RECENT AND UPCOMING EVENTS:

DECEMBER 3, 2009 – Louis J. Capozzi, Jr., Esq. and Donald R. Reavey, Esq. presented a webinar program for PANPHA on "Understanding your Real Estate Tax Assessment."

MARCH 6, 2010 – Bruce G. Baron, Esq. taught the full-day seminar as part of Slippery Rock University Department of Allied Health's licensing program for nursing home administrators on "The Government's Role in Health Care Policy, Regulation and Reimbursement," in Slippery Rock.

MARCH 11, 2010 – Bi-Annual Capozzi & Associates, P.C. Seminar on "Current Issues for Nursing Facilities in Pennsylvania," in Grantville, Pennsylvania at the John Henry Conference Room at Hollywood Casino, including continuing education credits for NHA's, CPA's, HR professionals, and attorneys (Fall Program scheduled for October 7, 2010).

March 16-17, 2010 - Bruce G. Baron, Esq. taught a full-day seminar as part of Penn State Greater Allegheny's licensing program for nursing home administrators on "The Government's Role in Health Care Policy, Regulation and Reimbursement" as well as the two-hour "Module 5" program of DPW's required training for personal care administrators on "Local, State and Federal Laws and Regulations Pertaining to the Operation of a Home," in McKeesport.

MAY 1, 2010 (Law Day) – Bi-Annual Capozzi & Associates, P.C. Adopt-A-Highway Cleanup on Interstate 81, Mile 62.5 (between Enola and Wertzville Road Exits in Cumberland County).

JUNE 11, 2010 – Capozzi & Associates, P.C. 13th Anniversary.

JUNE 11, 2010 - Louis J. Capozzi, Jr., Esq. and Donald R. Reavey, Esq. will be presenting another session of the webinar program for PANPHA on "Understanding your Real Estate Tax Assessment."

June 15, 2010 – Bruce G. Baron, Esq. will be teaching another session of the two-hour "Module 5" program of DPW's required training for personal care administrators at Penn State Greater Allegheny.

June 23-25, 2010 – Bruce G. Baron, Esq. is a scheduled speaker for the 2010 PANPHA Annual Conference, in Hershey, on "A Survival Guide to Special Audits for Nursing Homes."

[date TBA in 2010] – Andrew R. Eisemann, Esq., Michael M. Jerominski, Esq., and Bruce G. Baron, Esq. will be teaching a full-day seminar on "Managing Nursing Home Receivables and Collections" for the Center for Healthcare Administration and Finance (www.CHAF.org) in the Greater Pittsburgh Area. Check the CHAF website for updates on the date, time, and location.

Capozzi & Associates, P.C.
Attorneys at Law
2933 North Front Street
Harrisburg, PA 17110

Return Service Requested

PRESORTED
STANDARD
U.S. POSTAGE PAID
HARRISBURG, PA
PERMIT NO. 583

Capozzi & Associates, P.C.
Attorneys at Law

www.capozziassociates.com

The Quarterly

2933 North Front Street • Harrisburg, PA 17110
Telephone: (717) 233-4101
Fax: (717) 233-4103
April 2010

LANDMARK HEALTH CARE REFORM ACT INCLUDES PROVISIONS AFFECTING NURSING FACILITIES

On March 23, 2010, the President signed the Patient Protection and Affordable Care Act ("the Act"). On March 30, 2010, the President signed the Health Care and Education Reconciliation Act of 2010, which makes technical amendments to the Act. While this landmark legislation deals primarily with health insurance reform, it contains provisions directly affecting nursing facilities, including those in Title VI, Subtitle B of the Act relating to Nursing Home Transparency and Improvement (§§ 6101-6114). The Act also includes, in Title VIII, Section 8001-8002, the Community Living Assistance Services and Supports Act (CLASS Act, added as Title XXXII of the Public Health Service Act), a national voluntary long-term care insurance program to become available by October 1, 2012; additional programs for States to provide home- and community based alternatives to nursing facility care (Title II, Subtitle K and Section 10202); and, programs for workforce development (Title V).

Effective Immediately:

((a) Section 6101 of the Act requires nursing facilities participating in the Medicare and Medicaid Programs to keep and have available for submission to CMS, the OIG, DPW and the State Long Term Care Ombudsman information related to:

Entities or individuals with ownership or control in the facility;

Members of the facility's governing body, including the name, title, and period of service of each;

Officers, directors, members, partners, trustee, or other managing employees, including the name, title, and period of service of each;

Individuals or entities that exercise operational, financial, or managerial control over the facility or provide policies or procedures for any of the operations of the facility, including the organizational structure of each such entity;

Individuals or entities that lease or sublease the real property to the facility, including the organizational structure of each such entity;

Individual or entities that provide management or administrative services, management or clinical consulting, or accounting or financial services to the facility, including the organizational structure of each such entity.

This information will become subject to regulations in 2012 and thereafter made available to the public in 2013.

(b) Section 6402 (relating to Medicare & Medicaid Integrity Provisions) adds Section 1128J(d) requiring providers to report and return overpayments within sixty (60) days of the date on which they are identified with failure to comply subject to possible False Claims Act violations and civil monetary penalties.

(c) Section 6404(b) requires that any unbilled Medicare Part A or Part B claims for services prior to January 1, 2010 be submitted by December 31, 2010 in order to qualify for payment. Section 6404(a) changes the billing period for Medicare claims to one (1) year from the date of service.

(d) Title VI, Subtitle H, Sections 6701-6703 of the Act includes the new Elder Justice Act of 2009, which adds Sections 2011-2046 to Title XX of the Social Security Act and Section 1150B to Title XI of the Social Security Act. The new Section 1150B requires nursing facility providers: (i) to provide annual notice to their owners, operators, employees, managers, agents and contractors if that facility received at least $10,000 in federal funds the prior year and of their resulting obligation to timely report to the Federal Government and local law enforcement any reasonable suspicion on any crime against any individual who is a resident of or is receiving care from the facility; and, (ii). to post a sign (in a form to be established by the Federal Government) that provides employees notice of their rights to be free from retaliation related to their compliance with reporting requirements. This Section includes penalties for noncompliance and retaliation. The Title XX additions include grant programs to enhance staffing and the use of electronic health records in nursing facilities.

(e) Section 6201 of the Act provides for the establishment of a nationwide system for national and state background checks for nursing facility employees, contractors, and volunteers who would have one-on-one direct patient access and duties, including

Continued on page 2

LANDMARK HEALTH CARE REFORM ACT INCLUDES PROVISIONS AFFECTING NURSING FACILITIES *Continued from page 1*

fingerprinting requirements, which defines disqualifying information to include convictions for any offenses included in 42 U.S.C. § 1320a-7 (relating to exclusion of certain individuals from participation in Medicare and State health care programs) and findings of patient or resident abuse that are included on a State nurse aide registry.

Effective October 1, 2010:

Section 10325(a) preserves the planned October 1, 2010 implementation date for the change included in RUG-IV for therapy furnished on a concurrent basis, as well as the changes to the look back period to ensure that only those services furnished after admission to the SNF are used as factors in determining a case-mix classification under PPS.

Section 10325(b) preserves the planned October 1, 2010 implementation date for MDS 3.0.

Effective March 25, 2011:

Section 6103 provides for enhancements to the Nursing Home Compare Website, including additional staffing data, links to State survey information, public information and a standardized form for filing complaints, summary information on substantiated complaints, information on adjudicated criminal violations by the facility or its employers including those committed inside the facility, those involving abuse, neglect, exploitation, criminal sexual abuse, and crimes involving serious bodily injury, as well as CMPs levied against the facility, employees, contractors or other agents.

Section 6105 provides for the establishment of a standardized complaint form and procedures and timelines for the resolution of such complaints.

Section 6111 provides for a reduction in civil monetary penalties of up to 50% for certain self-reported and promptly corrected deficiencies, but precludes such reductions for repeat deficiencies and those found to result in a pattern of harm, widespread harm, immediate jeopardy, or the death of a resident. This section also authorizes new regulations on collection of CMPs, including provisions for independent informal dispute resolution.

Section 6113 establishes requirements and related sanctions for the NHA to submit written notification to the Federal Government, to the State long-term care ombudsman, to facility residents and to the residents' legal representatives or other responsible parties timely advance notice of the closure of the facility. This Section also precludes admission of new residents after the date of such notice. The required notice must include information on the facility's discharge plan, which is subject to advance approval by the State, for the transfer and adequate relocation of the residents by a date prior to the closure and assurances that the residents will be transferred to the most appropriate facility or other setting (including home- and community-based settings) in terms of quality, services and location, taking into consideration the needs, choice, and best interest of each resident.

Section 6121 requires nursing facilities to provide initial training (and such ongoing training as may be later required by regulation) for all nurse aides (whether employees or hired through an agency or under a contract) that includes dementia management training and patient abuse prevention training.

Effective October 1, 2011:

Section 2401 of the Act, as amended by Section 1205 of the Reconciliation Act, provides for the Community First Choice Option for States to implement home- and community-based attendant services and supports for individuals eligible for nursing facility services to choose to receive such home- and community-based attendant services and support in order to remain in their homes, as well as transitional costs including rent and utility deposits, first month's rent and utility costs, bedding, basic kitchen supplies, and other necessities required for an individual to make the transition from a nursing facility to a community-based home setting.

Section 3401(b) implements a "productivity adjustment" to the nursing facility market basket computation, which is estimated to total $14.6 Billion over the next ten (10) years.

Section 10325 delays implementation of RUG-IV until at least October 1, 2011.

Effective March 25, 2012:

Section 6104 of the Act provides for Medicare cost reports to include a separate section reporting wages and benefits for direct care staff that breaks out: RNs, LPNs, certified nurse assistants, and other medical and therapy staff. This information and other functional account information will be made available to others by September 25, 2012.

Section 6106 provides for electronic submission of information on direct care employee and contract staff to include: (a) the category of work for each; (b) resident census date and case-mix; (c) information on turnover, tenure, and hours of work for each category of staff; and, (d) a regular reporting schedule.

Requiring Quality Assurance and Performance Improvement Plans by 2013

Section 6102(c) of the Act requires a Quality Assurance and Performance Improvement Program is to be implemented by the Federal Government before 2012 that will establish standards relating to Quality Assurance and Performance Improvement and provide technical assistance to facilities on the development of Best Practices to meet the standards. Within one year after the standards are promulgated, nursing facility are required to submit Plans to meet the standards, including how to coordinate their quality assessment and assurance activities already required by the Conditions of Participation in 42 CFR Part 483.

Continued on page 3

NEW LEGISLATION AIMS TO ADVANCE THE USE OF HEALTH INFORMATION TECHNOLOGY

Title XIII of the American Recovery and Reinvestment Act, passed into law on February 7, 2009, and may be referred to as the Health Information Technology for Economic and Clinical Health Act or THE HITECH ACT for short. The Committee on Energy and Commerce of the Ways and Means Committee summarizes four major objectives along the way to accomplishing one goal: advancement of the use of health information technology. These include (1) requiring government to take a leadership role (2) investing $20 billion in health information technology (3) saving the government $10 billion through improved quality and error reduction, and (4) strengthening federal privacy and security laws. Overall the legislation strives to consolidate many of the efforts that have already been put underway in the healthcare industry in the past decade, providing incentives for those who participate and penalties for those who do not.

INCENTIVES - Incentives will be made available to certain eligible professionals and hospitals for investing in the infrastructure necessary to allow for and to promote the electronic exchange and use of health information. Funds will be distributed through Medicare and Medicaid in the form of incentive payments to "meaningful EHR users" and federal matching funds will be available to States to support administrative costs associated with these new programs. Financial incentives for hospitals will begin in October 2011 and end in 2015.

QUALIFICATIONS -The qualifications for receiving incentives have not yet been developed and will be defined in later regulations and materials. Generally, CMS requires that the hospital be a "meaningful user of a certified Electronic Health Record (EHR)" and meet all specified standards, policies, implementation specifications, timeframes and certification requirements. To be a "meaningful EHR user" the hospital must demonstrate the use of a certified EHR; use the electronic exchange of health information to improve the quality of health care and report on clinical quality. By 2010, CMS plans to publish proposed rules, develop systems to support the payment of incentives and begin payments to hospitals.

APPLICABILITY - Recently, CMS was questioned as to whether Long Term Care providers would be eligible for incentive payments under the Recovery Act's Medicare & Medicaid incentives for adoption and meaningful use of electronic health records, below is their response.

ANSWER

No. Nursing homes, per se, are not eligible. The following types of institutional providers are eligible for incentive payments under Medicare and/or Medicaid provided they meet the applicable criteria. Under Medicare, institutional providers eligible for the EHR incentive payments include "subsection (d) hospitals" as defined under section 1886(d) of the Social Security Act and critical access hospitals. Under Medicaid, these institutional providers are acute care hospitals and children's hospitals.

This however, does not automatically exempt Long Term Care Facilities from complying with the ACTS requirements with regard to the protection and confidentiality of protected health information (PHI). According to comments from CMS, all provisions of the ACT are applicable to Long Term Care Facilities with the exception of participation in the EHR incentive payments program and decisions about EHR standards, implementation specifications and certification criteria are currently under development that will impact Long Term Care.

COMPLIANCE - To strengthen the existing federal privacy and security law and to further protect confidential health related information hospitals will be required to comply with a Federal Breach Notification Rule. This rule requires an individual to be notified if there is an unauthorized disclosure or use of health information, allows patients to request an audit trail from the hospital showing all disclosures of health information and requires hospitals to obtain an authorization from the patient in order to use health information for marketing or fundraising activities. These requirements apply not only to all HIPAA covered entities but to business associates and vendors as well.

The list of requirements related to the protection of patient information defines the method and content of notification and calls for remedial action upon breach. In an effort to prepare a hospital for this new rule a hospital should at a minimum: identify systems containing confidential information, have information encrypted or destroyed, evaluate their existing privacy and security policies, implement safeguards to protect information, adopt an incident response plan, update Business Associates and vendor contracts and assign responsibilities to staff and management to insure a timely response to breaches. As with HIPAA policies and procedures, communication and training are valuable mechanisms for insuring that procedural guidelines are met with regard to avoiding and/or reporting breaches of security.

ENFORCEMENT - To encourage compliance with the Act, increased enforcement and enhanced fines are applicable. Formal investigations of complaints will be conducted and civil penalties may be imposed. Civil monetary penalties for violations of HIPAA have been increased and could result in fines of up to $50,000 per violation, not to exceed $1.5 million for all such violations during a calendar year where reasonable care has been exercised. Cases of willful neglect where no corrective action plan was implemented could result in a fine carrying no maximum penalty.

As of the release date of this article Congress is on track to move ahead swiftly with this legislation. The Health Information Technology (HIT) Policy and Standards Committees met for the final time in December and are prepared to release the interim rules, subject to a 60 day public comment period. HHS is soliciting bids for a payer database to support comparative effectiveness data and have created an additional 50 privacy and security related positions in the Office of the National Coordinator for Health Information Technology. In late December, President Obama named three heavy hitters to assist in implementation: a Cybersecurity Coordinator, a Chief Information Officer and a Chief Technology Officer.

A recent legal action emphasizes the significance of the enhanced requirements under the Hi Tech Act. A January 13th, 2010 press release posted on the Attorney General of Connecticut's website boasts of a lawsuit against Health Net for massive security breaches involving private medical records. The release stated "this marks the first action by a state attorney general involving violations of HIPAA since the Health Information Technology for Economic and Clinical Health Act authorized state attorneys to enforce HIPAA." Clearly, this is one governmental effort that is not going away.

If you would like more information on the HiTech Act, HIPPA or privacy and security of patient information you may contact Dawn L Richards at our firm.

CLARIFICATION FROM DPW AND CMS ABOUT CURRENT LIMITATIONS *Continued from page 6*

the individual of medical care and endanger the individual's life; or
(2) Deprive the individual or a financially dependent family member of food, shelter, or the necessities of life.

NOTE that the State Plan limits provide for OME deductions incurred in the six (6) months prior to the application for Medicaid, not the effective date of Medicaid eligibility; and, they expressly eliminate, except in undue hardship cases, the authority previously contained in DPW's Nursing Home Handbook that permitted OME deductions for balances resulting from transfer of asset penalty periods.

Nursing facilities must obtain information on the date of the application for Medicaid that is the basis for eligibility in order to compute the amount of prior private pay balances they can offset against the patient pay amount through the OME deduction. In cases where eligibility is not retroactive for the full three (3) months prior to the date of the application, nursing facilities will be able to recover more of the unpaid private pay balance through these offsets.

If you have questions about OME deductions and the current State Plan limits, you may call Bruce G. Baron, Esq. at our Firm.

STRUGGLES WITH GUARDIANS: Long-Term Care Facilities & § 5512.2 Hearings

By Michael M. Jerominski, Esquire

Efficient and competent guardians of the person and estate ("plenary guardians") are essential partners to any successful nursing home facility. Such a competent guardian, whether a family member or an organization that provides guardianship services, can mean the difference between uncertainty about a resident's medical wishes coupled with erratic payment to the facility on one hand and a clear view of the resident's desires and regular payment on the other.

A common problem involves Medicaid coverage gaps. Often a guardian who is family to the resident may fail to provide the information required to complete the application process, or may fail to appeal a denial of eligibility. In other cases, a guardian who is family may fail to provide information that may lead to a favorable outcome in an asset transfer penalty period determination. Even institutional guardians are not perfect.

Clearly not every guardian is capable or willing to perform the task properly. The process of having an emergency plenary guardianship established and then converted into a permanent one is a fairly well-worn path for many nursing home facilities. Less commonly used by nursing home facilities is the process of the review hearing established by 20 Pa. C.S.A. § 5512.2 in order to address the inadequacies of appointed guardians once in place.

20 Pa. C.S.A. § 5512.2 states that an Orphans' Court "may set a date for a review hearing in its order establishing the guardianship or hold a review hearing at any time it shall direct", meaning an Orphans' Court is free to set, for example, an annual hearing, or set a hearing date if the Court becomes aware of a possible change in circumstance. 20 Pa. C.S.A. § 5512.2(a). The Court shall also order a review hearing if the incapacitated person, the guardian or any interested party petitions the Court "for reason of a significant change in the person's capacity, a change in the need for guardianship services or the guardian's failure to perform his duties in accordance with the law or to act in the best interest of the incapacitated person." 20 Pa. C.S.A. § 5512.2(a). The wide class of possible petitioners which includes any "interested party" encompasses nursing home facilities. Poor handling of the estate of the incapacitated person—either non-payment to a nursing home facility or lack of cooperation in applying for various benefits—is an excellent peg on which to hang a case for a review hearing and a possible change of guardians. At the very least, when faced with a possible review hearing, many wayward guardians find religion, as it were, and substantially change their approach to their guardianship duties.

Circumstances that will lead a court to remove a guardian include:

1. The guardian is wasting or mismanaging the estate;
2. The estate is likely to become insolvent;
3. The guardian has failed to perform any duty imposed by law;
4. The guardian has come to suffer a sickness, physical and/or mental incapacity, and the condition is likely to continue, to the detriment of the estate;
5. The guardian has removed from Pennsylvania or has ceased to have a known place of residence in Pennsylvania without providing security or additional security as the court may direct;
6. The guardian is likely to jeopardize the interests of the estate by remaining in office.

Coupled with the expansive language of the sixth item on the above list, the preceding five situations are likely to cover nearly any problem a nursing home may encounter with regard to a plenary guardian.

A final caveat: despite the wide latitude granted by 20 Pa. C.S.A. § 5512.2, it is important to remember that frivolous petitions will be dismissed without a hearing. *Estate of Haertsch*, 649 A.2d 719 (Pa. Superior Ct. 1994); 20 Pa. C.S.A. § 5512.2(b).

If you facility has any questions about guardianships that may be ripe for a review hearing, you may contact Michael M. Jerominski, Esquire, at our firm.

LANDMARK HEALTH CARE REFORM ACT INCLUDES PROVISIONS AFFECTING NURSING FACILITIES *Continued from page 2*

Requiring Effective Compliance and Ethics Programs by March 2013

Section 6102 of the Act, requires, on and after March 23, 2013, that nursing facilities participating in the Medicare and Medicaid Programs have in operation "a compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative violations under this [the Social Security] Act and in promoting quality of care consistent with regulations…." Federal regulations are to be developed by March 2012 and the resulting programs must meet the following requirements:

The Program must be reasonably designed, implemented, and enforced so that it generally will be effective in preventing and detecting criminal, civil, and administrative violations under the Act and in promoting quality of care; and,

The Program must include at least the following specific components:

(a) The organization must have established compliance standards and procedures to be followed by its employees and other agents that are reasonably capable of reducing the prospect of criminal, civil and administrative violations under the Act;

(b) Specific individuals within high-level personnel of the organization must have been assigned overall responsibility to oversee compliance with such standards and procedures and have sufficient resources and authority to assure such compliance;

(c) The organization must have used due care not to delegate substantial discretionary authority to individuals whom the organization knew or should have known through the exercise of due diligence had a propensity to engage in criminal, civil, and administrative violations under the Act;

(d) The organization must have taken steps to communicate effectively its standards and procedures to all employees and other agents, such as by requiring participation in training programs or by disseminating publications that explain in a practical manner what is required;

(e) The organization must have taken reasonable steps to achieve compliance with its standards, such as by utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations under this Act by its employees and other agents and by having in place and publicizing a reporting system whereby employees and other agents could report violations by others within the organization without fear of retribution;

(f) The standards must have been consistently enforced through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect an offense;

(g) After an offense has been detected, the organization must have taken all reasonable steps to respond appropriately to the offense and to prevent further similar offenses, including any necessary modifications to its program to prevent and detect criminal, civil, and administrative violations under the Act; and,

(h) The organization must periodically undertake reassessment of its compliance program to identify changes necessary to reflect changes within the organization and its facilities.

If you have questions on the implications of the Act or its amendments for your facility or need assistance with updating your facility compliance and ethics policies and procedures to meet the requirements of the Act, you may contact Louis J. Capozzi, Jr., Esquire; Bruce G. Baron, Esquire; or Dawn L. Richards, Esquire at our Firm.

MANAGING YOUR ACCOUNTS RECEIVABLE

Andrew R. Eisemann, Esquire

This is a column for our clients devoted solely to the development and improvement of their accounts receivable management program. This is the fourth installment of our series, "Managing Your Accounts Receivable." I want to focus this installment on a critical player in your efforts to watch your bottom line: the resident's "Responsible Party", or, as some nursing facilities in Pennsylvania refer to this person, the "Legal Representative".

Why do I want to devote this space to a discussion of the Responsible Party? The weakest link in the admissions and account management process that negatively impacts a nursing facility's bottom line is frequently the identification and preparation of a resident's Responsible Party. Furthermore, a court in Pennsylvania recently addressed the liability of a responsible party for a nursing facility resident.

The reasons for this weak link include one or more of the following:

1. The Admission Agreement lacks a clear definition, or any definition whatsoever, of a Responsible Party, or it lacks a description of the duties and responsibilities of the Responsible Party;
2. The Admission Agreement properly explains that a Responsible Party will not be held personally liable for the debt, but, it fails to disclose that a Responsible Party can potentially be held financially liable in the amount that he or she fails to transfer from the resident's income or assets despite having access to the resident's resources;
3. The Admission Director identifies the resident on the first page of the Admission Agreement as the Responsible Party, although a member of the resident's family or a friend signs the signature line on the last page of the Admission Agreement;
4. The signature line of the Admission Agreement for the Responsible Party does not identify the signatory as the resident's Responsible Party;

Continued on page 4

MANAGING YOUR ACCOUNTS RECEIVABLE *Continued from page 3*

5. The Admission Director fails to identify a Responsible Party or neglects to name the person on the first page of the Admissions Agreement;
6. The Admission Director neglects to have the Responsible Party sign the last page of the Admission Agreement, which is a legally enforceable contract;
7. The Admission Director fails to adequately explain to the Responsible Party his or her duties or responsibilities, including assistance in the MA application process. Or, worse, the Admission Director directs the Responsible Party to not make any payments or escrow the resident's income while Medicaid is pending;
8. The Admission Director fails to adequately explain to the Responsible Party that the Admission Agreement is a legally enforceable and binding contract;
9. The Admission Director or Business Office fails to explain to the Responsible Party the benefits of arranging direct deposit of the resident's Social Security income either as Representative Payee or through the Resident Fund Management System. The same issue applies to the resident's pension income;
10. The Business Office fails to mail a monthly bill to the Responsible Party during the first several months after the facility admits the resident as a matter of policy while MA is pending; and,
11. Finally, the Business Office simply allows the Responsible Party to avoid payment or not cooperate for too long. In other words, the Responsible Party is taking advantage of a disorganized Business Office or its passive attempts at collection.

When the weak link breaks . . .. I am certain that you have experienced one or more of the following situations as a result of the weaknesses above: The family spends the resident's money on non-allowable expenses although the relative or resident truly believes that these expenditures were justified. A relative intentionally or fraudulently diverts the resident's funds for personal consumption or investments. The Responsible Party fails to fully cooperate in the Medicaid application process, including the transfer of financial documents or information. Finally, although the CAO directs the Responsible Party to "spend down" the resident's funds to qualify for Medicaid, he or she refuses, even if the amount is nominal. As a result of this last scenario, you're attempting to collect against a private pay resident with insignificant financial resources.

What law allows you to contract with a resident's family member or friend to act as the Responsible Party? There is no generally accepted meaning of the term, "Responsible Party', under the law. The Nursing Home Reform Act of 1987, however, permits the nursing facility to contract with a person who has access to the resident's income and resources to transfer payments from the resident's income and resources. 42 U.S.C. §1396r(c)(5)(B)(ii).

Furthermore, the Pennsylvania Administrative Code permits a resident to name a Responsible Party. 28 Pa. Code §201.24(a). This section of the Code defines the Responsible Party as someone who can make decisions on behalf of the resident, but it does not obligate a Responsible Party to make payments. In addition, this section prevents a nursing facility from naming an employee as a resident's Responsible Party, unless a court appoints the employee as the resident's guardian.

Accordingly, an Admission Agreement must be clear as to the definition, duties, and responsibilities of a Responsible Party to be legally enforceable. If the Admission Agreement is clear, the Responsible Party can be held legally liable for his or her failure to perform his duty to remit payment form the resident's funds. Of course, the Responsible Party may also be held liable personally if he diverts the resident's funds for non-allowable purposes, which requires a court order.

Is a Responsible Party a Guarantor? No. As most of you are aware, Medicaid law expressly restricts a nursing facility that is eligible for Medicaid or Medicare reimbursement from requiring a third party guarantee of payment to the facility as a condition of admission or continued stay. A Guarantor is someone who is personally liable for a debt from his or her own assets. An example of a Guarantor is the father who co-signs a car loan for his daughter. The law does not prohibit a third person voluntarily guarantee payment to the nursing facility. I continue to see, however, the term Guarantor in admission agreements, admission fact sheets, or account invoices even though the admission agreement does not clearly obligate a third party as a guarantor.

Why do you need to take a look at the Responsible Party clauses of your Admission Agreement? Although Pennsylvania court case law regarding the legal financial liability of a Responsible Party is scarce, the Allegheny County Court of Common Pleas recently addressed this issue in *Five Star Quality Care, Inc d/b/a Overlook Green v. Joyce and Charles Yablonski*. The opinion of this court will have a strong persuasive effect on the county courts throughout Pennsylvania. In summary, the court disallowed the nursing facility's claim against a resident's Responsible Party because the Admission Agreement did not "clearly and unambiguously" define the term "Responsible Party" or obligate the Responsible Party to guarantee payment.

Because it is the nursing facility or management company that drafts the Admission Agreement, the burden is on the nursing facility to ensure the requirements and obligations of a Responsible Party are "clear and unambiguous." Otherwise, the nursing facility's attempts to collect a debt against a Responsible Party in court may be weakened or unsuccessful.

If you would like more information on how your Admission Agreement can be used or modified to protect your facility's bottom line, including an analysis and revision of the contract terms related to the Responsible Party, you may contact Andrew R. Eisemann at our Firm at andrewe@capozziassociates.com.

CAPOZZI & ASSOCIATES, P.C. WELCOMES—

CRAIG I. ADLER, ESQ., *who recently became a shareholder in our Firm.*

Prior to joining the firm, Craig Adler was a partner in the law firm of Adler & Adler, a law firm which originated its practice with his grandfather Lewis Adler in 1934 and subsequently included his father Louis and brother William. Craig's practice focuses on real estate matters and he has lectured on the subject for the Dauphin County Bar Association and National Business Institute. He represents builders, developers, realtors and real estate purchasers and sellers. He has represented various parties before local municipalities in obtaining zoning relief, subdivision approvals and land development plan approvals.

Craig is a former member of the Board of Directors and Chairman of the Family Selection Committee of Habitat for Humanity of the Greater Harrisburg Area.

Craig received his undergraduate degree, magna cum laude, from Boston College (1985) where he was the recipient of the James E. Shaw Memorial Award from the School of Management, and his law degree from the University of Pennsylvania Law School (1988).

MICHAEL M. JEROMINSKI, ESQ., *who recently joined our Firm.*

Mike received his B.A. degree from St. John's College in Santa Fe, New Mexico and his law degree from the Dickinson School of Law of the Pennsylvania State University. His practice focuses on representing the special legal interests of long-term care facilities and the rights of creditors throughout Pennsylvania, with a special emphasis on collection, related civil litigation, guardianships, and estate and probate practice matters affecting long term care facilities.

Before coming to Capozzi and Associates, Mike was an attorney at the firm of Foreman, Foreman & Caraciolo in Harrisburg, where he focused on civil litigation.

Mr. Jerominski lives in Mechanicsburg with his wife and two children.

DAWN L. RICHARDS, ESQ., *who recently joined our Firm.*

Dawn served in the U.S. Army from 1983 until 1989, after which she was employed in health care finance and compliance programs at major for-profit hospital chains, including as a hospital CFO, as well as in the establishment of a managed care organization, until she began practicing law. While she was employed in health care finance, she also attended the University of Las Vegas, Nevada, where she received a Bachelor of Science in Accounting (Cum Laude 1991) and M.B.A. (Cum Laude, 1995). She received her law degree from Temple University School of Law in Philadelphia in 2008.

Prior to joining Capozzi and Associates, Ms. Richards practiced law in Pottsville, PA, including physician representation, Medicare appeals, Chapter 11 bankruptcy, business law, taxation and guardianship, as well as a law education program for seniors at county senior centers. Her practice at our Firm focuses on long-term care reimbursement litigation and assisting our clients with their compliance and ethics programs.

Ms. Richards is a member of the Schuylkill County and Pennsylvania Bar Associations, the American Health Lawyers Association and the Healthcare Financial Management Association, the Member Services Committee of the Schuylkill County Chamber of Commerce and the Schuylkill Women in Crisis Board. She resides in Pottsville, PA

CLARIFICATION FROM DPW AND CMS ABOUT CURRENT LIMITATIONS ON BILLING FOR OTHER MEDICAL EXPENSES (OME) AS OFFSET TO THE PATIENT PAY AMOUNT AND INCLUDING PRIVATE PAY BALANCES AS OME OFFSETS

In response to a Right-to-Know Law request filed by our Firm, DPW provided copies of correspondence between DPW and CMS relating to the elimination of the $10,000 lifetime cap on OME deductions enacted as part of Act 42 of 2005 as contrary to federal law. In the disclosed correspondence, CMS notes that Pennsylvania's rationale for imposing some limit on OME deductions included limiting the amount of unpaid private pay balances remaining as of the effective Medicaid eligibility date that could be claimed as OME deductions. Both DPW and CMS had previously recognized that unpaid private pay balances qualified for OME deduction offsets.

While CMS precluded DPW from implementing the $10,000 lifetime cap on OME deductions contained in Act 42, they provided guidance for DPW to implement an alternative limitation through the State Plan Amendment process. The current limitation, contained in the subsequently approved State Plan Amendment, which CMS permitted to be retroactive to October 1, 2005, reads as follows:

REASONABLE LIMITS ON AMOUNTS FOR NECESSARY MEDICAL OR REMEDIAL CARE NOT COVERED UNDER MEDICAID

> Long Term Care (LTC) medical expenses incurred six months prior to application for Medicaid are disallowed as a deduction, and medical and remedial expenses that were incurred as the result of imposition of a transfer of assets penalty period are limited to zero, unless application of these limits would result in undue hardship.
>
> Undue hardship is considered to exist when: (I) Denial of medical assistance would deprive

Continued on page 7