A Publication of the American Health Lawyers Association
Long Term Care, Senior Housing, In-Home Care, and
Rehabilitation Practice Group

Volume 15 • Issue 2 • December 2012

LTC-SIR Advisor

Four Recent Releases by CMS for Nursing Facilities

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The Centers for Medicare & Medicaid Services (CMS) is implementing changes that will affect four key areas: advance directives, end-of-life guidance, feeding tubes, and surveying. Specifically, on September 27, 2012, CMS issued four releases affecting Medicare- and Medicaid-certified nursing facilities (NFs) and skilled nursing facilities (SNFs). Three releases modify Appendix PP[1] of the State Operations Manual (SOM):

(1) Revising guidance at F155 for Advance Directives;[2]

(2) Revising F309 concerning end-of-life guidance for quality-of-care requirements;[3] and

(3) Providing additional reference material and guidance on feeding tubes at F322.[4]

Also, an advance copy of interim guidance located in the SOM's Appendix P[5] was released for use by the long term care surveyors when completing the traditional survey process for NFs and SNFs. Along with these Appendix P changes, CMS has provided Survey and Certification (S & C) memoranda; guidance and updates to the survey protocols; interpretive guidelines for surveying NFs and SNFs;[6] and even instructional materials for training.[7]

Appendix P Revisions

The State Agencies (SAs) contracting with CMS for now continue to utilize the Traditional Survey process during the conversion to the Quality Indicator Survey around the country but, according to survey protocol guidance, must have looked to the Appendix P changes by December 1, 2012.[8] These include the revised protocols, forms, and quality measures report.

Appendix P's changes are scattered through the multiple survey tasks and subtasks utilized in the survey process. As usual, CMS identifies the most recent changes in the interim guidance with red italicized font in the SOM to provide easy visual cues to identify the changes. These modifications update the process to include the changes to use of the Minimum Data Set (MDS) 3.0 and revise survey exhibits located in Chapter 9[9] of the SOM.

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The revisions include the following items of particular interest:

- The Entrance Conference guidance now includes a request for the actual daily work schedules for licensed and registered nursing staff for all shifts during the survey period. This request specifically includes that the schedules should be provided by the end of the entrance conference. The protocol allows for the facility to update these schedules during the survey.[10]
- Additional questions are now included in the Entrance Conference guidance related to dementia residents and residents receiving psychopharmacological medications.[11] Within an hour of the entrance conference, in addition to the usual information that must be provided to the survey team, the facility should provide a copy of the admission packet, a list of residents receiving antipsychotic medications over the past thirty days, and list of residents under the age of fifty-five.
- The completed Roster Sample Matrix and Resident Census and Conditions of Residents form are to be provided to the survey team within one hour of the entrance as they are identified as critical to the resident sample selection.[12]
- Initial tour guidance includes specific directions that the surveyors can allow or restrict the facility staff from touring with the surveyor. The protocol indicates that the surveyor may tour without facility staff if the staff hinder, argue, or make the completion of the task more difficult.[13]
- The definitions of interviewable residents have been updated to include reference to the Brief Interview for Mental Status test that is completed for residents when completing the MDS 3.0.[14]
- The resident sample selection process guidance has been enhanced to suggest to the surveyors to include: (1) residents admitted or readmitted within the past fourteen days; (2) residents with no or infrequent visitors; (3) residents with psychosocial, interactive, and/or behavioral needs; (4) residents totally dependent and bedfast; (5) residents receiving hospice or dialysis care; and (6) residents receiving psychopharmacological medications, specifically antipsychotic residents.[15]
- The guidance encourages the survey team to devote as much time as possible to observations and interviews and to minimize review time of records and policies and procedures.
- Task 5 (Information Gathering) now includes language regarding the confidentiality of the information provided to the surveyors in the interviews. The protocol indicates that staff is not to be present during resident and/or family member interviews unless the resident or family member specifically requests that the facility staff be present.[16]
- Another revision to Task 5 suggests that the survey team should not provide negative findings to a facility on a daily basis. In other words, the surveyors should complete their investigation prior to communicating negative findings and not necessarily provide a daily exit conference.[17]

Additional information is provided in the guidance and should be reviewed and referenced by providers to assure that they are knowledgeable about the survey protocol.

F155: Advance Directives

Specific advance directive guidance has been added at Tag F155,[18] which should have been implemented by the SAs by November 30, 2012. Surveyors also should have been trained by that date in accordance with the detailed training materials provided by CMS.

First, the interpretive guidelines bring about some definitional changes concerning advance care planning, life-sustaining treatment, and healthcare decision-making. Most significantly, the definition of advance care planning now requires that the resident's preferences, future care, and treatment be updated and identified throughout the resident's stay.[19]

Second, facilities must establish, maintain, and implement written policies and procedures regarding the residents' rights to formulate advance directives and to accept or refuse medical care. Specifically, where a resident refuses medical care, a resident now cannot be transferred or discharged until other criteria for discharge or transfer are first met.[20]

Third, the Investigative Protocol now provides for observation, interview, record, and policy review. The Investigative Protocols also include a number of questions and issues to consider when interviewing staff, residents, and physicians respecting the resident's advance care planning directives.

Finally, F155 guidance better defines the required expectation of a facility in identifying the resident's future care and implementing the resident's wishes when the resident is no longer able to exercise medical decision-making.

F309: End of Life

As with F155 respecting advance directives, SAs must implement F309 "end of life" changes no later than November 30, 2012.[21] By way of review, F309 requires facilities to provide care to assist the resident to achieve the highest practicable physical, mental,

and psychosocial well-being.[22] The modification to F309 now requires the facility to obtain more specific information regarding resident's well-being in approaching the end of life.

Again, some changes are definitional. New definitions clarify the terms imminently dying, palliative care, and terminally ill, as well as advance care planning.[23]

Second, CMS has provided educational resources regarding end-of-life care with web links in the guidance's end notes. The focus of these resources is on assessment as the resident approaches the end of life as well as management and care planning. Specifically, the resources suggest that the care plan focus on activities of daily living, hygiene/skin integrity, medical treatment, nutrition and hydration activities, and psychosocial needs.

Although F309 concerns "end of life," the tag also has been used broadly by surveyors to include a wide area of care issues. The new guidance further specifies what expectations are required as to end-of-life. A facility must:

- Assess the resident's clinical condition, risk factors, and preferences;
- Initiate discussions regarding advance care planning and the resident's choice to clarify the resident's goals and preferences regarding treatment at the end of life;
- Advise the resident that the focus of care could be shifted to palliative care to reduce pain and suffering;
- Define and implement resident-directed care, treatment interventions, services, and support consistent with the resident's choices;
- Communicate those goals and choices to the interdisciplinary team as well as any hospices, emergency departments, hospitals, or home health teams that could provide treatment to the resident; and
- Monitor and evaluate the impact of the interventions provided.[24]

The issuance even provides an example mnemonic to assist the facility in meeting the resident's end-of-life physical and psychosocial needs.[25]

With respect to hospice, the guidance focuses on coordination of the care and care planning with the hospice provider. Both the facility and the hospice provider are responsible for coordinating the resident's care through the care planning process. However, the facility is responsible for the overall care and comfort of the resident.[26]

Also, the guidance lists seventeen regulatory tags for potential investigation of care and services provided to a resident at the end of life. These address potential concerns related to structure, process, and/or outcome requirements in the survey process.[27]

Finally, the end-of-life guidance now requires providers to focus on the resident's advance care planning expressions, which not only includes advance directives, but also addresses the dying process on a holistic basis taking into consideration many aspects of the resident's wishes, including the resident's right to refuse care. The guidance specifically details the resident's right not to execute an advance directive and that he or she cannot be forced to execute such a directive. The thrust of this guidance is providing a care environment sharply focused on identifying, addressing, and meeting the needs of the end-of-life resident.

F322: Feeding Tubes

Also to have been implemented by November 30, 2012, F322[28] changes concern tube feedings. By way of review, the F322 sets forth that tube feedings are allowed only after a determination of a clinical condition warranting such use, made with adequate assessment and according to current standards of practice. The guidance acknowledges significant differences among and within states related to the use of tube feedings. The materials include references for review related to the variation of use.[29]

Similar to the definitions for the avoidable and unavoidable pressure ulcer,[30] this guidance defines avoidable/unavoidable use of a feeding tube. "Unavoidable feeding tube use" is defined as a clear indication for use or sufficient evidence that provides a benefit that outweighs associated risks.[31] Additionally, the discussion in the guidance at Consideration Regarding the Use of Feeding Tubes further describes unavoidable use of a tube feeding only if no other viable alternative to maintain adequate nutrition and/or hydration is possible and the feeding tube use is consistent with the clinical objective of maintaining or improving the nutrition and hydration. This apparent expansion of the definition of unavoidable cites a 2002 United Kingdom article on enteral feeding.[32] In analyzing the definition and the subsequent discussion regarding unavoidable use, the provider should expect that the survey team will scrutinize the medical record documentation to determine that such medical judgments have been made and documented about the necessity for use of the feeding tube. Even if the resident is admitted with the tube feeding, the guidance requires periodic reassessment and discussion with the resident and/or legal representative about the continuing appropriateness of the tube feeding.[33] Also, the facility must document the potential risks and complications of tube feeding use and its attempts to provide treatment and services to restore, if possible, adequate oral intake.[34]

The care planning process must address avoidance of possible side effects and complications of feeding tubes such as social isolation, discomfort, and lack of the opportunity to taste, chew, and appreciate food.

The guidance provides multiple reference articles in support of its statements about the lack of evidence supporting that enteral feedings improve clinical outcomes for residents with advanced dementia or other chronic neurological disorders such as Parkinson's disease.[35] The guidance references a discussion at F325 about the specific issues and concerns with feeding of those types of residents.

With the use of an unavoidable feeding tube, the facility staff must be technically proficient in current skills that promote safety and reduces complications. The guidance provides that the tube feeding services are to be provided to restore normal eating skills to the extent possible. The guidance emphasizes that tube feedings are to be used only when unavoidable. When considering potential citations for noncompliance, the surveyors are guided

to review twenty additional requirements and regulatory tags for possible cross-citations if there are concerns related to the provision of tube feedings.[36]

Generally, the revised guidance at F322 provides for numerous considerations including the determination of unavoidability prior to and for continued use of feeding tubes. The guidance acknowledges the controversy about use of feeding tubes for residents with advanced dementia but acknowledges that there is not a consensus among residents, families, and healthcare providers. Importantly to the providers, the recent issuance requires facilities to document the assessment, medical determinations, care planning, and ongoing administration for the resident with a feeding tube. Understanding that the stated regulatory requirement is that tube feedings are only used when unavoidable will guide providers in documenting the decision-making process of the resident and/or legal representative when presented with significant nutrition and hydration concerns.

Conclusion

The four issuances from CMS of September 27, 2012, provide a number of considerations for providers and their legal counsel. The Interpretive Guideline issuances at F309, F322, and F155 also contain a common theme regarding a resident and/or legal guardian exercising legal decision-making and advance-care planning. Each of these revisions focuses on the adequate assessment, decision-making, care planning, and documentation for the stated regulatory area. The revisions to Survey Protocol for the traditional survey update the surveyor processes to implement changes required by the current use of the MDS 3.0 and revise forms consistent with current practices.

1 Appendix PP of the State Operations Manual is more commonly referred to as the Interpretive Guidelines, *available at* www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads//som107_Appendixtoc.pdf.

2 CMS, S & C: 12-48-NH (Sept. 27, 2012). S & C memos are *available at* www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.html.

3 CMS, S & C: 12-47-NH (Sept. 27, 2012).

4 CMS, S & C: 12-46NH (Sept. 27, 2012).

5 Appendix P of the State Operations Manual is more commonly referred to as the Survey Protocol and is *available at* www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads//som107_Appendixtoc.pdf.

6 CMS, S & C: 12-45, NH (Sept. 27, 2012).

7 Attached with each of the S & C are copies of PowerPoint slides for training purposes. The slides also include speaker notes to provide more detailed guidance and to assist in consistency of the SA training programs. CMS has typically provided slides and training materials with recent S & C releases, which allows providers to have the opportunity to utilize the same training materials and to update their knowledge with the identical training materials being utilized with the surveyors across the country.

8 *Id.* at p.2.

9 Chapter 9 provides copies of the Exhibits utilized in the survey process including samples letters and commonly used forms, *available at* http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c09_exhibitstoc.pdf.

10 SOM, Appendix P, Task 2.

11 *Id.*

12 *Id.*

13 SOM, Appendix P, Task 3.

14 SOM, Appendix P, Task 4.

15 *Id.* Inclusion of these types of residents in the sample selection guidance tracks CMS' focus on readmission, residents with behavioral issues, residents with outside services such as dialysis and hospice, and residents receiving antipsychotic medications. These are areas of recent focus by CMS and the SAs and are topics that have been seen in the U.S. Department of Health & Human Services, Office of Inspector General reports and other governmental releases.

16 SOM, Appendix P, Task 5.

17 *Id.*

18 Interpreting the requirements of 42 C.F.R. § 483.10(b)(4) and (8).

19 CMS, SOM, Appendix P, F155.

20 F155 at p.5.

21 CMS, S & C: 12-48-NH, Sept. 27, 2012.

22 CMS, SOM, Appendix P, F309 implementing 42 C.F.R. § 483.25.

23 *Id.* at pp. 2-3.

24 *Id.* at 10. (Determination of Compliance) (Task 6).

25 *Id.* at 3.

26 *Id.* at pp. 9-10.

27 *Id.* at pp. 16-17.

28 Prior revisions to F322 were made by CMS on October 1, 2012. Additionally, this issuance collapses F321 into the revised requirements at F322. F321 previously included 42 C.F.R. § 483.25(g)(1), which required use of a tube feeding only when the clinical condition determined that it was unavoidable. F322 now incorporates the requirements of 42 § C.F.R. 483.25(g)(1) and (2).

29 CMS, SOM, Appendix P, F322 referencing Endnotes articles published from 2003 through 2010 in several medical journals including *Journal of the American Medical Association* and *Journal of American Medical Directors*.

30 *See* CMS, SOM, Appendix P, F314.

31 F322 at p. 2.

32 Pearce, C.B. & Duncan, H.D. (2002) Enteral feeding. Nasogastric, nasojejunal, percutaneous endoscopic gastrosotomy, or jejunostomy: its indications and limitations. *Postgraduate Medical Journal*, 78:199-203, *available at* http://pmj.bmj.com/content/78/918/198.abstract.

33 F322 at p. 9 (Investigative Protocol, Interview).

34 Determination of Compliance, Criteria for Compliance.

35 Consideration Regarding the Use of Feeding Tubes citing Endnote articles.

36 *Id.* at pp. 13-16 (Determination of Compliance, Potential Tags for Additional Investigations).

Social Media in the Workplace

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Counsel for long term care providers must be aware of the growing use of social media in the workplace, and the legal risks associated with that growth. Indeed, social media is no longer limited to personal interactions. It has also become a tool for advertising, politics, and even employment. This cannot be better illustrated than the fact that the Egyptian people, when rising up against the forty-year reign of Hosni Mubarak, turned to Facebook when the government attempted to eliminate the population's means of communication.[1] The role of social media must not be underestimated, and counsel must understand the legal realities affecting the use of social media in the long term care setting.

Social Media in the Hiring Process

Many companies use social media platforms such as Facebook to advertise their business, and others are utilizing such means to advertise available employment positions. However, employers should be aware that utilizing these tools in evaluating a candidate for hire may pose legal risks.

First, employers must take care to avoid making any decision based upon age, race, sex, religion, marital status, national origin, or disability *based upon social media*. Just as no job application should ever include any of the above so-called protected-class areas of inquiry, an employer should not use the same information even if not disclosed by the candidate in person.[2] If an employer ventures into the world of Facebook as part of due diligence, said employer may come into contact with such protected-class items. If an employment prospect is denied a job opportunity or denied even an interview (when the person is otherwise eminently qualified), the employer's Facebook investigations may expose the prospective employer to allegations that the decision not to hire (or not to interview) was based upon one of the protected classes referenced above. Using Facebook in the hiring process exposes the employer to the potential for unnecessary employment litigation. Therefore, employers should use caution if they decide to utilize Facebook and other social media outlets in the hiring process.

Social Media in the Disciplining and Firing Process

A discussion of disciplining employees and firing employees is interchangeable as each relates to social media. One need go no further than the Facebook page of the National Labor Relations Board (NLRB) when discussing the use of social media in the disciplining/firing process.[3] Two recent NLRB complaints against employers for utilizing Facebook in the firing process are instructive.

First, on May 24, 2011, NLRB filed a complaint on behalf of a former employee against an automobile dealership in the Chicago area.[4] The employer held a promotional event in an effort to attract customers to the dealership, and as part of the promotion, provided hot dogs and sodas to the prospective customers. An employee, on his home computer during his personal time, posted derogatory comments about the dealership stating that better food and drinks should have been provided to attract more customers. Other employees of the dealership chimed in and agreed with the employee's comments. The employer learned of the Facebook comments and demanded that the employee remove the comments. The employee did so, but was terminated anyway.

NLRB then filed an unfair labor practice complaint alleging that the dealership's actions violated Sections 7 and 8 of the National Labor Relations Act (NLRA).[5] Regardless of the ultimate outcome, the car dealership undoubtedly is expending substantial funds to defend its employment decision.

Second, in the case of *NLRB v. Hispanics United of Buffalo*,[6] NLRB alleged that the employer, a nonprofit that provides social services to low-income clients, unlawfully discharged five employees after they posted comments on Facebook (on their personal computers on personal time) which criticized working conditions and staffing issues. NLRB alleged that the Facebook comments were protected concerted activity within the meaning of Section 7 of the NLRA because it involved a conversation among coworkers about their terms and conditions of employment. Clearly, NLRB is closely monitoring such cases involving Facebook in the disciplining/firing process.

Likewise, NLRB filed such a complaint in *Souza v. American Medical Response*. The case originated in Connecticut. Souza posted derogatory comments about her supervisor and the company on her Facebook page on her personal computer on personal time. Other coworkers posted comments that agreed with Souza's comments, and the company terminated the employee. NLRB alleged that it was an unfair labor practice to terminate the subject employee. On the eve of the administrative trial on February 7, 2011, the case was settled in exchange for an undisclosed amount of money and the employer agreeing to change its policy regarding disciplining/firing employees based on online postings on personal time from personal computers.[7]

Facebook in the Nursing Home and Assisted Living Setting

Many senior citizens are becoming more tech savvy, and often have home computers, laptops, personal digital assistants, smart phones, and iPads. As a result, an increasing number of nursing home residents and assisted living residents are online in the long term care setting.[8] These technologies pose new questions for providers.

Recent decisions suggest that policies be implemented that prohibit an employee from "friending" a resident and from discussing any resident by name online.

There are two recent examples (in New Jersey and Oregon) of certified nursing assistants (CNAs) posting unflattering photographs of nursing home residents on Facebook.[9] In each instance,

the CNAs had their licenses revoked. They also both received jail sentences. In the New Jersey case, a CNA was accused of taking a photograph of a nursing home resident's genitals and then emailing the photograph to a friend. The friend then allegedly posted the photograph on her Facebook page. Prosecutors charged the pair with invasion of privacy. In the Oregon case, a CNA was charged with invasion of privacy and accused of taking photographs of nursing home residents and posting some on her Facebook page with demeaning comments. If these facilities had social media policies in place with corresponding orientation and employee training, the conduct at issue may have been avoided.

Finally, in the civil context, social media is becoming an oft-used discovery device. In a recent civil case, the author was able to utilize photos posted publicly on Facebook as a method to drastically reduce the damages claim by the plaintiff. Unlike plaintiff's attorneys, counsel for a facility has some ability to educate its employees with regard to social media.

NLRB Memorandums

The Acting General Counsel of NLRB has issued three memorandums to date that provide multiple examples of employer policies on social media,[10] which include NLRB's opinions regarding the legality of these various policies. This information should be considered when drafting policies on social media. The three NLRB memorandums discuss thirty-five various social media policies. Without discussing each in detail, the following general themes can be suggested:

- NLRB tends to favor policies that are not overly broad;
- NLRB is more prone to endorse a policy that contains specific examples that serve as a guide to company employees. For example, in the nursing home context, NLRB certainly recognizes that nursing home residents have a legal right to the privacy of their healthcare conditions; and
- NLRB is supportive of social media policies that protect nursing home residents from invasion of their privacy. Again, a policy that provides specific examples of prohibited social media postings will be more likely to be endorsed by NLRB.

In conclusion, the time is ripe to evaluate policies and procedures respecting social media. Consider including policies on company policy respecting the use of social media, especially as it relates to nursing home/assisted living residents and their families/friends. Remember that employers are legally entitled to prevent employees from utilizing company computers to use social media outlets, but that employers should be wary of interfering with personal computer use on personal time. Conversely, an employer generally will be entitled to discipline or discharge an employee if the employee divulges company trade secrets or divulges confidential information about a patient or nursing home resident. Finally, employers should exercise care when using social media outlets when making employment decisions.

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1 *See* Jose Antonio Vargas, *Spring Awakening: How an Egyptian Revolution Began on Facebook*, N.Y. Times, Feb. 17, 2012, *available at* www.nytimes.com/2012/02/19/books/review/how-an-egyptian-revolution-began-on-facebook.html?pagewanted=all.

2 *See generally* 42 U.S.C. § 1981 as amended.

3 *See* www.facebook.com/#!/NLRBpage.

4 *See* NLRB, News Release, Chicago car dealership wrongfully discharged employee for Facebook posts, complaint alleges, May 24, 2011, *available at* www.nlrb.gov/news/chicago-car-dealership-wrongfully-discharged-employee-facebook-posts-complaint-alleges.

5 29 U.S.C. §§ 151-169.

6 *See* NLRB, News Release, *Complaint issued against New York nonprofit for unlawfully discharging employees following Facebook posts*, May 18, 2011, *available at* www.nlrb.gov/news/complaint-issued-against-new-york-nonprofit-unlawfully-discharging-employees-following-facebook.

7 *See Company Settles Case in Firing Tied to Facebook*, N.Y. Times, Feb. 7, 2011 (for a discussion of the case), *available at* www.nytimes.com/2011/02/08/business/08labor.html.

8 *See, e.g.*, SkilledNursingFacilities.org, *Computers for Residents*, www.skilled-nursingfacilities.org/blog/life-in-nursing-homes/computers-residents/.

9 *See* NBC New York, *Nursing Home Worker Allegedly Took Pic of Resident's Genitals, Sent to Friend*, May 15, 2012, *available at* www.nbcnewyork.com/news/local/Nursing-Home-Resident-Facebook-Photo-Elderly-Resident-Genital-Charge-142809715.html and Huffington Post, *Oregon Nursing Assistant Ni Mai Chao Convicted After Posted Photos Of Dying Patients On Facebook*, Mar. 7, 2012, *available at* www.huffingtonpost.com/2012/03/07/nurse-dying-patient-photos-ni-mai-chao-oregon_n_1327171.html.

10 *See* NLRB, News Release, *Acting General Counsel releases report on social media cases*, Aug. 18, 2011, *available at* www.nlrb.gov/news/acting-general-counsel-releases-report-social-media-cases; NLRB, News Release, *Acting General Counsel issues second social media report*, Jan. 25, 2012, *available at* www.nlrb.gov/news/acting-general-counsel-issues-second-social-media-report; NLRB, News Release, *Acting General Counsel releases report on employer social media policies*, May 30, 2012, *available at* www.nlrb.gov/news/acting-general-counsel-releases-report-employer-social-media-policies.

Doughnuts or Data? The Role of Qualitative Data in Post-Acute Care Referrals

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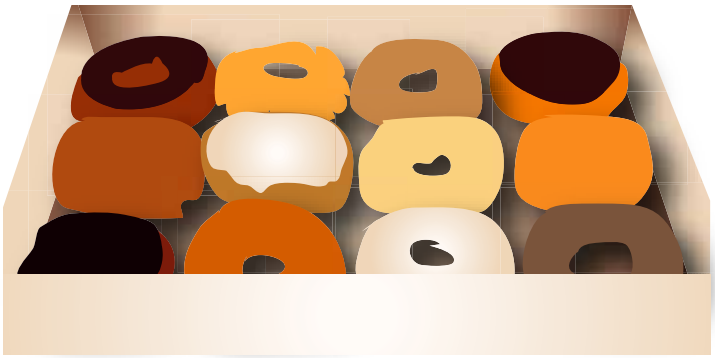

At a recent long term care association meeting, I had a conversation with a nursing home administrator, asking for her thoughts about how skilled nursing facility (SNF) admissions and discharges, particularly from hospitals, had changed over the years. Many individuals will identify with her reply. She remarked to me, "In the past, marketing to get discharges from the hospital never really involved much more than making sure you kept a good relationship with the hospital discharge planners. Actually, all you really had to do was bring them some boxes of donuts every once in a while and make sure they were happy." The irony of the conversation struck me. That conversation occurred during a program that was focusing largely on how nursing homes and hospitals work together in the future to reduce hospital readmissions.

That conversation led to the concept of this article, "You don't have enough doughnuts." This article discusses the basic principles and rules that govern hospital discharge planning obligations. It explains some of the issues involved in how "data-driven" post-acute referrals might take place in the future, if not the present. Increasingly, in the shadow of coming hospital readmission penalties, hospitals are finding that the answer to referral questions is not doughnuts, but data. Hospital decisions are driven by data to look for the post-acute provider partners who will keep patients from coming back to the hospital. Keeping those patients from rehospitalization not only results in better patient care, but also has a positive impact on the hospital partner's bottom line.

Whether real or imagined, a problem post-acute care providers often complain about is that the hospital is not sending many referrals. Their complaint may be that the hospital favors the provider down the street over their facility or agency. Increasingly in today's market these decisions are made because readmission data shows that the preferred provider is doing a better job of taking care of the patients and preventing hospital readmission.

Therefore, this article also examines the extent to which hospitals can steer patients toward particular post-acute treatment providers under Medicare discharge regulations.

Hospital Discharge Planning Requirements Under Medicare

Under the Medicare Hospital Conditions of Participation, a hospital has an extensive list of requirements with respect to discharge.[1] The hospital must have in effect a discharge planning process that applies to all patients, and the discharge planning evaluation must include an evaluation of the likelihood of a patient's need for post-hospital services and of the availability of those services.[2] The hospital must include the discharge planning evaluation in the patient's medical record for use in establishing an appropriate discharge plan, and the hospital must discuss the results of the evaluation with the patient or individual acting on his or her behalf.[3]

In addition, the patient and family members must be counseled, as needed, to prepare them for post-hospital care.[4] The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care.[5] The discharge plan also must be timely to allow for appropriate arrangements for post-hospital care to be made prior to discharge and to avoid unnecessary delays in discharge.[6]

The "List" of Post-Acute Providers

Hospitals, as part of the aforementioned counseling to patients being discharged to post-acute services, must furnish a list of post-acute care providers.[7] This list must be presented to those patients who are determined to require additional medical services following discharge.[8] The hospital staff must provide some guidance relative to available discharge locations. The regulations direct that:

- The hospital must provide to the patient (and/or his or her family) a list of home health agencies (HHAs) or SNFs that are available to the patient, participating in the Medicare program, and serve the appropriate geographic area requested by the patient;
- The hospital must list those Medicare providers who request to be listed. Except for SNFs, the providers must make a request to the hospital to be listed, and they must be located in the geographic area where the patient resides (in the case of HHAs) or the geographic area requested by the patient (in the case of SNFs);
- If the patient is in a managed care program, the list must indicate which entities have a contract with the managed care organizations;
- The hospital must document in the patient's medical record that the list was presented;
- The hospital has to counsel the patient about their freedom to choose among participating Medicare providers of

post-hospital care services and must, "when possible," respect patient and family preferences;

- The hospital must not specify or otherwise limit the qualified providers that are available to the patient; and
- The hospital must identify any (disclosable) financial interest (defined as direct or indirect ownership of 5% or more) that the hospital has in post-acute providers.[9]

All Medicare patients must have the freedom to choose their healthcare providers.[10] In 1998, the U.S. Department of Health & Human Services Office of Inspector General (OIG) identified a number of hospital risk areas. Included among them was "[p]atients' freedom of choice."[11] OIG noted that patients' freedom of choice was "particularly important for hospital discharge planners referring patients to home health agencies, [durable medical equipment] suppliers or long-term care and rehabilitation providers."[12] Thus, the law requires that, in presenting the list of post-acute providers to patients, "the discharge plan shall not specify or otherwise limit the qualified provider which may provide services."[13]

Can a Hospital "Steer" Patients to (or away from) Particular Providers?

Federal regulations provide that a hospital must not "specify or otherwise limit the qualified providers that are available to the patient."[14] This seems to suggest that hospitals cannot provide patients with post-acute treatment provider recommendations, even if the recommendations are based on legitimate facts like quality-of-care data. Doing so could inevitably steer patients toward particular providers. Even if a hospital creates its own list of HHAs and SNFs, it must abide by the patient choice requirements.

However, in addition to the requirement that the providers be qualified, the regulations also require that patients be transferred to "appropriate facilities."[15] Pursuant to 42 C.F.R. Section 482.43(d), the patient can be transferred by a hospital only to an "appropriate facility" where the patient would receive post-hospital care. An appropriate facility is defined as one that can meet the patient's medical needs.[16] Therefore, it seems that hospitals may be able to take quality-of-care data into consideration in determining whether an HHA or SNF should be deemed appropriate. If an HHA or SNF is not appropriate, then it should be excluded from the list of facilities given to the patient, even if it is otherwise qualified.

OIG Concerns and Opinions on Steering and Referrals

In 2011, OIG issued an Advisory Opinion about a company that provided an electronic referral service to hospitals.[17] The service provided the hospitals with a list of all licensed post-acute care providers. Hospitals used the service to send referral requests to those providers. Providers that chose not to use the service would still be listed, but they would receive referral requests via fax, instead of electronically. This fax service was more expensive, and it effectively eliminated any chance for the non-paying providers to enroll the referred patients. Because many hospitals awarded referrals to providers on a first-come, first-served basis, non-paying providers could not compete because they could not respond fast enough to the referral requests.

According to the OIG Advisory Opinion, this arrangement would likely violate the Anti-Kickback Statute (AKS). The AKS applies to any arrangement where even one purpose of the remuneration was to obtain money for the referral of services or to induce further referrals.[18] OIG reasoned that none of the Anti-Kickback safe harbors, listed in 42 C.F.R. Section 1001.952(f), applied because referral fees were not assessed uniformly among participants, and because they were not based solely upon the cost of operating the service. OIG found that the service posed more than a minimal risk of fraud or abuse under the AKS. Non-paying providers were effectively eliminated from the referral process, while paying providers were given a competitive advantage because of their speedy response time, rather than the quality of care offered. Because faxing was no less costly than electronic transmission, OIG found that the purpose of the distinction was to give paying providers a competitive advantage. OIG feared that paying providers might try to recoup costs by increasing the length of patient stays or the number of services provided, thereby increasing federal healthcare costs.

What Are the Future Implications?

Most long term care attorneys have probably heard at least once or twice from a post-acute care client who either had concerns about the flow of referrals from a hospital in their market, or had complaints about how a hospital was not referring clients to them. That being said, hospitals are increasingly taking on financial risks relative to readmissions. Section 3025 of the Patient Protection and Affordable Care Act established the Hospital Readmissions Reduction Program, which requires the Centers for Medicare & Medicaid Services to reduce payments to Inpatient Prospective Payment System hospitals with excess readmissions, effective for discharges that began on October 1, 2012. Various types of bundled payment provisions and other innovative programs are also making the quality of post-hospital care very important.

There appears to be little debate that "hospital readmissions data is going to be increasingly crucial to hospitals and nursing and rehab providers."[19] In the April 2009 *New England Journal of Medicine*, it was reported that 19.6% of Medicare fee-for-service beneficiaries who had been discharged from a hospital were readmitted to the hospital within thirty days, 34.0% within ninety days, and more than half (56.1%) within one year of discharge.[20] The costs to hospitals are significant based on these readmission rates. As early as 2013, a hospital can lose up to 1% of its federal reimbursement if it readmits too many patients within thirty days of discharge. In 2014, this figure increases to 2%; in 2015, the ceiling will be a possible 3% loss.

As most leaders in post-acute care and hospital companies have both publicly and privately observed, the following conclusions appear to follow:

- Decisions based on hard, reliable data are going to drive hospital decisions on discharges.
- Data, and the ability to collect, analyze, understand, and use data is critical to the current and future success of all post-acute providers.
- Post-acute providers who can marshal data to tell their "quality story" to hospital partners will be the ones who win those discharges in the future.
- Many hospitals may actively seek out post-acute partners who can deliver care in post-hospital care in specific areas, and then demonstrate the lowering of readmission rates.
- Driving discharge decisions based on quality is not likely to "cross the line" beyond which hospital providers can go.

Like all healthcare providers, post-acute providers face a challenge in the future. That challenge poses an opportunity for those who embrace and respond to the changes and the needs of their "new" acute care partners.

**The author would like to credit and express his gratitude to Summer Associate Emily F. Melson, 2013 JD Candidate, University of Virginia School of Law, for assistance with and research on this article.*

1 *See* 42 C.F.R. § 482.43.
2 *Id.* at § 482.43(b)(3).
3 *Id.* at § 482.43(b)(4).
4 *Id.* at § 482.43(c)(5).
5 *Id.* at § 482.43(d).
6 *Id.* at § 482.43(b)(5).
7 *Id.* at § 482.43(c)(6).
8 *Id.* at § 482.43(c)(6)(i).
9 *Id.* at § 482.43(c)(6).
10 42 U.S.C. § 1395a(a).
11 63 Fed. Reg. 8987, 8990 (Feb. 23, 1998).
12 *Id.* at n.22.
13 42 U.S.C. § 1395x(ee)(2)(H)(i). Note, however, that this provision does not apply if the patient is enrolled with a Medicare Choice organization under a Medicare Choice plan, and the patient is provided inpatient hospital services by a hospital under contract with the Medicare Choice organization. *See id.* at § 1395x(ee)(3).
14 42 C.F.R. § 482.43(c)(7).
15 *Id.* at § 482.43(d).
16 State Operations Manual (CMS Pub. 100-07), Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals at 345 (Interpretive Guidelines for 42 C.F.R. § 482.43(d) at A-0837), *available at* www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf; *see also* 59 Fed. Reg. 64141, 64149 (Dec. 3, 1994).
17 OIG Advisory Opinion No. 11-06 (May 13, 2011).
18 *United States v. Kats*, 871 F.2d 105 (9th Cir. 1989); *United States v. Greber,* 760 F.2d 68 (3d. Cir. 1985), *cert. denied*, 474 U.S. 988 (1985).
19 Berklan, James M., *Time to Put Data Into Your Hospital Relationships*, McKnight's Long-Term Care News & Assisted Living (June 27, 2012), *available at* www.mcknights.com/time-to-put-data-into-your-hospital-relationships/article/247554/.
20 Stephen F. Jencks, MD, Mark V. Williams, MD, and Eric A. Coleman, MD, MPH, *Rehospitalizations among Patients in the Medicare Fee-for-Service Program*, 360 New Eng. J. Med. 1,418-28 (Apr. 2, 2009).

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Hospital Readmissions

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On March 15, 2012, the Medicare Payment Advisory Commission (MedPAC) recommended reducing payments to skilled nursing facilities (SNFs) with high rates of rehospitalization compared with other SNFs.[1] Initially, the penalties would be based on risk-adjusted rates of rehospitalization of patients with respiratory infections, congestive heart failure, urinary tract infections, electrolyte imbalance, and sepsis.[2] However, MedPAC also recommends that the Centers for Medicare & Medicaid Services (CMS) consider penalizing SNFs for all rehospitalizations during Medicare stays, or for avoidable hospitalizations—*not just rehospitalizations*—of dual-eligible beneficiaries during both SNF and long term care stays.[3]

Along with the conditions that trigger financial penalties, the MedPAC report evaluates the period of time during which penalties should be imposed. MedPAC's recommendation is to start with rehospitalizations occurring during the Medicare-covered stay—that is, up to 100 days.[4] Eventually, however, the applicable period would be the entire Medicare-covered stay plus an additional thirty days.[5] According to MedPAC, these time periods will align the proposed SNF penalty with the readmission penalties imposed against hospitals under the Patient Protection and Affordable Care Act of 2010 (PPACA).[6] Likewise, a proposed penalty range of up to 3% of payments would, according to MedPAC, create consistency with hospital readmission penalties established in PPACA.[7]

Section 3025(a) of PPACA established the Hospital Readmissions Reduction Program (HRRP) by adding Section 1886(q) to the Social Security Act.[8] Under HRRP, and the implementing regulations, penalties reducing hospital payments for readmissions under the Hospital Inpatient Prospective Payment System will start in October 2012.[9] Excess readmissions for acute myocardial infarction, heart failure, and pneumonia will trigger hospital payment reductions for each Medicare admission, capped at 1% of Medicare payments in fiscal year (FY) 2013 and at 3% by FY 2015.[10] Beginning in 2015, the U.S. Department of Health & Human Services Secretary (Secretary) is, to the extent practicable, directed to expand the list of conditions and procedures to include chronic obstructive pulmonary disease, coronary artery bypass graft surgery, percutaneous transluminal coronary angioplasty, other vascular procedures, and possibly more.[11]

Under HRRP, "readmission" means "the admission of the individual [previously discharged from an applicable hospital] to the same or another applicable hospital within a time period specified by the Secretary [now set by rule at 30 days] from the date of such discharge."[12] Readmissions unrelated to the prior discharge are excluded.[13] The Secretary has set the minimum number of discharges for an applicable condition at twenty-five before the excess readmissions calculation would apply a payment penalty.[14]

A 2007 MedPAC report on reducing hospital readmissions played a crucial role in shaping HRRP.[15] The seven conditions and procedures MedPAC identified in the 2007 report are the seven included in HRRP.[16] The 2007 MedPAC report suggested public disclosure of hospital readmission rates.[17] In July 2009, CMS implemented MedPAC's idea of publicly disclosing hospital readmission rates, and Congress included this policy in PPACA.[18] Based on the extent to which Congress followed MedPAC's lead in developing HRRP, SNFs should anticipate that a readmissions reduction policy, if enacted, will largely replicate MedPAC's proposals.

Many SNFs may already be monitoring readmissions and preparing to present this information to hospitals to maintain or improve referral relationships in light of HRRP. The most recent MedPAC report gives SNFs another incentive to monitor and reduce hospital readmission rates.

Collecting reliable readmission data and implementing readmission prevention strategies also will be critical for participation in pilot programs under PPACA, including those relating to accountable care organizations (ACOs) and bundled payments. MedPAC's recommendations in the March 15, 2012, report appear designed to promote the broader PPACA goals for ACOs and bundled payments. According to the MedPAC report,

> Because a [SNF] rehospitalization policy would align the incentives of providers across sectors, *it represents a stepping stone toward paying for larger bundles of services*. Entities contemplating the development of *an accountable care organization or bundled payments* for a larger package of services would gain experience in managing care across settings so that rehospitalizations are minimized.[19]

Post-acute care providers may fear that ACOs and bundled payment pilot programs will ultimately lead to hospitals and hospital systems taking over SNFs, or, at a minimum, controlling the distribution of bundled payments. The 2012 MedPAC report reinforces this concern. While acknowledging that some hospital-based SNFs are selective about the SNF patients they admit, the report touts the rehospitalization rates of hospital-based facilities, and says the lower rates stem, at least in part, from greater physician and registered nurse presence and access to ancillary services.[20] MedPAC appears to suggest that a positive outcome of the proposed SNF rehospitalization policy would be to encourage hospitals to retain or develop SNFs, "because it facilitates better care coordination and helps manage the risk associated with larger payment bundles."[21]

Still, there are opportunities under PPACA for SNFs to demonstrate an ability to reduce rehospitalizations and to control the distribution of payment bundles. Under the Bundled Payments for Care Improvement pilot program, models three and six, post-acute providers can receive and distribute payment bundles for care provided to Medicare beneficiaries after hospital discharge.[22] One of the most significant challenges for SNFs and other post-acute providers in successfully leading the way in these models will be hospital readmissions, which will be included in the cost calculations.[23]

Another opportunity for SNFs under PPACA is the Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents, announced by CMS on March 15, 2012.[24] This program commits up to $128 million to reduce avoidable hospitalizations among nursing facility residents.[25] CMS will make awards to entities that partner with nursing homes to implement interventions to reduce avoidable hospitalizations.[26] The awards will range from $5 million to $30 million each.[27] Applications must include letters of intent from a minimum of fifteen nursing facilities (NFs) in the same state. The participating nursing homes must have a collective average census of 100 residents or more per facility.[28] The awards will be made to cover a four-year cooperative agreement period of performance, from August 2012-August 2016.[29]

The initiative requirements and guidelines demonstrate the measures that the Center for Medicare & Medicaid Innovation (CMMI) believes will reduce unnecessary hospitalizations. All awardees must:

- Hire staff who maintain a physical presence at NFs and partner with NF staff to implement preventive services;
- Work in cooperation with existing providers;
- Facilitate residents' transitions to and from inpatient hospitals and NFs;
- Provide support for improved communication and coordination among existing providers; and
- Coordinate and improve management and monitoring of prescription drugs, including psychotropic drugs.[30]

CMMI also suggests deploying nurse practitioners in NFs to manage residents' medical needs on the spot, when possible, and implementing quality improvement and communications tools to identify, assess, communicate, and document changes in resident status.[31] MedPAC, in its March 2012 report, suggests similar measures for reducing rehospitalizations. According to MedPAC, "a rehospitalization policy would prompt facilities to change their staffing, ensure good care transitions, improve their medication management, and educate families about advance directives and hospice services so that unnecessary hospitalizations do not occur."[32]

MedPAC acknowledges that some rehospitaliztion factors are not within a facility's control such as premature hospital discharge, worsening of a patient's condition requiring care SNFs typically do not provide, and physician preferences and concerns about malpractice.[33] MedPAC does not address how a policy based on financial penalties will alleviate these factors, and it is reasonable to question whether SNFs, which often operate with slim margins, can afford to implement the measures MedPAC and CMMI suggest for reducing rehospitalizations and avoidable hospitalizations.

Similarly, with regard to HRRP, there is criticism of the failure to fully address what accounts for the variations in readmission among hospitals.[34] Specifically, commenters to the HRRP rules argue that patient race, language, life circumstances, environmental factors, and socioeconomic status are not adequately addressed in the risk-adjustment methodology.[35] In response, CMS said the current risk-adjustment methodology is sufficient to account for different patient circumstances, but that it would monitor whether HRRP has a "disparate impact on hospitals that care for large numbers of disadvantaged patients."[36]

There are also concerns as to whether the financial penalties under HRRP will have the desired impact.[37] A report by the Congressional Research Service (CRS) states:

> Although the payment penalty may encourage most hospitals to find ways to reduce readmissions, there are additional financial incentives that may partially discourage such efforts. First, prevention strategies could be costly, particularly for some hospitals . . . Second, hospitals will be continued (sic) to be paid for each readmission . . . meaning hospitals can potentially reduce losses from the penalty with income from the readmissions. Third, there are annual caps on the payment penalty, which could create an incentive for some hospitals to limit their investments in patient safety and other readmission reduction strategies if the costs of such investments are greater than the potential payment penalty. Fourth, hospitals may be able to use administrative classifications to avoid measurement of some readmissions; for instance, *patients classified under observation status are considered outpatients and thus observational bed days would not count toward a hospital readmission*.[38]

The risk that hospitals will increase use of observation status to avoid measurement of some readmissions should concern NFs that rely on Medicare stays to compensate for poor Medicaid reimbursement; increased use of observational status will mean less residents returning from the hospital on Medicare-covered stays.

In addition to the concerns raised in the CRS report, under current payment models and care systems, there is a serious risk that a hospital bed freed up through reduced readmission rates will be filled with an additional initial (potentially higher-paying) patient who might otherwise have been cared for as an outpatient. Thus, in the absence of other interventions, reducing readmission rates may have no impact on total per capita costs within a community.[39]

SNFs and other post-acute care providers should monitor HRRP's unintended consequences, including any increased use of observation status, and be prepared to address this and other HRRP limitations with policymakers. SNFs should also be prepared to use positive outcomes from the Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents to argue that funding for targeted rehospitalization reduction measures, rather than financial penalties, is the most effective way to reduce avoidable hospitalizations and rehospitalizations.

It is reasonable to anticipate, however, that the push to impose rehospitalization penalties on SNFs, under the model set forth in the March 2012 MedPAC report, will move quickly. Because of this, and because of the important role limiting rehospitalizations will have in successful ACO and bundled payment pilot program participation, SNFs and other post-acute providers must begin measuring and attempting to reduce rehospitalizations. Generally, post-acute providers must work to receive a fair share of any savings achieved in the ACO and bundled payment pilot programs

from rehospitalization reduction, while learning how to operate and survive in the emerging healthcare payment paradigm.

1 Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy*, at 199 (Mar. 15, 2012), *available at* http://medpac.gov/documents/Mar12_EntireReport.pdf (last visited June 2, 2012).
2 *Id.* at 197.
3 *Id.*
4 *Id.*
5 *Id.*
6 *Id.* at 197–198 ("The extension [beyond the 100 Medicare-covered stay] would put hospitals and SNFs at similar risks for rehospitalizations that occur within a defined period after the beneficiary is discharged from their immediate care. . . . In the future, with 30-day windows after discharge for hospitals and SNFs, both sectors would have an incentive to promote successful care transitions from one provider to the next and, in the case of patients going home, the coordination of follow-up care.").
7 *Id.* at 199.
8 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010), *amended by* Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, Stat. 1029 (Mar. 30, 2010).
9 42 U.S.C. § 1395ww(q)(6); Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and FY 2012 Rates; Hospitals' FTE Resident Caps for Graduate Medical Education Payment, Final Rule, 76 Fed. Reg. 51476-51846 (Aug. 18, 2011).
10 PPACA § 3022(a).
11 *Id.*
12 42 U.S.C. § 1395ww(q)(5)(E).
13 42 U.S.C. § 1395ww(q)(5)(A).
14 Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and FY 2012 Rates, Final Rule, 76 Fed. Reg. 51476 (Aug. 18, 2011).
15 *Id.* at 51660 ("In its 2007 'Report to Congress: Promoting Better Efficiency in Medicare,' MedPAC noted the potential benefit to patients of lowering readmissions and suggested payment strategies that would incentivize hospitals to reduce these rates.").
16 Medicare Payment Advisory Commission, *Report to Congress: Promoting Greater Efficiency in Medicare*, at 116 (June 15, 2007), *available at* www.medpac.gov/documents/Jun07_EntireReport.pdf (last visited June 2, 2012).
17 *Id.* at 115,
18 PPACA § 3022(a)
19 *Id.* at 195.
20 *Id.*
21 *Id.*
22 *Bundled Payments for Care Improvement Initiative Request for Application, available at* www.innovations.cms.gov/Files/x/Bundled-Payments-for-Care-Improvement-Request-for-Applications.pdf (last visited June 2, 2012).
23 *Id.* at 17.
24 *Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents, available at* http://innovations.cms.gov/initiatives/rahnfr/index.html (last visited June 2, 2012).
25 *Id.*
26 *Id.*
27 *Solicitation for Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents, available at* http://innovations.cms.gov/Files/x/rhnfr.pdf (last visited June 2, 2012).
28 *Id.*
29 *Solicitation for Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents, available at* http://innovations.cms.gov/Files/x/rhnfr.pdf (last visited June 2, 2012).
30 *Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents, available at* http://innovations.cms.gov/initiatives/rahnfr/index.html (last visited June 2, 2012).
31 *Id.*
32 Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy*, at 195 (Mar. 15, 2012), *available at* http://medpac.gov/documents/Mar12_EntireReport.pdf (last visited June 2, 2012).
33 *Id.*
34 Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and FY 2012 Rates, Final Rule, 76 Fed. Reg. 51476 (Aug. 18, 2011).
35 *Id.* at 51670.
36 *Id.* at 51670-51671.
37 Julie Stone & Geoffrey J. Hoffman (Congressional Research Service), *Medicare Hospital Readmissions: Issues, Policy Options and PPACA* (2010).
38 *Id.* at 33.
39 David C. Goodman, Elliott S. Fisher, Chian-Hue Chang, *After Hospitalization: A Dartmouth Atlas Report on Post-Acute Care for Medicare Beneficiaries* (2011).

Lifesaving Finance or Financing Lifesaving? Revised Loan Program for Fire Safety Sprinklers

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Introduction—Automatic Fire Sprinklers and Nursing Homes

Automatic fire sprinklers are individual units that are heat activated and attached to a network of pressurized water piping throughout a building. A detector device will trigger the sprinkler to open at a particular temperature (usually 165°), thus showering the heat source with water and extinguishing the fire. Sprinklers operate automatically and do not depend on the attention and alertness of any human beings. The National Fire Protection Association (NFPA) has estimated from its studies that fire deaths are reduced by between 74% and 91% in sprinklered buildings. Since the 1940s and 1950s, fire safety sprinkler systems have been installed in many communities in the United States and most building codes require sprinklers for many new buildings, especially multistory buildings or buildings where it is particularly difficult to evacuate occupants. In addition, some locations have required retrofitted sprinklers in older buildings for many years.[1]

The elderly and frail residents of nursing homes are particularly vulnerable to injury or death in the event of a fire, because they are often unable to exit the building without assistance. In 2003 there were two tragic nursing home fires. One was in Nashville, TN, and the other in Hartford, CT. Together, thirty-one people lost their lives. Neither building was protected with automatic fire sprinklers, and both fires occurred at night, when staffing was lowest.

The Centers for Medicare & Medicaid Services (CMS) responded first with an interim final rule[2] that required battery-operated smoke detectors in resident sleeping rooms and public areas, unless there was a hard-wired smoke detector system or sprinkler system in place. Thereafter, in 2008 CMS adopted a final rule[3] that all existing nursing homes must be fully protected with fire safety sprinklers in accordance with the 1999 edition of NFPA 13[4] by August 13, 2013, and established a five-year transitional period. CMS staff cited data from NFPA in a 2004 U.S. Government Accountability Office report that there is an 82% reduction in the chance of death occurring in a sprinklered building over one without sprinklers. In addition, CMS noted that there has never been a multiple-death fire in a long term facility that was protected with an automatic fire sprinkler system.

When the final rule was adopted, five years seemed a reasonable time to allow for owners of facilities to comply. Indeed, some states have required all nursing homes to be retrofitted with automatic fire safety sprinklers (Alabama, Connecticut, Illinois, Tennessee, and Virginia),[5] and some municipalities have adopted similar requirements.

Now, as we move into the winter of 2012, that August 13, 2013, deadline looms nearer. Conventional financing is very difficult because a borrower cannot demonstrate that the installation of the fire safety improvements will add any revenue to operations, and so it is hard to underwrite the source of repayment for the additional loan. To make matters worse, a poor economy and crises in our financial institutions have made it even more difficult to obtain financing for these upgrades.

While new facilities have been constructed with full sprinkler protection for some time and many existing facilities have had sprinklers installed on a retrofit basis already, many facilities remain that still lack such protection. No waivers from CMS are available.

Government-Insured Financing of Sprinkler Installation Costs

The U.S. Department of Housing and Urban Development (HUD) administers the programs of the Federal Housing Administration (FHA). It has had the authority since 1974 to provide insured financing of fire safety equipment costs under Section 232(i) of the National Housing Act.[6] Although these loans have been available since 1974, based on a review of the published FHA-Insured database,[7] no loans have actually ever closed under Section 232(i). Perhaps this reflects the cumbersome processing rules and the availability of credit from other sources, or perhaps owners had little appetite for incurring debt for upgrades that were not

mandated by CMS. In any event, it seems clear that the existing program has been ineffective as offered. Recognizing this and recognizing the impending CMS deadline, on March 14, 2012, HUD issued a waiver[8] of certain of the requirements under the Section 232(i) program to make it easier to assist nursing home owners who need to install sprinklers before August 13, 2013.

HUD's streamlining and modernizing efforts dovetail with the implementation of the LEAN processing for healthcare properties in general. Improvements include the reduction and consolidation of application paperwork. Preparation of draft closing documents is completed at an earlier stage to facilitate quicker closings. Highly experienced HUD underwriters are geographically disbursed so that loan applications are processed nationally on a first-come, first-served basis. These changes have led to more standardized underwriting and quicker processing times.

The authors are in the process of assembling a pilot program of loan applications to process with HUD in a partnership to assist HUD in the development of its revised program guidance for Section 232(i). There is likely room to streamline further as long as the guidelines stay well within the boundaries of existing laws. These authors expect that the most important guidelines are:

- The loan program is available for nursing homes, intermediate care facilities, board and care facilities, and assisted living facilities.
- The current Section 232(i) guidelines indicate that the loan must be in first position unless the first mortgage is an FHA-insured mortgage. However, this requirement may be under consideration for revision by HUD, based on recent email newsletter communications from HUD. While it may be very difficult to persuade a lender to subordinate its existing first mortgage to new financing, the alternative could be even more bleak if the facility cannot comply with CMS requirements by August 13, 2013.
- Project must meet a 1.45 debt service coverage ratio.
- The loan is limited to 100% of the cost of equipment and installation, based upon the discussion at the HUD LEAN Training (held September 13-15, 2011).
- The amortization of the loan will be five, ten, or fifteen years. If the mortgage is more than $50,000, the term may be as long as twenty years. In any event, the term may not be longer than HUD's estimate of the remaining economic life of the structure.
- No appraisals are required.
- HUD appears to be contemplating eliminating the requirement for a Property Capital Needs Assessment.
- Eligible uses of loan proceeds are acquisition and installation of sprinkler systems and other fire safety equipment including the cost of structural modifications needed to install the system. HUD still needs to verify whether a minimal amount of critical or non-critical repair can be tolerated within this program.
- Compliance with federal prevailing wage requirements under the Davis Bacon Act is not required.
- The construction contract may be a lump sum or cost-plus form of contract.

Final processing rules are still being developed by HUD, and as noted in this article, some uncertainties remain about all the details of these loans. Although HUD is still developing its final processing rules, the recent waiver issued by HUD permits additional streamlining in processing so that all nursing homes can meet the deadline for sprinkler installation. Representatives of HUD continue to express their strong desire to provide safe housing for all individuals, which is one of HUD's primary missions.

Financing of Sprinklers as Part of Refinancing of Entire Facility

Given the attractive rates and longer terms offered by FHA-insured loans in general, owners of facilities, with or without existing FHA-insured loans, may consider a refinance of existing debt now rather than seek separate sprinkler financing. If an owner's existing debt has relatively high interest and is capable of being refinanced (is not subject to prepayment restrictions), then a refinance of the entire existing debt under HUD Section 232/223(f) could provide the additional funds needed for the expense of sprinkler installation at the same time that the overall debt service might be reduced to improve cash flow. A refinance also would allow additional repairs and improvements that the Section 232(i) loan does not cover. If an FHA-insured loan is unable to be refinanced due to prepayment restrictions, another option would be the Section 241 program.[9] In short, HUD provides multiple financing choices for owners to meet the 2013 CMS deadline.

Who Are the Good Candidates for 232(i) Loans?

In general, FHA rules require that its insured financing must always be in first priority position (although a recent email HUD newsletter suggests that HUD may be relaxing this requirement for these sprinkler loans). It is unlikely that a commercial lender or a bond trustee will voluntarily subordinate first priority to allow an FHA-insured loan for sprinkler upgrades. Thus, the best candidates for financing are projects that have already been financed with FHA-insured mortgages. Many of those projects have likely been refinanced recently and will have upgraded their fire safety as part of that process.

Most FHA loans are not prepayable at par (without a premium) until a certain number of years after the date of the loan, and thereafter have prepayment premiums that can be substantial in the first few years after the lockout ends. Even with the recent low interest rates, many owners may be unable to refinance, or the refinancing may be too expensive due to the prepayment premium, and thus owners facing these issues would be good candidates for financing sprinkler improvements under 232(i).

The recent Medicare rate reduction and proposed Medicaid rate reductions not only exacerbate the timing issue but make existing FHA-insured facilities more vulnerable to maintaining healthy debt service ratios. In some cases these rate reductions can be so severe as to preclude refinancing the first FHA-insured mortgage, whether it is locked from prepayment or not due to a reduction in value based on the cash flow.

The logical candidates for the Section 232(i) sprinkler finance program will be unsprinklered or partially sprinklered facilities that were financed within the last five to ten years (and thus still under lockout or expensive prepayment) but prior to 2008 (when the new CMS requirements were issued and HUD required sprinkler upgrade as a condition to any new insured loan). For the projects that closed loans within this period of time, there would have been no requirement to upgrade their sprinkler systems at closing, and they have no cost-effective options for additional financing other than the Section 232(i) program.

Final Thoughts

New program guidance for Section 232(i) loans are in progress, and HUD seeks to finalize this guidance with its experience with a pilot group of loans. The waiver issued by HUD on March 14, 2012, waived certain requirements provides additional streamlining for the program. The authors' goals are to work with HUD and the pilot group quickly in order to ensure sufficient time for implementation of the Section 232(i) program to meet the CMS deadline of August 13, 2013. Long term care facilities that already have FHA-insured financing will be the easiest loans to process under Section 232(i). Any FHA-insured loan, including these fire safety equipment loans, must be processed by an approved FHA lender. An owner's first step is to contact an FHA lender, preferably one with interest and experience with this program.

1 Russell Fleming, *The Fire Sprinkler Situation in the United States*, National Fire Sprinkler Association 2002, *available at* www.sprinklerworld.org/vds.doc.
2 70 Fed. Reg. 15229 (Mar. 25, 2005), added paragraph (a)(7) to 42 C.F.R. § 483.70.
3 73 Fed. Reg. 47075 (Aug. 13, 2008).
4 *Standard for the Installation of Sprinkler Systems*, National Fire Protection Association.
5 *Retrofit Fire Sprinkler Program – A Partial Listing, available at* www.nfsa.org/info/retrofit.html. At the time this article went to press, this document had been taken down from the CMS website.
6 12 U.S.C. § 1715w, as amended.
7 *Available at* http://portal.hud.gov/hudportal/HUD?src=/program_offices/housing/comp/rpts/mfh/mf_f47.
8 Department of Housing and Urban Development, Waiver of Requirements of 24 C.F.R. § 232.505(a), 232.520, 232.540(b), 232.605 and 232.620, Mar. 15, 2012.
9 Section 241 of the National Housing Act permits FHA insured loans for additional improvements to insured projects as secondary financing with collateral security subordinate to existing FHA insured first mortgage financing.

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