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Targeting Enforcement: Healthcare Reform Quickly Brings More Choices for Skilled Nursing Facilities Seeking to Challenge Survey Deficiencies, but Possible Traps Await

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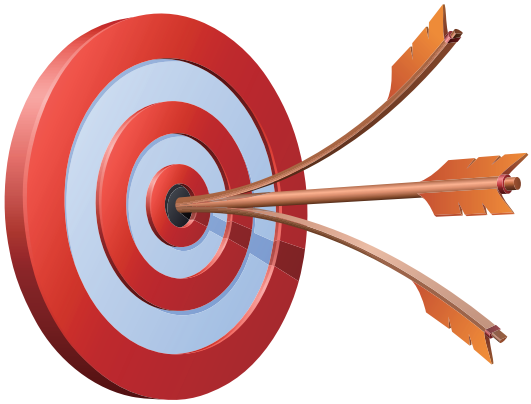
The array of obligations placed upon skilled nursing facilities[1] (SNFs or facilities) is endless in this dawning era of healthcare reform, but there is one often overlooked change coming. The new opportunities to adequately respond to and potentially fight deficiencies identified in an annual survey cycle is one of the more complicated and fast-moving components. In fact, *unlike* the compliance plan, reporting obligations, and required disclosure components of healthcare reform, proposed regulations for the significant new enforcement provisions of the Patient Protection and Affordable Care Act (Act or PPACA) have already been issued, commented upon, and are awaiting final promulgation.[2] SNFs that are unaware of the new appeals parameters or are unable to navigate the analysis of which process to invoke and when will be left standing behind with survey deficiencies that may, at best, be inaccurate and worse, devastating from an operational, financial, and public relations standpoint.



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Current Enforcement Process

The Social Security Act governs the compliance of SNFs with the Medicare requirements for participation.[3] Once an annual survey has occurred and indentified deficiencies, CMS can impose sanctions. Frequently those sanctions take the form of civil money penalties (CMP) imposed at a range of $3,050 – $10,000 per day for Level 4 deficiencies (i.e., immediate jeopardy) or $50 – $3,000 per day for lower-level deficiencies. CMS may also impose CMPs on a per-instance basis.

There are now two paths by which facilities can appeal poor survey results. First, a facility can attempt to refute survey findings by requesting an "informal dispute resolution" (IDR) process with the State Survey Agency.[4] These appeals are truly informal, and specific procedural rules have historically been left solely to the discretion of the states, resulting in wide variations in process from state to state.

Second, a facility may appeal the remedies (usually CMPs) imposed by CMS via a much more formal (and more slow-going) process with CMS directly.[5] The U.S. Department of Health and Human Services' Departmental Appeals Board (Appeals Board) has promulgated procedures for such appeals.[6] Often, the Appeals Board may settle an appeal based on an earlier state IDR resolution concerning the validity of the deficiency, but it is not bound by such state conclusions; i.e., CMS has ultimate authority for determining CMP impositions. Currently, a CMP is not due until after the final agency decision resulting from this appeal process, which could be years in the future.[7] Alternatively, a facility may waive its right to a hearing within specified timeframes and thereby have the CMP reduced by 35%.[8 9]

A New Process of Enforcement

PPACA Section 6111, placed under the heading "Targeting Enforcement," amends the Social Security Act at 42 U.S.C. § 1395i-3(h)(2)(B)(ii), effective March 23, 2011, relating to the imposition, collection of, and challenges to CMPs for Medicare-certified facilities found to have deficiencies. The following core provisions of the Act are especially relevant to SNFs and their counsel trying to understand how healthcare reform will alter the way they respond to surveys finding deficiencies. *First*, under the Act, facilities that self-report and promptly correct a deficiency within ten days of the imposition of a CMP may have the penalty reduced by up to 50% (subject to exceptions for repeat deficiencies or deficiencies assigned a scope and severity of "H" or above).[10] *Second*, facilities will have the opportunity to participate in an "independent" IDR process not later than thirty days after the imposition of a CMP, and penalties may not be imposed until the IDR is complete.[11] *Third*, the Act provides for placing the CMP in escrow once the independent IDR is complete or ninety days have passed, pending the exhaustion of further appeals, the return of such money where the facility successfully appeals the penalty, and to what use the penalty may be put if such appeals are unsuccessful.[12]

Initially, it was unclear whether PPACA was meant to result in a federal government takeover of the IDR process, a new and separate federal IDR process, or simply new rules for state IDR proceedings that would retain the CMS appeals process. But surprisingly quickly, CMS published proposed regulations in the July 12, 2010, *Federal Register* that sought to clear up these and other uncertainties. CMS received close to 400 comments, and the regulations are awaiting final promulgation. But by March 2011, facilities must be prepared to make new, important, and highly impactful strategic decisions about responding to identified deficiencies and the ensuing penalties that could be imposed as a result. The following discussion is a summary of the proposed regulations and an analysis of how the proposed regulations may impact facilities.

Penalty Reduction for Prompt Self-Reporting and Deficiency Correction

The Act states that "in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed . . . not later than 10 calendar days after the date of such imposition, the Secretary may reduce the amount of the penalty imposed by not more than 50%."[13]

The meaning of "self-reports" seems nebulous, given that under the terms of the statute, a facility does not receive notice of a CMP until well after a survey is concluded and a plan of correction has been submitted. The proposed regulations recognize the illogicality of this language and attempt to remedy the apparent congressional oversight, noting that "[t]o credit a facility with 'self-reporting' only after a facility has been surveyed and noncompliance has been discovered by CMS would not meet the common sense meaning of 'self-reporting.'"[14] But on the other hand, a "self report" prior to a survey could effectively lead surveyors directly to areas for which a deficiency can be found and a penalty imposed. In fact, one could argue that CMS might be prone to impose a higher CMP, armed with the knowledge that a 50% reduction can be invoked by the deficient facility.

In order to clarify this issue, CMS has "proposed to give meaning to this provision in a manner that can best encourage facilities to self-report their noncompliance so that they can take the necessary corrective action as quickly as possible, without waiting for the State or CMS to identify or to cite the noncompliance, and thus be rewarded for their efforts."[15] To that end, CMS proposes that the 50% reduction be available only after the facility meets certain conditions pursuant to proposed 42 C.F.R. § 488.438(c)(2)(i),(ii).

First, the facility must self-report its noncompliance to CMS or the state *before* it is identified by, or reported to CMS or the state via a survey or other means.[16] CMS also proffers that the facility must correct its noncompliance within ten calendar days of the date that the facility identified the deficiency.[17] But as noted by several comments filed with CMS, this proposed timeframe is directly contradictory to the underlying statutory language which by its terms gives a facility a much longer time period within which to correct (i.e. ten days after a penalty is imposed). A second potential problem is that a self reported "deficiency" might not be exactly what is eventually cited as a deficient practice, leaving a facility with more corrective action to implement and uncertainty about whether the original self-report will qualify it for a 50% reduction.

Second, proposed 42 C.F.R. § 488.438(c)(2)(iii) says that a facility must waive its right to a hearing in order to receive the 50% reduction. "This is because, by the facility's own admission through its self-reporting and correction, it has acknowledged its noncompliance, thereby substantially eliminating the basis for any formal appeal."[18] While this might be good for CMS, it is not necessarily good for the facility, nor is it part of the Act. Comments to the proposed regulations urge CMS to clarify that self-reporting is:

(1) Not deemed an admission of noncompliance for any purpose other than asserting a right to the 50% CMP reduction;

(2) Is not a basis for increasing a CMP;

(3) Cannot be used against a facility in an otherwise valid appeal; and

(4) Does not constitute a wavier of any quality assurance or other legal privilege.

CMS also specifies that a facility may receive only one of the possible CMP reductions—either 35% for waiving its right to a CMS hearing or 50% for self-reporting, correcting, *and* waiving the right to a CMS appeals hearing.[19]

Third, CMS clarifies that the CMP reduction it offers for advance reporting and correction will always be at the statutory maximum of 50% in order to "reinforce the incentive of a facility to invest in its program improvement."[20]

In the end, this provision of the Act is of limited benefit to facilities. Facilities may prefer to risk survey identification, especially where a deficiency may be borderline or arguable. In that case, the 35% reduction for waiving a CMS appeals hearing remains available. Otherwise, claiming a 50% reduction for CMPs imposed as a result of reporting and swiftly correcting potential "deficiencies," which are already required to be reported pursuant to 42 C.F.R. § 483.13(c)(2), may be the only advantage to facilities. The reality is that the 50% CMP reduction is not available for deficiencies cited at level "H" or higher, and it is those deficiencies that are most likely to result in the assessment of CMPs.

Independent IDR Process

The Act states that "not later than 30 days after the imposition of [a] penalty, . . . the facility [shall] have the opportunity to participate in an *independent informal dispute resolution process* which generates a written record prior to the collection of such a penalty."[21] The proposed regulations clarify that a second state IDR process will now be available in addition to that already in place.[22] It is of note, however, that the directives in the statute as well as proposed regulations governing the new independent IDR process constitute a fairly dramatic enlargement of federal authority in this area, given that states previously acted almost entirely autonomously in constructing and implementing IDR procedures.

The intent behind similar language included in America's Affordable Health Choices Act of 2009, H.R. 3200, 111th Cong., which was never enacted, informs CMS' interpretation of this provision.[23] Essentially, CMS reveals that in order to address the perceived problem that existing state IDR processes favor nursing home operators at the expense of resident welfare, CMS interprets the Act as intending to institute an additional state IDR process that is more "independent." To this end, CMS proposes at 42 C.F.R. § 488.431(a)(5) that independent IDRs be conducted:

> by the State under section 1864 of the [Social Security] Act, or an entity approved by the State and CMS . . . such as: (i) A component of an umbrella State agency provided that the component is organizationally separate from the state survey agency; (ii) an independent entity with healthcare experience selected by the State and approved by CMS; or (iii) a distinct part of the State survey agency, so long as the entity or individual(s) conducting the independent informal dispute resolution has no conflict of interest and has not had any part in the survey findings under dispute.[24]

CMS has also instituted a timetable and other provisions surrounding such "independent IDRs" that are available only at the facility's request and that must generate a written record prior to the collection of any penalty.[25] Pursuant to proposed Section 488.431(a), a facility must request the independent IDR within thirty days of being notified of a CMP imposition, and the IDR must be completed within sixty days of such imposition.[26] Moreover, the independent IDR process must include notifying an involved resident of the facility or resident representative, as well as the state long term care ombudsman, that they have an opportunity to provide written comment.[27] The preamble to the proposed rule also leaves open the possibility that CMS may develop even more "operational details" as guidance in the State Operations Manual.[28]

CMS further proposes that "the new independent [IDR] process be an additional option for nursing homes and that nursing homes would retain the option to use the existing [IDR] process under § 488.331."[29] This is because CMS believes "that the current [IDR] resolution process can be expeditious and that it addresses a greater range of noncompliance issues," i.e. issues having to do with enforcement options other than CMPs. Thus, where CMPs are imposed, facilities will have a choice of whether to pursue the new independent IDR process pursuant to this provision and/or the existing state IDR process.[30] Practically speaking, the independent IDR process will be primarily used for immediate jeopardy deficiencies and those identified as substandard quality of care because these types of deficiencies are most likely to result in CMPs.

Next, CMS states that such independent IDRs will be conducted at the requesting facility's expense and that a system of user fees will be established so that the costs are not borne by the Medicare Trust Fund or other public sources. CMS also believes user fees will ensure that a facility electing to use the new independent process believes that there is a distinct benefit as compared with either the current process or a formal CMS appeal.[31] CMS comments that:

> [i]n electing to use the new process, we expect that the nursing home will generally consider the user fee to be less costly than filing a formal appeal. Those lesser costs

> may derive from both lower preparation, legal, and filing fees, together with the 35% reduction in the [CMP] that is available under § 488.436 in situations where a nursing home elects not to request a formal hearing.[32]

It appears that CMS envisions that facilities will choose either state-level IDR or a formal CMS appeal, although both remain available. The proposed regulations describe a system of fees that could be imposed on a per-deficiency basis and could be as high as $3,000 per deficiency depending on the complexity and level of physician or expert review needed. CMS specifically requested comments on the amount and contingencies of user fees regarding, for example, whether they should be reduced or returned if the requesting facility successfully disputes a deficiency, and the result was a resounding plea to eliminate any system of user fees (which is not a component of the Act itself).[33] CMS further maintains that the current IDR process will continue to be available to facilities at "no charge" should they elect to use that rather than the new, independent IDR process.[34]

Finally, CMS emphasizes at 42 C.F.R. § 488.431(a) that it will continue to retain ultimate authority for survey findings and the imposition of CMPs; i.e., the results of all state IDR proceedings will remain advisory to, not binding upon CMS' decision as to whether and to what extent to collect CMPs.[35]

Use of the independent IDR process has some apparent disadvantages such as:

(1) The payment of a substantial fee to utilize the process; and

(2) Selecting the independent IDR process may require the penalty to be placed in escrow thirty days earlier than the alternative (at sixty days after CMP imposition, the time at which an independent IDR must be completed, rather than ninety days).[36]

Moreover, the new process adds the participation of persons previously not given a voice.

On the other hand, the new independent IDR process:

(1) Allows ample time for a facility to make a request—thirty days; and

(2) The results will be realized quickly with a written record available for any further appeals to CMS.

Indeed, the required resolution of an independent IDR within sixty days of the date the penalty is imposed would still give the facility the option to timely waive a formal CMS appeal and obtain a 35% reduction in the CMP, or to still request a CMS appeal. The favorable time frame to resolution is perhaps the greatest benefit, along with consistency in procedure across state lines for multi-state providers.[37]

Collection and Disposition of CMPs

Finally, the Act calls for new regulations for the collection and disposition of CMPs. Currently, facilities are able to avoid paying CMPs until after the entire appeals process concludes (including a formal CMS appeal if chosen), a process that often takes years.[38] CMS characterizes this practice as highly problematic, concluding that it "diminishes the immediacy of the enforcement response, insulates the facility from the repercussions of enforcement, and may undermine the sanction's deterrent effect."[39] To address this issue, the Act provides that CMS may collect and place CMPs into an escrow account pending the resolution of any appeals. [40]

The Act also provides that a CMP imposed on a per-day basis will not be *imposed* until after a facility has been able to complete an independent IDR.[41] But to the chagrin of many commenters, CMS interprets this provision "to mean that any per day [CMP] would be effective *and continue to accrue* but would not be collected during the time that the determination of noncompliance which led to the imposition of a [CMP] is subject to the independent [IDR]."[42] Many comments filed with CMS challenged this inconsistency, and argued that the plain language of the Act itself directs that no penalty accrue at all until the independent IDR concludes:

> In the case where the penalty is imposed for each day of noncompliance, provide that a penalty *may not be imposed* for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under item (ii) is completed.

Section 6111 (a)(B)(IV)(bb). Nevertheless, 42 C.F.R. § 488.431 (b)(1) proposes that CMS will collect CMPs at the earlier of when an independent IDR is completed (which must occur within sixty days of a facility's notice of the imposition of a CMP) *or* ninety days after such notice, and that CMS "may collect the portion of the per day [CMP] that has accrued up to the time of collection . . . ."[43]

Finally, CMPs will be held in escrow pending the resolution of any formal CMS appeals, allowing time for CMS to appeal any decision by an administrative law judge reversing the CMP imposition in whole or in part.[44] If CMS' goal was to reduce the number of appeals on the DAB docket, this is perhaps the greatest push in that direction.

The disposition of CMPs held in escrow will depend on the outcome of any IDR and/or formal CMS appeal in accordance with Sections 488.431(b)(1)(i),(ii).[45] If the facility is successful, the penalty money will be returned to it with interest, and if CMS prevails, it will keep the money held in escrow.[46] The proposed regulations clarify that where a facility is partially successful in contesting one or more deficiencies, the CMP may be adjusted and a portion of the escrowed money returned, although the details of any adjustment process remain unclear.[47]

Suggested Strategies

While the long term care community has often been able to remain under the radar in terms of national initiatives and reforms, such as compliance plans and electronic health records, this pattern is not the case for enforcement initiatives. When final regulations are promulgated, surveyed and financially penalized

facilities must be ready to perform a meaningful financial and operational analysis to determine the best approach among the options discussed above.

Reporting Deficiencies

Facilities have little to gain by reporting "deficiencies" to possibly gain a 50% reduction in CMPs because the 50% reduction will not even be an option for the most frequently imposed CMPs (those deficiencies cited at level H and above). Instead, facilities should simply continue reporting potential incidents of abuse, neglect, and injuries of unknown origin (and now reasonable suspicion of crimes as required by the Elder Justice Act), and if they are not doing so already, use those reported incidents as opportunities to correct any practice that could be considered deficient. If a CMP is imposed for a deficiency that is related to such a reported incident, consider invoking the 50% reduction.

Independent IDR

Whether to invoke the independent IDR will be a highly fact-specific decision. Much of the analysis will depend on the level of CMP imposed versus the user fee, if any, established by the state. The facts of the deficiency and a careful analysis of the chance of success will of course be critical. Because the independent IDR process is not available unless a CMP is imposed, a facility will likely not know immediately whether it is even an option. Facilities should request the traditional state IDR to preserve their rights. But it is likely that in cases where significant CMPs are imposed, the favorable timeframe and procedural protections of the independent IDR will be worth the potential expense. As with the current state IDR process, the independent IDR will continue to be a worthwhile "trial run" for a formal CMS appeal, and knowing the outcome in a timely manner will permit a facility to make a well-informed decision about whether to pursue further appeal or waive the right to proceed further, gaining a 35% reduction in the CMP.

Escrow Accounts

Until CMS considers and responds to commenter concerns about the proposed collection and return of CMPs, facilities have little to act upon at the present time. But if as anticipated, CMPs will be collected upon conclusion of the independent IDR or at least within ninety days, pursing IDR becomes another valuable option because if successful, a facility may avoid collection of the penalty completely. What is also unknown at this time is how quickly CMS will consider the state IDR decision (by which it is not bound) and whether it will collect the CMP prior to that time. The guidance of legal counsel with expertise in this area as decisions are made is critical to avoid missteps or lost opportunities.

1 The analysis in this article also applies to certified NFs.
2 75 Fed. Reg. 39641 (July 12, 2010).
3 42 U.S.C. § 1395i-3.
4 42 C.F.R § 488.331.
5 42 C.F.R. § 498.3(a)(3)(ii).
6 Dep't of Health & Human Servs. Dep'tal Appeals Board, Civ. Remedies Div. rocedures (effective July 6, 2009).
7 42 C.F.R. § 488.432.
8 Caution is advised when opting to waive federal appeal rights and invoke a 35% reduction if state IDR proceedings are pending. Once the facility has opted to pay a CMP at a 35% reduced rate, CMS will not refund any money even if the facility is eventually successful at the state IDR in eliminating the deficiency that formed the sole basis for the CMP.
9 42 C.F.R. at § 488.436.
10 42 U.S.C.S. § 1395i-3(h)(2)(B)(ii)(II),(III).
11 42 U.S.C.S. § 1395i-3(h)(2)(B)(ii)(IV)(aa).
12 42 U.S.C.S. § 1395i-3 (h)(2)(B)(ii)(IV)(bb)-(ff).
13 42. U.S.C.S. § 1395i-3(h)(2)(B)(ii)(II),(III).
14 75 Fed. Reg. 39641, 39645.
15 *Id.*
16 *Id.*
17 *Id.*
18 75 Fed. Reg. 39641, 39645.
19 75 Fed. Reg 39645–46.
20 *Id.* at 39645. See 42 U.S.C.S. § 1395i-3(h)(2)(B)(ii)(II),(III) (allowing a reduction of the imposed penalty "by not more than 50%").
21 42 U.S.C.S. § 1395i-3(h)(2)(B)(ii)(IV)(aa) (emphasis added).
22 75 Fed. Reg. 39641, 39646–47.
23 75 Fed. Reg. 39641, 39646.
24 *Id.* at 39647.
25 *Id.* at 39646.
26 *Id.*
27 *Id.*
28 *Id.* at 39646.
29 *Id.*
30 *Id.*
31 *Id.*
32 *Id* at 39647.
33 *Id* at 39646–47.
34 *Id.* at 39646. This assertion, however, seems to be in tension with the above-quoted language that "States may elect to make the independent process available to a wider array of situations," seemingly allowing states to abandon current IDR processes altogether for the new, fee-based independent process. 75 Fed. Reg. 39641, 39646. Although any limitation on current IDR rights would be problematic for facilities and the use of the independent IDR process for a "wider array of situations" would tax the resources of state agencies given the speed with which independent IDRs are required to occur.
35 *Id.*
36 *Infra.*
37 The Act's directive that any CMPs "levied against the facility" be posted on Nursing Home Compare (www.medicare.gov/NHCompare) is a further incentive to use independent IDR to resolve issues quickly.
38 75 Fed. Reg. at 39643.
39 *Id.*
40 42 U.S.C.S. § 1395i-3(h)(2)(B)(ii)(IV)(bb)-(ff).
41 *Id.* at (h)(2)(B)(ii)(IV)(bb).
42 75 Fed. Reg. 39641, 39643.
43 *Id.* at 39644. It is of note that there appears to be another inconsistency here. CMS states that "[t]he 90 day period is the maximum combined time period permitted from the date of the notice of [CMP] imposition (when a facility has the opportunity to request an independent [IDR]) to the date for completion of the independent [IDR] process itself." 75 Fed. Reg. 39641, 39644. However, CMS also clearly states in new 42 C.F.R. § 488.431 that the informal IDR should be completed within "60 days of notice of *imposition of [CMP]*," not within sixty days of the date of the independent IDR request, the latter of which would result in the combined ninety-day period referenced in the above escrow account provision. *See id.* at 39649 (emphasis added).
44 *Id.*
45 *Id.*
46 *Id.* at 39643–44.
47 *Id.* at 39644.