I-9 Pitfalls: Small Errors Found in I-9s that Can Cost Big

By Jennifer Parser

The Form I-9 is a mandatory employment eligibility verification form. Completion of the I-9 by both employer and employee must occur within three days of hire for every employee hired after November 7, 1986, regardless of nationality or immigration status. I-9 violations can occur even if your workforce is legal. A paperwork violation can be something as simple as failing to date or sign Form I-9. Fines can range from $110 to $1,100 per paperwork violation, but increase exponentially for knowing violations. For instance, employers convicted of having knowingly hired unauthorized aliens or continuing to employ aliens who are or became unauthorized to work in the United States may face fines of up to $3,000 per employee and/or six months imprisonment. The following rules should assist your organization in being I-9 compliant.

1. I-9s cannot be used to screen job applicants. They can only be used to confirm employment eligibility after hiring.
2. If you are copying blank I-9 forms for completion, both sides must be copied or the I-9 is incomplete, potentially resulting in a fine. This means that the List of Acceptable Documents on the back of the I-9 is part of a complete I-9.
3. Any changes to an existing I-9 must be done by striking through, correcting and having you, as employer and the employee initial those changes as relevant.
4. If a Form I-9 is incomplete or needs correcting, you also have the option of using an updated form and attaching it to the old I-9.
5. Are you using a current Form I-9? Below is a chart showing which Form I-9 should be used:

If hired on or after	Use Form
July 5, 2007	06/05/07
March 3, 2009	02/02/09
September 7, 2009	08/07/09, but the 02/02/09 edition is also accepted

6. You do not need to maintain copies of the documentation showing identity and employment eligibility that is presented as part of the I-9 process. But if you do, you must do so for all employees or risk being held liable for document abuse.
7. Employee name changes require completion of either Section 3 or a new Form I-9, but changes of address do not.
8. Any document used to indicate employment authorization with an expiration date needs to be followed up on by completing Section 3 of the I-9 or by doing a new I-9. All I-9s with expiring documentation should be pulled and placed in a separate binder with a notification system for you as employer to notify the employee between four to six months of expiration to obtain new proof of employment eligibility and present it to you.
9. Do you know the I-9 retention rules, and does your organization have a written policy? You should! The retention rules are three years from date of hire or one year after termination, whichever is longer.
10. If your organization acquires a business and its employees, you can use the previous owners' I-9s but you are responsible for any mistakes in them.
11. If you use subcontractors or independent contractors, you are not responsible for their employees' I-9s working on your premises unless you have reason to know they are not employment authorized. In March 2005, Walmart agreed to settle on a fine of $11 million for trying to circumvent I-9 compliance by using a subcontractor who hired workers lacking employment authorization to clean its stores.
12. If you use an outside I-9 management and storage contractor, be certain to confirm that your contractor is able to retrieve and make the information requested by an Immigration and Customs Enforcement (ICE) notice of inspection available in its required time frame of 72 business hours.

The best way to be prepared for an ICE inspection is to have conducted your own internal audit to make certain your I-9s are compliant. Be sure you have clear, consistent I-9 compliance, review and retention policies in place, including the discarding of I-9s that no longer need to be retained.

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. Parser may be reached at jparser@poyners.com or 919.783.2955.

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HOSPICE ENDNOTES
for the North Carolina Hospice Community from Poyner Spruill LLP

By Mike Hale

MedPAC Assesses Hospice Payment Adequacy

In last month's *Hospice EndNotes*, we discussed the Medicare Payment and Advisory Commission's (MedPAC) November 2009 report on hospice visit patterns. In this article, we will review MedPAC's December 2009 report on hospice payment adequacy. In its December meeting, MedPAC assessed hospice payment adequacy by looking at four factors: access to care, quality of care, access to capital, and payments and costs. A brief summary of the findings is provided below.

Access to Care
MedPAC determined that Medicare beneficiaries have good access to hospice care. This finding is supported, in part, by the following data:

- 40% of Medicare decedents used hospice in 2008, compared to 23% in 2000.
- The number of new hospice providers continues to grow by approximately 6% per year, with the strongest growth being in the for-profit sector.
- The average length of stay for hospice patients has increased from 82 days in 2006 to 83 days in 2008.
- There is no evidence that the hospice cap impedes access to hospice care.

Quality of Care
MedPAC recognized that there is no publicly available quality data covering all hospices and the limited data that is available is sponsored by associations.

Access to Capital
MedPAC reported that our credit markets are recovering and that publicly traded hospices have good financial reports and solid access to capital. However, MedPAC was unable to evaluate access to capital by nonprofit providers due to limited data.

Payments and Costs
MedPAC's review of hospice payments and costs included the following data:

- The average cost per patient day in 2007 was $134, which ranged from $121 per patient day for for-profit providers to $148 per patient day for non-profit providers.
- Hospices with longer lengths of stay have lower costs per patient day.
- The average margin for hospice providers has ranged from 4.5% to 6.5% since 2001, and the average margin in 2007 was 5.9%.
- The projected hospice margin in 2010 is 4.6%.

The recommendation made by MedPAC staff to the commissioners after the presentation was to "update the payment rate of increase for 2011 by the projected rate of increase in the hospital market basket index, less the commission's adjustment of 1.3% for the productivity factor." The 2011 hospital market basket increase is estimated to be 2.4% to 2.5%. The commissioners approved the rate adjustment recommendation in their January 2010 meeting along with a decision to include MedPAC's March 2009 recommendations in their March 2010 report to Congress. These recommendations include:

- Congress should direct the secretary of the Department of Health and Human Services (Secretary) 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;

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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

RALEIGH CHARLOTTE ROCKY MOUNT SOUTHERN PINES WWW.POYNERSPRUILL.COM
301 Fayetteville St., Suite 1900, Raleigh, NC 27601/P.O. Box 1801, Raleigh, NC 27602-1801 P: 919.783.6400 F: 919.783.1075

By Cindy Morgan

Delegation versus Supervision: What's the Difference? Do You Have It "Right"?

"You can delegate authority, but you can never delegate responsibility for delegating a task to someone else. If you picked the right man, fine, but if you picked the wrong man, the responsibility is yours—not his," said Richard E. Krafve, a past vice president and general manager of Ford Motor Company. No matter the setting, whether the auto industry or the health care setting this statement remains true. Registered nurses (RNs) have the ultimate decisions when it comes to delegating care to patients in hospice. This is a huge responsibility and should never be taken lightly.

On the other hand, supervision, according to the National Council of State Boards of Nursing, is "the provision of guidance or direction, evaluation and follow-up by the licensed nurse for accomplishment of a nursing task delegated to unlicensed assistive personnel." Supervision means continuous monitoring to ensure that the tasks delegated are being delivered appropriately and effectively.

State nursing practice acts usually address delegation and supervision. In North Carolina, the Nursing Practice Act outlines the 10 components of the "practice of nursing by a registered nurse". [NC G.S. 90-171.20 (7)]. Two of the 10 components relate directly to delegation and supervision: (d) teaching, assigning, delegating to or supervising other personnel in implementing the treatment regimen; and (i) supervising, teaching and evaluating those who perform or are preparing to perform nursing functions and administering nursing programs and nursing services.

In addition to our Nursing Practice Act, the Medicare Hospice Conditions of Participation (CoPs) requires confirmation of competency as well as supervision. A primary focus of safe care delivery is validating competencies before delegating a task. Once the hospice RN verifies competency and assigns tasks to the hospice aide, then continued and consistent supervision is necessary by the RN to ensure that quality of care is maintained. As pointed out in previous articles, one of the leading survey deficiencies under the CoPs is failure to meet the hospice aide supervision requirements.

Delegation is defined as entrusting a person acting as an agent or representative, or empowering a person to act for another. Simply said, allowing someone to do something in your place. The advantages to delegation include allowing the RN to be able to oversee more patients or concentrate on bigger, more complex issues. On the other hand, if not managed appropriately, the RN may be "stretched too thin" and the supervision component that is so important on an ongoing basis may be neglected. The main point to remember is that delegating tasks does not remove the responsibility that lies with the RN.

Delegation takes us back to the basics of the nursing process: assessing, planning, implementing and evaluating with each patient contact. This process will enable the nurse to make sure quality care is delivered and the staff they delegate is qualified and competent to deliver the care needed in each situation.

The National Council of State Boards of Nursing lists the "Five Rights to Delegation" (Rights) in a position paper titled, "Delegation: Concepts and Decision Making Process" (1995, www.ncsbn.org/323/htm).

- Right Task - One that is delegable for a specific patient
- Right Circumstances - Appropriate patient setting, available resources, and other relevant factors considered
- Right Person - Right person is delegating the right task to the right person to be performed on the right person
- Right Direction/Communication - Clear, concise description of the task, including its objective, limits and expectations
- Right Supervision - Appropriate monitoring, evaluation, intervention, as needed and feedback

Remember that delegating tasks does not remove the responsibility from the person who is delegating. Utilizing these Rights as guidelines for delegating tasks to other health care providers should serve RNs well in ensuring that patient care is quality driven. Pairing the right delegation decisions with ongoing supervision requirements further ensure that patient care is safely delivered.

For more information about this article, please contact Cindy Morgan of AHHC of NC at 919.971.8731 or cindymorgan@homeandhospicecare.org.

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MedPAC Assesses Hospice... continued from page 1

- 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.

· Congress should also direct the Secretary to:

- Require that a hospice physician or advanced practice nurse visit the patient to determine continued eligibility prior to the 180th-day recertification and each subsequent recertification, and attest that such visits took place; and
- Require that all patient stays in excess of 180 days be medically reviewed for those hospices that have stays exceeding 180 days and where such stays make up 40% or more of their total cases.

· The Secretary should also direct the Office of Inspector General to investigate:

- The prevalence of financial relationships between hospices and long-term care facilities such as nursing facilities and assisted living facilities that may reflect a conflict of interest and influence admissions to hospice;
- Differences in patterns of nursing home referrals to hospices;
- The appropriateness of enrollment practices for hospices with unusual utilization patterns (for example, high frequencies of very long stays, very short stays or enrollment of patients discharged from other hospices); and
- The appropriateness of hospice marketing materials and other admissions practices and potential correlations between length of stay and deficiencies in marketing or admission practices.

· The Secretary should also collect additional data on hospice care and improve the quality of all data collected to facilitate the management of the hospice benefit. Additional data could be collected from claims as a condition of payment and from hospice cost reports.

MedPAC continues to be concerned that the hospice Medicare benefit 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." You should continue to audit your hospice length of stay and identify additional ways to contain costs since hospice rate increases will likely be very limited over the next several years.

Mike Hale is a health care attorney in the Raleigh office. 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.

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38th Annual Convention & Expo

The Association for Home & Hospice Care of NC invites you to its 38th Annual Convention & Exposition May 3-5, 2010 and it's special Home Health & Hospice Executive Summit sponsored by Poyner Spruill. For more information, please contact Richard Fowlkes by email at richardfowlkes@homeandhospicecare.org