or maintenance services. To avoid liability based on knowledge of their workers' illegality, your HR department should not review the independent contractor's workers' I-9s. First, reviewing these workers' I-9s would give your organization either actual or constructive knowledge of a potentially illegal worker. Second, doing so may also be evidence of an employer/employee relationship with the worker.

Knowing or having constructive knowledge that the independent contractor's employees on your premises lack employment authorization can be considered harboring, a felony carrying a maximum of 10 years' imprisonment and the greater of $250,000 in fines or twice the gain these workers afforded your company. Wal-Mart agreed to a settlement with ICE of $11 million in penalties for turning a blind eye to a subcontractor that cleaned Wal-Mart's premises with an illegal workforce. ICE defines constructive knowledge as "knowledge which may be fairly inferred through notice of certain facts and circumstances which would leave a person, through the exercise of reasonable care, to know about a certain condition."

At a minimum, there are several protective measures you can take if you use such independent contractors. Have your agreements with any independent contractor reaffirm an independent contractor relationship, confirm the legality of its workforce and provide indemnification of your hospital in the event you are targeted by ICE for any illegal workers on your premises. Note that this protection may still not absolve your hospital of liability if the independent contractor's workforce is illegal and is being supervised, controlled and otherwise treated like employees by your managers. Train your managers to treat independent contractors and its workers as such, and not as hospital employees.

The second form of independent contractor often found in a hospital setting is a doctor performing services as a locum

tenens. Once again, do not review this doctor's I-9 or ask for employment authorization, since by doing so you may acquire knowledge of his employment authorization as well as risk having him considered to be your employee. Instead, reaffirm the independent contractor relationship in his contract and have him certify that he is employment authorized and will indemnify the hospital for any sanctions or attorneys' fees resulting from an ICE investigation. It is also good practice to require the doctor to produce an opinion letter from an immigration attorney that his immigration status has been reviewed and that he is indeed authorized to work in the U.S.

In assessing the risk of sanctions by ICE based on illegal workers employed by an independent contractor, you should not rely upon an IRS determination by your filing an SS-8 as to whether an independent contractor relationship exists. In a case litigated in 1993, the court did not follow the IRS determination but instead relied upon the definitions of "employee" and "independent contractor" found in the Aliens and Nationality Chapter of the Code of Federal Regulations:

"The term employee means an individual who provides services or labor for an employer for other wages but does not mean independent contractors as defined in paragraph (j) of this section...

"(j) The term independent contractor includes individuals or entities who carry on independent business, contract to do a piece of work according to their own means and methods, and are subject to control only as to results. Whether an individual or entity is an independent contractor, regardless of what the individual or entity calls itself, will be determined on a case-by-case basis. Factors to be considered in that determination include, but are not limited to, whether the individual or entity supplies the tools or materials; makes services available to the general public; works for a number of clients at the same time; has an opportunity for profit or loss as a result of labor or services provided; invests in the facilities for work; directs the order or sequence in which the work is to be done and determines the hours during which the work is to be done."

Even if a hospital's independent contractor meets the definition quoted above, the hospital is still liable if it knows or has constructive knowledge of the workers' illegal status, such as it might acquire through examining the individuals' I-9s.

Some Questions to Determine If Your Hospital Would Survive an ICE Audit

Some initial questions to use in determining whether your hospital would survive an ICE audit are the following:

- When does your HR Department use Form I-9s? Are job applicants completing them as part of the hiring process or once they are hired?
- Is your HR Department copying blank I-9 forms for completion? If so, are they copying a current vs. outdated I-9 and if so, is it complete?
- How are your HR managers and your employees correcting any mistakes or completing any omissions in the I-9?
- How and where does your organization maintain its I-9s?
- Is HR requesting certain documentation from the employee in completing the I-9?
- Is HR copying that documentation, and if so, is it being kept?
- Where is such supporting documentation kept?
- Do you know when an I-9 must be updated or reverified?
- Do you have a "tickler" system for employment authorization documentation that has an expiration date, and if so, do you know how much time you should give an employee to supply current documentation?
- Do you know the I-9 retention rules, and does your organization have a written policy about their retention and destruction?
- If your hospital acquires a business and its employees, do you know if you are liable for errors in the previous owners' I-9s?
- Does your hospital use subcontractors or independent contractors? If so, are you properly protected in the event that a member of its workforce on your premises is illegal?
- Are your managers trained not to treat the independent contractors' workers as employees?
- Can HR easily access and retrieve I-9 documentation if requested by a 72-hour ICE Notice of Inspection?

Conclusion

The best way to avoid I-9 and related problems is to be pro-active. Don't wait for an ICE Notice of Inspection or worse, an unannounced raid, to deal with defective or missing I-9s or to ascertain exposure through your independent contractor. To avoid problems with ICE, have clear, consistent I-9 policies in place; conduct your own I-9 internal audit on a regular basis; and review your independent contractor relationships.

Jennifer Parser practices in the areas of immigration, employment and international law. She is licensed in the state of New York and is not licensed in North Carolina. Jennifer may be reached at **jparser@poynerspruill.com** or **919.783.2955**.

Delegation versus Supervision — What's the Difference? Do You Have It "Right"?

by Mike Hale and Cindy Morgan, RN, MSN, CHC

"You can delegate authority, but you can never delegate responsibility for delegating a task to someone else. If you picked the right man, fine, but if you picked the wrong man, the responsibility is yours—not his," said Richard E. Krafve, a past Vice-President and General Manager of Ford Motor Company. No matter the setting, whether the auto industry or health care, this statement remains true. Registered nurses (RNs) have the ultimate decisions when it comes to delegating care to patients in hospitals. This is a huge responsibility and should never be taken lightly.

On the other hand, supervision, according to The National Council of State Boards of Nursing, is "the provision of guidance or direction, evaluation and follow-up by the licensed nurse for accomplishment of a nursing task delegated to unlicensed assistive personnel." Supervision is continuous monitoring to ensure the tasks delegated are being delivered appropriately and effectively.

State nursing practice acts usually address delegation and supervision. In North Carolina, the Nursing Practice Act outlines the 10 components of the "practice of nursing by a registered nurse." NC G.S. 90-171.20 (7). Two of the 10 components relate directly to delegation and supervision as follows: (d) teaching, assigning, delegating to or supervising other personnel in implementing the treatment regimen; and (i) supervising, teaching and evaluating those who perform or are preparing to perform nursing functions and administering nursing programs and nursing services.

In addition to our Nursing Practice Act, the Medicare Hospital Conditions of Participation (CoPs) require the RN to assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available. A primary focus of safe care delivery is validating competencies before delegating a task. Once the RN verifies competency and assigns the tasks, then continued and consistent supervision is necessary by the RN to ensure that quality of care is maintained. One of the leading survey deficiencies under the CoPs for a number of Medicare-certified providers is failure to meet the nursing supervision requirements.

Delegation is defined as entrusting a person acting as an agent or representative or empowering a person to act for another, or said simply in other words, allowing someone to do something in your place. The advantages to delegation include allowing the RN to be able to oversee more patients or concentrate on bigger, more complex issues. On the other hand, if not managed appropriately, the RN may be "stretched too thin" and the supervision component that is so important on an ongoing basis may be neglected. The main point to remember is that delegating tasks does not remove the responsibility that lies with the RN.

Delegation takes us back to the basics of the nursing process: assessing, planning, implementing and evaluating with each patient contact. This process will enable the nurse to ensure that quality care is delivered and that the staff to whom the nurse delegates is qualified and competent to deliver the care needed in each situation.

The National Council of State Boards of Nursing lists the following Five Rights to Delegation (Rights) in a position paper titled "Delegation: Concepts and Decision Making Process," 1995, www.ncsbn.org/323/htm.

- Right Task – One that is delegable for a specific patient
- Right Circumstances – Appropriate patient setting, available resources and other relevant factors considered
- Right Person – Right person is delegating the right task to the right person to be performed on the right person
- Right Direction/Communication – Clear, concise description of the task, including its objective, limits and expectations
- Right Supervision – Appropriate monitoring, evaluation and intervention, as needed, and feedback

Remember that delegating tasks does not remove the responsibility from the person who is delegating. Utilizing these rights as guidelines for delegating tasks to other health care personnel should serve RNs well in ensuring patient care is quality driven. Pairing the "right" delegation decisions with on going supervision requirements further ensures patient care is safely delivered.

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False Claims Act and Stark Developments. Third, the Act includes a number of initiatives to bolster the government's efforts to fight health care fraud and abuse in Medicare, Medicaid, the children's health insurance program (CHIP), and private insurance. Section 1313 details the applicability of the federal False Claims Act (and its remedies) to claims filed related to the soon-to-be created American Health Benefit Exchanges (by states) to provide consumer choices and health insurance competition. Next, Section 6409 of the Act requires CMS to develop a Stark Self-Referral Disclosure Protocol (SRDP) for actual and potential self-referral violations. The requirement of developing the SRDP comes almost exactly one year after the Office of Inspector General (OIG) stated that self-disclosures of only Stark violations would no longer be accepted under the existing Self-Disclosure Protocol. The Act does not involve any other federal agency (not the OIG or the U.S. Department of Justice) in the development or implementation of the SRDP, although collaboration between agencies seems likely to ensure consistency and full resolution of disputes. Starting this year, Section 6003 of the Act requires referring physicians to provide patients with written lists of suppliers for imaging services or other specified designated health services in the patient's area of residence when the physician is relying on the in-office ancillary services exception to Stark. Finally, Section 6001 of the Act further limits the Stark exception on physician ownership of hospitals to whole hospitals and otherwise places significant restrictions on physician-owned hospitals.

Grants for Training Primary Care Clinicians. Fourth, the several provisions of the Act focus on an enhanced role for primary care and the health care workforce, including a section authorizing multiple federal grants (potentially to eligible hospitals) for enhanced education and training programs for primary care clinicians. These grants may be awarded to hospitals, medical or osteopathic medical schools, other physician training programs, or nonprofit entities that successfully apply for them. The grants for these training and education programs will last up to five years. The training programs must focus on family medicine, general internal medicine or general pediatrics. One of the goals of Section 5301 of the Act is to increase the number of primary care clinicians and encourage this increase through grants and funded programs to hospitals, schools of medicine and others able to make this goal a reality.

Physician Incentive Payments. Fifth, other physician payment-related provisions include a new program aimed at incentivizing physicians based on quality of care versus volume of services and a 10% incentive payment for primary care services to primary care physicians (and allied health professionals) under Section 5501 starting in 2011. General surgeons practicing in health professional shortage areas (HPSAs) are also eligible for a 10% incentive payment on "major surgical procedures" starting in 2011. These incentive payments to primary care clinicians and general surgeons are to end in 2016 unless the funding for the incentives is increased by future legislation.

Preventive Services Provided by FQHCs. Sixth, the Act expands Medicare payments to preventive services provided in federally qualified health centers (FQHCs) by 2011 and calls for the development of a prospective payment system for services furnished by FQHCs. New health plans will be required to cover preventive services with little or no cost to patients. Improved preventive care is associated with fewer acute episodes for medical conditions and therefore reduced expenditures for health care.

List of Hospital's Standard Charges. Seventh, the Act requires each hospital to establish and make public a list of its standard charges for items and services, including by diagnosis-related groups (DRGs). This measure is contained in Section 2718 of the Act and relates to reducing the cost of health care. Not only does this section require clear accounting for costs and the public list of hospital charges, it also strives to "ensure consumers receive value" for their health insurance premiums by mandating a rebate to consumers under specified conditions.

Excise Tax on High-Cost Employer-Funded Health Plans. Eighth, a hospital as an employer will be subject to an excise tax on high-cost employer-provided plans costing over $27,500 for family coverage and $10,200 for individual coverage. Higher thresholds for the imposition of this tax are effective for rescue squad and ambulance crews as high-risk professionals. The Act makes other changes to the required covered services, newly impermissible exclusions and limits, the cost, and other aspects of insurance coverage offered by employers. In addition, the Act imposes a 2.9% excise tax on the sale of medical devices by manufacturers and importers, but generally speaking, this tax should not be applicable to hospitals (or affiliates) reselling medical devices not manufactured or imported by hospitals.

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No Surprises Found by the Government Accountability Office: Sharing Personal Health Information Through Health Information Exchanges Improves Patient Care

by Kim Licata

On February 17, 2010, the Government Accountability Office (GAO) released its Report to Congressional Committees on Electronic Personal Health Information Exchange (GAO-10-361), a study initiated to promote the use of information technology for the electronic exchange of health information among providers and other health care entities involved in the delivery of health care services. The many benefits of appropriate and well-designed electronic exchange of health information motivated Congress to pass the Health Information Technology for Economic and Clinical Health (HITECH) Act as part of the American Recovery and Reinvestment Act of 2009 to incentivize the adoption of technology to promote such electronic information exchange. While the GAO study does not provide particularly unexpected results, the report confirms the common adoption by health information exchanges (HIEs) of seven elements of the Fair Information Practices underlying the regulations and policies of the Health Insurance Portability and Profitability Act of 1996 (HIPAA) and validates the purpose of HIE and electronic information exchange.

The Study Design

The study focused on case studies of four HIEs of approximately 60 HIEs reported to be operational. Within these case studies, the GAO also studied a selection of the providers identified as active participants in the HIEs. Additionally, the GAO interviewed two integrated health care delivery systems, two professional associations and a state electronic health collaborative. The study took place between May 2009 and February 2010.

Standards and Rules Applicable to Exchange of Health Information

It is currently unclear exactly which set of federal regulations establish privacy and security requirements of HIEs, but in general, HIEs have adopted the core elements upon which HIPAA's privacy and security regulations were based. In the coming weeks, the issuance of the anxiously awaited HITECH regulations may clarify the extent to which HIPAA's Privacy and Security Rules may apply to information exchange by HIEs.

After establishing the privacy principles adopted by HIEs, the report examined and noted the following benefits of a successful information exchange:

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- Informing individuals about the use of their i
- Obtaining individual consent
- Facilitating individual access to and correctio
- Limiting use and disclosure to a specific purp
- Providing security safeguards
- Ensuring that data is accurate, timely and cor
- Establishing accountability for how personal

- Increased patient safety
- Improved quality of health care
- Enhanced efficiency of administrative functions
- Reduced costs
- Decreases in the duplication of diagnostic procedures
- Prevention of medical errors

None of these stated benefits surprises health care entities working in health information technology, and all of them have consistently been offered as justifications for incentivizing providers and health care entities to convert to electronic health information records.

Many of the hospitals in western North Carolina have joined an exchange linking the data from their facilities to other area facilities to coordinate patient care and improve outcomes. To date, participants in the exchange have had positive interactions with each other and have found the electronic exchange of information has confirmed many of the findings of this report. The success of this program in western North Carolina should provide further incentive to hospitals in other areas of the state to investigate whether joining a health information exchange is an appropriate step toward more streamlined and coordinated patient care for the patients living in their service areas.

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Keep in mind, as North Carolina providers continue to grapple with how to design an effective, yet protected, statewide health information superhighway, this GAO report, other studies, and experts in the field gain significance. Joining a HIE raises many legal issues—particularly liability, privacy and security issues—such that involving a qualified consultant or attorney to prepare or review the necessary agreements, as well as associated policies and procedures, is essential to maximizing the benefits of health information exchange while minimizing the potential risks.

To read the GAO report, go to http://www.gao.gov/cgi-bin/getrpt?GAO-10-361, with highlights identified by the GAO at http://www.gao.gov/highlights/d10361high.pdf.

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"Independent" Board to Set New Medicare Payment Formulas. Ninth, Section 3403 of the Act authorizes the creation of the Independent Medicare Advisory Board (the Board), which will determine new Medicare payment formulas. The Board is prohibited under the Act from proposing to raise beneficiary premium, ration care and raise revenues. The Board also cannot propose to reduce payment rates for items and services provided prior to December 31, 2019. This Section involves the Chief Actuary of CMS and is intended to reduce Medicare expenditures over time.

Demonstration Project for Development of Alternative Tort Litigation Systems. Finally, Section 10607 of the Act creates a demonstration project under which states are eligible for grants to develop, implement and evaluate alternatives to the current tort litigation system to resolve disputes over injuries allegedly caused by health care providers or organizations. The alternatives under these grants must resolve the disputes as well as promote a reduction in health care errors through the encouragement of reporting patient safety data related to these disputes to patient safety organizations or other entities that "engage in efforts to improve patient safety and the quality of health care." The government has sought to increase the reporting of patient safety data, especially as it relates to pending malpractice claims, for the purpose of improving care and reducing preventable errors through various initiatives for the past five years. States awarded such grants will be required to report their findings and analysis to the Secretary of HHS.

Conclusion. The Act offers multiple opportunities for hospitals to improve patient care, finances and health care workforce. While the lengthy Act provides details for many opportunities, we can expect further refinements, amendments and explanations in future legislation and regulations. Since much of the Act's implementation will not occur until 2011 to 2014, we also anticipate that some provisions of the Act will substantially change or even be eliminated. Much time and effort will likely be spent in the next decade striving to decipher and then implement the many reform measures of the Act. In the interim, hospitals are encouraged to consult with an attorney or consultant familiar with the Act concerning the Act's applicability to you.

For more information on the Patient Protection and Affordable Care Act of 2010 or other health law-related issues, please contact **Kim Licata** at **919.783.2949** or **klicata@poynerspruill.com**.

The Newest Addition to Our Health Care Group

Poyner Spruill welcomes its 10th full-time attorney, Kim Licata, to our experienced Health Care group. Kim joins us with previous legal experience as in-house counsel for a physician staffing company and as an attorney in large law firms in the Southeast. At Poyner Spruill, Kim will work on a variety of health care matters, with a focus on counseling long term care providers, physicians, hospitals, and e-Health companies on the ever-changing health care laws and rules. Kim devotes much of her practice to aiding retirement communities, skilled nursing facilities and other long term care providers in operational, litigation and compliance matters from policy development and implementation to risk management.

Kim earned her bachelor of arts degree in American government and philosophy from the University of Virginia in May 1993. While excelling as an Echols Scholar at the University of Virginia and graduating with her undergraduate degree in three years, Kim switched her ACC loyalties to the Tar Heels of the University of North Carolina, where she received her law degree in May 1996. While in law school, Kim was active in the *North Carolina Law Review* and enjoyed being a Chancellors' Scholar, which gave her the opportunity to work with and be mentored by several outstanding professors.

After law school Kim practiced health care law and public sector litigation at Dickstein Shapiro LLP in the District of Columbia until 1998, when she moved to Research Triangle Park, North Carolina to join the Health Care group of Womble Carlyle Sandridge & Rice PLLC. Kim's legal experience includes administrative and regulatory advice, medical malpractice and product liability litigation defense, and general business and litigation counseling. She delights in working with clients and keeping clients and colleagues updated on the legal intricacies applicable to providers and companies in the health care world. You'll be able to see Kim's work in both our award-winning newsletters and in presentations to our clients and health care companies in our region.

In addition to having spent time as a law firm attorney, Kim gained insight into corporate decision making and executive management pressures when she joined Sterling Healthcare as a Senior Vice President and General Counsel. Kim's responsibilities as the sole in-house counsel for the physician staffing company included management of all legal representation (for the company and its numerous subsidiaries from bankruptcy and corporate issues to risk management and medical malpractice defense), oversight of hospital and physician contracting, and corporate adherence to federal and state laws and regulations. Prior to the company's relocation to Florida, Kim worked with a new turn around team and investors to begin the company's successful sale.

Kim participates in school and community activities in Chapel Hill and, time permitting, enjoys a good book, traveling and photography. We are thrilled to have Kim join our health care team and look forward to your working with her.

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