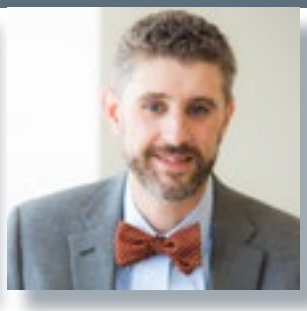
DECEMBER 2015

EndNotes

News for North Carolina's Hospice and Palliative Care Community

Winds of Change Blowing Across the Hospice Landscape

by Ken Burgess and Matt Fisher



Recent Medicare developments indicate that end-of-life health care providers can expect to face continuing change in an already dynamic sector. These latest turns are part of an ongoing trend toward redefining hospice and end-of-life care in the United States.

Paying Doctors for Counseling on End-of-Life Care. The Centers for Medicare & Medicaid Services (CMS) released a new proposed rule on July 8, 2015, that would pay doctors for counseling patients about advance planning for their end-of-life health care. The proposed rule would create two new billing codes to reimburse physicians, nurse practitioners and physician assistants for face-to-face consultations with a patient and any family or caregivers the patient may want to include, regarding options for health care at the end of life, such as under what circumstances the patient would want life-sustaining treatments. One code would cover the first 30 minutes, and the other code would cover any additional 30-minute blocks that are needed.

The move to reimburse physicians for their role in counseling patients on advance care planning comes at a time when there is a growing national dialogue about giving people more control over how and where they live their final days. It's an inevitable conversation as the United States' population continues to age, with an estimated 10,000 baby boomers joining Medicare every day, and as Medicare, the largest insurer of end-of-life care, continues to explore how best to manage the costly and complex needs of patients in the final year of life. There has long been a push by many health care providers and seniors to improve discussions with patients and families about advance planning for health care at the end of life. Those working in the hospice and palliative care sector know far too well the sensitivity of this topic and the difficulties that can arise when patients feel strongly about how and where they want to live their final days, but have not taken the necessary steps – such as signing a living will or health care power of attorney – to ensure their wishes are followed and respected by their doctors, care team and family.

The rule proposed by CMS would not limit the number of conversations to be reimbursed with one patient, in essence recognizing that these types of conversations vary depending on the needs of each patient and family. Currently, Medicare only covers counseling regarding advance care planning under very limited circumstances. The CMS plan is built in part upon recommendations of the American Medical Association to create billing codes for counseling sessions in which patients could discuss the range of options available to them. Patients would be able to choose whether to engage in such end-of-life counseling with their doctors. The aim of this policy change is to inform patients of their options in a meaningful way as they approach death.

The finalized provision for reimbursement of physician counseling on end-of-life care would take effect in January 2016. Details of the reimbursement, including the rate, are expected this fall when CMS finalizes the 2016 Medicare physician fee schedule.

Restructuring Hospice Reimbursement. CMS recently finalized significant changes in the structure of hospice payments, with the publication of its hospice wage index and payment rate update for fiscal year 2016. Under this final rule published July 31, 2015, CMS will continue to reimburse providers for hospice services as a bundled benefit, but beginning January 1, 2016, it will pay higher reimbursement in the first 60 days of hospice care and the last seven days of life

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D.C. Circuit Resuscitates Elimination of Companionship and Domestic Service Exemptions for Third-Party Employers

By Kevin Ceglowski

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What Happened?

The ongoing legal battle over the U.S. Department of Labor (DOL) Final Rule changing the definitions of "companionship services" and live-in domestic employees again turned against employers on August 21, 2015. The US Court of Appeals for the D.C. Circuit issued its decision in *Home Care Association of America v. Weil* and unanimously reversed a lower court decision holding the DOL exceeded its authority when it issued the Final Rule. The Final Rule was to take effect on January 1, 2015, but enforcement was stayed pending the appeal.

What Changes in the Final Rule?

Companionship services are redefined as follows:

- Provision of "fellowship and protection" for an elderly person or person with an illness, injury, or disability who requires assistance in caring for himself or herself.
- Provision of "care" if the care is provided attendant to and in conjunction with the provision of fellowship and protection and if it does not exceed 20% of the total hours worked per person and per workweek.

"Fellowship and Protection" is redefined as follows:

- "Fellowship" means to engage the person in social, physical, and mental activities.
- "Protection" means to be present with the person in his or her home or to accompany the person when outside of the home to monitor the person's safety and well-being.
- Examples of fellowship and protection include conversation; reading; games; crafts; accompanying the person on walks; and going on errands, to appointments, or to social events with the person.

"Care" is redefined as follows:

- "Care" performed attendant to and in conjunction with the provision of fellowship and protection and if they do not exceed 20% of the employee's total hours worked per workweek per consumer.
- Assistance with activities of daily living (such as dressing, grooming, feeding, bathing, toileting, and transferring) and instrumental activities of daily living, which are tasks that enable a person to live independently at home (such as meal preparation, driving, light housework, finance management, assistance with the physical taking of medications, and medical care arrangements).
- Medically related services provided by trained personnel (RN, LPN, CNA) are not included in companionship services.
- Live-in domestic service workers who reside in an employer's home permanently or for an extended period must receive minimum wage and overtime if they are jointly employed by a third party.

Under the Final Rule, third-party employers of direct care workers (such as home care staffing agencies) are not permitted to claim either the exemption for companionship services or the exemption for live-in domestic service employees. The exemption is unavailable even when the employee is jointly employed by the third-party employer and the individual, family, or household using the services. However, the individual, family, or household may claim any applicable exemption.

What Now?

The plaintiffs representing the home care industry recently announced plans to appeal the D.C. Circuit's decision to the U.S. Supreme Court, so the final outcome is uncertain. For now, employers in states such as North Carolina and South Carolina without state laws already requiring minimum wage and overtime pay for these employees are back where they were in December 2014: facing the prospect of having to pay minimum wage and overtime to companionship services employees and live-in domestic service employees, and having to satisfy all recordkeeping requirements under the FLSA for these employees. Employers can potentially reduce wage expenses by managing schedules and staffing to minimize overtime (e.g., 40-hour workweeks only, or split schedules such as 25-hour worrkweeks followed by 50-hour workweeks) and by lowering base wages to reduce the overtime impact, keeping in mind they must pay at least minimum wage. Alternatively, employers can hire additional staff and split client services among multiple staff members to reduce or eliminate overtime obligations.

The August 21, 2015 order from the D.C. Circuit Court of Appeals became effective October 13, 2015 because the opponents of the Final Rule were not successful in having that date stayed pending further appeal. DOL did not begin enforcement of the Final Rule until November 12, 2015. From November 12, 2015 through December 31, 2015, DOL will exercise discretion in whether to enforce the Final Rule, with consideration given to the extent to which employers make good faith efforts to comply with the Final Rule. Full enforcement of the Final Rule will begin January 1, 2016. In addition to DOL enforcement of the Final Rule, individual employees might file FLSA lawsuits claiming violations of the law. Prudent employers should consult with employment counsel about best strategies for managing this risk while the legal process continues to the Supreme Court.

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where certain criteria are met. Under the new structure, there will be a two-tier per diem rate for routine home care, a higher rate for the first 60 days, and a reduced base payment rate for Day 61 and later. In addition, Medicare will make a Service Intensity Add-On (SIA) payment to cover up to four hours of skilled care provided to patients in the last seven days of life subject to certain requirements. This new payment structure is aimed in part at addressing the challenges of a per diem reimbursement rate structure for hospice services with highly variable costs. The two-tiered routine home care rate and SIA payment are intended to better align reimbursement rates to costs incurred in delivering care throughout a patient's length of stay. Another objective of the new payment structure is to help incentivize hospice agencies to serve short-stay patients, who often require significant resources at higher costs.

With regard to the two-tiered rate for routine home care, if a patient changes hospice agencies or is discharged and readmitted, the amount of time previously spent in hospice will follow the patient where the gap in the patient's hospice enrollment is less than 60 days. However, where a patient has a gap of 60 days or more in hospice enrollment, the new hospice provider will be eligible for the higher rate for the first 60 days of the patient's new enrollment.

The SIA payment will cover up to four hours of direct care provided by a registered nurse or social worker during a patient's last seven days of life provided: (1) the patient is receiving routine home care for that day; (2) the day of care is within seven days of death and the patient is discharged or deceased; and (3) direct patient care is provided by an RN or social worker. This supplemental end-of-life payment will apply regardless of a patient's length of stay. The amount of the SIA payment will be equal to the continuous home care rate multiplied by the number of hours of direct patient care provided by an RN or a social worker, up to a maximum of four hours per day. Questions remain about the details of how these significant changes to hospice reimbursement will be implemented. Although providers and others pushed hard for a delayed implementation period so that the new reimbursement structure could be piloted, CMS elected to forge ahead with the new two-tiered payment set to take effect January 1, 2016. CMS recently clarified that for services provided between October 1 and December 31, 2015, hospices will be paid a single routine home care per diem amount based upon the FY 2015 hospice payment rates.

> "And in the end, it's not the years in your life that count. It's the life in your years."
>
> *~ Abraham Lincoln*

Hospice Plus Treatment Pilot. Perhaps one of the most dynamic potential changes on the horizon is reflected in a five-year demonstration project set to begin in 2016, in which 140 hospices across the country will offer terminally-ill Medicare patients end-of-life care and counseling at the same time they offer those patients treatment to extend their lives. The Medicare Care Choices Model was established by the Affordable Care Act. Patients involved in this pilot would not have to make the difficult Hobson's choice between palliative and life-extending care, as terminally ill Medicare patients typically must do. A leading reason Medicare patients with terminal prognoses historically have not elected hospice care until their final days is that they did not want to give up hope that curative treatments would work.

The overwhelming response of hospice providers interested in participating in this model program prompted CMS to increase the original limit of 30 hospice providers to 140 hospices. The program will be implemented in phases, with half of the hospices starting in 2016 and the other half beginning in January 2018. The demonstration hospice sites will be open to patients who have advanced-stage cancer, chronic obstructive pulmonary disease, congestive heart failure, or AIDS, with a prognosis of six months or less to live. Under the model, Medicare hospice patients will be able to continue to receive life-extending care such as physical therapy, prescriptions, medical equipment, physician services, and short-term hospital stays for pain or symptom management. The participating hospices will receive a monthly payment of $200 to $400 per patient for hospice care rather than a per diem payment, and other providers will be able to bill Medicare for curative services.

One hope behind this experiment is that if patients are allowed to pursue both care paths, more patients will choose to receive hospice services that improve the quality of their final

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Trends in HIPAA Enforcement Actions

What They Mean for Phase 2 Audit Preparation and Compliance Planning

Poyner Spruill LLP
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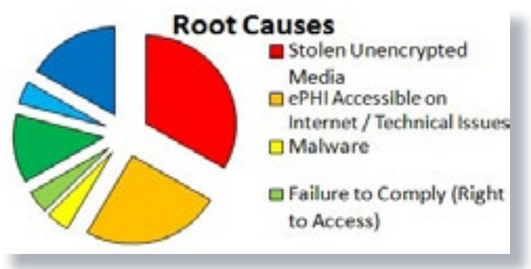
By Tara Cho

The Office of Civil Rights (OCR) recently announced plans to begin the next round of its HIPAA audit program in early 2016. In comments responding to two reports issued by the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services on September 29, 2015, OCR announced that it will begin Phase 2 of the HIPAA audits early next year. Consistent with prior descriptions of the Phase 2 audits, OCR stated in its recent response to OIG that the audits would include a combination of desk audits and on-site audits, will involve both covered entities and business associates, and will target specific common areas of noncompliance. OCR Director Jocelyn Samuels previously indicated that in the Phase 2 desk audits, covered entities and business associates will have two weeks to upload applicable HIPAA policies and procedures to a portal for OCR auditors to review. This remote audit approach will not allow for additional clarifications or discussion between the auditor and entity; therefore, policies and procedures must be accurate and complete and ready to upload.

In addition to being prepared for the Phase 2 audits, privacy and information security requirements impact the entire scope of a provider's operations and are key components of a comprehensive compliance strategy. Ensuring the privacy and security of patients' Protected Health Information (PHI) is especially important as regulatory oversight increases for hospice providers with efforts to hold those providers more accountable for their quality of care.

Trends from past HIPAA enforcement actions by OCR can help providers focus their compliance planning, identify potential vulnerabilities and be best prepared should they be the subject of an OCR audit. Reviewing the root causes of these enforcement actions can point to valuable lessons learned. The most common root cause for enforcement actions from 2008-2014 related to stolen, unencrypted media such as laptops or USB drives. This category was followed by a number of enforcement actions stemming from technical issues or implementation errors that made Electronic Protected Health Information (ePHI) accessible to the public on the internet or subject to other unauthorized access. There were also several actions related to the improper disposal of hard copy PHI and failure to comply with requirements of the Privacy Rule, such as providing patients a right to access their PHI or inappropriate uses and disclosures by staff or other authorized users.

Most of these enforcement actions resulted from investigations following breach notification by the covered entity or individual complaints to OCR. Therefore, in addition to the high costs of settlement amounts and required corrective action plans that result from regulatory enforcement actions such as these, providers must also consider the costs associated with a breach, including: expenses involved in actual breach notification, investigation and cyber forensics costs, legal fees, and reputational damage when planning a risk management strategy. It is also notable that enforcement actions span across various types of entities including non-profits, large retail pharmacies, regional medical centers, large health systems, government agencies, and at least one hospice provider. Surprisingly, although different entities may share the same root cause for the incident that triggered investigation and enforcement, there seems to be a correlation between the entity's ability to pay and the size of the settlement. For example, a retail pharmacy paid $2.25 million for inappropriate disposal of PHI in a store dumpster while a smaller health system paid $800,000 for leaving 71 boxes of paper medical records in a physician's driveway accessible to the public. The risks to the hard copy PHI were very similar, but the settlement amounts reflect on the size and capabilities of the different entities. Regardless of size and operations, entities should be aware of their regulatory obligations and the threats to their networks, systems, and data.



So, what can covered entities and business associates learn from these enforcement actions?

- **Encrypt! Encrypt! Encrypt!** Although encryption is not a mandatory specification in the HIPAA Security Rule, encryption can greatly mitigate the potential risks that result from theft or loss of a portable device (e.g., mobile phone or laptop) or removable media (e.g., CD or USB drive). Encryption can also be a safe harbor from breach reporting requirements and OCR has repeatedly noted the importance of applying encryption whenever possible.
- **Risk Analyses.** Conduct on-going risk analyses of systems, networks, equipment and other repositories or access points to ePHI. Implement remediation plans and update policies and procedures to address critical risks identified during such risk analyses.
- **Device Management.** Don't sell, retire or reissue computers, portable devices, or even leased copiers or scanners without securely wiping all content. Implement appropriate policies and controls around mobile devices, particularly personal mobile devices used for work.
- **Hard-Copy PHI.** Do not underestimate or forget the security threats to non-electronic PHI and the associated requirements. Maintain policies and procedures to implement Privacy Rule requirements and to control the security and disposal of hard copy PHI.
- **Training.** Train employees and monitor adherence to HIPAA policies and procedures, including permissible uses and disclosures and incident reporting. In addition, educate employees with a general understanding of the threats and vulnerabilities to PHI and other sensitive data staff may access or handle.
- **Incident Response.** Develop and test an incident response plan to quickly identify and mitigate potential security incidents.
- **Audit Preparedness.** Hospices and their care partners and business associates should prepare for the upcoming Phase 2 audits and help minimize the risks and vulnerabilities described above by:
  - Conducting a gap assessment of current policies and procedures to confirm alignment with the Privacy and Security Rules.
  - Updating their risk analysis to identify threats and vulnerabilities to PHI and prioritize remediation items based on the criticality of and risk to the data.
  - Reviewing business associate agreements and associated policies and procedures for the oversight of service providers.
  - Developing an audit response plan or compiling a repository to have HIPAA-specific policies and procedures easily accessible and ready to provide upon request.
  - Familiarize all staff, including senior management, with the entity's privacy and security compliance program, HIPAA requirements, general risks associated with PHI, and the contact person or department for questions about these areas or any requests or inquiries from OCR or other agencies.

These takeaways are just some of the key components of a comprehensive compliance program. For additional details on applicable requirements, preventive measures or other considerations related to HIPAA compliance, please contact Tara Cho.

Tara Cho *practices in privacy and information security. As a Certified Information Privacy Professional, she advises on privacy issues and identification of potential risks and the development of associated policies and procedures to maintain compliance. She may be reached at 919.783.1079 or tcho@poynerspruill.com.*

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months and days and reduce the cost of end-of-life care. Many hospice and palliative care experts believe more people would choose hospice care if they understood it better and did not have to give up treatments that could possibly extend their lives. Such a shift would have a substantial cost savings potential if patients ultimately opted for quality of life and decided to forego burdensome curative treatments. Nearly one-third of Medicare's $600 billion annual budget is estimated to be spent on treatment in the last six months of life, much of which is spent on costly life-extending services with limited benefits.

The experience of hospices under the Medicare Care Choices Model will help determine whether and how this shift in policy would impact Medicare costs. Of course, in addition to the cost-saving potential, this project holds the potential to significantly improve patients' quality of life by bringing more patients to hospice sooner – helping patients live life to the fullest in their final months and days as comfortably and free of pain as possible.

Ken Burgess' *practice has focused heavily, but not exclusively, on issues affecting long term care providers. He has advised them on a wide variety of legal planning issues arising in the skilled nursing facility setting, assisted living setting, hospice, home health and other spheres of long term care. He may be reached at kburgess@poynerspruill.com or 919.783.2917.*

Matt Fisher's *practice focuses on the representation of health care providers, with an emphasis on Certificate of Need law. Matt's practice centers on the litigation of Certificate of Need awards and denials and assisting health care providers with the development of Certificate of Need applications. He may be reached at mfisher@poynerspruill.com or 919.783.2924.*

Iain Stauffer Joins Our Team

We are thrilled to announce Iain Stauffer has joined our Raleigh office. Iain came to the firm from the North Carolina Attorney General's Office where he served as an attorney for 12 years, most recently with the Public Assistance Section. In that position, he represented the North Carolina Department of Health and Human Services and the Division of Medical Assistance in complex litigation involving Medicaid in federal and state courts. In addition, Iain provided advice and counsel in many areas of the Medicaid program, including compliance, program integrity, and managed care. Iain appeared in numerous actions at the Office of Administrative Hearings involving Medicaid audit, overpayment, reimbursement and authorization matters.

Iain's practice at the firm will focus on advising and representing health care providers in Medicare and Medicaid reimbursement, enrollment, compliance, litigation, and regulatory issues. He may be reached at istauffer@poynerspruill.com or 919.783.2982.

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