



HOSPICE ENDNOTES

for the North Carolina Hospice Community from Poyner Spruill LLP

Wage and Hour Pitfalls for Hospice Employers

Employers in the hospice industry are frequently faced with wage and hour issues involving the Fair Labor Standards Act and North Carolina Wage and Hour Act, including provisions specifically pertaining to health care workers. Many of these issues can be confusing and troublesome.

First, employers must be aware of joint employment problems. Employees who work for more than one entity in a related family of companies may be eligible for overtime when aggregate hours for both entities exceed 40 in a workweek. Where the separate entities share common officers, policies, or benefits and are owned by a single parent company, the Department of Labor will treat both entities as joint employers for wage and hour purposes.

Hospice employers should also be aware that RNs are not automatically exempt from minimum wage and overtime requirements. RNs may qualify for the professional exemption if they are state certified and their work involves using advanced knowledge gained through a nursing course of study. Simply being an RN is not enough. Similarly, the exemption for employees practicing medicine is narrow. Professionals must be paid at least \$455 per week to be exempt, but professionals who "practice medicine" need not be paid a salary. This exception to the salary rule does not cover pharmacists, nurses, therapists, dietitians, social workers, speech pathologists, or psychologists. Workers in those professions must be paid at least \$455 per week to be exempt.

As a general rule, an exempt employee is entitled to his or her full salary, without deductions. If improper deductions are made, the employer can lose the exemption and have to pay the employee overtime. Deductions may be made for absences of one or more full days for personal, sick, or FMLA reasons, or for disciplinary suspensions. If deductions are made, the employer must comply with state law regarding the timing and form of notice to the employee.

Employers that require uniforms may not reduce a nonexempt employee's pay below the minimum wage to reimburse the employer for the uniforms. If an employee is wearing the uniforms outside of work and causing damage requiring continual replacement of uniforms, the employer can require repayment through wage assignment or direct reimbursement.

Training and travel time is another area of confusion for many employers. Employers do not need to pay employees for their regular commutes, but most other travel time and training time must be paid. Exempt employees are not entitled to additional salary for required travel and training time. Non-exempt employees, however, must be paid for hours worked as discussed in the following paragraph.



By Kevin Ceglowski

Training. Lectures, meetings, and training sessions required by the employer must be paid. Training may be unpaid only if all the following requirements are met:

- (1) the training is voluntary;
- (2) it is not during normal working hours;
- (3) it is not directly job related; and
- (4) no work is required during the training

Employers should be aware of any overtime liability based on time spent by employees in training sessions. If an employee is staying overnight for training, an employer's obligation to pay the employee ends once the training session is over and the employee is free to do what he or she wants. Time spent traveling to and from training sessions is treated the same as other travel time for work, and is subject to the following travel time rules.

Travel Time. Whether employee travel time is considered work time depends on the type of travel. An employee's normal commute is not work time. If an employee is required to travel to another city for the day, but returns home the same day, the employer must pay the employee for the time spent traveling to the extent it exceeds the employee's normal commuting time. Employee travel as part of his or her normal work, such as travel between job sites, must be counted as hours worked. Time spent by an employee traveling out of town for work must be paid when it includes the hours normally worked by an employee, even if the travel is on a day the employee would not normally work.

These tips address only a few of the many wage and hour issues hospice employers may face. Additional information is available from the Department of Labor, and if you have specific questions about a wage issue, you should consult an attorney.

For more information about employment law issues, please contact Kevin Ceglowski at 919.783.2853 or kceglowski@poynerspruill.com.



ATTORNEYS AT LAW



By Mike Hale

MedPAC Stays on Track for Hospice Payment Reform

The Medicare Payment and Advisory Commission (MedPAC) met in early November 2009 to discuss, among other topics, hospice visit patterns. Even though the hospice visit patterns identified by MedPAC were somewhat limited due to available visit data, the data collected continues to support MedPAC's previous recommendation to reform the hospice Medicare benefit (HMB) and adjust hospice payments based on the length of stay rather than the current flat per diem rate.

As you may recall, MedPAC submitted a report to Congress in March 2009, which highlighted a concern that the HMB contains an incentive for hospice providers to promote long hospice stays rather than focus on the appropriate timing of admissions, as demonstrated by a "strong correlation between the length of stay and profitability." MedPAC noted that the average length of stay for hospice patients increased from 62 days in 2000 to 82 days in 2006. Hospice stays at the 90th percentile of distribution increased from 144 days in 2000 to 212 days in 2005, and declined in this same time period for stays at or below the median length of stay. Therefore, according to the hearing transcript, only the long lengths of stay are getting longer.

EDITORS

Mike Hale, Poyner Spruill LLP

Jessica Lewis, Poyner Spruill LLP

Tim Rogers, Chief Executive Officer, AHHC of NC

Cindy Morgan, BSN, MSN, AHHC of NC

In light of this concern, MedPAC made several recommendations, including that Congress should direct the Secretary of the Department of Health and Human Services to change the Medicare payment system for hospices to:

- Have relatively higher payments per day at the beginning of the episode and relatively lower payments per day as the length of the episode increases;
- Include a relatively higher payment for the costs associated with patient death at the end of the episode; and
- Implement the payment system changes in 2013 with a brief transitional period.

Based on the recent visit data presented by MedPAC, all indications are that MedPAC will continue to recommend hospice payment reform in a manner similar, if not identical, to its earlier recommendations. MedPAC's recent findings include:

- The average number of combined visits per week for social workers, hospice aides and nurses is greater for patients with shorter stays than longer stays.
- The provision of hospice visits follows a U-shaped pattern, with the highest number of visits being in the first and last seven days of care.
- Visit frequency and visit hours per week do not vary much by diagnosis once length of stay is taken into account.
- Both the number of visits and visit hours per week are greater for short stays than long stays.
- Short stay patients receive greater share of visits from nurses relative to hospice aides than long stay patients.
- After taking into account length of stay, cancer patients receive a slightly higher share of visits from nurses than patients with other diagnoses.
- Hospice visits are slightly more frequent for nursing facility and assisted living facility residents than patients in the home after taking into account the length of stay.
- Medicare claims data shows a similar number of visits for rural and urban hospices as well as different size hospices.
- There are more hospice aide visits per week for freestanding and home health-based hospices and for-profit hospices.

MedPAC concludes by acknowledging that its analysis confirms its earlier findings and continues to support the need for hospice payment reform, and further indicates that additional research steps may include additional analysis of claims data, proprietary data on travel

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By Jennifer Parser

Visa Options for Hiring Foreign Nurses

The U.S. Department of Labor predicts a growing need for registered nurses due to an aging population and technological advances that emphasize preventive health care. In fact, according to the Bureau of Labor Statistics, health care is one of the two industry sectors expected to have the largest employment growth, adding four million jobs between 2008 and 2018. To fill this need, employers will have to hire more foreign nurses and health care professionals. There are a variety of nonimmigrant and immigrant visa options for foreign nurses. Let's look at them.

Nonimmigrant or Temporary Work Visas for Nurses

Before either an immigrant or nonimmigrant visa can be issued to a foreign nurse, a VisaScreen certificate must be granted by the Commission on Graduates of Foreign Nursing Schools (CGFNS). This certificate signifies that the applicant's education, training, license, and experience are the equivalent of a US nurse of the same type; that the appropriate license is unrestricted; and that the applicant is fluent in English. Certain nurses are exempt from the equivalency evaluation and English language proficiency testing if their degree is from Australia, Canada (English-speaking territories only), Ireland, New Zealand, South Africa, the United Kingdom, or the United States. The CGFNS, the International Commission on Healthcare Professions and the Educational Testing Service Test of English as a Foreign Language administer the VisaScreen and English language tests, respectively. A VisaScreen is valid for five years. Additionally, the registered nurse or professional nurse must have a full and unrestricted license to practice professional nursing in the state of intended employment or evidence of having passed the examination offered worldwide by the National Council of State Boards of Nursing. The examination is known as the

National Council Licensure Examination (NCLEX-RN). North Carolina requires the NCLEX-RN as well as the CGFNS VisaScreen or, alternatively, an educational evaluation from the CGFNS, the International Education Research Foundation or Josef Silny & Associates. If the nursing degree was not taught in English, North Carolina will accept the Test of English as a Foreign Language, Test of English for International Communication Service International Examination or the International English Language Testing System.

The following nonimmigrant visas are only available to registered nurses. Licensed practical nurses and licensed vocational nurses must apply for a permanent resident visa and, upon approval, wait for a visa number to become available, since only a limited number are available annually.

TN Visa

A registered nurse who is a Canadian or Mexican national (not necessarily born there) can work in the United States as a TN visa holder under the North American Free Trade Agreement. In addition to being qualified as a nurse by their home country, such registered nurses must have been certified by the Commission of Graduates of Foreign Nursing Students International (CGFNS) and its division, The International Commission of Health Care Professionals (IChP) in order to obtain the VisaScreen certificate. If approved for TN visa status, Canadian nurses do not need the actual visa inserted in their passports, but Mexican nurses must obtain the visa at a US consulate in Mexico. The TN visa is issued for one year and extensions can be indefinite and up to three years in length per extension. Although extendible indefinitely, the TN visa carries with it strong nonimmigrant intent so that its issuance is dependent upon the TN visa holder continuing to demonstrate ties with Canada or Mexico and an intent to return there at the expiration of the authorized stay.

H-1B Visa

The H-1B visa option is for a "specialty occupation," which is normally an occupation requiring a US bachelor's degree or equivalent. This can sometimes be used for RNs, but not always since it's possible to be an RN without getting a US bachelor's degree or its foreign equivalent. However, if the RN's practice area necessarily requires four years of post-secondary education, he or she may qualify for H-1B visa status. Some examples of nurses who require more advanced training to meet the standard to qualify for an H-1B are clinical nurse specialists, nurse practitioners, certified registered nurse anesthetists, nurse managers or supervisors, and critical care nurses.

To obtain any of the above visas, all registered nurses must pass the NCLEX-RN. In addition, a registered nurse must meet state licensing requirements where he or she will practice and be certified by the CGFNS for the VisaScreen certificate.

Immigrant or Permanent Resident Visas for Nurses

Only registered nurses or physical therapists are exempt from labor certification, the first step to permanent US residence. Labor certification is the process of proving to the US Department of Labor that the prospective employer unsuccessfully attempted to hire a US worker, either a US citizen or permanent resident, through a detailed recruitment process. Unlike registered nurses, licensed practical nurses and licensed vocational nurses are not exempt from the labor certification process. As a result, they can only be hired through the lengthy immigrant, or permanent resident visa process, which includes the labor certification component. Therefore, since licensed practical nurses and licensed vocational nurses are not eligible for nonimmigrant visas, they must wait abroad until the labor certification process is complete, the immigrant visa is approved, and there is a visa available to them. This results in a long delay since the nursing profession falls into an immigrant visa category, known as the third preference, that has only a limited number of visas annually and is perennially oversubscribed. Even though registered nurses and professional nurses are listed on Schedule A, Group I as pre-certified for employment in the United States by the Department of Labor, the third preference category still applies to them, so they also have a lengthy wait. The challenge to an employer is to keep its foreign employees in the United States in nonimmigrant visa status while waiting for a permanent resident visa to be both approved and available.

The date on which a petition for permanent residence is filed is extremely important because this is the date that places the applicant in line for a visa and is known as the "priority date." A nurse can change employers once the application is approved even if a visa is not available and retain the same priority date. Once a visa becomes available, a nurse may only apply to adjust status to permanent resident from within the US if here on a valid nonimmigrant visa with the CGFNS certificate, a full and unrestricted RN license in the state of the intended employment, or proof of passing the NCLEX, and a VisaScreen.

The process for bringing nurses to the United States is highly technical and can be frustrating. With immigration reform on the horizon and a long-standing nursing shortage in the US, we hope the number of visas available to nurses will be increased and the lengthy waits decreased. In the meantime, Poyner Spruill is happy to assist employers with hands-on guidance in hiring foreign-trained nurses.

Jennifer Parser practices in the areas of immigration, employment and international law. She is licensed in the state of New York, and is not licensed in North Carolina. Jennifer may be reached at jparser@poyners.com or 919.783.2955.

Hospice Licensing Rules Amended for Respite Care

On December 17, 2009, the North Carolina Rules Review Commission approved an amendment to the Hospice Licensing Rules governing staffing requirements for hospice inpatient units to more closely align with the Medicare Hospice Conditions of Participation. Effective January 1, 2010, "the presence of a registered nurse (RN) to provide direct care on all shifts is not required for patients receiving respite care unless specific nursing needs are in an individual patient's plan of care." However, 24-hour patient care RN staff is required if a patient in the inpatient facility is receiving general inpatient care for symptom management. 10A NCAC 13K .1202

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time by patient location, and proprietary data on other hospice costs, including prescription drug and durable medical equipment use.

Since hospice payment reform seems to be inevitable and will likely be based at least in part on length of stay, you should audit your own visit and length-of-stay patterns to identify potential problematic areas. MedPAC also met on December 10, 2009, to discuss hospices' payment adequacy. More about that meeting and its findings will be available in next month's *Hospice EndNotes*.

Mike Hale is a health care attorney in the Raleigh office of Poyner Spruill LLP. He advises clients on a variety of regulatory, contractual and operational issues in hospice, home care and long term care settings. Mike may be reached at 919.783.2968 or mhale@poynerspruill.com.