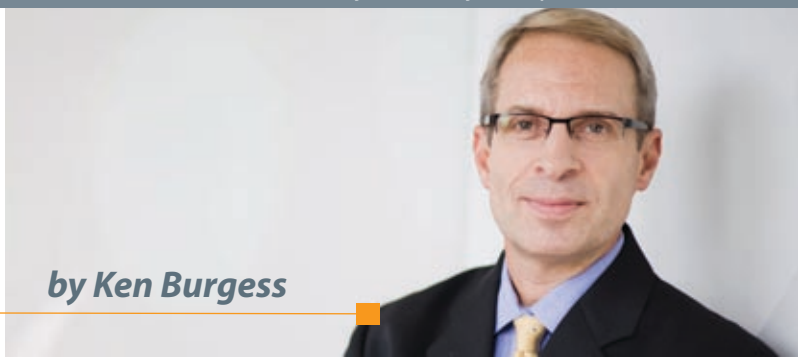
DECEMBER 2010

SHORTS ON LONG TERM CARE
for the North Carolina LTC Community from Poyner Spruill LLP

CMS Issues Draft Revised Survey and Enforcement Guidance On SNF Advance Directives Policies and Implementation



by Ken Burgess

In early October, the Centers for Medicare and Medicaid Services (CMS) issued draft revised guidance to surveyors on the responsibility of SNFs to have policies and procedures, and to properly implement and honor advance directives (living wills, health care powers of attorney, the MOST form) of residents. There's good news and bad news in this.

The good news is that the N.C. long term care industry is far ahead of the curve on advance directives information. The N.C. Healthcare Facilities Association, working with our firm, has developed, distributed and trained on policies and procedures governing advance directives in SNFs in the last couple of years. The model policy we developed for the association is consistent with the expectations of CMS regarding end of life care planning and documentation, including advance directives. So, if you have obtained, implemented and are following that policy, you should be in great shape.

The bad news is that this revised guidance seems to signal a heightened focus on advance directives in SNFs. As with all recent CMS survey/enforcement guidance, the CMS October guidance on advance directives not only explains facility obligations regarding end of life care planning and options, but also directs surveyors about what to look for and how to survey for compliance with those obligations. Each facility should obtain this guidance and, in our opinion, train staff on it, paying particular attention to the examples CMS gives surveyors of the various scope and severity levels that should or may be assigned to various failures of the facility to properly educate about, plan for, assist residents with and implement advance directives.

The guidance identifies FTag 155 (entitled Advance Directives) as the primary tag for citations involving advance directives, but also directs surveyors to consider related citations at FTag 154 (right to be fully informed); FTag 242 (self-determination and participation in care); FTag 278 (accuracy of assessments); FTag 279 (care plans); FTag 289 (care plan revision); FTag 282 (care provided by qualified persons in accordance with plans of care); FTag 329 (unnecessary drugs); FTag 285 (physician supervision); FTag 501 (medical director requirements); and FTag 514 (clinical records).

Taken together, the inclusion of these FTags, and their corresponding federal regulations, signals CMS's expectation, as fully described in the October guidance, that end of life care planning and delivery must include:

- Educating residents about their end of life care planning options AND assisting them in implementing an advance directive if they choose;
- Educating staff about advance directives and how to follow them;
- Ensuring that resident care plans are consistent with a resident's advance directives;
- Ensuring that the clinical records are consistent with and reflect existing advance directives;
- Periodically reviewing residents' advance directives to ensure they remain consistent with the wishes of a resident or his or her legal surrogate AND that care plans and clinical records accurately reflect a resident's current wishes;
- Ensuring that treating physicians are involved in these decisions, aware of a resident's choices and directing care consistent with those wishes;
- Ensuring that medical directors have been involved in the development of a facility's policies and procedures governing advance directives;

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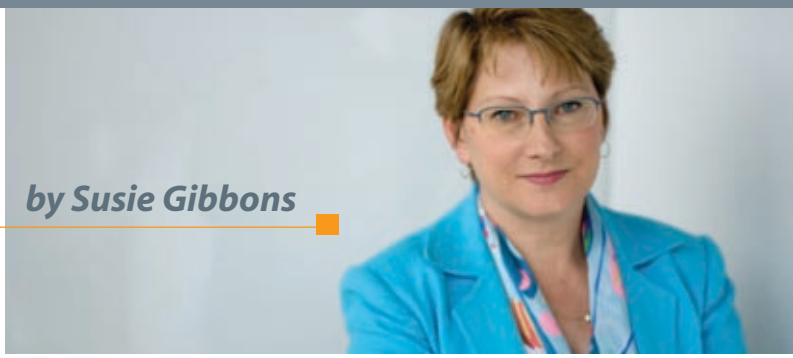
TriCare Network Contracts Create Affirmative Action Obligations for Health Care Providers



by Susie Gibbons

The Office of Federal Contracts Compliance (OFCCP) has made no secret of its desire to impose affirmative action obligations on hospitals. It moved quite a bit closer to this goal last month by winning a case against a hospital that had signed a TriCare network contract. In *OFCCP v. Florida Hospital of Orlando*, the hospital challenged OFCCP's jurisdiction over it, and the Administrative Law Judge ruled in OFCCP's favor. While this case dealt with a hospital in Florida, hospitals here in North Carolina can expect to see OFCCP issuing Notices of Audit to facilities in North Carolina, because the Florida case is strong precedent supporting OFCCP's jurisdiction over hospitals that contract to provide TriCare network services.

OFCCP is the federal government agency charged with enforcing Executive Order 11246, Section 503 of the Rehabilitation Act, and the Vietnam Era Veterans' Readjustment Assistance Act (VEVRAA). Companies that have a contract or subcontract of $10,000 or more with a federal executive agency, such as the Department of Defense, are subject to the OFCCP's regulations. TriCare is a Department of Defense program that provides worldwide health care for active duty and retired military personnel and their families. Humana Military Healthcare Services, Inc. is the direct contractor with the Department of Defense for administration of the program. Humana's contract provides that it "shall provide a managed, stable, high-quality network, or networks, of individual and institutional health care providers." Humana subcontracts with hospitals and doctors to provide network services for TriCare beneficiaries.

OFCCP has taken the position that a health care provider that enters into a network contract with Humana must comply with the equal opportunity/affirmative action obligations of Executive Order 11246, Section 503 of the Rehabilitation Act of 1973 and VEVRAA. On October 18, 2010, an administrative law judge upheld OFCCP's position, finding that because Florida Hospital of Orlando had entered into a medical contract with Humana to provide medical services to TriCare beneficiaries, it was a covered government subcontractor.

The ALJ rejected Florida Hospital of Orlando's argument that TriCare is structured like Medicare and therefore should not be considered a covered government contract. The OFCCP has previously conceded that provider agreements pursuant to which hospitals and other health care providers receive reimbursement for services covered under Medicare parts A and B are not covered government contracts under the laws enforced by OFCCP. However, the TriCare contracts are not simply reimbursement arrangements, but are contracts to provide the actual medical services, and thus OFCCP, and now the ALJ, distinguishes the TriCare contracts from Medicare provider agreements.

This decision will provide OFCCP with the ammunition it needs to pursue other hospitals that have entered into contracts to be TriCare network providers, and to require them to comply with the equal opportunity/affirmative action obligations. These obligations include implementing an Affirmative Action Program. This requires employers to create written Affirmative Action Plans for minorities, women, veterans, and disabled applicants and employees. In addition, companies must engage in affirmative action outreach activities. These activities include listing open positions with the Employment Security Commission and communicating with and encouraging referral of applicants from veterans' and disabled advocacy groups. The regulations also require companies to evaluate personnel actions and compensation on an annual basis to see if specific racial, ethnic or gender groups have been negatively impacted. Finally, regulations impose special record-keeping requirements for applicants. OFCCP routinely audits government contractors and subcontractors to determine whether they are in compliance with these obligations, and to look for and remedy discriminatory employment decisions. Failure to comply with the equal employment opportunity/affirmative action obligations places companies at significant risk. Sanctions can include back pay, required reporting and the loss of federal contracts.

All hospitals should review their TriCare contracts and determine whether OFCCP could contend that they are subject to the equal employment opportunity/affirmative action obligations, and whether they intend to implement Affirmative Action Programs or try to dispute OFCCP's jurisdiction if a notice of audit is received.

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CMS Issues Draft (*continued from page 1*)

- Ensuring that facility staff know who is authorized to make care choices for an incompetent resident and that the individual upon whom they rely for those choices is the proper person, under state law, to make such choices; and
- Ensuring that staff are fully aware of a resident's expressed care wishes AND that care is delivered consistent with those wishes.

In directing surveyors on how to select scope and severity classifications for violations of advance directive regulations and FTags, CMS says such violations never qualify as "no actual harm with potential for no more than minimal harm," or severity level 1 in CMS parlance. So, all deficiencies will be scored at either harm level 2, no actual harm with potential for more than minimal harm (levels D, E or F on the grid); actual harm that is no immediate jeopardy (levels G, H or I on the grid); or immediate jeopardy (levels J, K or L on the grid).

Some examples CMS gives of immediate jeopardy deficiencies based on end of life care planning and delivery include:

- A resident is transferred to a hospital after an acute change in condition where a feeding tube is inserted, inconsistent with the resident's documented wishes;
- As a result of the failure of a facility to systematically assess and document the decision-making capacity of residents, the facility excludes residents with cognitive impairment, regardless of level, from participating in their care planning decisions; and
- Continuing care that is inconsistent with a resident's expressed wishes.

Examples of a G level deficiency, or actual harm, include:

- Allowing family members to override the documented wishes of a resident and providing care, based on family member insistence, that is inconsistent with the resident's wishes (such as for life-sustaining care) and/or failing to recognize that one or more family members lack legal standing under state law to make decisions for the resident (you will recall the N.C. statute that creates a hierarchy of individuals who can make decisions for an incompetent resident without an advance directive, and this example highlights the importance of facility staff understanding this hierarchy and honoring it – see the "decision tree" poster Poyner Spruill sent to all SNF and assisted living facilities a few months ago for posting in the facility); and
- Performing CPR on a resident and transferring him to the hospital for further care when that is inconsistent with the resident's documented wishes.

A level 2 harm situation would occur where facility staff are unaware of and/or have failed to document a resident's end of life care planning choices but no care inconsistent with those wishes has yet been delivered, or where a resident has expressed a desire to create an advance directive but has been offered no assistance in doing so and has no advance directive in place.

This guidance underscores the importance of incorporating end of life care planning, and ongoing review and updating of clinical records as residents' preferences change over time, into the normal care planning and care delivery process. The American Health Care Association is submitting comments on this draft surveyor guidance. We'll continue to monitor the progress of the guidance and report to you when it's final, and whether any significant changes are included in the final version.

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Ken's Quote of the Month

"If you surrender to the wind, you can ride it."

Toni Morrison

CMS Issues New Proposed Conditions of Participation for SNFs Providing or Arranging for Hospice Services

By Ken Burgess, Jessica Lewis and Kim Licata

On October 22, 2010, CMS published proposed Medicare conditions of participation for SNFs that directly provide or arrange for the provision of hospice services in their facilities. CMS estimates that 35% of hospice patients nationally receive that service in SNFs. The proposed rule for SNFs follows, and closely parallels, revised Medicare conditions of participation for hospices issued by CMS in June 2008. That rule included substantial provisions governing the relationship of SNFs and hospices that provide services in SNFs, and CMS has attempted to closely mirror those provisions in this proposed regulation.

A major focus of the proposed regulation is on contracts between SNFs and hospice providers and what must be included in those contracts. The proposed rule, like the June 2008 hospice regulations, focuses heavily on the division of responsibility between the SNF, which is required to provide room and board and care related to a resident's needs that are unrelated to their terminal illness, and the hospice, which is responsible for providing palliative care related to the resident's terminal condition. Under the June 2008 hospice regulations, hospices have very specific services they must provide directly and, where they contract with the SNF or other providers to offer services they are not required to provide directly, those regulations dictate certain obligations the hospice must undertake to ensure continuity of care, coordination with care the SNF must provide, and communication between the SNF and hospice. The new proposed SNF regulations also focus on coordination of care, communication between the SNF and hospice, and ensuring that each provider understands and carries out its delegated responsibilities for long term care residents electing the hospice benefit.

Some of the key provisions of the proposed regulation include:

- The SNF must ensure that hospice services meet professional standards that apply to the hospice provider and "the timeliness of the services." A well-drafted agreement will require that the hospice do this, and the failure to do so will be identified as a material breach in the agreement.
- The timing and the content of the agreement is critical. The LTC facility **must have in place** a signed written agreement (with 11 required provisions) with the hospice provider **before** any hospice services are furnished to any resident. Some of the proposed required provisions include: (a) identification of all hospice services to be provided; (b) specification of the hospice's responsibilities and those of the SNF under each resident's care plan; (c) a clear communication process (including documentation) between the SNF and the hospice provider to ensure resident needs are addressed 24 hours a day; (d) the events that require the SNF to immediately notify the hospice provider (a significant change in the resident's physical, mental, social, or emotional status; clinical complications that suggest a need to alter the place of care; a need to transfer the resident from the facility for any condition that is not related to the terminal condition; or the resident's death); (e) the hospice's responsibility for determining the course of appropriate hospice care, which must be updated as needed; (f) the SNF's responsibility to provide 24-hour room and board, personal care, and nursing needs at the appropriate level of care; and (g) the SNF's duty to report any allegations of mistreatment, neglect, abuse, or injuries of a resident by hospice personnel to the hospice administrator "immediately" once the SNF is aware of such allegations.
- The SNF must designate a member of the resident's interdisciplinary team to be responsible for working with the hospice provider and coordinating the resident's care between SNF and hospice. These responsibilities (from the rule) principally involve collaboration and communication to coordinate the care of each resident.
- The SNF arranging hospice care must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the SNF to attain or maintain the resident's well-being.

This proposed regulation, which we expect to become final without major revisions, will require that all SNF-hospice agreements be reviewed and probably revised once the rule is final. Poyner Spruill's health care team published a series of model SNF-hospice agreements in June 2008 when the revised hospice conditions of participation were published, which included provisions on the provision of hospice services in SNFs. Included in those was a template specifically for hospices and SNFs who have shared responsibility for hospice residents receiving end of life care in nursing facilities.

CMS is accepting public comments on the proposed regulations until December 21, 2010.

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