

PMDA

news

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PMDA 1992 - 2007

15 Years of Excellence in Long-Term Care Medicine

President's Message

by J. Kenneth Brubaker, MD, CMD



My New Year's Resolutions for PMDA

The beginning of a **New Year** is a time to make new commitments and resolutions. The two most common **New Year's Resolutions** that I hear about are to **Lose Weight** and to begin a **Serious Exercise** program. Do these resolutions sound familiar?

I find it very interesting that many of the **New Year's Resolutions** focus on one's health. I would like to share my **New Year's Resolutions** for PMDA. These also relate to improving health, that is the health of our organization. I strongly believe that each member of PMDA can contribute to enabling my **New Year's Resolutions** to be successful.

1. PMDA will experience significant growth in membership through the leadership of Dr. Lou DeMaria and the Membership Committee.
2. PMDA will develop at least 3 or 4 strong regional provider groups under the direction of Drs. Sarah Noorbaksh and Dan Haimowitz and Regional Meeting Committee.
3. PMDA members will increase their sharing of knowledge and experiences with each other via e-mail and our newsletters.
4. PMDA members will begin to develop skills in effectively communicating with their local legislative representatives regarding important health care issues that affect the quality of care in our nursing homes and assisted living facilities.
5. PMDA, with the leadership of Dr. Gary Bennett and the Strategic Partnerships Committee, will begin to develop stronger relationships/networks with other organizations that are involved in long-term care in Pennsylvania.
6. PMDA, through the leadership of Drs. Dave Nace and Tom Lawrence and the Public Policy Committee, will develop a clear priority of advocacy issues that can be effectively communicated to our networking partners and to our legislators in Harrisburg.
7. PMDA, through its recently established Political Action Subcommittee, will begin to communicate at hearings and other significant events in Harrisburg in support of PMDA's advocacy issues.
8. PMDA will experience another successful symposium on October 26, 2007 with an increase of attendance by 50%.
9. PMDA's website will continue to grow and meet the informational and educational needs of our members.

I believe all PMDA members can and will contribute to make this our best year ever as we celebrate our 15th anniversary! ■

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PMDA Public Policy Update

by Thomas Lawrence, MD & David A. Nace, MD, MPH, Co-Chairs Public Policy Committee

February 2007

Advance Directive for Health Care Act Goes into Effect (Act 169 of 2006) in Pennsylvania

In November 2006, Governor Rendell signed Act 169 into law. Act 169 provides a legal framework for the establishment and use of advance directives and health care (proxy) decision-making for incompetent patients.

The new law seeks to clarify the use of living wills, health care power of attorneys, and the role and ordering of family members when no formal health care power of attorney exists. Under Act 169, the Department of Health is also required to consult with an advisory committee to consider the adoption of the Physician Orders for Life Sustaining Treatment form, known simply as the POLST.

The Pennsylvania Medical Society has provided useful information on their website reviewing the Act and listing new key features. This information, including a booklet entitled "Advance Health Care Directives and Health Care Decision-making for Incompetent Patients: A Guide to Act 169 of 2006 for Physicians and Other Health Care Providers" can be found at www.pamedsoc.org. PMDA strongly suggests that its members review the information as it will have an important impact on clinical and administrative practice in all long-term care settings.

POLST Initiative Gets Marching Orders

The Physician Orders for Life Sustaining Treatment form, or POLST, has been gaining attention in Western Pennsylvania over the past several years. It is now being given a formal push for the entire state. POLST is a program which reduces barriers to self determination of individuals by the creation of an actionable document, a physician order. Both living will and health care power of attorney documents have had limited impact on improving self determination. Living wills are specific to patients who are not able to make decisions

on their behalf and who have a terminal condition or are permanently unconscious. Thus, they do not assist patients who are competent or who may be frail, but not necessarily have a terminal condition. Health care power of attorney documents suffer similar drawbacks.

To address these problems, the Center for Ethics in Health Care at Oregon Health & Science University developed a multi-disciplinary task force in 1991. This task force ultimately created and launched the POLST program. Since then, several states have adopted the POLST or similar programs including our neighboring state West Virginia. POLST programs attempt to allow effective communication of patient wishes between care sites. Because of the emphasis on transitions of care and their success in other states, PMDA strongly supports the adoption of a POLST program in Pennsylvania.

Act 169 now requires the Pennsylvania Department of Health to consult with an advisory committee to explore adoption of a POLST program. While not officially adopted by the DOH, long-term care facilities can still use the POLST form as an aid to improving end of life care. As mentioned, a number of long-term care facilities in Western PA are already doing so and feedback has been positive. For more information, please visit the website www.polst.org or contact the Public Policy and Advisory Committee.

PMDA will continue to support and follow POLST developments and will provide an update in future newsletters.

Drug Regulations Updated (F329 & F428)

CMS has completed an update to the F329 & F428 tag guidelines, addressing unnecessary drugs and the required drug regimen review process. The new guidelines went into effect December 18, 2006 and surveyor education on these guidelines is currently underway. Several Ftags were condensed as part of this most recent review.

These new guidelines are extremely detailed and will need to be reviewed by all long-term care providers. They represent an

attempt to reduce the risks involved with medication use in nursing homes, including drug-disease and drug-drug interactions. The new guidance requires scrutiny of all medications prescribed in nursing facilities, not just psychotropic medications. The guidance also goes beyond the traditional Beers list approach that dominated the last set of revisions to the F329 tag. Moreover, clinicians must document the rationale for the medication use, particularly those medications considered to be high risk in nursing facility residents. There must also be evidence that the resident is being appropriately monitored and attempts at tapering or removal are considered.

Information is available on the AMDA website www.amda.com. To access the information, click on "Advocacy" on the list at the left hand side of the home page, click on "Regulations and Compliance," then click on "Surveyor Guidance for Unnecessary Medications." There is also a power point training inservice entitled "AMDA Inservice on F329 Compliance." Additional training information is scheduled to be released on this website in the next few weeks.

PMDA requests its members to review the new regulations carefully and to forward any questions, concerns, or experience with the new guidelines to the Public Policy and Advocacy Committee.

New AMDA Toolkit On Immunizations

AMDA recently updated their toolkit "Immunizations in the Long-Term Care Setting." PMDA members, Drs. Thomas Lawrence and David A. Nace participated in the development of the kit. The kit provides useful information to improve immunization rates among long-term care residents and staff, particularly for influenza and pneumococcal disease. More information is available at www.amda.com.

Infection Control Guidelines to be Revised

As part of the ongoing effort to update the federal nursing home licensure regulations,

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Anemia and Chronic Kidney Disease in LTC

by Neelofer Sohail, MD, Fellow in Geriatric Medicine, Lancaster General Hospital

Chronic Kidney Disease (CKD) is on the rise in the United States with the number of patients treated with dialysis or transplantation reaching more than 300,000 in 1997.¹

According to the National Kidney Foundation (NKF)⁴ Chronic Kidney Disease (CKD) is defined as kidney damage for >3 months, as defined by structural or functional abnormalities of the kidney with or without decreased Glomerular Filtration Rate (GFR) or GFR < 60 ml/min for >3 months, with or without kidney damage. Clinicians should be phasing out use of the term Chronic Renal Failure in favor of Chronic Kidney Disease. Patients should be identified in their Medical Problem List by the correct stage of CKD:

Stage	Description	GFR mL/ min/1.73 m ²	Action
I	Kidney damage with normal or ↑ GFR	≥ 90	Diagnosis & treatment. Treatment of comorbid conditions. Slowing of progression. CV disease risk reduction.
2	Kidney damage with mild ↓ GFR	60-89	Estimating progression.
T	for Transplant		
3	Moderate ↓ GFR	30-59	Evaluating & treating complications.
4	Severe ↓ GFR	15-29	Preparing for kidney replacement therapy.
5	Kidney failure	< 15 (or dialysis)	Replacement (if uremia is present).
D	for Dialysis		

Serum creatinine alone is a poor indicator of kidney function since it is affected by multiple factors. The Glomerular Filtration Rate (GFR) is considered the best overall index of renal function. The **MDRD 7 formula** is the most accurate formula used to predict GFR in the elderly. It calculates the estimated GFR (ml/min/1.73m²) as follows:

$170 \times (\text{Scr}) \times \text{age} \times (\text{BUN}) - 0.170 \times (\text{alb}) \times (0.762 \text{ if female}) \times (1.180 \text{ if black})$

Severe age related decline in renal function is associated with reduced erythropoietin secretion and anemia. According to the 3rd NHANES study, the prevalence of anemia increased from 1% at an estimated GFR of 60 ml/min to 9% at an estimated GFR of 30 ml/min to 33% at an estimated GFR of 15 ml/min. The National Geriatrics Research Consortium conducted a survey of anemia in nursing homes and found that as many as 50% of the patients with

anemia, although not in overt renal failure, were found to have reduced serum erythropoietin levels.

Anemia is defined by the World Health Organization as a hemoglobin concentration less than 12 gm/dl in women and below 13 gm/dl in men. Anemia is associated with many negative consequences among patients with Chronic Kidney Disease, including lower exercise tolerance and poorer quality of life, left ventricular hypertrophy, congestive heart failure² and the risk of falls.³ Anemia in old age is also an independent risk factor for decline in physical performance.⁴

Randomized controlled trials suggest that normalization of the hemoglobin level prevents left ventricular dilation in patients with severe kidney dysfunction without symptomatic cardiac disease.

Basic laboratory evaluation:

The National Kidney Foundation (NKF) recommends an anemia workup if GFR is < 60 ml/min and Hgb is < 12 g/dl. Basic work up includes hemoglobin, MCV, reticulocyte count, ferritin, transferrin saturation, iron, vitamin B12 and folate levels. Identify anemia of CKD in the elderly by assessment of the GFR and Hgb < 11 g/dl. Other etiologies of anemia such as blood loss, nutritional deficit and chronic inflammation should be ruled out.

Treatment:

According to the NKF/KDOQI guidelines,⁵ treatment is directed at dose initiation, monitoring and titration, and maintenance.

Effective therapy for CKD anemia requires monitoring and replacing iron stores. If iron therapy corrects the anemia the NKF/KDOQI guidelines recommend no further treatment. If no iron deficiency is detected or if the anemia persists after correction with iron then the following products are used.

The treatment options include erythropoiesis-stimulating proteins (ESPs) such as Epoetin alfa and Darbopoetin alfa. The Epoetin alfa starting dose is 50-100 units/Kg and can be given SQ or IV 1-3 times per week. The Darbopoetin alfa starting dose is 0.45 ug once weekly and should be administered once every 2 weeks if a patient was previously receiving Epoetin alfa once weekly (based on a 70 Kg adult). If iron stores are not adequate they need to be supplemented with PO or IV iron. One indicator of iron stores is the ferritin level which should ideally be >100. The goal for iron saturation is >20%. The dose of the ESPs should be used to keep the Hb level between 11 and 12 g/dl.

Patient oriented evidence that matters:

Despite the large number of studies that report a high prevalence of anemia in the elderly, the data on outcomes for anemia are incomplete. Yet it is an important clinical factor that should be considered. Identifying and treating the underlying causes can improve the care of patients with CKD and anemia. New evidence

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Federal Law Mandates Compliance Programs for Medical Assistance Entities

by Paula G. Sanders, Esquire, Post & Schell, PC

The Deficit Reduction Act of 2005, P.L. 109-171 (S 1932)(Feb. 8, 2006), codified at 42 U.S.C. § 1396a(a)(68) (hereinafter “DRA”) contains provisions that require, among other things, that states amend their State Plans to require that entities that make or receive at least \$5 million in annual Medicaid payments¹ (including funding under waiver programs) (“Entities”) establish specific compliance policies and include certain provisions with respect to federal and state fraud laws and whistleblower protections in employee handbooks by January 1, 2007. **Any entity that does not comply with the provisions of a revised State plan² and that continues to submit Medicaid claims after January 1, 2007, could potentially be liable for submitting false claims under the federal False Claims Act.** The DRA significantly changes the compliance landscape for large Medicaid providers. Entities that receive more than \$5 million per year from Medicaid can no longer rely on statements made by the Office of Inspector General (“OIG”) about “voluntary” compliance programs.³ If an entity is covered by the DRA, compliance policies and procedures will be mandatory by January 1, 2007.

Who is an “Entity?”

In its letter to State Medicaid Directors dated December 13, 2006 (SMDL #06-025),⁴ the Centers for Medicare and Medicaid Services (“CMS”) clarified that the term “entity” includes a governmental agency, organization, unit, corporation, partnership or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit,

which receives or makes payments, under a State Plan approved under Title 19 or under any waiver of such Plan, totaling at least \$5,000,000 annually. CMS is instructing the states to combine payments made to an entity to determine whether or not the \$5,000,000 threshold is met. Toward that end, the Guidance further provides that:

if an entity furnishes items of services at more than a single location or under more than one contractual or other payment arrangement, the provision of Section 1902(a)(68) of the Social Security Act, 42 U.S.C. § 1396a(a)(68), will apply if the aggregate payment to that entity meets the \$5,000,000 threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

On a national teleconference on January 11, 2007, CMS confirmed its intent that payments to separate but related corporations should be combined to determine whether the “over-arching entity” reaches the \$5,000,000 threshold.

While CMS has instructed the states to construe private entities as broadly as possible, it is taking a much more narrow approach to governmental “components.” On the January 11, 2007 teleconference, CMS emphasized that each component of government should be evaluated as a separate entity. It is unlikely that there will be any aggregation of Medicaid payments for components of state or local government. Additionally, a governmental component providing Medicaid healthcare items or services for which Medicaid payments are made would qualify as an entity (e.g., a

State mental health facility or school district providing school based health services). A government agency which merely administers the Medicaid program, in whole or in part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

What Does the DRA Require?

The DRA contains three (3) requirements applicable to Entities:⁵

The entity’s written compliance policies must include *detailed provisions* regarding the entity’s *procedures for detecting and preventing fraud, waste, and abuse*.

1. Written compliance policies that include *detailed provisions* regarding the entity’s *procedures for detecting and preventing fraud, waste, and abuse*.
2. Written policies for *all employees* of the entity, including management, as well as for *contractors and agents* of the entity that contain information regarding:
 - The federal False Claims Act, 31 U.S.C. §§ 3729—3733;
 - Administrative remedies for false claims and false statements established under 31 U.S.C. §§3801, *et seq.*;
 - Any state laws pertaining to civil or criminal penalties for false claims and statements;
 - In Pennsylvania, this would include 62 P.S. §§ 1407 (relating to provider prohibited acts, criminal penalties

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¹ To determine whether or not an entity has received \$5,000,000, states are told to look at payments made during the federal fiscal year. Future determinations regarding an entity’s responsibility will be made by January of each subsequent year, based upon the amount of payments an entity either received or made under the state plan during the preceding federal fiscal year.

² As of the date of this memorandum, Pennsylvania has not amended its State Plan to comply with the DRA. States have until March 31, 2007 to submit a State Plan Amendment that can have an effective date retroactive to January 1, 2007.

³ See, e.g., OIG Compliance Program Guidance for Nursing Facilities, 65 Fed. Reg. 14289, 14290 (March 16, 2000), “The Office of Inspector General...continues its efforts to promote voluntarily implemented compliance programs for the health care industry...[S]uperficial efforts or programs hastily constructed and implemented...likely will be ineffective and may expose the nursing facility to greater liability than if it had no compliance program at all.”

⁴ The CMS guidance can be accessed at <http://www.cms.hhs.gov/smdl/downloads/SMD121306.pdf>

⁵ The DRA only requires Entities to provide specific information about the federal False Claims Act, the federal Program Fraud Civil Remedies Act and state laws pertaining to false claims. Effective compliance programs should also address other applicable federal and state civil and criminal laws.

Pennsylvania Medical Directors Association 1992-2007

15 Years of Excellence in Long-Term Care

PMDA History

This year, the PMDA newsletter will be highlighting significant events in the first 15 years of our organization. In this issue we focus on the first five years.

In March, 1992, Duncan MacLean MD was authorized to form the state chapter organizing committee for Pennsylvania by then AMDA President Eric Tangalos at the AMDA Symposium in Denver. The Pennsylvania Medical Directors Association was voted into existence by twenty AMDA members in Hershey PA on August 6, 1992. Dr. MacLean was elected as its Charter President.

For the first several years, PMDA administrative offices were housed at the Geriatrics Department of Pinnacle Health/ Polyclinic Hospital in Harrisburg. In August, 1997 administrative services were relocated to the Association Management Services suite at the Pennsylvania Medical Society.

By that time membership had already grown to 206 members, and the move signified the maturation of PMDA into a full-fledged association. Heather Miller became the first Executive Director.

The first issue of the PMDA newsletter was printed in June, 1993. You are now reading the 35th!

The first PMDA Annual Symposium was held 1994 with Dr. MacLean serving as Course Director and had an attendance of 68. He also served as Course Director for the second symposium held in 1995.

PMDA's First Five Presidents:

- 1) Duncan MacLean, 1993
- 2) Michael Shank, 1994
- 3) Barbara Hoffmann, 1995
- 4) Susan Denman, 1996
- 5) Dan Steiner, 1997

Milestones in the First Five Years:

August, 1993:

PMDA hosts the Pennsylvania Long-Term Care Network

September, 1994:

1st Annual Symposium held in Harrisburg, 68 attendees

May, 1995:

Duncan MacLean represents PMDA at the White House Conference on Aging

February, 1997:

Past President Barbara Hoffmann elected to the AMDA Board of Directors

August, 1997:

PMDA moves administrative services to the Pennsylvania Medical Society, Heather Miller becomes first Executive Director ■

PMDA Public Policy Update

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CMS has formed a panel to revise the infection control guidelines for nursing facilities. The panel met January 25-26, 2007 in Baltimore to begin the revision process which is expected to take 18-24 months. PMDA member, Dr. David Nace is part of this panel.

Checklist Of Important Items For Review

The topics discussed above are all important to long-term care practice. Unfortunately, it is not possible to review each topic in greater detail at this time. Below is a checklist meant to help PMDA members identify and track items for which they need additional information. We hope this helps.

- Pennsylvania Medical Society General Interest Publication on Act 169 (www.pamedsoc.org/advancedirectives)
- POLST Form (www.polst.org)
- Updated Surveyor Guidance for F 329 and F 428 (www.amda.com)
- AMDA Inservice on F329 (www.amda.com)
- AMDA Toolkit Immunizations in the LTC Setting (www.amda.com)
- Contacting the Public Policy and Advocacy Committee—If you have any questions, comments, concerns, or want to share any experiences about any of the issues discussed above, please contact us at www.pamda.org. ■

Welcome New Members

PMDA welcomes the following new members to the Association

Individual Members (Physicians)

Thomas Renaldo, DO

Individual Members (NPs or PAs)

Madeline F. Mattern, NP-C

Affiliate Members

Martin S. Kardon

JCAHO Top 10 Tips for Physicians

- 1) Wash hands before and after patient contact.
 - Use soap, water (15 seconds) and clean paper towels OR
 - If your hands are not visibly soiled, use alcohol gel hand rub and rub until hands are dry.
- 2) Correctly identify patients using two identifiers.
 - Ask the patient his/her name and date of birth.
- 3) Obtain or check a list of the patient's medications at home at the time of first contact.
 - ED visit, admission or first ambulatory visit.
 - Make sure the medications added or stopped are reconciled at the time of transfer or discharge.
- 4) Do not use unapproved abbreviations in hand written or free text notes.
- 5) When communicating verbal orders or test results:
 - Give the patient's name and DOB.
 - Be sure the information communicated is read back to you correctly.
 - Confirm the information to the receiver.
- 6) During shift changes, transfers of patients to another level of care or other handoffs, be sure to:
 - Identify the patient correctly.
 - Allow the information receiver to ask questions.
 - Address care, treatment or services; current status; recent or anticipated changes.
- 7) Utilize the Universal Protocol prior to the start of procedures and be sure that you know you have:
 - The correct patient.
 - The correct procedure.
 - The correct (marked, in most cases) site and side.
 - The correct (and correctly displayed) images.
 - The correct implants and/or special equipment.
 - Be sure that all assisting with the procedure agree on these points during the TIME OUT done before the procedure begins.
- 8) Be sure that all medications that you do not draw up and administer yourself are labeled with drug name, dose and expiration date. This includes medications on the sterile field.
- 9) Secure all medications unless you are administering them immediately. Never carry medications on your person unless you are going to administer them immediately.
- 10) Be sure you know the National Patient Safety Goals and their applicability to your practice.

Anemia and Chronic Kidney Disease in LTC

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suggests that increasing the Hgb level over 12 g/dl increases the risk of death and cardiovascular events. Only 25 patients would need to be dosed to a target hemoglobin of 13.5 g/dl instead of 11.3 g/dl to cause one adverse event.⁶ ■

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4. Brenda W.J.H.Penninx, PhD, Jack M.Guralnik, MD, PhD, Graziano Onder, MD, PhD, Luigi Ferruci, MD, Robert B. Wallace, MD, Marco Pahor, MD. Anemia and decline in physical performance among older persons. The American Journal Of Medicine. Vol 115, August 1, 2003.
5. Clinical Practice Guidelines for chronic kidney disease: Evaluation, classification and stratification. NKF DOQI.
6. Prescriber's Letter. Vol. 14, No. 1, January 2007.

Federal Law Mandates Compliance Programs for Medical Assistance Entities

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- and civil remedies) and 1408 (relating to other prohibited acts, criminal penalties and civil remedies), and the Pennsylvania Whistleblower Law, 43 P.S. §§ 1421-1428.
- Whistle-blower protections under the foregoing laws, including the right of its employees to be protected from discharge, demotion, suspension, threat, harassment, discrimination, or retaliation in the event the employee files a claim pursuant to the Federal False Claims Act or otherwise makes a good faith report alleging fraud, waste or abuse in a Federal health care program, including the Medicare and MA Programs, to the provider or to the appropriate authorities.
 - Detailed provisions regarding the entity's policies and procedures to prevent and detect fraud, waste, and abuse in federal health care programs.
3. Inclusion in employee handbooks of specific discussions of the following:
 - The federal False Claims Act, 31 U.S.C. §§ 3729—3733;
 - Administrative remedies for false claims and false statements established under 31 U.S.C. §§3801, *et seq.*;
 - Any state laws pertaining to civil or criminal penalties for false claims and statements;

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Federal Law Mandates Compliance Programs for Medical Assistance Entities

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- The rights of employees to be protected as whistle-blowers; and
- The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

Issues Regarding "Written Policies"

The CMS Guidance provides that covered entities are responsible to establish and disseminate written policies which must also be adopted by its contractors or agents. Note that there is nothing in the DRA to suggest that contractors and agents must "adopt" a covered entity's written policies. This provision of the Guidance was the subject of heated discussion on the January 11, 2007 teleconference, and CMS has committed to further evaluation on this issue.

Written policies may be on paper or in electronic form as long as they are readily available to all employees, contractors or agents. As we had previously advised, although there is a reference to any employee handbook, there is no requirement that an entity create an employee handbook if none already exists.

Employees, Contractors and Agents

An employee is defined as any officer or employee of the entity. The term contractor or agent includes "any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of Medicaid healthcare items or services, performs billing or coding functions, or is involved in monitoring of healthcare provided by the entity."

CMS is currently evaluating whether attending physicians in nursing homes who do not have a formal contractual arrangement with the facility are contractors or agents. CMS has indicated that they will be issuing additional guidance on this question in the near future.

Enforcement in Pennsylvania

The Pennsylvania Department of Public Welfare ("DPW"), through its Bureau of Program Integrity ("BPI"), is responsible for enforcing compliance with the DRA. On December 27, 2006, the DPW issued Medical Assistance Bulletin Number 99-07-01 (the "Bulletin")⁶ to inform providers that they must submit an annual **Attestation of Compliance with Section 6032 of the Federal Deficit Reduction Act**. The Attestation must be signed by the Provider's Chief Executive Officer/President/Vice President and Corporate Secretary/Treasurer. The first Attestation must be submitted to BPI no later than December 31, 2007.

The Attestation states:

I hereby attest that, as a condition for receiving payments, I have read Section 6032 of the Deficit Reduction Act of 2005 (the Act), and have examined the entity's policies and procedures. Based on that review, the entity is in compliance with the requirements of the Act to educate employees and contractors concerning the Federal False Claims Act established under sections 3729 through 3733 of Title 31, United States Code, administrative remedies for false

claims and statements established under Chapter 38 of Title 31, United States Code, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste and abuse in Federal health care programs. Furthermore, the entity will continue to comply with these provisions to remain eligible for payment under the Medical Assistance program. I understand the statements made herein are subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and of the laws referenced in Section 6032 of the Act.

The Attestation will be one of many tools that BPI may use. When DPW submits its State Plan Amendment to CMS, it must identify:

- The manner by which it will ensure an entity's compliance;
- A description of the methodology of compliance oversight; and
- The frequency with which it will reassess compliance on an ongoing basis.

Note that CMS has the discretion to independently determine compliance through audits of entities or other means. CMS may also review a state's procedure through its routine oversight of states. Thus, it is possible that covered entities may be reviewed by a number of agencies.

Next Steps

- Review existing policies and modify as necessary.
- Educate employees (note that CMS has clarified that "training" is not required).
- Identify your covered contractors and agents.
- Determine how you will notify contractors and agents.
- Involve your Board. The DPW Attestation requires an entity's most senior officers to be knowledgeable about the entity's policies and procedures to prevent and detect fraud waste and abuse and to attest that the facility will continue to comply with the provisions of the DRA to remain eligible for payment under the MA Program. Very serious consequences may affect both the signing individuals as well as the entity if DPW determines that the attestation is false or incorrect. An improperly completed attestation could potentially result in civil and criminal penalties.
- Continue to look for further clarification and guidance from CMS and DPW. ■

This article does not offer specific legal advice, nor does it create an attorney-client relationship. You should not reach any legal conclusions based on the information contained in this article without first seeking the advice of counsel.

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⁶ The Bulletin can be accessed at <http://www.dpw.state.pa.us/General/Bulletins/003673169.aspx?BulletinDetailId=4044>



PMDA 1992 - 2007

15 Years of Excellence in Long-Term Care Medicine

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**Hotel Accommodations
Deadline September 24, 2007
Make Your Reservations Early!!**

A limited block of rooms is being held at the brand new Wyndham Gettysburg Hotel for the 2007 PMDA Annual Meeting attendees and exhibitors. Please be sure to make your room reservations ASAP to insure room availability, even before the cutoff date. Reservations may be made by calling 1-866-845-8885. Identify yourself as part of the PMDA group and you will immediately receive your confirmation.

For more details...look for the registration brochure in July and keep checking the website www.pamda.org

PMDA's 2007 Annual Meeting

Mark Your Calendars & Make Reservations Now!

Highlighted topics will be presented such as...

- ◆ Legal Issues in Long-Term Care
- ◆ Medication Transition Management:
Reconciliation Tools
- ◆ Medication Regimen Review (Tag F428)
- ◆ Unnecessary Medications (Tag F329)
- ◆ Oral Examination in Geriatric Patients
- ◆ Update on Diabetes Management
- ◆ Public Policy Discussion



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