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# *The Quarterly*

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## **ACT 25 OF 2003: NEW PROVIDER ASSESSMENT LAW IS A NEW FUNDING SOURCE FOR LONG TERM CARE**

*By Louis J. Capozzi, Jr., Esquire*

The Department of Public Welfare (DPW), with support from the Rendell Administration, unveiled its proposal for a nursing home assessment during a May 30th “closed-door” meeting with provider representatives. The nursing home assessments were included in the enacted 2003-04 budget for Medical Assistance-Long Term Care. Under DPW’s initial proposed plan, \$252 million in nursing home assessments will draw down \$344 million in federal matching funds, thus providing \$596 million for payments to eligible facilities. Of that amount, \$320 million (state and federal monies) will be used to fund existing Medicaid rates and provide for a 4.3% average annual per diem rate increase. Additionally, the assessment revenue plus federal matching funds will be used to fund \$276 million in supplementation payments to the assessed facilities.

There were several obstacles to overcome before this funding would become available to DPW:

- 1) The Pennsylvania legislature needed to pass enabling legislation to allow the Commonwealth to impose the assessment and collect the anticipated revenues. This was accomplished on September 30, 2003 after the Governor

signed Act 25 of 2003.

- 2) Because of certain design features of the proposed plan, DPW must seek a federal waiver, known as the “Uniformity and Broad Based Waiver”, from the Centers for Medicare and Medicaid Services (CMS). Act 25 requires DPW to do this and CMS has advised that it takes about six (6) months to process a waiver request.
- 3) To authorize the additional supplementation payments to the assessed facilities, DPW must also receive CMS approval of a State Plan Amendment that sets forth the proposed changes in methods and standards for setting nursing facility payment rates.

Because of the initial uncertainty of overcoming these above obstacles in time to establish the July 1 nursing facility payment rates, DPW published simultaneous public notices in the *Pennsylvania Bulletin*. One notice, in the event that the assessment was not implemented, announced rate reductions by a factor to reduce aggregate payments by \$320 million. The other notice announced DPW’s intention to file a

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State Plan Amendment with CMS to implement the assessment and supplementation program. Now that Act 25 is law, DPW has released July, 2003 draft case-mix rate data reflecting increases resulting from the assessments.

DPW's initial assessment proposal would tax non-governmental nursing facilities at one of four (4) rates, depending on each provider's Medical Assistance (MA) occupancy, multiplied by the facility's number of non-Medicare resident days. The rate for facilities not participating in the MA program is zero. The supplementation payments are to be distributed under a five-level system, again, depending on the percentage of MA occupancy.

DPW received several viable alternative models for both the assessment rates and the supplementa-

tion payments, including some resulting in more federal revenues and less adverse impact on providers than DPW's initial model. DPW announced on October 8, 2003 that it submitted both its initial model and one new alternative that has an assessment rate of \$19.00 times the provider's MA occupancy percentage times its number of non-Medicare resident days and a supplementation rate of \$18.79 times the provider's MA days, included MCO, LTC CAP, MA Hospice, and leave days. This alternative results in only a few minor instances of providers receiving less through the supplementation payment than they pay on the assessment. Capozzi & Associates will continue to monitor and report developments as they occur.

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## **ACT 142, DPW'S FINAL STANDING PRACTICE ORDER AND THEIR IMPORTANCE TO A SUCCESSFUL MEDICAL ASSISTANCE APPEAL**

*By Daniel K. Natirboff, Esquire and Sean Swalin, Law Clerk*

The Pennsylvania Legislature recently enacted legislation changing the procedures that govern Medical Assistance ("MA") provider appeals. Act 142 of 2002 established that jurisdiction no longer vests with the Board of Claims over Medical Assistance Provider disputes with DPW for matters filed after the publication of a Final Standing Practice Order governing Medical Assistance Appeals as of June 28, 2003. As a concession to providers that had concerns about the ability of DPW's Bureau of Hearings and Appeals ("BHA") to fairly adjudicate all Provider appeals, Act 142, 2002 mandated changes to BHA procedures. Adopted to comply with Act 142, the Final Standing Practice Order of the Department of Public Welfare ("Order"), 33 Pa.B. 3053, establishes rules governing MA provider appeals brought in BHA. These changes take effect on all appeals filed in BHA after July 1, 2003 and also impact appeals

filed between December 23, 2002 and July 1, 2003. As these procedures take effect, it will become a more complex task to prepare, file and pursue appeals in BHA and comply with all of the new requirements under the Order.

Prior to the enactment of Act 142, the procedures of MA provider appeals followed the General Rules of Administrative Practice and Procedure ("GRAPP"), which are found in 1 Pa. Code. These rules provided a loosely constructed framework through which MA provider appeals were guided. While GRAPP addressed many procedures that were applicable to MA provider appeals, it lacked a definitive structure that was present where other administrative agencies promulgated and adopted their own procedures. Act 142 has addressed these concerns. BHA in adopting the Final Standing Practice Order as mandated by Act 142 has created a number of rules and procedures which to some

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extent implement parts of the Act and also supplement or are arguably contrary to the Act. There are a few “goodies” for Providers in the Final Standing Practice Order, most of which were mandated by Act 142, (e.g., depositions and interrogatories). Some provisions such as mandatory Position Papers may benefit all parties. Other provisions established by the Order but curiously absent from Act 142, can only benefit DPW (e.g., limitation on what can be appealed and how, dismissal of appeals for failure to file a position paper). As we begin proceeding under the new rules, many questions will arise concerning the maze of new procedures that will need to be followed.

We will briefly highlight a couple of those changes. First, while there was no mandatory disclosure under the GRAPP, Act 142 now provides for mandatory disclosures that **MUST** be made by each party when pursuing a MA provider appeal.

Under the mandatory disclosure requirement, a provider is required to disclose virtually all information that will be used at the hearing within 45 days of the BHA’s initial pre-hearing order. This includes the names and addresses of all persons who provided any information that will be used in the appeal and a copy or description by category and location of all documents, data, compilations and tangible things that were relied upon in drafting the request for a hearing.

The second mandatory disclosure requirement is the filing of a Position Paper within 60 days of the close of discovery. A Position Paper must state all of the relevant facts and present arguments that set forth the provider’s position for the appeal. This is essentially a legal brief. Failure to file a timely Position Paper on the Provider’s part will result in dismissal of the Provider’s Appeal under the Order. If DPW’s counsel fails to file a Position Paper, the worst that can happen is a reprimand from the Chief Counsel.

Third, the Order provides for increased discov-

ery that was not available under the old rules such as: interrogatories, requests for the production of documents, expert reports, requests for admissions and depositions of witnesses and designees of parties. These methods to discover additional information are useful tools by which a provider, and the program office, can perfect their case in an MA provider appeal. It is often the mastery of these additional forms of discovery that can make or break a provider’s appeal.

Fourth, some of the other new procedures include new rules for documentary filings, Requests for Hearing, Petitions for Relief, intervention, mediation, prehearing conferences and Requests for Reconsideration. Providers are expected to state in detail the reasons why the Provider believes DPW’s determination is factually and/or legally wrong.

The scope of the Standing Practice Order and its importance in successfully appealing a Medical Assistance matter cannot be underestimated. It has effectively recreated the process and procedures for pursuing Medical Assistance Appeals. In other ways the new procedures before BHA will result in a system that is more equitable for Providers. In some ways Providers will bear an increased burden and are more likely to have their appeals dismissed or diminished if they are not handled carefully.

It is also important to note that the provisions of the Final Standing Practice Order are not set in stone. These procedures were intended by the legislature to be a gap-filler until DPW promulgated regulations implementing changes mandated by Act 142. To assist in the process of promulgating regulations, Act 142 provided for an Advisory Committee. We are pleased to announce that Louis J. Capozzi, Jr., Esquire has been appointed to participate on that Committee. Providers with questions on how to perfect or prosecute a Medical Assistance Appeal under the Act 142 and/or Standing Practice Order changes are encouraged to contact us at Capozzi & Associates, P.C.

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# MEDICARE PROGRAM PROPOSES TO LIMIT BAD DEBT PAYMENTS AND CONFIRMS POLICY TO PRECLUDE BAD DEBT PAYMENTS FOR FEE BASED SERVICES

By Louis J. Capozzi, Jr., Esquire

When the Medicare Program implemented the Prospective Payment System (PPS) for nursing facility payments in 1998, payment for “Medicare Bad Debts” were continued (42 CFR §§ 413.80, 413.350, 64 FR 41644, July 30, 1999). When the Medicare Program changed its method of reimbursement for many services provided to nursing facility residents from cost-based to fee schedules (Program Memorandum Transmittal No. A-01-94, August 1, 2001), a debate arose concerning whether bad debts related to such payments would be eligible for reimbursement as Medicare Bad Debts. While the Medicare Provider Reimbursement Review Board determined in a prior non-nursing facility appeal, that fee schedule-based services were not eligible for Medicare Bad Debt payments (Appeal of Corporacion de Las Vegas, Inc., Puerto Rico, December 29, 1998, Decision No. 99-D11), nursing facilities pursued appeals to obtain Medicare Bad Debt payments related to therapy services provided to facility residents. The Centers for Medicare & Medicaid Services (CMS) opposes payment arguing that Medicare Bad Debt payments are not available for services reimbursed on a fee schedule basis.

The Medicare Program has recently proposed new rules to further limit Medicare Bad Debt payments to nursing facility providers at 68 F.R. 6682, February 10, 2003, which also restates its opposition to payments in cases of services subject to payment on a fee schedule basis (68 F.R. 6683, 6685). CMS estimates that the new rules will cost Medicare nursing facility providers an aggregate total of \$310,000,000 between 2003 and 2007, or about 0.5% of total Medicare payments to those facilities (68 F.R. 6686).

The proposed regulation would amend 42 CFR § 413.80(i) to expand the preclusion of Medicare Bad Debt payments on fee schedule-based payments from only anesthesiologists services to all services paid under a reasonable charge-based methodology or a fee schedule (which the rulemaking at 68 F.R. 6685

describes as a “clarification” and not a “change in policy”). The proposed regulation would add 42 CFR § 413.80(h)(2) to implement sliding scale caps on the amount of Medicare Bad Debt that can be reimbursed, with a reduction of:

- (a) 10% for cost reporting periods beginning on or after October 1, 2003;
- (b) 20% for cost reporting periods beginning on or after October 1, 2004; and,
- (c) 30% for cost reporting periods beginning on or after October 1, 2005.

Comments on these proposed changes had to be filed with and received by CMS, by April 11, 2003, and, our firm filed comments arguing against the rule changes.

The rulemaking notes that a prior attempt by CMS to limit Medicare Bad Debt reimbursement was invalidated by the U.S. Court of Appeals for the D.C. Circuit in 1998 (*Kidney Center of Hollywood, et al. v. Shalala*, 133 F.3d 78). While Congress expressly authorized a limitation on Bad Debt reimbursement for hospitals by statute (Section 541 of Pub.L. 106-554 or “BIPA”), Congress has not enacted such a limit on Bad Debt reimbursement for other providers. In the rulemaking, CMS seeks to justify the expansion of the limit to other providers as a matter of equity and uniformity, as consistent with changes in the role of Medicare reimbursement in the PPS-context, and to provide more incentive for providers to attempt collections from beneficiaries. One problem with CMS’s rationale is that Pennsylvania nursing facility providers are precluded from seeking to collect unpaid Medicare coinsurance and deductibles from Medicaid dually-eligible patients (55 Pa. Code § 1187.102(c)); and, therefore, are not able to decrease the amount of Medicare Bad Debt attributable to services provided to such dually-eligible beneficiaries through collection efforts.

Questions about the proposed rules and their potential impact on your Medicare payments and appeals may be addressed to our offices in Harrisburg.

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# THE CLIMATE FOR SEEKING EXEMPTION FROM REAL ESTATE TAXES FOR NON-PROFIT ENTITIES HAS NEVER BEEN BETTER

*By Donald R. Reavey, Esquire*

After the passage of the Institutions of Purely Public Charities Act in 1997, also known as Act 55, there was some reluctance among local taxing bodies to recognize its constitutional validity. The Act sets forth definitive financial parameters to be satisfied before an entity will qualify for exemption from real estate taxes. However, a recent Pennsylvania Supreme Court decision has changed the reasoning of many of the local taxing bodies across the State.

The Supreme Court decision involved a non-profit entity known as Community Options which arranged for various services for mentally retarded adults. Community Options initially sought real estate tax exemption under Act 55 before their local board of assessment appeals. The local taxing bodies objected to this appeal on the basis of their belief that Act 55 was unconstitutional. Apparently, the local taxing board failed to apply Act 55 in deciding that Community Options failed to qualify for exemption from real estate taxes.

The case was appealed to the Supreme Court of

Pennsylvania. The constitutional challenge was again raised at the Supreme Court level, and despite the local taxing bodies insistence, the Supreme Court did not rule on the constitutionality of the Act but continued to apply Act 55 in its decision. This was a serious set back for any constitutional attack by local taxing bodies.

Since the publication of the Community Options decision by the Supreme Court on December 31, 2002, we have seen a substantial change in how Act 55 is treated at the local level, and both trial courts and the Commonwealth Court have continued to apply Act 55. As recently as May 1st of this year, we have won several cases before local boards of assessment appeals simply by demonstrating that our clients met the financial criteria outlined in Act 55.

For further information regarding Act 55 or whether or not your non-profit entity would meet the financial criteria required, please contact our Harrisburg office.

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## NURSING FACILITY MALPRACTICE INSURANCE ASSESSMENTS UNDER ACT 13-2002

*By Daniel J. Pederson, Esquire*

Pennsylvania enacted malpractice reform legislation in 2002 and is continuing to consider further reforms. The major reforms enacted in 2002 are contained in the Medical Care Availability and Reduction of Error Act, known for short as "M-Care" or Act 13-2002 (40 P.S. §§ 1303.101 – 1303.5108), which, among its several goals, makes changes to the secondary malpractice insurance system previously established by the Health Care Services Malpractice Act (40 P.S. §§ 1301.101 *et seq.*), including replacement of the "CAT Fund" (40 P.S. §§ 1301.701 *et seq.*) with a new "M-Care Fund"

(Section 712 of Act 13-2002).

Under M-Care, all remaining "CAT Fund" assets and liabilities are transferred to the new "M-Care Fund" (Section 712(b) of Act 13-2002). The new "M-Care Fund", like the "CAT Fund" is funded with *assessments on participating health care providers* (Section 712(d) of Act 13-2002), which, under both systems, includes *nursing facilities* (Definition of "health care provider" in Section 103 of Act 13-2002 and Definition of "participating health care provider" in Section 702 of Act 13-2002). M-Care provides for continuation of sur-

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charges imposed under the “CAT Fund”. M-Care requires public notice of the assessment by November 1 for the succeeding calendar year (Section 712(d)(2) of Act 13-2002).

All nursing facilities in the Commonwealth are required to participate in the M-Care Fund (Section 711(e)). As with the “CAT Fund”, the failure of a nursing facility to maintain insurance required by M-Care results, after notice and an opportunity to cure the problem, in the suspension or revocation of its license until it does comply (Section 711(c)).

The Insurance Department published notices relating to the first assessment under Act 13-2002 in September 2002 at 32 Pa.B. 4409 (describing the timing and methods of notification) and 32 Pa.B. 4666 (proposing the 2003 assessment rate of 43% and inviting comments). The Department has also established an M-Care Website to assist providers, insurers, and others with information about M-Care, including manuals, reporting forms, and frequently asked questions: <http://www.mcare.state.pa.us/mclf/site/default.asp>.

The Website also includes information on the prevailing premiums being used to compute the assessment for nursing facilities, which are listed for four (4) “territories” in the Commonwealth: (#1) Delaware County and Philadelphia; (#2) All Counties Not in Other Territories; (#3) Allegheny, Crawford, Erie, Lackawanna, Lawrence, Luzerne and Mercer Counties; and (#4) Bucks, Chester, and Montgomery Counties. Nursing facilities are also classified into three (3) types, each with its separate territory rates: (A) Extended Care Facilities (i.e., hospital based); (B) Convalescent Facilities (50% or more of residents 65 and under); and (C) Skilled Nursing Facilities (50% or more of residents over 65).

The Insurance Department posted on its M-Care Website a July 22, 2003 letter advising that

Governor Rendell authorized a delay in the collection of the 2003 assessment until September 15, 2003, with respect to all malpractice policies written or renewed after January 1, 2003 and before September 15, 2003.

While the “CAT Fund” statute did not expressly establish a system for provider appeals of assessments, M-Care specifically states (Section 712(d)(3)) that: “Any appeal of the assessment shall be filed with the [Insurance] department [of the Commonwealth].” The Pennsylvania Commissioner of Insurance is granted authority to promulgate regulations to implement and administer such matters (Section 748 of Act 13-2002). The Insurance Department published Notice No. 2002-08 in the *Pennsylvania Bulletin* on September 15, 2002 (32 Pa.B. 4554), advising that administrative appeals under M-Care would be governed by the Administrative Agency Law (2 Pa. C.S.A. §§ 501 et seq.), the General Rules of Administrative Practice and Procedure (1 Pa. Code, Part II), and the Department’s existing Special Rules of Administrative Practice and Procedure (31 Pa. Code § 56.1-56.3). There are no regulations that limit the issues that can be presented in such appeals.

While the M-Care Website provides information on the standard rates used for assessments, M-Care also provides for additional increases of up to 20% of the prevailing premium used to set an individual nursing facility’s assessment rate (Section 712(g)) based on the frequency or severity of claims paid by the Fund on behalf of that provider. The appeal process established by M-Care also applies to such adjustments in a provider’s assessment.

If you have questions about the assessment or appeal provisions of M-Care or about the impact of this important new statute on your facility, feel free to contact our Harrisburg Office.

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# NON-QUALIFIED DEFERRED COMPENSATION PLANS:

## *Good for the Organization, Good for Key Employees*

*By Robert P. Grubb, Esquire*

Securing and retaining top level, key employees is vital to the success of every organization. A robust compensation package is perhaps the single most important factor a key employee will use in determining whether or not to stay with or join your organization. A non-qualified deferred compensation plan, can be beneficial to the organization in retaining the employ of key employees and beneficial to the key employee by providing a more robust compensation package.

In general, a non-qualified deferred compensation plan is a contract between the organization and the employee or group of employees. The plan is a *deferred compensation* plan in that the organization promises to pay future or deferred compensation, (at retirement or some other event) in exchange for services rendered today. It is a *non-qualified* plan in that it is not subject to the same level of regulation, limits on participation or tax favored treatment that accompany traditional qualified retirement plans.

These plans are attractive to the highly compensated employee because they allow the employee to defer part of their income until retirement and presumably, a lower income tax bracket. The deferred compensation plan can be stacked on top of the organization's existing qualified plan(s) permitting the key employee to accumulate retirement benefits in excess of the annual contribution limitations placed on qualified plans. From the employee's perspective, these plans contribute to their future (retirement) wealth and security.

The organization benefits from non-qualified deferred compensation plans as well. These plans are not subject to ERISA and its reporting and filing requirements. Unlike qualified plans, the organization may discriminate in favor of key employees and may tie the amount of deferred compensation to economic performance. Additionally, the organization may choose to design a plan with an extended and/or cliff vesting schedule. Sometimes called "golden handcuffs," these plans encourage the long-term retention of key employees. The employer may include forfeiture provisions such as a non-compete clause to discourage a key employee from employ-

ment with a direct competitor. Finally, the plan can be designed so that the organization recaptures all of its cost in the plan.

The employee's income tax is deferred until they have a right to receive the funds or, when properly constructed, when the deferred compensation is actually paid. Unlike the qualified plan, the employer is not entitled to a tax deduction until the employee has a right to receive the funds. Additionally, the income earned inside the plan must be reported by the employer and the tax paid each year. Creative funding of the deferred plan, such as through the use of a company owned life insurance (COLI) product, can allow the income to grow tax deferred. Tax-exempt organizations will not pay income tax on the income earned inside the plan however there are additional considerations in order to maximize the deferral of income to the key employee of the tax-exempt organization. The tax treatment of the non-qualified plan is not as favorable as is that with a qualified plan. Even so, the ability to discriminate among participants plus the lack of limitations on excess retirement contributions, make these plans desirable.

To implement a non-qualified deferred compensation plan the organization must first select the key employee(s) it wants to participate in the plan. The organization then formally adopts the plan and authorizes the annual funding of the plan. A deferred compensation agreement is designed and drafted by legal counsel to meet your organization's objectives. Enrollment forms, applications and beneficiary designations are completed by the employee(s) and a one page ERISA notice is filed with the U.S. Dept. of Labor.

Securing and retaining key employees is vital to the success of your organization. Attractive benefits, low administration requirements at potentially low cost would be ideal for both the organization and the employee. A non-qualified deferred compensation plan may be the "lock" that fits your "key" employee(s). For more information on how a carefully designed and properly implemented plan can benefit your organization call Bob Grubb, at 717-233-4101 or email him at bobg@capozziassociates.com.

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**Comparison of Plan Features**

**Qualified Pension Plan**

Income tax on contributions deferred  
 Income tax on plan earnings deferred

Contributions tax-deductible by employer in year of contribution

Employee owns benefits

Cannot discriminate in favor of key employees

Organization may not recover cost of plan

Limited contribution amounts and benefits

Subject to short vesting requirements

Subject to minimum distribution requirements

Assets secure from creditors of employer

Organization incurs fiduciary liability

IRA rollover permitted

Plan must be funded

Extensive ERISA reporting requirements

Substantial administration costs

Death benefits may be subject to income tax

**Non-Qualified Deferred Compensation Plan**

Income tax on contributions deferred  
 Income tax on plan earnings not deferred (unless funded with COLI)

Contributions not tax-deductible by employer in year of contribution

Employer owns benefits

Can discriminate in favor of key employees

Organization may recover cost of plan

Flexible contribution amounts and benefits

Not subject to short vesting requirements

Not subject to minimum distribution requirements

Assets unsecured from creditors of employer

Organization incurs no fiduciary liability

IRA rollover not permitted

Option to use funded or unfunded plan

Simplified reporting requirements

Reduced administration costs

Favorable income tax treatment of death benefits available (if funded with COLI)

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