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# *The Quarterly*

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## **DPW'S BUREAU OF HEARINGS AND APPEALS DECLARES DPW STATEMENTS OF POLICY LIMITING NURSING HOME BED EXPANSION INVALID AS AN UNPROMULGATED REGULATION**

*by Daniel K. Natirboff, Esquire*

In *Appeal of St. Anne Home* BHA Docket No. 61-99-016, DPW's Bureau of Hearings and Appeals recently sustained the provider's appeal finding that: 1) Statements of Policy published on January 10, 1998 and codified at 55 Pa. Code §§1101.77a and 1187.21a were invalid and unenforceable because they were not promulgated as regulations following the procedures required by the Commonwealth Documents Law; and 2) the facility presented sufficient evidence to prove that DPW failed to handle the facility's request for expansion in a reasonable manner and the Department was incorrect in denying Appellant's expansion request. DPW has been limiting bed expansion in the Commonwealth using the Statements of Policy since their publication in 1998. The agency contends that these Statements of Policy give it the power to terminate a facility's Medicaid Provider Agreement if it seeks to expand without DPW approval through an Exception Request. The Exception Request process is set forth in the SOP at 55 Pa. Code §1187.21a. Since the initial two groups of Exception Requests, which included facilities that already received Department of Health approval for expansion under the now defunct Certificate of Need program, the Department has been denying almost all Exception Requests and fighting appeals of the Exception Request denials in a most draconian manner. DPW has even extended its alleged authority under the Statements of Policy to threaten termination of two providers merging their beds under one provider agreement viewing such a transaction as the closing of one facility and the expansion of another.

The Department's stated position for its Statements of Policy is that there are more than enough beds in the Commonwealth and that the Department wishes to expand Home and Community

Based services as a priority for Medicaid funding. Providers counter that since the legislature allowed the Certificate of Need program to sunset, DPW should not step into the void asserting control over bed expansion and should let market forces control the number of beds in the Commonwealth. Providers also contend that Home and Community Based options should be expanded but are not a substitute for nursing facility care in all situations, that DPW by asserting bed surplus statewide is overlooking bed need in particular areas and MA recipient freedom of choice and that DPW's Statements of Policy are contrary to federal regulations requiring a finding of "good cause" to terminate a facility's provider agreement. See 42 CFR §442.12(d). In *Millcreek Manor v. DPW*, 796 A.2d 100, Commonwealth Court remanded Millcreek's appeal to BHA finding that BHA had improperly failed to address whether DPW's Statements of Policy were inconsistent with federal law or otherwise invalid as an unpromulgated regulation. Now in *St. Anne Home* BHA has addressed the issue of whether the Statement of Policy is invalid as an unpromulgated regulation and has courageously found with the Provider. Predictably, DPW has requested and been granted Reconsideration by the Secretary of Public Welfare. We will endeavor to keep providers informed of relevant legal developments in this important area of Medical Assistance law.

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*Daniel K. Natirboff, Esquire is a shareholder and Chairman of Capozzi & Associates' Litigation Department. He represented the provider in the St. Anne Home case and appeared and argued on behalf of St. Anne Home and Loving Care Nursing Center in the Millcreek Manor case. All questions relating to nursing facility exception requests and expansion can be addressed to him at Capozzi & Associates, P.C.*

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## MSA CLASSIFICATION AND REIMBURSEMENT

by *Louis J. Capozzi, Jr.*

Metropolitan Statistical Area (MSA) classification, as determined by the Federal Office of Management and Budget (OMB), plays an important role in Medicaid reimbursement. Recent changes by OMB to the MSA classification system could require changes to the Pennsylvania Medicaid regulations (55 Pa. Code §1187.94 and .95 which relate to the use of MSAs in Medicare rate setting and to wage indexes used for Medicare rate setting) Prior to June 6, 2003, the OMB MSA classification system consisted of groupings of counties and areas throughout the nation into various Levels — A, B, C, D, and non-MSA. 55 Pa. Code §1187.94 used these levels, along with facility size, to develop 12 Peer Groups. (Peer Groups 13 and 14 come are statewide groupings of special rehabilitation and hospital-based facilities, respectively), each of which has limits based on the costs of group members.

On June 6, 2003, OMB Bulletin 03-04 revised the list of Metropolitan Statistical Areas, while simultaneously eliminating the A, B, C and non-MSA Level classification system, and adding the new “Micropolitan” and Combined Statistical Areas. Additionally, several changes were made to the previous MSA groupings. Pike County was moved from the Newburg, NY to the Newark, NJ MSA. Lebanon County was removed from the Harrisburg MSA, and was granted its own MSA group. Armstrong County was added to the Pittsburgh MSA. Mercer County was added to the Youngstown, OH MSA. Columbia County was removed from the Scranton MSA. Somerset County was removed from the Johnstown MSA.

These changes may affect Peer Group Price calculations. If these new designations are used with the old system (A, B, and C), both “step-ups” (e.g. Level B to Level A) and “step-downs” (e.g. Level C to non-MSA) occur. The effect is rather significant increases or decreases in Medicaid reimbursement. As an example, the new MSA classifications are applied to determine FYE 6/30/04 peer group prices. DPW has issued unofficial estimates but not yet published the official numbers. Pike County would transfer from Level B to Level A, and its facilities would move from Peer Group

6 to Peer Group 3, with increased Peer Group Price limits totaling \$9.88 per MA resident, per day.

While forty-five Pennsylvania facilities are potentially directly affected by the changes made by the OMB Bulletin. Many others may be indirectly affected by the changes to their peer group database caused by the changes in classification, by possible changes to the Medical Assistance Regulations and by possible changes to Medicaid Regulations adjusting to OMB's new classification system and standards. Currently, it is unclear how (and when) these changes will be taken into account by DPW.

According to Section 315 of BIPA 2000, skilled nursing facilities are also granted the right to request reclassification for Medicare reimbursement purposes. However, before a reclass can occur, a specific wage index for Nursing Homes is required. The Secretary of Health and Human Services has not yet acted to develop a wage index specific for Skilled Nursing facilities, but instead continues to use that which exists for Hospitals. Hospitals, *are* permitted to request geographic reclassification, by submitting a formal request to the Medicare Geographic Classification Review Board (MGCRB). If a hospital, or a group of hospitals can demonstrate that various requirements have been met, including overlap of workforce, adjacent to the desired reclassified MSA, evidence of wages being similar to the area to which reclassification is sought, and in cases where there is a desire to move from rural to MSA, adequate population data must be provided to demonstrate that the facility (or county) is no longer considered rural, and instead deserves Metropolitan statistical designation.

Presently, CMS and the MGCRB have not reclassified any Skilled Nursing Facilities for Medicare reimbursement purposes. It is also hoped that DPW will entertain requests for MSA reclassifications for Medicaid purposes. Should you have any questions or concerns regarding the OMB Bulletin, the MSA classification system, and/or the effect that possible MSA reclassification will have on Medicaid/Medicare reimbursement, please contact our Harrisburg office.

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## SOME RECENT DECISIONS IN MATTERS HANDLED BY CAPOZZI & ASSOCIATES, P.C.

### 1. SUPREME COURT OF PENNSYLVANIA AGREES TO DETERMINE WHETHER THE BOARD OF CLAIMS HAS JURISDICTION OVER MA PROVIDER PAYMENT DISPUTES WITH DPW FILED BEFORE JULY 1, 2003.

While Act 142-2002 consolidated jurisdiction over all MA Provider Appeals filed on or after July 1, 2003, in DPW's Bureau of Hearing and Appeals, the Act provided that the Board of Claims would continue to hear and determine cases filed before July 1, 2003. The Commonwealth Court of Pennsylvania, however, in 2002 and 2003 issued decisions that reversed more than 20 years of prior caselaw upholding Board of Claims jurisdiction over MA Provider payment disputes with DPW. The Supreme Court of Pennsylvania, by order of December 22, 2003, granted our Application for Allowance of an Appeal to resolve the jurisdictional issues, which affect more than 300 cases pending before the Board of Claims. *Department of Public Welfare v. Presbyterian Medical Center of Oakmont*, No. 405 WAL 2003 and 70 WAP 2003.

### 2. NON-PROFIT HOME/ASSISTED LIVING CENTER GRANTED COMPLETE TAX EXEMPTION!

In the Fall of 2002, Presbyterian Homes notified the Erie County taxing authorities that it wished to terminate its existing PILOT agreement which set a yearly amount to be paid in place of the full payment of real estate taxes. A PILOT agreement is an agreement with a local taxing body to make Payments In Lieu Of Taxes (PILOT) in recognition of the services provided to a non-profit entity by the local community. The cancellation of the PILOT agreement allowed Presbyterian Homes to take a timely appeal of its status as an exempt charity for tax year commencing 2003 before the Erie County Board of Assessment Appeals.

The Erie County Board, as well as other Boards throughout the State, have become increasingly receptive to arguments regarding a non-profit entities' entitlement to real estate tax exemption under Act 55, commonly known as the Institutions of Purely Public Charities Act. As you know, Act 55 passed the

legislature in 1997 and it has the effect of clarifying the requirements that a non-profit entity must meet in order to qualify for real estate tax exemption. The Act was initially met with great resistance from local Boards of Assessment Appeals on the basis that they believed the Act to be unconstitutional.

It is our belief that most Boards of Assessment Appeals have adjusted their thinking in regards to the constitutionality of the Act after the publication of the *Community Options* decision by the Supreme Court of Pennsylvania on December 31, 2002. That decision did not find that Act 55 was unconstitutional and continued to apply the financial requirements criteria outlined in Act 55 in its decision *Presbyterian Homes'* case before the Board was based entirely on an Act 55 analysis and was accepted by the Board without hesitation. In July of this year the Board granted *Presbyterian Homes'* request for complete real estate tax exemption of its nursing facility and its assisted living center. The decision was not appealed by the local taxing bodies. *Presbyterian Homes by the Presbytery of Lake Erie Tax Exemption Appeal, before the Erie County Board of Assessment Appeals, Exemption Nos. E02-100, E02-101, E02-102, E02-103, hearing held May 1, 2003.*

### **3. VISITING NURSE ASSOCIATION WINS COMPLETE TAX EXEMPTION!**

The Visiting Nurse Association (VNA) of Erie appealed the decision of the Erie County Board of Assessment to place its facility on the tax rolls for 2003. Similar to the decision regarding *Presbyterian Homes*, above, the Erie County Board of Assessment Appeals accepted our argument regarding a non-profit entities' entitlement to real estate tax exemption under Act 55, commonly known as the Institutions of Purely Public Charities Act.

In June 2003, the Board granted the VNA of Erie's request for complete real estate tax exemption of its facility located in downtown Erie. The decision was not appealed by the local taxing bodies. *Visiting Nurses Association of Erie, Tax Exemption Appeal, before the Erie County Board of Assessment Appeals, Exemption No. E02-104 hearing held May 1, 2003.*

### **4. ASSESSED VALUE OF NURSING FACILITY REDUCED IN TAX APPEAL**

During 2002, Luzerne County assessed the Lakeside Nursing Center at a fair market value of nearly one million dollars. While the County's annual tax bills showed a valuation of only \$77,000, this figure was misleading. This figure represented only the value at the last County-wide reassessment. The true implied fair market valuation, as accepted by the County at the hearing, was one million dollars. This translated into a suggested market value of nearly \$32,000.00 per licensed nursing bed.

Our understanding of the state of the nursing home industry led us to believe that this property was grossly overvalued. Using an expert appraiser whose primary experience has centered on the valuation of nursing facilities throughout the State, we were able to present a convincing case before the Board. The Board accepted the testimony of our expert appraiser and we were able to achieve a 50% reduction of the assessed value of this property by 50%. Our success at the Board level will have a great impact on the continued success and viability of the Lakeside Nursing Center. *Lakeside Nursing Center, Tax Assessment Appeal before the Luzerne County Board of Assessment Appeals, hearing held on October 2, 2003.*

### **5. NON-PROFIT HOME IS FINALLY GRANTED BED EXCEPTION**

The Bureau of Hearings and Appeals sustained a provider appeal of a denial of an exception request to add certified beds. The Bureau found that: (a) the Statement of Policy published on January 10, 1998 (55 Pa. Code § 1187.21a; 28 Pa.B. 138) requiring such exceptions to add certified beds is invalid and unenforceable because it is an unpromulgated regulation; and (b) the provider presented sufficient evidence to prove that the Bureau of Long Term Care Programs failed to handle the expansion request in a reasonable manner and that the Bureau was incorrect when it denied the exception request. *St. Anne Home, Docket No. 61-99-016 (October 3, 2003), reconsideration granted and pending decision by the Secretary of Public Welfare.*

### **6. UNIVERSITY PARK NURSING CENTER WINS OCCUPANCY WAIVER AND MONEY**

The Bureau sustained the provider's appeal to obtain a waiver of the 90% occupancy adjustment (55 Pa. Code § 1181.233(f)) and an increase of MA payments in the amount of \$110,955.74 for November 15, 1991 through December 31, 1992, finding that the facility met the requirements for waiver as a "new facility" and that the Bureau of Long Term Care Programs had no basis to deny depreciation or interest reimbursement under the facts of the case to offset the additional payments. In this case, the premises had been previously operated as a nursing facility that ceased operations in 1989 and the Department of Health determined that the new facility did not require a CON because beds at issue were exempt from review because of prior approval. *University Park Nursing Center, Docket Nos. 23-94-163, 23-96-084 (July 22, 2003), FINAL DECISION.*

### **7. ENTRANCE FEE USAGE AND DISCHARGE FOR NON-PAYMENT**

Currently pending before the Secretary of Public Welfare is a case of first impression that is likely to affect how continuing care communities can use the entrance fee when a resident is being discharged for non-payment. In this case, a Non-MA resident, who transferred to a nursing facility from an independent living facility within the same campus, challenged the provider's discharge notice that arose from her failure to pay for care and her request to apply the balance of the entrance fee paid for an independent living apartment. Under the terms of the independent living residency agreement, the entrance fee did not become her property until death, until she left the entire facility, or until she demonstrated that her lack of ability to pay was not due to giving away assets that she had promised to use to pay for services, in order to use current funds to make gifts to relatives and spend down to qualify for Medicaid. The Bureau of Hearings and Appeals granted a stay of discharge pending the outcome of the appeal and determined that this provision of the residency agreement violated the Medicaid Act's preclusion of discrimination in admissions or transfers based on source of payment (42 U.S.C. § 1396r(c)(4)(A), requiring "identical policies and practices" to assure "equal access") and required nursing facility provider to use the balance as payment for unpaid stay prior to billing MA Program for care. Provider sought reconsideration on basis that there was no violation of statute; that the Bureau's position permitted resident to evade obligations of contract for

independent living and give away funds that she promised to use to pay for services; that the Bureau's position was contrary to public policy and the purposes of the MA Program; and that Bureau altered facts as stipulated by the parties. We are awaiting a decision from the Secretary as the Bureau of Hearings and Appeals agreed that case was not mooted by resident becoming MA eligible and immune from discharge since other cases involving the same question were likely. *Discharge Appeal, Case No. 21K0041-002 (September 30, 2003), reconsideration granted and pending decision by the Secretary of Public Welfare.*

#### ALSO OF INTEREST

#### PENNSYLVANIA SUPREME COURT DECLARES CRIMINAL RECORDS CHAPTER OF OLDER ADULTS PROTECTIVE SERVICES ACT UNCONSTITUTIONAL AS APPLIED TO PERSONS WITH LISTED CONVICTIONS WHO HAVE A HISTORY OF BEING REHABILITATED AND RELIABLE WORKERS

*NIXON ET AL. v. COMMONWEALTH*, \_\_\_ Pa. \_\_\_, \_\_\_ A.2d \_\_\_ (No. 004 M.D. Appeal Dkt. 2002, Decision filed December 30, 2003), affirming 789 A.2d 376 (Pa. Cmwh. 2001) (En Banc). The Supreme Court held that: "the criminal records chapter, particularly with regard to its application to the Employees, does not bear a real and substantial relationship to the Commonwealth's interest in protecting the elderly, disabled, and infirm from victimization, and therefore unconstitutionally infringes on the Employees' right to pursue an occupation [as established by Article I, § 1 of the Pennsylvania Constitution]." Slip Opinion at page 19. The Court's decision is

written by Justice Nigro, joined by Justices Castille (who filed a concurring opinion), Lamb, and Saylor, with Chief Justice Cappy and Justice Newman concurring in the result only (in a joint concurring opinion), and Justice Eakin disagreeing in a dissenting opinion. The Supreme Court found that the Legislature could not reasonably bar some convicted persons from employment in covered facilities while permitting other persons convicted of the same offenses but who were employed prior to July 1, 1998. The Supreme Court did not address the question of whether the Legislature could constitutionally implement an absolute bar against such employment by any convicted persons. Slip Opinion at Footnote 16.

The Supreme Court's decision ends the continuing constitutionality and applicability of the criminal records chapter of the Act (35 P.S. §§ 10225.501-10225.508) that has been in place since the Commonwealth Appealed from the Commonwealth Court's 2001 decision.

As a result of the decision of the Supreme Court of Pennsylvania in this case, Pennsylvania nursing facilities can not rely on the criminal records chapter of the Act to preclude employment; however, nothing in the decision affects the application to nursing facilities participating in the Medicare or Medical Assistance Programs of federal laws and regulations precluding employment of individuals convicted of certain Program related offenses (e.g., 42 CFR § 483.13(c)(1)(ii)(A), precluding employment of individuals found guilty of abusing, neglecting, or mistreating residents).

If you have questions about the application of this decision at your facility, including changes in your compliance program or materials, call our Harrisburg office to speak with Dan Pedersen, Esquire or Mike Hynum, Esquire.

## MILITARY SERVICE: PROTECTIONS FOR EMPLOYERS AND EMPLOYEES

*by Doreena Craig Sloan, Esquire, (Major, USAF Reserve)*

The National Guard and Reserve make up more than half of the men and women serving in our armed forces today. Many of our clients have been affected in some manner by the activation of these citizen soldiers. With more than 197,000 reservists and national guard troops currently activated, it is important to be aware of the laws that protect workers seeking to return to their civilian jobs after military service. The Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994 is a federal statute that guarantees the rights of military service members to take a leave of absence from their civilian jobs for active military service and to return to their jobs with accrued seniority and other employment protections. (38 U.S. Code Chapter 43)

As an employer, the law places certain obligations upon you. There are six major obligations that will be highlighted. First, upon return from active duty, the employee is entitled to reinstatement to the position that he or she would have had if his or her continuous employment had not been interrupted. Second, you must extend the same rights and benefits that are generally provided to individuals of similar status that are on a leave of absence. Third, you must continue medical benefits under the same terms and conditions as when actively employed if military service is 31 days or less. Fourth, there is optional continuation of medical benefits under terms similar to COBRA when an employee is called to military service for more than 31 days. Fifth, the employee is entitled to all sen-

iority, rights and benefits upon return to work as if the employee has remained continuously employed (i.e., vacation allowances, pension credit, 401 (k) contributions, etc). And sixth, the employee has protection from discharge upon return to work except for cause for a period of time.

The law also places obligations upon the employee to ensure entitlement to these, and other, benefits. First, the employee must give timely notice of their need to perform military service except as required by military necessity. Second, the employee must apply for reemployment within a set time after release from military duty. If service is less than 31 days, the person must normally return to work on the first workday after release from active military service. If service lasted between 31 and 180 days, the individual must normally reapply within 14 days after completing active service. In those cases where service lasted more than 180 days, the individual must reapply within 90 days after the completion of service. Third, the person must be released from active military service under honorable conditions.

USERRA also prohibits discrimination against service members in employment and provides training obligations for employers under certain circumstances. Employers do not have to reemploy a returning service member if "the employer's circumstances have so changed as to make such reemployment impossible or unreasonable." In addition, employees hired for a brief, nonrecurring period without reasonable

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expectation that employment will continue indefinitely or for a significant time are not entitled to reinstatement rights.

For those of you who have National Guard or Reserve members on your staff, it is important that you know that you are vital to enabling them to serve our country. There are a few things that you should do. First, get to know your employees' military commanders and supervisors. Second, review your personnel policies to determine how they accommodate and support participation in the National Guard or Reserve. Third, ensure that your entire management team understands the national value of your employees' service in our defense. Fourth, expect that there may be occasional concerns with your employment of "citizen soldiers" and their requirement to perform military duty and seek to resolve them as soon as possible. If they can't be resolved internally, there is an Ombudsman Program available that provides information, informal mediation, and referral services to resolve employer conflicts. The U.S. Department of Labor serves as the enforcement arm to USERRA.

There are opportunities for civilian employers to interact with the units that their employees are attached to that should be considered to get a better understanding of what your employee does while on military duty. While each base or unit is different, most commanders are committed to sharing their mission and being positive contributors to the local and national communities from which their members come. There are "*Briefings with the Boss*" sessions which provide an informal forum in which local employers, unit commanders, advocacy organizations like the Employer Support of the Guard and Reserve members, and community leaders meet to network and discuss issues that may arise from employee par-

ticipation in the National Guard and Reserve. Additionally, there are "*Bosslifts*" where employers and supervisors are transported to military training sites where they observe National Guard and Reserve members on duty as part of the Total Force. Check with your members to determine the dates and activities planned and participate as you are able.

Many employers have gone above and beyond what the law requires. The National Committee for Employer Support of the Guard and Reserve (ESGR) sponsors an *Awards Program* that is designed to recognize employers for employment policies and practices that are supportive of their employees' participation in the National Guard and Reserve. Some employers have continued the salaries of members called to active duty for varied periods. There are employers who have provided a pay differential that pays the difference between what their employee earned in their civilian employment and what they earn as military pay; often there is a substantial dollar difference. Additionally, some employers have continued health benefits for their employees and their families for varied periods.

Having had the opportunity to serve as an active duty Air Force Judge Advocate, and as a Pennsylvania Air National Guard Judge Advocate, I have had many opportunities to work with military members, employers and veterans locally, nationally, and internationally regarding the issues that have been highlighted in this article and many others. The information contained in this article is designed to provide you with a general guide to USERRA. Situations may differ drastically and there are exceptions that may trigger differing results. We stand ready to assist you in navigating these legal waters. Please contact our Harrisburg Office with any questions.

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## ASSISTED LIVING AND PERSONAL CARE HOMES — TIMES OF CHANGE?

*by Daniel J. Pedersen, Esquire*

The Personal Care/Assisted Living community in Pennsylvania is on the edge of its seat as of late, anxiously waiting what changes, if any, will come to the statutes and rules that regulate its business. Not only has the Department of Public Welfare, the state agency that regulates these entities, proposed sweeping changes to the regulations, but several bills are also pending in the Pennsylvania House and Senate which could potentially make major changes to the present system. All of these measures call for a far greater degree of regulation, control, guidance, and monitoring. In Pennsylvania, and for the most part, throughout the nation, there is a large push for the development of programs that enable senior citizens to "age in place." There is also the call for the reduction in skilled nursing facilities, to be replaced by Personal Care Homes (PCHs) and Assisted Living Facilities (ALFs). Although changes to the regulations has been a topic of discussion for years, and numerous bills proposing changes have been raised in the Pennsylvania legislature for the past several years, it appears as though some changes are imminent.

The Pennsylvania Department of Public Welfare's proposed revisions to the PCH regulations were first published in the Pennsylvania Bulletin in October 2002. These regulations are scheduled to replace the existing PCH regulations at 55 Pa. Code Chapter 2620. The revisions follow more of a regulatory model instead of allowing the facilities the almost complete liberty in its day to day operations and relationships with residents that has been the norm. Advisory Committee and sub-

committee meetings were established. Each presented findings to the Department on October 11, 2003, for guidance in the drafting of the final regulations. At another such meeting, held on November 13, 2003, DPW entertained additional advice, concerns and findings from the sub-committees. It is rumored that DPW greatly desires that final regulations be published by February 2004, and that these final rules have already been drafted — only minimally taking into account the recommendations of the sub-committees.

Senate Bill 136, House Bill 420, and Senate Bill 567 are bills that have been raised in the Pennsylvania General Assembly, and are currently awaiting review in the Senate's Public Health and Welfare Committee. Bills 136 and 420 are each known as the "Pennsylvania Assisted Living Act." These bills propose a new statute providing for an additional level of care, "Assisted Living", which would be situated in between Personal Care and Skilled Nursing on the spectrum of care. Senate Bill 567 ("Personal Care Home Reform Act"), however, simply proposes to replace the entire existing Personal Care Home enabling Statute, calling for stricter regulations, and a greater degree of control to be exerted over Personal Care Homes. This bill proposes to use more of a regulatory model, much like that which exists at Skilled Nursing Facilities (SNFs), essentially making the PCH industry far more structured, impersonal, and less casual, and is similar in scope to the proposed regulatory changes that have already been proposed. Therefore, if either of the Assisted Living bills, or the

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PCH reform bill is passed, DPW will have to draft new regulations — regulations that are very likely to be similar to the draft regulations that were already proposed and discussed over the past year, and are slated to be implemented in February.

Some speculate that if the DPW proposed regulations are implemented, these pending bills will disappear. Others feel that there is a greater need to provide more structure to the underlying statute that provides the guidelines for the regulations, and one, or several of these bills will become law in the near future, resulting in another round of regulation drafts, open discussions, and Pennsylvania Bulletin publications. Should either SB 136 or HB 420 pass, additional discussion will brew over the existence of both Personal Care Homes and Assisted Living “residences,” and how Skilled Nursing Homes will be affected. With both options possibly becoming available, the type of licensure Personal Care facilities may wish to pursue will become an important decision. Still others recommend a distinction among Assisted Living and Personal Care Homes based upon size rather than level of care. This type of arrangement would greatly benefit the smaller facilities, as many feel that cost and the compliance requirements of the stricter regulations could possibly destroy the smaller Personal Care facilities.

Ultimately, there is little doubt that changes to the ALF/PCH regulations will be forthcoming. Whether the existing

regulations are changed directly, or the underlying statutes are first modified requiring change to the regulations at some point in the future remains to be determined. Nonetheless, ALF's and PCH's are going to be faced with a greater amount of guidance from DPW, will have to make a greater effort at compliance, will face more severe penalties, and will have stricter guidelines to follow to ensure that licensure is retained. Additionally, should Medicaid ever become involved in the PCH/ ALF environment (a scenario that is becoming more and more likely with the desire to promote “aging in place” and the reduction of SNF's) a greater amount of regulation from the federal and state levels will result, and Medicaid fraud and abuse will become a critical element of compliance. Finally, it is important to note that the three pending Bills in the Pennsylvania General Assembly are just the tip of the iceberg with respect to statutes and regulations that affect the elder care community. There are presently over 50 proposed bills for consideration in the Pennsylvania Legislature (and many more to come) that have a direct impact on SNF's and/or PCH's. Approximately 10% of the bills proposed in a two-year House session will be enacted; therefore, keep your eyes open for other possible legislative acts that will have an affect on your facility.

Should you have any questions regarding the proposed legislation or the pending legislative Bills, or any other legislative activity that affects your facility, please contact our Harrisburg Office.

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## RELEASE OF THE HIPAA SECURITY RULE

*by Daniel J. Pedersen, Esquire*

On February 20, 2003, the “Final” version of the HIPAA Security Rule was published in the Federal Register. (Although the Rule is dubbed “Final,” it is still subject to a comment period and minor changes by way of provider comments. Both the Privacy Rule and the Transactions Rule went through several “Final” versions before the Rules were truly complete.) The Security Rule is the third of the major HIPAA rules related to the Administrative Simplification portion of Title II of the Health Insurance Portability and Accountability Act, which was first conceived in 1996. The Security Rule follows in the footsteps of its siblings, the Privacy and Electronic Transactions and Code Sets Rules, by leading providers down a path of ever-increasing reliance on computers and electronic processing. Compliance with the Security Rule is not required until April 21, 2005.

In general, the Security Rule stresses confidentiality, integrity and protection against reasonably anticipated threats or hazards to information by addressing common sense things like locking of doors, and use of passwords as well as more technical aspects of computer systems, such as passwords, firewalls, total system security, and back-up capabilities. The Administrative Safeguards provision requires each covered entity to perform a risk analysis, implement measures to address identified risks, impose sanctions on violators, and periodically review computer system activity. Other areas of concern include system back up, disaster planning, policy and procedure implementation, security awareness and training, password use, and the development of Business Associate Contracts. The Physical Safeguards element of the Rule requires the implementation of policies and procedures, contingency and security plans, access controls, and computer

use. On the other hand, the Technical Safeguards portion requires such things as access controls, unique user identifiers, automatic computer logoff, and encryption (with respect to computers and electronically stored data).

Recently, CMS also issued some news regarding the Electronic Transactions and Code Sets Rule, which affects the electronic date interchange (EDI) related to coding and transmission of MDS reports, billing issues, and other electronic submissions for payment. Initially, the rule required that electronic submission under the HIPAA formats occur by October 16, 2003. However, a degree of non-compliance was evident, and CMS offered a longer transition period, as both CMS and DPW will continue to accept claims in both HIPAA compliant formats and prior formats, for “some period of time.” Additionally, DPW requires that all providers become HIPAA certified prior to the submission of any HIPAA format transactions. This can be done by simply submitting a test submission to DPW in a HIPAA format (e.g. 835 or 837). You should already be or close to being in compliance with the Transactions Rule, and submitting Medicare and Medicaid claims electronically in the proper HIPAA formats. If you are not already in compliance or close to being in compliance, we can help.

It should not be too overwhelming to meet the requirements of the Security Rule. Much like its predecessors, it will take time, effort, and a little capital to become HIPAA compliant. Although it may appear daunting, the task is not an impossible one. Feel free to contact Capozzi & Associates for additional information about the HIPAA Rules, and for assistance in implementing a HIPAA Compliance Program at your facility.

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## NEW MEDICARE REFORM LAW GOES BEYOND NEW DRUG BENEFITS

*by Daniel J. Pedersen, Esquire*

The Medicare Prescription Drug, improvement, and Modernization Act of 2003 includes several provisions that will affect Medicare payments and benefits before the new drug benefits go into effect. These provisions include:

**Relief for Rural Providers.** The Act increases payments for rural and small hospitals (Sections 401, 402); for rural and urban ambulance services (Section 414); for air ambulance services in rural areas (Section 415); and for home health services in rural areas (Section 421). The Act also provides protection from anti-kick-back laws for projects involving rural health center efforts to benefit medically underserved populations (Section 431).

**Increase Medicaid Allotments to States for Hospitals.** The Act increases allotments to States for Disproportionate Share Payments for Hospitals beginning in 2004, but requires States to report of which hospitals receive the payments (Section 1001).

**Increased SNF Payments for AIDS Patients.** The Act provides for a 128% increase in Medicare PPS payments, effective October 1, 2004, for AIDS patients, pending corrective adjustments to the RUGS payment methodology (Section 511).

**Moratorium on Outpatient Therapy Caps.** The Act reinstates the Moratorium on the \$1500 caps on Medicare Outpatient Therapy Services from December 8, 2003 (when the President signed the Act into law) through all of 2004 and 2005 (Section 624).

**Provisions for Waivers of Disapproval of Nurse Aide Training Programs.** The Secretary of the U.S. Department of Health & Human Services can waive a disapproval and permit the Program to continue in cases where the penalty imposed is not related to the quality of care provided to facility residents (Section 932).

**Added Mammography Screening Payments.** The Act increases payments for mammography screening services and, effective January 1, 2005, adds increases for mammography diagnostic services (Section 614).

**Adds New Part B Preventive Care Coverage.** Effective January 1, 2005, adds coverage for Initial Preventative Physical Exam, including electrocardiogram and education, counseling, and referral for covered screening services (Section 611); coverage for cardiovascular screening blood tests (Section 612); and coverage for Diabetes Screening tests (Section 613).

**Adds Coverage for New Pancreatic Islet Cell Transplants.** Effective October 1, 2004, permits payment for pancreatic islet cell investigational transplants done in clinical trails (Section 733).

**Changes to Medicare Part B Deductible and Premium.** Increase Part B deductible to \$110 in 2005 with annual percentage increases thereafter (Section 629) and, effective 2007, implements increases in premium payments for individuals with modified adjustment gross income of \$80,000 or more (Section 811).

**Implementation of Health Savings Accounts.** Special tax treatment for accounts available only for persons with health care insurance deductibles of \$1,000 or

more to save for expenses not covered by insurance (Section 1201).

**Changes to Medicare Appeals Process.** Personnel will move from Social Security Administration to U.S. Department of Health & Human Services by 2005 (Section 931); effective October 1, 2004, expedited appeals for cases where no facts are in dispute and challenge to law or regulation is not within the authority of Departmental Appeals Board, as well as in provider cases involving termination of participation, penalties imposed automatically, and substandard care findings resulting in loss of approval of nurse aide training programs (Section 932). In addition, evidence must be presented where possible at the reconsideration level and not later in the process (Section 933). The time for reconsideration and redetermination in beneficiary appeal cases to occur has also been increased to 60 days (Section 940). Providers will be able to file appeals on behalf of deceased beneficiaries where there is no one else available (Section 939).

**Limitations of Prepayment Review.** Effective after one year, random prepayment review must follow a specified standard protocol and both random and non-random reviews can only be used in limited circumstances (Section 934).

**Limitations on Collection and Determination of Provider Overpayments.** The Act defines "hardship" permitting more than 30-day repayment period and periods of up to 5 years to repay overpayments; defines standards for post-payment audits; and, limits the use of extrapolation as a basis for recoupment unless there is a finding of a sustained or high level of payment error or that documented educational intervention has failed to correct the payment errors, while precluding administrative or judicial review of the Secretary's finding of a sustained or high level of payment error (Section 935). The Act also mandates development of a process for providers to correct minor errors and omissions without going through the appeals process (Section 937).

**Limits on Medicare Regulatory Procedures.** The Act requires the Medicare Program to go through specified procedures to make any changes to the Evaluation & Management (E&M) documentation guidelines for physician services (Section 941); and, also establishes procedures and limitations for changes to Medicare regulations (Sections 902 and 903), including protection against penalties or interest for providers who rely on written Medicare guidance when submitting claims (Section 903).

### WELCOME

Attorney Michael B. Volk joined Capozzi & Associates during the fall of 2003 as an Associate in the Litigation Department. He is a graduate of the Texas Wesleyan University School of Law. After graduation from law school, Mr. Volk served as a general practitioner in the Dallas, Texas area. Prior to attending law school, Mr. Volk served in the United States Air Force and was employed by a major defense contractor. Mr. Volk earned a BA from St. Vincent College and an MBA from the University of North Texas.

## UPCOMING EVENTS

Louis J. Capozzi, Jr., will be participating in the "Core of Knowledge for Nursing Home Administrators" program sponsored by Slippery Rock University on Saturday, **March 6, 2004** at the Wexford/North Hills Site and Saturday, **August 28, 2004** at the Slippery Rock Site. He will be presenting a seminar entitled "The Government's Role in Health Care Policy, Reimbursement and Regulation."

Louis J. Capozzi, Jr., will be presenting for the Lorman Education Seminar on Medicaid, Medicare and Medical Assistance in Pennsylvania in Pittsburgh on **April 2, 2004**.

Robert G. Grubb, Esquire, will be presenting a Wills and Trusts Workshop during February 2004 in the Carlisle and Chambersburg Areas and in Lancaster in March 2004. Please contact the Harrisburg Office for exact dates, times, and locations.

## ADVOCATING FOR OUR CLIENTS OUTSIDE THE COURTROOM

1. Our firm was chosen to conduct legislative monitoring by the Pennsylvania Assisted Living Association (PALA). We will continue to monitor and present PALA's views on issues, legislation and regulations of interest to the assisted living industry in Pennsylvania.

2. Louis J. Capozzi, Jr., Esquire, was recently appointed to the Act 142 Committee by Governor Ed Rendell and is working to ensure fair treatment for providers that have filed appeals within the Bureau of Hearings and Appeals and to address changes in jurisdiction from the Board of Claims to the Bureau of Hearings and Appeals for Provider disputes with DPW.

Note: While 67 Pa. C.S.A. § 1102(E)(2)(VIII), as added by Act 142-2002, requires the Bureau of Hearings and Appeals of the Department of Public Welfare to make decisions relating to MA Provider Appeals available electronically without cost to the public as of July 1, 2003, the Bureau has not yet established a website for public access to its decisions. Regulations to implement this requirements have been drafted by Louis J. Capozzi, Jr., Esquire, as a member of the Advisory Committee established pursuant to Act 142-2002 to develop procedural regulations for provider appeals before the Department of Public Welfare, but have not been acted on by the Advisory Committee or the Department to date.

3. Louis J. Capozzi, Jr. and Michael A. Hynum, Esquire, are serving on the Pennsylvania Bar Association Health Law Committee. Lou is serving as the Chairman of the Legislative Subcommittee.

**BEST WISHES FOR A PROSPEROUS AND HAPPY NEW YEAR!**

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