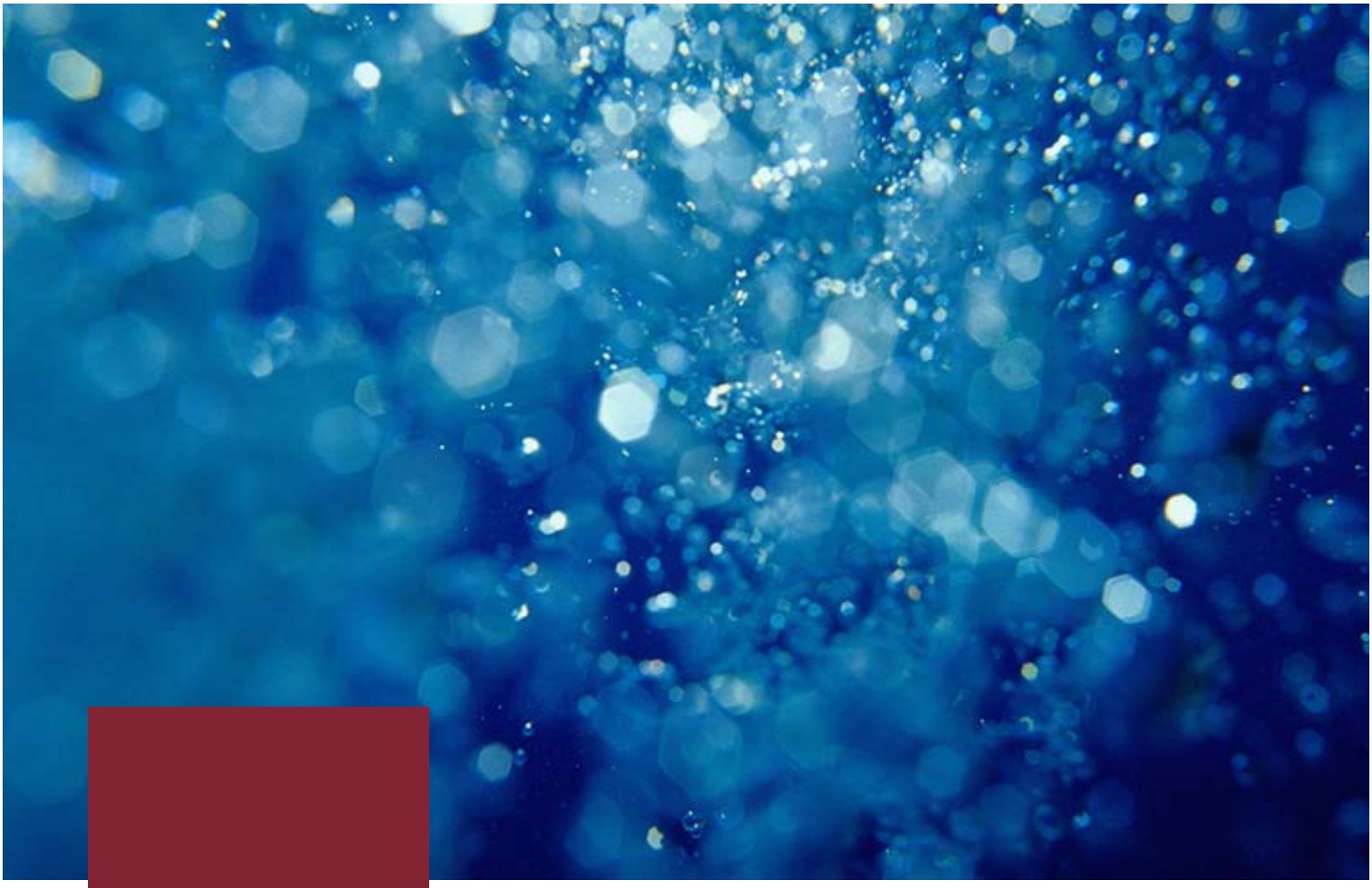

K&L GATES

Recent Legal and Regulatory Developments Affecting Long-Term Care Providers

In 2012 PHCA/CALM Convention
Session U
November 13, 2012

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I. RECENT LITIGATION AFFECTING PROVIDERS OF LONG-TERM RESIDENTIAL CARE

A. U.S. Supreme Court

1. *National Federation of Independent Businesses v. Sebelius*, 132 S. Ct. 2566, 183 L. Ed. 2d 450 (2012)

By different five to four majorities, the Court held that the requirement of the Affordable Care Act that most individuals must either purchase health insurance or make a "shared responsibility payment" is an invalid exercise of the power granted to Congress by the commerce clause of the U.S. Constitution, but is a permissible use of the power to raise taxes. The Court also held that provisions of the Act which would withdraw Medicaid funding from states that do not expand their Medicaid programs to cover persons with incomes up to 133 percent of the poverty level are an invalid mandate interfering with the powers retained by the states and not granted by the Constitution to the federal government.

Under the commerce clause, the Court observed that it has long been recognized that Congress may regulate "the channels of interstate commerce, persons or things in interstate commerce, and activities that substantially affect interstate commerce," but held that the power to regulate commerce "must be read carefully to avoid creating a general federal authority akin to the police power" which is reserved to the states by the 10th amendment. While the power to regulate activities that substantially affect interstate commerce can be "expansive," and may even apply to "seemingly local matters," such as a farmer's decision to grow wheat for himself and his livestock, the Court concluded that the power to regulate commerce "presupposes the existence of commercial activity to be regulated," and cannot be used to compel individuals to engage in commercial activities. Applying these principles to the Affordable Care Act, the Court concluded that the individual mandate represents an improper and invalid exercise of the commerce clause because it "does not regulate existing commercial activity", but instead "compels individuals to become active in commerce by purchasing a product."

Notwithstanding the Affordable Care Act's characterization of the shared responsibility payment as a "penalty," the Court found that the terminology used in the law does not control whether the payment falls under Congress's power to tax. Instead, a "functional approach" must be used to evaluate the "substance and application" of the payment to determine whether it is an invalid exercise of the taxing power. Using such an approach, the Court concluded that the payment constitutes a tax because it "is not so high that there is really no choice but to buy health insurance"; the obligation to make the payment is not limited to "willful violations, as penalties for unlawful acts often are"; and the payment is collected solely by the IRS through the normal means of taxation. While the obligation to make the payment creates an incentive to purchase health insurance, the payment is not an impermissible penalty because "neither the Affordable Care Act nor any other law attaches negative legal consequences to not buying health insurance, beyond requiring a payment to the IRS."

Seven members of the Court found that the Medicaid expansion provided by the Affordable Care Act violates the Constitution by threatening states with the loss of their existing Medicaid funding if they decline to comply with the expansion. The Court held that the spending clause of the U.S. Constitution, which grants Congress the power to pay debts and "provide for the general welfare of the United States," may be used to establish cooperative state-federal programs, provided that states retain the ability to "voluntarily and knowingly" accept the terms of such programs. If programs established under the spending clause, however, are used "as a means of pressuring the States to accept a sending clause program, the legislation runs counter to this Nation's system of federalism." As a result, provisions of the Affordable Care Act which threaten states with the loss of over ten percent of their overall budgets (which would result if federal financial participation in the Medicaid program were to be withdrawn) represent an unconstitutional form of "economic dragooning that leaves the States with no real option but to acquiesce in the Medicaid expansion."

2. *Douglas v. Independent Living Center of Southern California*, 132 S. Ct. 1204, 182 L. Ed. 2d 101 (2012)

In 2008 and 2009, California passed three laws reducing Medicaid payment for nearly all Medicaid providers in the state. A combination of Medicaid providers and recipients filed lawsuits in federal district court to enjoin implementation of the Medicaid payment changes. They argued that pursuant to the Supremacy Clause, the statutes were inconsistent with and preempted by federal law requiring that the state Medicaid agency develop "methods and procedures" to ensure that Medicaid "payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population." The 9th Circuit Court of Appeals upheld an injunction blocking implementation of portions of the California statutes.

After CMS approved Medicaid State Plan Amendments, the Supreme Court vacated the decision of the 9th Circuit Court of Appeals and remanded back to the Circuit Court to determine whether the plaintiffs may maintain Supremacy Clause actions now that CMS has approved the state statutes. The Court held that CMS' approval does not make these cases moot, but puts the cases "in a different posture, since the federal agency charged with administering Medicaid has now found that the rate reductions comply with federal law." The Court held that the actions of CMS do not change the substantive question whether California's statutes are consistent with federal law, but it may require respondents to seek review of CMS determination under the Administrative Procedure Act rather than in a Supremacy Clause action against California. The Court held that to allows a Supremacy Clause action to proceed once CMS has reached a decision threatens potential inconsistency or confusion, and "would seem inefficient" because it allow the substantive issues in dispute to be addressed without CMS being a party to the proceedings.

The Court did not endorse the position of four justices who suggested that a private cause of action cannot be based on the Supremacy Clause, but strongly suggested

it was appropriate to challenge the approval of State Plan Amendments by CMS under the Administrative Agency Law.

3. *Marmet Health Center v. Brown*, 132 S. Ct. 1201, 182 L. Ed. 2d 42 (2012)

The Federal Arbitration Act ("FAA") was found to preempt a judicial doctrine of the West Virginia Court of Appeals declaring to be unenforceable as a matter of public policy all pre-dispute arbitration agreements that apply to claims alleging personal injury or wrongful death against nursing homes.

The FAA provides that a "written provision in … a contract evidencing a transaction involving commerce to settle by arbitration a controversy thereafter arising out of such contract or transaction … shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract." 9 U.S.C. § 2.

The Court held that the FAA includes no exception for personal-injury or wrongful death claims and "reflects an emphatic federal policy in favor or arbitral dispute resolution." As a result, the law requires courts to enforce agreements to arbitrate and overrides state laws which prohibit the arbitration of particular types of claims.

Marmet Health is the latest in a series of recent Supreme Court decisions preempting state laws which interfere with the federal policy in favor of arbitration. For example, in *AT&T Mobility LLC v. Concepcion*, 563 U.S. ___, ___, 131 S. Ct. 1740, 1747, 179 L. Ed. 2d 742 (2011), the Court held that the FAA preempted a California judicial doctrine declaring class waivers in consumer arbitration agreements to be unconscionable and unenforceable if the waivers constitute adhesion contracts, the waivers apply to disputes involving small amounts of damages, and consumers make allegations of intentional fraud. In *Preston v. Ferrer*, 552 U.S. 346, 356, 128 S. Ct. 978, 169 L. Ed. 2d 917 (2008), the FAA was held to preempt a state law granting a state commissioner exclusive jurisdiction to decide an issue the parties agreed to arbitrate. In *Mastrobuono v. Shearson Lehman Hutton, Inc.*, 514 U.S. 52, 56, 115 S. Ct. 1212, 131 L. Ed. 2d 76 (1995), a state law requiring judicial resolution of claims involving punitive damages was found to be preempted by the FAA. In *Perry v. Thomas*, 482 U.S. 483, 491, 107 S. Ct. 2520, 96 L. Ed. 2d 426 (1987), the FAA was found to preempt a state-law requirement that litigants be provided a judicial forum for wage disputes, and in *Southland Corp. v. Keating*, 465 U.S. 1, 10, 104 S. Ct. 852, 79 L. Ed. 2d 1 (1984), the Court determined that the FAA preempted a state law prohibiting the arbitration of disputes subject to the California Financial Investment Law.

The Supreme Court remanded back to the West Virginia Court of Appeals the question of whether a pre-dispute arbitration agreement is unenforceable because of unconscionability. The Court instructed the West Virginia Court that agreement to arbitrate personal injury or wrongful death claims could only be found to be unenforceable "under state common law principles that are not specific to arbitration and pre-empted by the FAA."

4. *CompuCredit Corp. v. Greenwood*, 132 S. Ct. 665, 181 L. Ed. 2d 586 (2012)

A decision of the 9th Circuit Court of Appeals was reversed which held that claims alleging violations of the federal Credit Repair Organizations Act were not subject to arbitration.

The Credit Repair Organizations Act requires credit repair organizations to provide consumers with a statement that includes the sentence, "You have a right to sue a credit repair organization that violates the [Act]." The 9th Circuit held that because the law provided consumers a "right to sue," the law superseded the provisions of the FAA authorizing pre-dispute arbitration agreements.

In reversing the 9th Circuit, the Court held that the FAA establishes "a liberal federal policy favoring arbitration" which requires that courts enforce arbitration agreements according to their terms "even when federal statutory claims are at issue, unless the FAA's mandate has been overridden by a contrary congressional command."

B. Third Circuit Court of Appeals

1. *Nichole Med. Equipment & Supply, Inc. v. Tricenturion, Inc.*, 2012 U.S. App. LEXIS 19218 (3rd Cir. 2012)

The 3rd Circuit upheld a decision of the U.S. District Court for the Eastern District of Pennsylvania dismissing claims made by a durable medical equipment supplier that a Program Safeguard Contractor engaged by CMS to audit Medicare payments wrongfully instructed Medicare carriers and Medicare Administrative Contractors to recoup amounts paid for its services, thereby driving the supplier into bankruptcy.

Nichole Medical alleged that it was forced into insolvency because Tricenturion developed and implemented a business pattern and practice of ignoring and failing to follow statutory and regulatory guidelines and procedures with regard to its audit activities. Nichole Medical asked the District Court to award compensation for "economic damages, attorney's fees, costs, loss of sales, loss of revenue, loss of profits, and other expenses." Nichole Medical's claims were based on state tort law of negligence; unjust enrichment; intentional interference with contractual relations; extreme and outrageous conduct; malicious prosecution; and trespass and a breach of the statutory duty of care pursuant to 42 U.S.C. §1320c-6(b) which requires "due care in all professional conduct … in compliance with … professionally accepted norms of care and treatment."

The District Court granted a motion to dismiss based on Nichole Medical's failure to exhaust its claims before a CMS administrative law judge and the Medicare Appeals Council and because the challenged conduct was within the scope of Tricenturion's official duties under the Medicare Act, thereby qualifying Tricenturion for immunity from suit. Although Nichole pursued relief from the CMS ALJ and the Medicare

Appeals Council, the Court found that it failed to exhaust available remedies by failing to bring its tort of breach of duties claims in administrative proceedings before CMS.

Upon appeal, Nichole Medical argued that it was not required to first raise its tort and breach of duty claims before CMS because the agency lacked the power to award the type of damages being sought and by arguing that requirement to exhaust administrative remedies apply only to matters arising under the Medicare Act, and not to state law tort claims. Nichole Medical also argued that government contractors who engage in illegal conduct have no claim to official immunity.

The Circuit Court rejected Nichole Medical's claims that it was not required to raise its tort law and breach of duty claims before CMS before seeking further relief by finding that the claims were "inextricably intertwined" with claims for benefits that fall within the jurisdiction of CMS and requiring the claims to be raised within administrative proceedings before CMS allows the agency "with the benefit of its experience and expertise," to "resolve whatever issues it can, limiting the number of issues before judicial review (and limiting review on those issues according to the appropriate standard of deference)."

The Circuit Court also held that Tricenturion's actions did not constitute illegal conduct which fell outside the scope of its official duties. The Court noted that Tricenturion was authorized to suspend and recoup payments when it possessed reliable information that an overpayment had been made, and although the recoupments were ultimately reversed due to the failure to follow requirements for making statistical projections, 22 of the 39 claims which led to the recoupments were improperly paid and actually did result in overpayments.

2. *Jewish Home of Eastern PA v. Centers for Medicare and Medicaid Services*, 469 Fed. Appx. 99, 2012 LEXIS 5350 (3rd Cir. 2012)

A petition seeking review of a civil penalty imposed by CMS for deficiencies in nursing care based upon claims of selective enforcement was dismissed on the grounds that the same issues were raised in *Jewish Home of Eastern Pa. v. Centers for Medicare and Medicaid Services*, 413 Fed. Appx. 532 (3rd Cir. 2011).

In the 2011 proceedings, the Jewish Home alleged that CMS engaged in selective enforcement based upon statistical evidence, testimony regarding religious bias, and claims that CMS failed to take meaningful action to investigate its claims of religious bias. The testimony regarding religious bias involved comments made by a CMS inspector in response to an explanation provided by the Jewish Home that it provided activities for residents of all denominations on Saturdays. When the inspector was advised that the facility provided a non-denominational service for the blessing of food using a Hebrew name, Kiddush, the inspector commented that she was Christian and would feel uncomfortable attending the activity.

The Third Circuit in 2011 held that to support a claim of selective enforcement, evidence must be presented on "an intentional or purposeful discriminatory purpose, and

not mere unequal treatment or adverse effect." In particular, it must be demonstrated that the facility was treated differently from other facilities and that the selective treatment was based on an unjustifiable standard, such as race, religion, some arbitrary factor, or to prevent the exercise of fundamental rights.

In 2011 the Court concluded that the evidence presented failed to show that the Jewish Home was treated differently from other similar facilities and that the comments of the inspector were insufficient to demonstrate intentional discrimination, because the comments were not contemporaneous to the surveys upon which the penalties were based, and were not relevant or facially discriminatory.

In the 2012 proceeding, the Jewish Home challenged new penalty assessments based on similar facts and based on a new claim that the Jewish Home was denied an evidentiary hearing on its selective enforcement claim. The Court rejected these claims because the underlying basis for the discriminatory enforcement claims was the same as that presented in 2011 and a person is not entitled to an evidentiary hearing to explore an issue that was previously litigated to final judgment.

3. *Lewis v. Alexander*, 685 F.3d 325 (3rd Cir. 2012)

The 3rd Circuit upheld a decision by the U.S. District Court for the Eastern District of Pennsylvania which found that a class action seeking to invalidate several provisions of Act 2005-42 which regulated special needs trusts as preempted by federal regulations raised justiciable claims subject to a private right of action under both Section 1983 of the Civil Rights Act and the Supremacy Clause of the U.S. Constitution.

Federal regulations allow assets transferred to special needs trusts to be disregarded in determining the Medicaid eligibility provided that the trusts are managed by nonprofit organizations; separate accounts are maintained for each beneficiary, but the accounts are pooled for investment and management purposes; trusts are established solely for the benefit of individuals who are disabled by a parent, grandparent, legal guardian, or court; and if amounts remaining in each beneficiary's account are not retained by the trust upon the death of the beneficiary, the trust must pay the State for the cost of Medical Assistance paid on behalf of the beneficiary before making other distributions. Act 2005-42 attempted to further limit the use of special needs trusts by requiring that trusts be approved by a court; established for disabled individuals under the age of 65 who have special needs that would not otherwise be met; distributions be used for the sole benefit of beneficiaries and have a reasonable relationship to the needs of beneficiaries; not more than 50% of amounts remaining in accounts upon the death of beneficiaries may be retained by the trusts if the Commonwealth is not paid for the cost of Medicaid benefits provided to beneficiaries; and by allowing the Department of Public Welfare to petition for the termination of special needs trusts.

The District Court approved designation of the plaintiffs as class action representatives and granted declaratory relief invalidating virtually all of the provisions of Act 2005-42 restricting special needs trusts as preempted by federal law. On appeal, the Department of Public Welfare challenged the justiciability of plaintiffs' claims, their

ability to bring a private right of action, and the District Court's judgment that Act 2005-14's regulation of special needs trusts is preempted by federal law. The Department argued the plaintiffs' claims were not justiciable because the Department had not sought to enforce most of the provisions of Act 2005-42, and as a result the plaintiffs' were not injured in fact and the plaintiffs' claims were not ripe. The Department argued that the absence of an express declaration by Congress preempting state laws governing special needs trusts reserved to states the power to supplement federal requirements.

The Circuit Court held that the plaintiffs' claims are justiciable because all of the plaintiffs fall within the scope of these statutory provisions, would be burdened by these provisions if they were enforced; and DPW has stated that it intends to enforce all the requirements of the statute should it prevail. The Court also found that Act 2005-42 imposed burdens on the very nature of special needs trusts thereby affecting all beneficiaries and trustees.

The Court also held that the plaintiffs have a private right of action under both Section 1983 and the Supremacy Clause of the Constitution and the 50% repayment, "special needs, expenditure and age provisions of Act 2005-42 are preempted because they conflict with the federal objective of promoting special needs trusts and shielding contributions to such trusts from being disallowed for purposes of determining Medicaid eligibility", but the enforcement provisions of the Act are valid "when used to enforce provisions not otherwise preempted by federal law."

4. *Handron v. Sec'y Department of Health and Human Services*, 677 F.3d 144 (3rd Cir. 2012)

The 3rd Circuit upheld a decision of the U.S. District Court for the District of New Jersey dismissing a claim for attorneys' fees filed by a psychologist who substantially prevailed in proceedings protesting claims that he overbilled Medicare.

The case involved claims that a psychologist overbilled the Medicare program by more than $600,000, which upon appeal were reduced by an administrative law judge to an overpayment of $5,434.48. The psychologist then moved, pursuant to the Equal Access to Justice Act, 5 U.S.C. § 504(a)(1), to recoup the tens of thousands of dollars in attorneys' fees and expenses he incurred in fighting the overpayment demand. His request for fees was denied by an administrative appeals council and the District Court based on their conclusion that the hearing before the ALJ was not an "adversary adjudication," as is required for an award of fees under the EAJA.

While the Circuit Court expressed sympathy with Dr. Handron's plight, it found that it was "constrained to agree with the determination, given the statutory definition of an 'adversary adjudication.'"

The Equal Access to Justice Act empowers individuals and small businesses that prevail against the government, either in an administrative proceeding or in a civil action, to collect their fees and other expenses from the government, but limits recoveries to adversary adjudications. An "adversary adjudication" is defined as "an adjudication

under…in which the position of the United States is represented by counsel or otherwise." Because no attorney or other representative of the CMS appeared at the hearing before the ALJ to defend the overpayment claim, but the agency only provided documents requested by the ALJ to explain the procedure that its consultants used to sample Dr. Handron's claims and extrapolate findings from them, the District Court concluded that the proceeding before the ALJ did not constitute an adversary adjudication.

The Circuit Court disagreed with the District Court's conclusion that adversary adjudication does not occur when no representative of the government appears to defend its position, and held that written submissions may be sufficient to characterize a proceeding as an adversary adjudication. On the other hand, the Court concluded that the written materials submitted to the ALJ were not sufficient to make the proceeding an adversary adjudication because the materials provided did not set forth "the minimum level purposeful advocacy of a legal position directed at the decision-maker" that would be "akin to that provided by counsel." In addition, the Court found that, "The fact that the government previously took a position (and committed it to writing) cannot mean that any time such position is appealed, the subsequent proceeding implicates the EAJA merely because the writing is presented to the ALJ."

C. Pennsylvania Federal District Court

1. *Christ the King Manor v. Sebelius,* 2012 U.S. Dist. LEXIS 102570 (E.D. Pa. 2012)

The District Court for the Eastern District of Pennsylvania granted a motion for summary judgment dismissing claims that CMS improperly approved State Plan Amendments approving the budget adjustment factor ("BAF") used in computing PA Medicaid payments to nursing facilities for fiscal years 2008 to 2011.

The plaintiffs alleged that the approval of the budget adjustment factor violated provisions of 42 U.S.C. § 1396a(a)(30)(A) which required payment rates to be "consistent with economy, efficiency and quality of care" because DPW allegedly failed to submit any information to CMS required to determine compliance with these standards and CMS approved payment rates not high enough to allow for "quality care" and without any review of the impact of the proposed rates on the quality of care. Instead, the plaintiffs alleged the plan amendments were submitted and improperly approved based on purely budgetary considerations.

The plaintiffs also alleged that the procedures used by DPW to give notice and seek comments regarding changes in payment rates violated requirements of federal law and regulations. In particular, the plaintiffs alleged that notices regarding proposed payment rates were not published for comment before they took effect; the notices failed to provide an estimate of the increase or decrease of annual expenditures; and failed to identify any county offices where copies of the notices were available for public inspection.

The District Court dismissed the plaintiffs' subsection 30(A) claims because it found there was substantial evidence in the administrative record pertaining to the plan amendments to support their approval. In evaluating the sufficiency of the evidence considered, the Court based its decision on an interpretation of subsection 30(A) as dealing only with the health needs of recipients of nursing care and as "evincing no direct concerns for the economic situation of providers." The Court also held that CMS was authorized to approve the plan amendments based on "policy statements and precedents previously approved by the Administrator."

The Court held that the approval of the plan amendments was based on substantial relevant evidence because (1) the BAF merely decreased the rate of growth of payments using previously approved budget adjustment procedures and did not decrease payments to nursing facilities; (2) DPW had mechanisms in place for ensuring compliance with subsection 30(A), including inspections, investigations of complaints and monitoring; (3) a review conducted by CMS of the previously approved budget adjustment process did not indicate that beneficiaries were having trouble accessing care; and (4) the BAF was not approved based on purely budgetary considerations, but instead the approval took into consideration the factors specified by subsection 30(A).

The Court rejected the plaintiffs' claims about the adequacy of public notices because DPW published a notice of its intent to submit amendments to the state plan before changes to payment rates took effect, solicited public comments regarding the plan amendments for 30 days and described in reasonable detail the methodology that would be used to calculate provider payment rates, and stated that copies of the proposed changes could be reviewed for comment at county assistance offices. Based on these findings, the Court concluded that CMS acted reasonably in approving DPW's public process for giving notice and seeking comments regarding the determination of payment rates.

2. *Thrower v. Commonwealth of Pennsylvania*, 2011 U.S. Dist. LEXIS 111828 (W.D. Pa. 2011)

The District Court dismissed a claim under § 1983 of the Civil Rights Act and state law for wrongful death and survival damages claim arising due to the improper administration of prescription medications against several individual employees of the Ebensberg Center, an intermediate care facility operated by the Commonwealth. The claims were dismissed because the complaint failed to plead with reasonable specificity the alleged wrongdoing of each named employee sufficient to establish a claim under § 1983, but instead was hypothesized based on the nature of the employee's duties. With the § 1983 claims dismissed, the Court held that it lacked jurisdiction to consider the plaintiff's state law tort claims.

The Court held that "plaintiffs must plead that each government official through his own actions violated the Constitution," and that "personal involvement can be shown through allegations of personal direction or actual knowledge and acquiescence," but "failure to demonstrate this requisite involvement is fatal to a § 1983 claim."

D. Pennsylvania Appellate Courts

1. *Setlock v. Pinebrook Personal Care and Retirement Center*, Pa. Super., Docket No. 1548 MDA 2011 (October 23, 2012)

Pinebrook Personal Care and Retirement Center appealed an order denying Pinebrook's petition to compel arbitration in the wrongful death action filed by Mary Ellen Setlock, the Executrix of the Estate of Mary Ryan, seeking an award of punitive damages and damages for pain and suffering. The wrongful death action alleged that Ms. Ryan died due to accident caused because she was being transported by employees of Pinebrook to a medical appointment in a wheelchair not equipped with a foot rest and without being harnessed into the wheelchair. As a result of Ms. Ryan's inability to lift her feet as she was being pushed in the wheelchair, her feet became entangled below the wheelchair as she was being pushed causing her to be catapulted through the air from the wheelchair and landing on her head and face.

Pinebrook filed a motion to compel arbitration based upon a provision of Ms. Ryan's Resident Agreement which provided that "any dispute or controversy arising out of or in connection with or under or pursuant to [the] Agreement shall be determined by arbitration." While Ms. Ryan's estate acknowledged that the arbitration agreement was valid and properly executed, it alleged the agreement did not contemplate the arbitration of tort claims because the Resident Agreement made no mention of Pinebrook agreeing to provide professional medical and nursing services or to properly train its professional staff or to provide safe, adequate, and functioning durable medical equipment such as the wheelchair.

Based upon the proposition that "arbitration agreements are to be strictly construed and not extended by implication," a divided three judge panel of the Court found that because the Resident Agreement only provided for private room accommodations; assistance with tasks of daily living; social, physical, intellectual and recreational activities; assistance in arranging visits to physicians, clinics, or hospitals; transportation to hospital, doctor or dentists visits; medications; emergency care; financial services; and similar issues, but made no mention of medical care, "to make the leap to include tort liability for the wrongful death of Mary Ryan as encompassed under the terms of the Residential Agreement is far too attenuated."

The Court concluded that the arbitration agreement only applied "to causes of actions arising from issues governed by the Resident Agreement," which did not contain any provisions "governing the standard of medical care to be provided by Pinebrook's employees" and did "not account for liability of Pinebrook based on actions at the facility or off premises at another facility." The Court found that the "mere fact that the Resident Agreement included a payment schedule for transporting residents to and from the doctor's appointment cannot be extended to encompass all claims sounding in tort that may have arisen from such transportation."

In arriving at its ruling, the Court relied on *Midomo Company, Inc. v. Presbyterian Housing Development Company*, 739 A.2d 180 (Pa. Super. 1999). *Midomo*

involved claims of fraudulent misrepresentation, non-disclosure and negligent misrepresentation with respect to a development agreement which contained a mediation and arbitration clause. The mediation and arbitration clause, however, specifically articulated five specific scenarios for which mediation and arbitration were to be "the sole and exclusive procedures for the resolution of disputes," but further stated that "in those instances where [the clause] does not apply, the parties [shall] submit to the jurisdiction of any appropriate court." The Court in *Midomo* held that mediation and arbitration was not required because the claims rose differed from the five specified scenarios. In *Setlock*, the Court acknowledged that "the arbitration agreement did not specifically articulate scenarios in which arbitration should apply as the clause in *Midomo*," but nonetheless concluded that "the scope of the Residential Agreement primarily governed the financial options and obligations of the residents and their representatives, and included a provision for arbitrating any disputes arising within those areas covered by the agreement."

Judge Gantman filed a strong dissenting opinion to the opinion of Judges Lazarus and Mundy. Judge Gantman observed that the Court's ruling conflicted with prior holdings of the Superior Court in *Callan v. Oxford Land Development, Inc.*, 858 A.2d 1229, 1233 (Pa. Super. 2004) ("Where a contract dispute arises between parties to a contract containing an unlimited arbitration clause, the parties must resolve their dispute through arbitration."); *Midomo,* 739 A.2d at 188 ("[W]here a contract provides for arbitration of all claims or disputes arising out of or relating to the contract, the parties intended to submit all of their grievances to arbitration, regardless of whether the claims sounded in tort or contract."); and *Shadduck v. Christopher J. Kaclik, Inc.*, 713 A.2d 635 (Pa. Super. 1998) (holding parties intended to submit all of their grievances to arbitration, regardless of whether claims sounded in tort or contract; arbitration provision did not include limiting language that only contract claims fell within purview of agreement).

2. *Elwyn v. DeLuca*, 48 A.3d 457 (Pa. Super. 2012)

This case involved the question of when non-signatories to an arbitration agreement can enforce the agreement with respect to claims brought against the non-signatories because of "an obvious and close nexus between the non-signatories and the contract or the contracting parties."

Previously in *Dodds v. Pulte Home Corp.*, 909 A.2d 348 (Pa. Super. 2006), the Superior Court held that where claims were brought against a home builder alleging that a home was not properly constructed and repaired, and against the builder's parent company for fraudulent representations regarding the quality of the home, an agreement to submit to arbitration "any controversy, claim, or dispute arising out of or relating to this agreement or purchase of the home . . . shall be settled by arbitration," was held to apply to the claim against the parent company. The Court noted that the arbitration agreement related to both the agreement and the purchase of the home, and held the arbitration agreement applied to the claims against the parent company because of an obvious and close nexus between the claims against the builder and its parent company.

In *Elwyn v. DeLuca*, the Court applied these principles to a claim brought by a non-profit organization against a construction contractor for nonpayment of subcontractors, and against the owner of the subcontractor, who was also a board member of the nonprofit organization, for misrepresentation and breach of fiduciary duty to the nonprofit organization. The agreement between the nonprofit organization and the contractor required the arbitration of "any claim arising out of or related to the contract," and defined the term "claim" to refer to "disputes and matters in question between the owner and contractor arising out of related or to the contract." The Superior Court held that the arbitration agreement did not apply to the claims against the owner of the construction contractor because the term claim was limited to disputes related to the contract, and because the breach of fiduciary duty claims against the owner as a member of the board of the nonprofit organization were "not inextricably entwined with the contract", but instead related to the owner's actions as a board member, rather than merely as owner of the construction contracting firm. In arriving at these conclusions, the Court relied upon the principle established in *Cumberland-Perry Area Vocational-Technical School v. Bogar & Bink*, 396 A.2d 433, 434-35 (Pa. Super. 1978), that "arbitration agreements are to be strictly construed and such agreements should not be extended by implication."

3. *Health Care & Retirement Corporation v. Pittas*, 46 A.3d 719 (Pa. Super. 2012)

Pennsylvania's filial support law, 23 Pa.C.S. § 4603, requires a parent, child or spouse to "care for and maintain or financially assist" an "indigent person," regardless of whether the indigent person is a "public charge," provided that the "liable person" has "sufficient financial ability to support the indigent person" and provided that a child is not required to care for and maintain or financially support a parent who abandoned the child for more than ten years during the child's minority. The amount of liability is required to be set by the court in the judicial district in which the indigent person resides, and for medical assistance costs other than the costs of nursing care, the annual financial liability is equal to six times the excess of the liable person's average monthly income over the amount required for the financial support of the liable person and his or her dependents, but DPW may by regulation "adjust the liability" or totally eliminate the liability to the extent of available appropriations. A petition to enforce filial support obligations may be filed by an indigent person or "any other person or public body or public agency having any interest in the care, maintenance or assistance of such indigent person" and a court order directing the provision of filial support may be enforced by holding a liable person in contempt and sentencing the individual to imprisonment for up to six months.

HCR v. Pittas dealt with a claim for filial support pursued by HCR against the child of a woman injured in an automobile accident that failed to pay HCR for a significant portion of the cost of rehabilitative nursing care and then left the country and moved to Greece. The trial court (through a panel of arbitrators) awarded HCR $92,943, and the child against whom the order was issued filed an appeal with the Superior Court arguing that the trial court committed errors of law or engaged in an abuse of discretion by imposing the burden of proof on the child to demonstrate his inability to support his

mother, not considering alternative sources of income available to meet his mother's obligations (i.e., from her husband, other adult children, and from public assistance), and in finding that his mother was indigent. According to the Superior Court's decision, the appellant's annual income was "in excess of $85,000" and his mother's annual income was approximately $12,000.

The Superior Court upheld the decision of the trial court. The court agreed with the appellant that the burden of proof was on HCR to prove the appellant had the ability to support his mother, but concluded the evidence submitted to the trial court was sufficient to support a finding that the appellant was able to support his mother. The court also concluded that the law does not require the trial court to consider whether alternative sources of income may be available to support an indigent person, and noted that the appellant could have, but did not, join his mother's husband and his siblings to the case. Finally, the court concluded that sufficient evidence was available to the trial court to support a finding that appellant's mother was indigent.

4. *Mesivtah Eitz Chaim of Bobov, Inc. v. Pike County Bd. of Assessment*, __ Pa. __, 44 A.3d 3 (2012)

The Bobov Orthodox Jewish community requested the Supreme Court to review an unpublished decision of the Commonwealth Court upholding a Pike County Trial Court decision denying it an exemption from real estate taxes as a "purely public charity" entitled to tax exemptions under Article VIII, § 2(a)(v) of the Pennsylvania Constitution because the facility did not relieve the government of some of its burdens. The tax exemption was claimed for a summer camp providing lectures and classes on the Orthodox Jewish faith together with food and recreational activities funded by donations, rental income from a building in Brooklyn, and tuition from its students. The camp provided financial assistance to some students, and made its facilities open to the public, but provided only limited services to residents of Pike County. The Commonwealth Court ruled that the camp was not entitled to claim a tax exemption because "occasional use of appellant's recreational and dining facilities by Pike County residents was insufficient to prove appellant relieved Pike County's government of some of its burden." The appellants argued that the Commonwealth Court erred in failing to give due deference to the General Assembly's determination in the Purely Public Charity Act, 10 P.S. §§ 371-385 (Act 1997-55), that an institution may be found to "relieve the government of some of its burdens" if the entity "advances or promotes religion and is owned and operated by a corporation or other entity as a religious ministry and otherwise satisfies the criteria set forth in section."

The Supreme Court agreed to review the case for the purpose of considering whether the enactment of criteria in the Act 55 for determining if an organization qualifies as a "purely public charity" under Pennsylvania's Constitution is deserving of deference in deciding whether an organization qualifies as a purely public charity under Pennsylvania's Constitution, or whether the test provided in *Hospital Utilization Project v. Commonwealth*, 507 Pa. 1, 487 A.2d 1306, 1317 (Pa. 1985) (i.e., the so-called "HUP test"), "occupied the constitutional field, leaving no room for legislative influence and input?"

The HUP test provides an entity qualifies as a purely public charity if it (1) advances a charitable purpose; (2) donates or renders gratuitously a substantial portion of its services; (3) benefits a substantial and indefinite class of persons who are legitimate subjects of charity; (4) relieves the government of some of its burden; and (5) operates entirely free from private profit motive. Act 55 sets forth specific standards and procedures to determine if these requirements are satisfied, some of which were more lenient than prior judicial determinations of whether an entity qualified constitutionally as a purely public charity. The case was of broad interest to the health care community in general because if the Supreme Court found that the HUP test occupied the field and left no room for legislative influence and input, tax exemptions granted to nonprofit hospitals, nursing homes, assisted living facilities and continuing care communities in reliance on the provisions of Act 55 could be subject to challenge.

The appellants did not argue that compliance with Act 55 alone qualified the summer camp for an exemption from real estate taxes, but instead argued what constitutes an institution of purely public charity should be permitted to "evolve as the General Assembly sees fit, instead of being fixed by the HUP test." In particular, the appellant contended that as a religious organization, it relieves the government of some of its burden by creating greater moral and social awareness in society.

In a 4 to 3 decision authored by Justice Eakin (with the concurrence of Justices Baer, Todd and McCaffery, and a dissenting opinion issued by Justice Saylor in which Justices Castille and Orie Melvin joined), the Court held that, "[T]o receive an exemption without violating the Constitution, the party must meet the definition of 'purely public charity' as measured by the test in HUP. If it does so, it may qualify for exemption if it meets the statute's requirements. Act 55, however, cannot excuse the constitutional minimum - if you do not qualify under the HUP test, you never get to the statute." As a result, "An entity seeking a statutory exemption from taxation must first establish that it is a 'purely public charity' under Article VIII, Section 2 of the Pennsylvania Constitution before the question of whether that entity meets the qualifications of a statutory exemption can be reached." The Court did not, however, declare the Purely Public Charity Act unconstitutional, as feared by many interveners.

5. *Novitsky v. Pa. Department of Public Welfare*, 42 A.3d 1165 (Pa. Cmwlth. 2012)

Florence Novitsky appealed an order of the Office of Hearings and Appeals of the Department of Public Welfare upholding a claim by the Commonwealth's Office of Inspector General for $72,538.28 in overpayments of Medical Assistance long-term care benefits. The OIG concluded that Mrs. Novitsky was not eligible for Medicaid benefits because within 15 months prior to the filing of applications for benefits in 2008 and 2009, her husband, Rabbi Abraham Novitsky, had transferred to other accounts more than $663,000 in assets, which he failed to disclose in filing applications for Medicaid benefits on his wife's behalf. The Department's regulations prohibit the award of benefits to medically needed applicants for assistance with more than $8,000 in available assets available after taking into consideration the maximum federal community spouse resource allowance of $109,560.

Rabbi Novitsky appealed the decision of the OHA by arguing that although the accounts in question were held in his name, (1) the funds were held for the benefit of his grandchildren; (2) in completing the applications for assistance, he believed in good faith that he did not own the funds; (3) in completing the 2009 application, he had not responded to a question inquiring whether funds had been transferred from accounts within the past 36 months, and that his wife should not be responsible for his failure to properly complete the application for assistance or the Department's failure to make proper inquiries; (4) the nursing home that received the Medicaid payments should be held responsible for the overpayments; and (5) based on all of the relevant facts and circumstances the Department should waive the request for the recovery of Medicaid overpayments.

The Commonwealth Court upheld the decision of the OHA because the appellant failed, despite being given multiple opportunities to do so, to provide evidence that more than $179,000 of the funds in question were property of third parties. The Court also held that a Medicaid recipient can be held liable for the acts of an agent filing applications for assistance on the recipient's behalf; the recipient, not the Department, had the burden of demonstrating eligibility for assistance; the Department has discretion to determine whether to recover overpayments for a recipient of a provider; and that equitable arguments cannot bar an overpayment claim.

6. *Highland Park Care Center v. MCARE Fund*, 36 A.3d 608 (Pa. Cmwlth. 2012)

The MCARE Fund regulations, 31 Pa.Code §242.6(a)(3), require assessments to be received by the Fund within 60 days from the effective date of a health care provider's primary insurance policy. The regulations provide that any provider who fails to timely pay the assessment will not be covered by the MCARE Fund in the event of a loss. 31 Pa.Code §242.17(b). Highland Park Care Center appealed a decision of the Fund denying a claim for MCARE coverage where it paid its assessment within one month of the effective date of its primary insurance policy, but its insurance carrier failed to remit the assessment to the MCARE Fund within 60 days of the effective date of the policy.

The Court held that where a health care provider makes a timely payment of an assessment; is not on notice of when the assessment is paid to the MCARE Fund; and lacks the ability to directly pay the assessment to the Fund, the provider is eligible for MCARE benefits.

7. *Wilco Mechanical Services, Inc., v. Department of General Services*, 33 A.3d 654 (Pa. Cmwlth. 2011)

Wilco appealed a denial of certification as a women's business enterprise by the Department of General Services arguing that it was unlawfully denied a right to an administrative hearing to protest the denial by the Department. Wilco based its claim on provisions of the Administrative Agency Law that provide that "[n]o adjudication of a Commonwealth agency shall be valid as to any party unless he shall have been afforded reasonable notice of a hearing and an opportunity to be heard." 2 Pa. C.S. § 504.

The Commonwealth Court rejected the appeal concluding that to have a right to a hearing a party "must have more than a unilateral expectation, but rather, a legitimate and enforceable claim under the law." In this case, because the entire certification process for women's and minority business is established pursuant to an executive order and a statement of policy, rather than pursuant to statutes and regulations, the Court held that the denial of the certification was not an adjudication subject to judicial review.

In arriving at its conclusion, the Court cited with favor *Greenstein v. Pa. Department of Health*, 512 A.2d 739 (Pa. Cmwlth. 1986), which addressed the question of whether the department could approve Pennsylvania Blue Shield's termination of a physician's participating provider agreement without providing the physician an opportunity for a hearing before the department. In rejecting Dr. Greenstein's appeal, the court held that the department's actions did not constitute an adjudication subject to the hearing requirements of the Administrative Agency Law because the department's actions, in the view of the Court, did not affect his "privileges, immunities, duties, liabilities or obligations." *Wilco* and *Greenstein* may be applicable to the rights of long-term care providers to the extent managed care organizations are utilized to provide services on behalf of the Department of Public Welfare.

8. *500 Hance Court v. Pa. Prevailing Wage Appeals Board*, __ Pa. __, 33 A.3d 555 (Pa. 2011)

In this case, the Supreme Court addressed the question of whether a pre-development lease agreement with an organization whose activities are subject to the Prevailing Wage Law makes the construction of a facility by a non-governmental organization subject to the Prevailing Wage Law and, if so, under what circumstances a pre-development lease agreement would have such an effect.

Under Pennsylvania law, charter schools undertaking construction activities are generally subject to the Prevailing Wage Law in much the same manner as public school districts. As a result, a charter school entering into a lease agreement in which its security deposit would be used to construct interior finishing for a new building agreed that the interior finishing work would be subject to prevailing wage requirements. The Prevailing Wage Appeals Board, however, determined that the construction of the exterior shell for the building by a private contractor was also subject to prevailing wage requirements by applying standards used by the U.S. Department of Labor to interpret the Federal Davis Bacon Act known as the Phoenix Field Office Test. According to these standards a lease agreement with an organization subject to prevailing wage requirements may make a construction project subject to prevailing wage requirements depending upon (1) the length of the lease; (2) the government's involvement in the construction project (e.g., whether the building is built to government requirements and whether the government has inspection rights as the work progresses); (3) the extent to which the structure will be used for private rather than public purposes; (4) whether construction costs will be fully paid by the lease payments; and (5) whether the contract is written as a lease solely in order to evade prevailing wage requirements.

Applying the Phoenix Field Office Test, the Board found that the exterior building shell was subject to the Prevailing Wage Law because the building was being constructed solely for use by a charter school; and in addition to the financing provided for interior finishing, the stream of lease payments the charter school agreed to make was tantamount to construction financing. The Board further found that an amendment to the lease agreement executed to specify that the charter school's payment, initially characterized only as a security deposit, would in fact be used to finance the build-out, and that the developer was responsible for obtaining private mortgage financing for the shell construction, constituted artful drafting and a subterfuge unlawfully intended to evade the requirements of the Prevailing Wage Law.

The Supreme Court upheld a decision by the Commonwealth Court reversing the ruling of the Board. The Court held that parties remain free after entering into a contract to "modify their relationship to account for legal requirements (such as prevailing wages) which may attach to one, but not another, manner of transacting." The court also found that the bifurcation of a project into separate stages, such as the shell construction and the build-out, was a business practice designed to pursue legitimate commercial objectives, rather than a subterfuge used to evade the Prevailing Wage Law. The Court also found the use of the Phoenix Field Office Test to determine whether the lease agreement made the building construction subject to the Prevailing Wage Law because the test does not account for a key attribute of business transactions, namely the allocation of risk. In this case, because the private developer assumed the risks and responsibilities associated with constructing the building shell, the court found that the Board was incorrect in finding the lease agreement made the building construction subject to prevailing wage requirements.

The *500 Hance Court* decision is relevant to the long-term care industry in cases in which tax increment financing or government grants are used to finance some distinct part of a construction project, but not others. In these cases, the mere execution of a long-term lease agreement for the use of portions of the construction project not being supported by government grants or subsidies, will not cause the remaining portions of the project to be subject to the Prevailing Wage Law.

9. *Keystone Freight Corporation v. Stricker*, 31 A.3d 967 (Pa. Super. 2011)

After Keystone Freight Corporation obtained a favorable jury verdict denying a wrongful death claim, it instituted a tort action against the plaintiff, the executrix of the decedent's estate, for wrongful use of civil process of Pennsylvania's so-called Dragonetti Act, 42 Pa.C.S. § 8351. The Superior Court upheld a summary judgment decision of the trial court dismissing the claim for wrongful use of civil process.

The Dragonetti Act provides that a person who takes part in the procurement, initiation or continuation of civil proceedings against another is subject to liability to the other for wrongful use of civil proceedings if (1) he acts in a grossly negligent manner or without probable cause and primarily for a purpose other than that of securing the proper discovery, joinder of parties or adjudication of the claim in which the proceedings are based; and (2) the proceedings have terminated in favor of the person against whom they are brought. The statute defines the probable cause as a reasonable belief in the facts

upon which a claim is based and (1) a reasonable belief that under the facts asserted the claim may be valid under the existing or developing law; (2) a belief in reliance upon the advice of counsel, sought in good faith and full disclosure of all relevant facts; or (3) a belief, as an attorney of record, in good faith that the procurement, initiation or continuation of a civil cause is not intended to merely harass or maliciously injure the opposite party.

A wrongful death action was filed against Keystone Freight after an elderly man died at the scene of a rear end collision with a truck operated by Keystone. The EMTs who attended the victim at the scene of the accident, the county medical examiner, and an independent forensic expert all concluded that the victim died of a heart attack before the collision that rendered him unconscious at the scene. In addition, eye witness testimony indicated that the victim did not slow down or attempt to stop before colliding with the rear end of the truck. Notwithstanding these medical reports and testimony, the plaintiff filed a wrongful death claim against Keystone relying on an exert accident reconstruction which concluded the collision would not have occurred had the driver not been improperly backing the truck onto a highway and the report of a medical expert finding that the victim died of blunt force trauma rather than a heart attack.

The Superior Court held that the existence of medical expert testimony that the driver died of blunt force trauma alone was not sufficient to bar a claim for the wrongful use of civil process if Keystone could establish that the plaintiff's counsel acted in a "grossly negligent manner" and in the pursuit of an improper purpose. The Court upheld the dismissal of the Dragonetti Act claim, however, because it concluded that the record did not support a finding that the plaintiff acted out of "personal animus" or for any other improper motive, and that there was no evidence that either the plaintiff or the plaintiff's counsel acted in a grossly negligent manner. The Court defined gross negligence to mean "the want of even scant care and the failure to exercise even that care which a careless person would use," and held that an attorney may pursue a claim as long as "the attorney believes that there is a slight chance that his client's claims will be successful." In addition, the Court appears to have held that the plaintiff and its counsel could not be found to have acted in a grossly negligent manner unless they "knew or should have known that their case was meritless."

10. *George Lehmann and Ann Lehmann, Parents and Natural Guardians of C.L. v. Department of Public Welfare*, 30 A.3d 580 (Pa. Cmwlth. 2011)

The parents of a 12 year old child, C.L., suffering from a genetic disorder associated with growth deficiencies, Kabuki Syndrome, appealed a decision of the Gateway Health Plan disapproving the continuation of medical payments for growth hormone therapy based on a finding that the treatment was not medically necessary. Gateway's finding was based on testing which indicated that C.L. did not have a growth hormone deficiency and the absence of clinical evidence that growth hormone therapy was medically appropriate for the treatment of Kabuki Syndrome. An ALJ with the Bureau of Hearings and Appeals rejected Gateway's findings based on a determination that growth hormone therapy was determined by the FDA to be medically appropriate for "idiopathic," i.e., unexplained, "short stature"; and evidence submitted by the appellants

indicating that growth hormone therapy was "reasonably expected to reduce or ameliorate the physical and development effects of C.L.'s Idiopathic Short Stature." The record also indicates that C.L.'s condition was unique because children with Kabuki Syndrome rarely live beyond age seven, and that prior treatment of C.L. with growth hormone therapy had generated positive results. The Secretary of Public Welfare reversed the findings of the ALJ based on determinations that the clinical studies relied upon by the ALJ involved children with a dual diagnosis of Kabuki Syndrome and growth hormone deficiency; it is not the standard of care within the medical community to treat Kabuki Syndrome with growth hormone therapy; and C.L. did not have idiopathic short stature, as his short stature was secondary to Kabuki Syndrome.

The Commonwealth Court reversed the decision of the Secretary of Public Welfare. The Court held that the role of the Secretary in reviewing decisions of the Bureau of Hearings and Appeals is limited to "matters of law and established departmental policy," and that the Secretary may not review findings of fact made by the hearing examiner or set aside findings of fact supported by substantial evidence, but instead may only remand a case back to the Bureau for further findings of fact. The Court also rejected the Department's claim that the Secretary was reversing findings of fact not supported by substantial evidence because the Secretary never found that the ALJ's decision was not supported by substantial evidence, and instead made additional findings. The Court also ruled that "if the Secretary finds that the ALJ's decision is not supported by substantial evidence, his discretion is limited to affirming, amending, or reversing the decision of the Director, or remanding the case to the hearing officer for further findings of fact," and not to making new findings.

11. *O'Donnell v. Hovnanian Enterprises*, 29 A.3d 1183 (Pa. Super. 2011)

The Court found that the right to enforce an arbitration agreement was waived when Hovnanian Enterprises confronted with a class action claim filed two successive sets of preliminary objections to the claim which did not raise the issue of whether the dispute was subject to an arbitration agreement, and after a ruling sustaining in part and overruling in part the preliminary objections, executed a Tolling Agreement which discontinued the litigation without prejudice for two years, and only after settlement negotiations were unsuccessful and an amended complaint was filed consistent with the ruling of the preliminary objections, at that time raised for the first time the defense that the dispute was subject to arbitration.

The Court held that, "The simple fact that the Hovnanian Parties allowed the Preliminary Objection process to proceed for months, with the arbitration argument at the ready, involves a conscious engagement with the judicial process that cannot be ignored." The Court also found that Hovnanian's conduct was inconsistent with reliance on terms of the contract providing for the arbitration of disputes and resulted in an undue advantage to Hovnanian and prejudice to the plaintiffs through the dismissal of one count of their complaint and an avoidable, two-year delay in proceeding to binding arbitration.

In rejecting Hovnanian's claim that it had not waived its right to arbitration, the Court noted that "the mere filing of a complaint does not demonstrate waiver of the right

to arbitration" and that "a party that avails itself of the judicial process by attempting to win favorable rulings from the judicial system following the filing of a complaint does waive their right to proceed through arbitration." On the other hand, a party may be found to waive the right to arbitration based on a variety of factors, including whether the party (1) failed to raise the issue of arbitration promptly, (2) engaged in discovery, (3) filed pretrial motions which do not raise the issue of arbitration, (4) waited for adverse rulings on pretrial motions before asserting arbitration, or (5) waited until the case is ready for trial before asserting arbitration.

12. *Wayne M. Chiurazzi Law Inc. v. MRO Corporation*, 27 A.3d 1272 (Pa. Super. 2011)

The MRO Corporation challenged a trial court's holding that the Medical Records Act, 42 Pa.C.S.A. §§ 6151-6160, prohibits an entity that reproduces medical records without a subpoena from charging an amount that exceeds the actual and reasonable expenses of reproducing such medical records.

The Medical Records Act provides that when a subpoena is served upon any health care provider or facility requiring the production of medical charts or records, the health care provider or facility may notify the attorney for the party causing service of the subpoena within three days of the health care provider's or facility's election to proceed under the Act and of the estimated actual and reasonable expenses of reproducing the charts or records. The Act further provides a schedule of fees for searching and retrieving records, and for providing paper copies of records, that may be adjusted annually by the Department of Health unless the parties give prior approval to charging different amounts. In addition, the Act provides that the patient or his designee, including his attorney, has the right to obtain copies of medical records for the patient's own use without a subpoena, subject to the requirement that a health care provider or facility may not charge a fee in excess of the amounts set forth in the fee schedule provided in the Act.

In a class action proceeding, the plaintiff contended that a health care facility may only charge its actual and reasonable expenses where these expenses are less than the fee schedule provided by the Medical Records Act. MRO Corporation filed preliminary objections claiming that it may impose any charge that does not exceed the amounts specified by the Act; that the requirements of the Medical Records Act do not apply to an independent for-profit company that reproduces records for health care entities; and that the "prior approval" requirements for charging different amounts are satisfied when the customer is provided an invoice setting forth prices and the customer reviews and pays the invoice without objection before receiving the records.

The Superior Court held that the calculation of estimated actual and reasonable expenses for paper copies is not required by the Medical Records Act and that a statutory schedule of fees set forth in the Act, as adjusted annually by the Secretary of Health, creates safe harbor rates for the estimated actual and reasonable expenses of producing paper copies of medical records. On the other hand, the Court also concluded that the statutory schedule does not create safe harbor copying rates for non-paper copies, such as

copies produced on CD-ROM and by electronic means. As a result, until the legislature further addresses this issue, entities that reproduce medical records can be held responsible for calculating, and then charging, the estimated actual and reasonable copying expenses of producing such non-paper copies.

Because the Medical Records Act refers to "estimated" expenses, the Court held that calculations do not have to be done on a case-by-case basis, and that claims are barred by the prior approval provision of the Act when a customer is given notice of the fees to be charged and pays the fees without objection before receiving the medical records.

13. *Maibach, LLC v. Board of Supervisors of Rapho Township*, 26 A.3d 1213 (Pa. Cmwlth. 2011)

In this case the Commonwealth Court addressed the question of whether a voluntarily negotiated impact fee proposed to a municipality in order to obtain conditional use approval for a land development may be modified unilaterally by the municipality in granting land use approval and whether, if the modified fee is held to be invalid, the original agreement can be enforced.

Section 503-A(b) of the Municipalities Planning Code provides that, "No municipality shall have the power to require as a condition for approval of a land development or subdivision application the construction, dedication or payment of any offsite improvements or capital expenditures of any nature whatsoever or impose any contribution in lieu thereof." Notwithstanding these restrictions, land developers often voluntarily propose to make offsite improvements or pay impact fees to address local concerns that arise with respect to zoning and land development applications.

In order to address concerns about safety issues created by the development of an ethanol facility and enhance the ability of the local fire department to respond to incidents that could arise as a result of the development of the facility, Maibach had proposed to pay a fee of $0.0025 for each gallon of ethanol produced at the facility, provided that at least 75% of the proceeds would be used for the purchase of equipment or training for the fire department, and at least 2% would be used by the township's emergency management agency. In approving the proposed land development, the township increased the fee to $0.005 per-gallon and eliminated the restrictions on the use of the funds by the township.

Upon appeal, the revised fee was found to be in violation of section 503-A(b) of the Municipalities Planning Code and the Court of Common Pleas refused to enforce the original fee agreement between Maibach and the township and the Commonwealth Court sustained the decision of the Court of Common Pleas. In support of its decision, the Commonwealth relied upon *Trojnacki v. Board of Supervisors of Solebury Township*, 842 A.2d 503 (Pa. Cmwlth. 2004), invaliding a requirement imposed in a land use approval requiring the planting of trees in off-site locations to mitigate the loss of trees on the property under development. The Court's reliance on *Trojnacki* illustrates that its

holding equally applies not only to impact fees, but also to requirements to make offsite land improvements.

E. Other Courts

1. *Jimmo v. Sebelius*, Civil Action No. 5:11-CV-17-CR (D. Vt. 2012)

The Vermont Legal Aid Society brought a claim on behalf of five individuals from Vermont, Connecticut, Rhode Island, and Maine and five advocacy organizations alleging that the use of an "improvement standard" to qualify for long-term care and nursing services has resulted in the denial, termination, or reduction of coverage of skilled services for thousands of Medicare beneficiaries.

The improvement standard is a term used to encompass all Medicare coverage denials issued because a patient's condition is stable, chronic, or not improving, or because the agency or contractor perceives that the skilled services only "maintain" the patient's condition. While neither the Medicare statute nor the implementing regulations refer to an improvement standard, the standard has become part of Medicare contractors' internal guidelines contained in the Medicare Benefit Policy Manual and local coverage determinations made by Medicare administrative contractors.

HHS agreed to settlement case by revising coverage standards for skilled nursing facilities ("SNFs"), home health ("HH"), outpatient therapy benefits ("OPT") and for services performed in an inpatient rehabilitation facility in the Medicare Benefit Policy Manual. The revisions will provide that skilled nursing services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a registered nurse, or a licensed practical (vocational) nurse are necessary. Skilled nursing services would be covered where such skilled nursing services are necessary to maintain the patient's current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided. When, however, the individualized assessment does not demonstrate such a necessity for skilled care, including when the services needed do not require skilled nursing care because they could safely and effectively be performed by the patient or unskilled caregivers, such services will not be covered under the SNF or HH benefits. The settlement agreement would also require that CMS revise its manual provisions related to therapy to clarify that SNF, HH, and OPT coverage of therapy does not turn on the presence or absence of an individual's potential for improvement from the therapy, but rather on the beneficiary's need for skilled care.

The proposed settlement agreement will require CMS to engage in a nationwide education campaign regarding its maintenance coverage standards and to develop protocols for reviewing random samples of coverage decisions, and taking corrective action when the coverage standards are not being properly applied.

2. *Laff v. Jewish Home of Greater Harrisburg*, 2012 Pa. D.&C. Dec., LEXIS 131 (Dauphin Co. 2012)

The Court of Common Pleas of Dauphin County denied a request for summary judgment seeking to dismiss claims of alleged abuse and neglect rendered to a resident of a personal care home who was later transferred to a skilled nursing home operated by the same defendant.

The case involved claims filed by the executor of the estate from a patient of the defendant who allegedly died due to "negligent, reckless and outrageous care." The plaintiff alleged that although the decedent was assessed as having "poor safety awareness and requiring 24 hour supervision"; fell on multiple occasions while in the defendant's personal care home; was treated for foot problems, which significantly increased risks of fall; and was on medications that caused ambulation problems; the defendant failed to develop and implement a fall prevention plan and kept her in the personal care home for too long before moving her to its skilled nursing facility. After the decedent was transferred to the skilled nursing facility, the complaint alleges that the defendant failed to assess and prepare an adequate care plan to address her foot problems; delayed for four days responding to a Stage II pressure ulcer and delayed treatment for seven days; failed to monitor and maintain her nutrition and hydration; and failed to adequately manage her medications.

In support of her negligence claims, the plaintiff also alleged the defendant was cited by the Department of Health and fined $10,000 for deficiencies in its care of Ms. Glass and claimed the defendants' conduct represented negligence *per se* because it violated Pennsylvania's criminal statute relating to the neglect of care dependent persons.

The plaintiff raised separate claims of corporate negligence based on allegations similar to *Scampone v. Grane Healthcare Co, Inc.*, 11 A.3d 967 (Pa. Super. 2010), allowance of appeal granted, 609 Pa. 264, 15 A.3d 427 (2011), against both the company that owned and operated the personal care home and the company that owned and operated the skilled nursing facility. In a manner similar to the claims raised in *Scampone*, the plaintiff alleged that the defendants intentionally understaffed their facilities; concealed inadequate staffing from regulators; and knowingly failed to address complaints relating to the deficiencies in care provided to residents.

The defendants moved for summary judgment alleging that the plaintiff's claims were "essentially violations of the Health Care Facilities Act and that such claims are beyond the subject matter jurisdiction of the Court of Common Pleas" and were inapplicable to the defendants' personal care home which was not subject to the Health Care Facilities Act. The defendants moved to dismiss the negligence *per se* claims because the Neglect of Care Dependent Persons Law does not create a private right of action. The defendants also sought summary judgment to dismiss the corporate negligence claim against their personal care home because the corporate negligence theory recognized in *Scampone* applies only to hospitals and skilled nursing facilities.

The Court denied the defendants' motions for summary judgment and held that the plaintiff's negligence claims were not causes of action for violation of the Health Care Facilities Act or the Neglect of Care Dependent Persons Law, but in both cases the

laws were relevant only for purposes of providing evidence of the relevant standards of care and as evidence in support of the negligence claims.

The Court also did not grant summary judgment dismissing the corporate negligence claim against the personal care home because "the corporate defendants are one in the same for both facilities"; "corporate officials for the defendants preside over, manage and control" both facilities; and both facilities are controlled by a single board of directors. Accordingly, the motion for summary judgment was not granted because "it is not clear as a matter of law that plaintiff cannot maintain a claim of corporate liability for care rendered" in the personal care home.

II. FEDERAL ACTIVITY 2011-2012

Much of the recent federal activity focuses on the sometimes competing interests of improving quality of care while reducing the cost of the care. The following are examples of these activities.

A. Quality: CMS Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents

1. Purpose

a. To improve care for people living in nursing facilities who are enrolled in Medicare and Medicaid; provide better, person-centered care.

b. To reduce expenditures and avoidable hospitalizations among nursing facility residents by funding organizations that would partner with nursing facilities to provide enhanced on-site services and supports to nursing facility residents; catch issues early.

c. To identify which interventions best meet the objectives of the initiative and to understand the factors driving the results.

2. Protocol

a. CMS will partner with eligible, independent, non-nursing facility organizations to improve care for long-term nursing facility residents.

b. Independent organizations eligible to participate include physician practices, care management organizations, and other public and non-profit entities.

c. Independent organizations will work with nursing facilities and states to provide coordinated, person-centered care.

i. Each independent organization must have its own evidence-based intervention and improvement strategy.

ii. Each independent organization must partner with at least 15 Medicare-Medicaid certified nursing facilities in the same state where the interventions will occur. The average number of all residents (long and short stay residents) across all of the 15 or more facility partners must be at least 100.

iii. Staff will be present on-site at the nursing facilities to provide preventive services and improve coordination and communication among providers.

iv. Staff will endeavor to make transitions of care more seamless.

3. External Review Process

a. Independent evaluator will assess the effect of the proposed interventions on the objects including:

i. Reducing frequency of avoidable hospital admissions and readmissions,

ii. Improving nursing facility health outcomes,

iii. Improving the transition process between inpatient hospitals and nursing facilities,

iv. Reducing overall health care spending without restricting access to care or choice of providers.

b. Evaluators will have access to nursing facility resident assessment data and data on nursing facility surveys and complaint surveys.

c. Evaluators will review Medicare and Medicaid claims data to measure impact on combined Medicare and Medicaid expenditures.

d. Evaluators will collect other qualitative and quantitative data specific to the project.

4. Timeline

a. Initiative announced March 15, 2012

b. Applications due June 14, 2012

c. Awards September 27, 2012

i. CMS entered into seven cooperative agreement awards with entities partnering with 145 nursing facilities.

ii. UPMC Community Provider Services is one of the award recipients. The intervention and improvement strategy partners the entity with 16 nursing facilities in Western Pennsylvania and will provide facility-based nurse practitioners to assist with determining resident care plan goals, and conduct acute change in condition assessments. The initiative will also use telehealth and information technologies to connect the participating nursing facilities into the Western Pennsylvania Health Information Exchange.

B. Privacy

1. Proposed HIPAA/HITECH Regulations

a. Health Information Technology for Economic and Clinical Health (HITECH) Act modified exemptions from disclosures that must be included in an accounting.

i. Existing regulations permit disclosures for treatment, payment, and health care operations purposes to be excluded from accountings (i.e., these disclosures do not need to be recorded and tracked for accounting purposes).

ii. The proposed regulations eliminate the exemption for treatment, payment, and health care operations purposes although the regulations limit the period for which they must be tracked to three years (as opposed to the six year period for other disclosures).

b. The purpose of the modification is to allow individuals to have a better understanding of how their health information is being used and to whom it is being disclosed.

c. The ability to provide an accounting that includes disclosures for treatment, payment, and health care operations purposes must be tied to the system managing the disclosures, which must be able to track them.

2. HIPAA Audits

a. OCR has stated that it will more aggressively enforce compliance with HIPAA's privacy and security requirements and has begun a series of audits in furtherance of this goal.

b. Covered entities are subject to an array of fines and penalties for noncompliance including corrective action plans that may require monitoring and oversight of the compliance efforts.

3. Breaches of Unsecured Protected Health Information

a. Breaches are becoming frequent.

b. OCR will investigate reported breaches and request documentation and other evidence of HIPAA compliance, including:

i. Existing policies and procedures,

ii. All records related to the internal investigation conducted upon learning of the breach,

iii. Proof (i.e., documentation) that the entity was in compliance with its policies and procedures.

C. Pharmacy

1. Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents Report (2011)

a. The goal of the report was to identify the extent to which residents were being prescribed atypical antipsychotic drugs for off-label purposes and to ensure that Medicare was not paying inappropriately for those prescriptions.

b. The report found that, for the period studied, Medicare claims for the atypical antipsychotic drugs were overwhelmingly associated with off-label uses.

c. The report recommended assessing current safeguards to inappropriate prescribing of the drugs for residents and additional enforcement methods for preventing inappropriate prescribing and action.

2. Nursing Home Pain Relief Act (2011)

a. DEA asserts that facilities are not "agents of the practitioners" under the Controlled Substances Act and require that physicians fax prescriptions for Schedule II controlled drugs directly to

pharmacies. Verbal orders are not permitted unless in an emergency (defined).

b. DEA's position has caused delays in facilities being able to obtain the controlled drugs for residents and delays pain relief including pain associated with end of life symptoms.

c. The proposed legislation would allow skilled nursing facilities to designate an individual as a "facility designee" to act as agent for physician-prescribers for the purpose of dispensing a controlled substance to a resident.

d. The proposed legislation establishes policies and procedures for practitioner, pharmacy, and the facility.

e. Last major action on the legislation was in September 2011.

D. Technology - Electronic Health Records Incentive Program

1. Eligible professionals, eligible hospitals, and critical access hospitals are eligible to participate in the incentive program and to receive incentive payments to the extent they can demonstrate meaningful use of certified electronic health record technology. If they fail to demonstrate meaningful use, they will be subject to downward payment adjustments beginning in 2015.

2. The push for electronic health records will continue and will apply to all providers of care, especially as patients (or their personal representatives) become accustomed to the ability to access and/or communicate with providers electronically regarding their care.

3. Facilities that adopt the use of electronic health records, however, may face challenges during surveys because of a lack of appreciation on the part of the surveyor.

III. STATE STATUTORY AND REGULATORY HIGHLIGHTS OF 2011-2012

A. <u>Statutory Highlights</u>

1. *Statutory Changes – 2011*

a. Act No. 2011-17 (commonly known as the "Fair Share Act") amended the Judicial Code relating to comparative negligence to:

i. Eliminate joint and several liability as a general rule

ii. Establish proportionate liability as a general rule with exceptions in certain civil actions for:

- Intentional misrepresentation
- Intentional tort
- Release or threatened release of hazardous substances
- Certain liquor code violations

iii. Joint and several liability may also apply to a defendant who is determined to be liable for 60% or more of the total liability apportioned to all parties.

b. Act No. 2011-18 created the Pennsylvania Web Accountability and Transparency Act (PennWATCH Act)

i. By December 31, 2012, the Governor's Office of Administration is to develop and implement a website showing appropriations and expenditures to Commonwealth agencies and other public and private entities from state and federal funds.

ii. Other entities include an individual, corporation, association, union, LLC, LLP, other business entity, including nonprofits, political subdivisions and other local government entities.

iii. Exempts "social services payments" to individuals for cash assistance, medical and other health-related or welfare-related benefits and services, education and training benefits or aging services. It does not exempt payments to nursing facilities or other health care providers for medical services.

c. Act No. 2011-22 amended the Public Welfare Code to:

i. Authorize the Department of Public Welfare (DPW) to develop "rules, regulations, procedures and standards consistent with law" for administration of assistance programs on the following:

- Eligibility and the nature and extent of assistance
- Authorize providers to condition services on payment of co-payments
- Modify benefits and design different benefit packages
- Establish or revise payment rates, fee schedules and payment methodologies
- Restrict or eliminate presumptive eligibility
- Establish provider qualifications

ii. DPW mandated to take any necessary action specified above to maintain expenditures within appropriation limits under the appropriation act for fiscal year 2011-2012.

iii. To take the actions needed, DPW was required to promulgate regulations under a process exempt from requirements of the Commonwealth Documents Law and Regulatory Review Act.

- Regulations must be published by June 30, 2012
- Regulations may be retroactive to July 1, 2011

iv. Required DPW to apply a "revenue adjustment neutrality factor" to nursing facility payment rates so that the "estimated statewide day-weighted average payment rate in effect for the fiscal year is limited to the amount permitted by the funds appropriated under the General Appropriation Act for that fiscal year."

- The revenue adjustment neutrality factor must remain in effect until June 30, 2013 or until a new rate-setting methodology is published to replace Chapters 1187 and 1189 of the Department's regulations.

v. Extended the time period for DPW development of regulations on review of proposals by nursing facilities to increase Medicaid-certified nursing facility beds to June 30, 2012.

vi. Act 22 spawned a flurry of regulatory activity by DPW; regulations affecting long-term care providers are identified below under new regulations.

d. Act No. 2011-26 amended the Fiscal Code to, among other things:

i. Establish a working group to include personnel from DPW and the County Commissioners Association for the development of a pilot program "for allocation of county human services funding as multiple purpose grants, permitting counties to utilize funds at the county level normally provided in categorical allocations, such as child welfare, mental health, substance abuse and similar programs." Pilot to be implemented in 12-13.

ii. Apply certain federal prohibitions on use of public funds for aliens to "payments and providers."

- Benefits not available to aliens who are not "qualified aliens" under federal law.
- Qualified aliens are not eligible for SSI or food stamps.
- Qualified alien status must be verified to determine eligibility.

e. Act No. 2011-59 amended the Confidentiality of HIV-Related Information Act to advance the policy of routine HIV testing as part of general medical care by:

i. Replacing the requirement for "written" consent with "documented" consent

ii. Allowing for "opt-out" testing

f. Act No. 2011-76 amended the Regulatory Review Act to provide for consideration of small businesses when promulgating regulations.

i. The definition of small business conforms to the size standards of the U.S. Small Business Administration.

ii. Provides for an economic impact statement related to small businesses.

iii. Provides for a regulatory flexibility analysis.

g. Act No. 2011-112 amended the Family Caregiver Support Act (now the Pennsylvania Caregiver Support Act) to:

i. Clarify certain provisions such as definitions of primary caregiver, care receiver and adult with chronic dementia,

ii Base eligibility for reimbursement to primary caregiver on care receiver household income under 200% of the federal poverty guidelines,

iii. Provide for no entitlement to support.

h. Act No. 2011-120 amends the law authorizing the State Board of Vehicle Manufacturers, Dealers and Salespersons to define "mobility vehicle" and "mobility vehicle dealers" and to license such dealers.

i. Act No. 2011-128 established the Long-Term Care Nursing Facility Independent Informal Dispute Resolution (IDR) Act.

i. The Act establishes an independent IDR process to allow providers to dispute state licensure survey deficiencies.

ii. IDR may be carried out by Department staff at no charge or by Department's independent agent on a fee-for-service basis, dependent on provider's choice.

iii. The independent agent is a federally-designated Medicare quality improvement organization (QIO).

iv. Minimum procedures must conform to the federal IDR procedures for contesting certification deficiencies.

2. *Statutory Changes – 2012*

a. Act No. 2012-34 and Act No. 2012-35 amend the Practical Nursing Law and the Professional Nursing Law, respectively, to address restrictions on use of the title "nurse," but to allow a descriptive title for "nurse assistive personnel" when an individual is under the supervision of a professional or practical nurse.

b. Act No. 2012-36 amends Title 51, relating to Military Affairs, to consolidate the provisions of the Long-Term Care Patients Access to Pharmaceuticals Act by adding Chapter 95.

i. Applies to persons eligible for benefits provided by the U.S. Department of Veterans Affairs.

ii. Allows long-term care nursing facility pharmacies (operated by the facility or under contract) to obtain drugs through the Department of Veterans Affairs "drug source facility" and repackage and relabel the drug for unit dose dispensing.

iii. Requires certain security and record-keeping measures.

c. Act No. 2012-68 amends the Vital Statistics Law to authorize certified registered nurse practitioners to pronounce death.

d. Act No. 2012-80 amends the Public Welfare Code to, among other things:

i. Extend the nursing facility assessment by 4 years through June 30, 2016.

ii. Establish a human services block grant pilot program. The Disability Rights Network, on behalf of individuals and advocacy organizations, and other parties, filed a lawsuit in Commonwealth Court to enjoin implementation of Act 80 on constitutional grounds and for violations of the Commonwealth Documents Law.

e. Act No. 2012-108 conforms the law of Pennsylvania regarding jurisdiction over guardianships and conservatorships to the rules in place in 29 other states by adopting the Uniform Adult Guardianship and Protective Proceedings Jurisdiction Act as promulgated by the Uniform Law Commission in 2007. The legislation uses the term "protective proceeding" rather than the term conservatorship to conform to the terminology used in most other states.

i. First priority for jurisdiction over protective proceedings is given to an individual's "home state," which is the state in which the individual was physically present for at least six consecutive months immediately prior to commencement of the proceeding.

ii. A significant-connection state has jurisdiction if an individual has not had a home state within the past six months or the home state declines jurisdiction. A "significant-connection state" is any state in which the individual has a significant connection other than mere physical presence and where substantial evidence concerning the individual is available.

iii. A court in the state where the individual is currently physically present is granted jurisdiction to appoint a guardian in an emergency, and a court in a state where an individual's real or tangible personal property is located is given jurisdiction to appoint a conservator or issue another protective order with respect to that property.

iv. Also established a procedure for transferring a guardianship or conservatorship between states and allows guardianship or protective proceeding orders issued in other states to be filed with Pennsylvania courts and thereafter generally exercise all powers in Pennsylvania authorized by the orders issued in other states.

f. Act No. 2012-121 establishes the Pennsylvania eHealth Information Technology Act.

i. Creates a new independent agency to be known as the Pennsylvania eHealth Partnership Authority, which is to be operated by a 15 member board of directors, one member which is to be a representative of a personal care home, assisted living facility, nursing facility, continuing care facility or behavioral health facility.

ii. Primary responsibility of Board is to develop, establish and maintain a health information exchange to promote efficient and effective exchange of electronic health record data among health care providers, health care payers and "participants," which are defined as entities that have been approved to send and receive health information.

g. Act No. 2012-139 amends the Judicial Code provision on subpoena of records to provide for charges by health care providers or facilities who receive a subpoena for medical records.

B. Regulatory and Agency Guidance Highlights

1. *Regulations – Department of Health*

a. On December 10, 2011, the Department of Health published final regulations on photo identification badges. The regulations were effective on December 10, 2012. 28 Pa. Code, Chapter 53.

2. *Regulations – Department of Public Welfare*

a. On August 27, 2011, the DPW published a final-form rulemaking regarding the transition to the Resource Utilization Group III (RUG-III) classification system, version 5.12 44 Grouper and the most recent classifiable resident assessments to determine case-mix indices (CMI). The changes affect reimbursement rates for nonpublic nursing facilities and incentive payments for county nursing facilities. The regulations were effective retroactive to July 1, 2010. 55 Pa. Code §§ 1187.96(a) and (e), 1187.97, 1189.105(b).

b. Act 2011-22 regulations

i. On April 14, 2012, DPW published final-omitted rules amending regulations on the state supplementary payment (SSP) for individuals who qualify for supplemental security income (SSI). The regulations established the level of SSP by regulation and eliminated DPW's ability to change the levels by notice, through Appendix A to the regulations. The regulations were effective July 1, 2011. 55 Pa. Code §§ 299.11, 299.36, 299.37.

ii. On April 14, 2012, DPW amended the copayment provision of the Medical Assistance rules to (1) eliminate reimbursement of certain copayments to recipients, (2) increase copayment amounts, (3) permit further updates to copayments by publication of a notice in the *Pennsylvania Bulletin*, (4) add or clarify certain existing copayment exclusions to the regulations. The amended regulation took effect on May 15, 2012. 55 Pa. Code § 1101.63.

iii. On May 19, 2012, DPW promulgated new final-omitted regulations on long-term living home and community-based services. The regulations establish provider qualification and participation requirements, provider payment, billing and audit requirements and procedures for provider disqualification and appeal. The majority of the regulations took effect upon publication in the *Pennsylvania Bulletin*, with some regulations requiring CMS approval of the waiver amendments. 55 Pa. Code, Chapter 52.

c. On June 30, 2012, DPW promulgated regulations on the nursing facility review process for the addition of Medical Assistance certified beds. These regulations were in response to a legislative mandate to develop regulations after the Statement of Policy setting forth review standards was determined by the Commonwealth Court to be a binding norm in *Eastwood Nursing and Rehabilitation Center v. Department of Public Welfare*, 910 A. 2d 134 (2006). 55 Pa. Code §§ 1187.171-1187.177. The Department, by separate publication in the *Pennsylvania Bulletin*, rescinded the Statement of Policy at 55 Pa. Code § 1187.21a, which formerly addressed the bed review process.

3. *Department of Labor & Industry*

a. On July 14, 2012, the Department of Labor & Industry (L&I) published proposed regulations pursuant to the Prohibition of Excessive Overtime in Health Care Act, 43 P.S. §§ 932.1-932.6. The regulations propose to implement the complaint, investigation, penalties and appeal procedures related to enforcement of the Act by L&I. 42 Pa. B. 4468 (July 14, 2012).

4. *Agency Notices and Guidance Documents*

a. State Plan Amendment Notices - DPW periodically publishes notices relating to payment methodologies for nursing facilities and the intent to submit a state plan amendment for approval by CMS.

i. DPW published a notice announcing a plan to continue supplemental payments to nonpublic nursing facilities and MA Day One Incentive payments for county nursing facilities beyond June 30, 2012. 42 Pa. B. 3821 (June 30, 2012).

ii. DPW published a notice regarding its intent to amend the State Plan to revise the method by which the budget adjustment factor is calculated for nonpublic nursing facilities in fiscal year 2012-2013. 42 Pa. B. 3822 (June 30, 2012).

iii. DPW published a notice that it would be seeking a state plan amendment to continue performance incentive payments to qualifying county nursing facilities in fiscal year 2010-2013. 42 Pa. B. 3823 (June 30, 2012).

iv. DPW published a notice to add a new category of supplemental payment for ventilator care, effective July 1, 2012. 42 Pa. B. 3824 (June 30, 2012).

b. On June 9, 2012, DPW published a Notice announcing the rate-setting methodology and fee schedule rates for long-term care MA waivers (Aging, Attendant Care, COMMCARE, Independence and OBRA Waivers). 42 Pa. B. 3343 (June 9, 2012).

c. Personal Care Home Licensing

i. On October 1, 2012, DPW issued a revised Regulatory Compliance Guide (RCG). http://www.dpw.state.pa.us/provider/longtermcareservices/regulatorycomplianceguidercg/index.htm.

- DPW revised the explanation of grace periods in the Introduction to the RCG, p. 4

- Added the following to the explanation of Abuse and Abuse Reporting in the Regulatory Issues and Frequently Occurring Situations section of the RCG, p. 181

> In the event that abuse is reported, the home should send a supervision plan for approval in accordance with 15.156 as well as the home's plan to investigate the situation along with the reportable incident form. If the Department does not approve the supervision plan, the home will be contacted and directed to modify the plan. Upon conclusion of the home's investigation, the home should send a final report that describes the

investigation methods and findings. Following review of the final report, the Department will inform the home whether the supervision plan may be lifted.

- Revised the section in Regulatory Issues and Frequently Occurring Situations entitled Preadmission Screening, Medical Evaluation and Assessment Support Plan: Best Practices, pp. 212-220

- Added Appendix B: Requirements and Best Practices for Reportable Incidents, pp. 237-241

For more information, please contact the lawyers included in this proposal, or visit www.klgates.com.

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