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CLIENT ADVISORY

May 15, 2013

Spring Cleaning: CMS Busy Updating Survey Guidance and Policy

Public Availability and Access to Statements of Deficiencies Increases – S&C: 13-21-ALL (March 22, 2013)

As nursing facilities are aware, CMS' website, Nursing Home Compare [http://medicare.gov/nursinghomecompare/] began posting redacted statements of deficiencies (Form 2567) in July 2012 as a result of portions of the Affordable Care Act. Beginning in April 2013, CMS began posting 2567 survey reports **for the preceding** three years, to include both standard surveys and complaint surveys. CMS also plans to add indicators for the scope and severity of each deficiency cited on 2567 forms.

Importantly, CMS **will not post corresponding facility plans of correction** on Nursing Home Compare because, "a facility's POC is not captured electronically by CMS." CMS points both to facilities themselves and to the States as the source for plans of correction, noting that "each state is required to maintain a consumer oriented website … including nursing home CMS-2567 reports and the facility POC."

CMS plans to publish FAQs that may answer further questions.

Nursing facilities must consider the impact of this increased public access. The availability of more information regarding a facility's survey history without the corresponding POC could increase public concern and poor public perception of nursing facilities. While CMS expects to see an increase in requests for POCs at the state level, this seems unlikely. The ready availability of 2567 survey reports without the facility's corresponding plan to correct, highlights the importance of ensuring that 2567 survey reports are accurate and that deficiencies that are inaccurate or simply wrong, are appropriately challenged. Facilities should also remember to make 2567 survey reports (with the POC) available in public areas of the building **and** post a notice of their availability. Making the past three years' survey reports available should also be considered, given CMS' plan to do the same.

Civil Money Penalties: CMS Issues New Guidance for Determining Amount to Impose and When – Admin Info: 13-21-NH (March 22, 2013)

Beginning with surveys conducted on or after April 1, 2013 all Regional Offices are required to use CMS-issued guidance and a new calculation worksheet to determine the amount and type of civil money penalties imposed for nursing facility enforcement purposes. A close reading of this required guidance highlights several issues:

- CMS directs that CMPs be considered for deficiencies cited at scope and severity levels of G and above (or F where substandard quality of care is present). For deficiencies cited at lower levels of scope and severity, CMS directs that the Regional Office "should consider imposing alternative remedies other than a CMP."
- CMS believes that a per instance CMP is a better result for facilities because its guidance suggests that a per instance CMP be imposed where facilities have a "good compliance history," where the deficiency is isolated, where the facility has an opportunity to correct deficiencies or where specific dates of past noncompliance cannot be ascertained by surveyors.
- CMS defines a "good compliance history" as:
  - ◊ A facility is not a special focus facility,
  - ◊ The facility has not had immediate jeopardy findings within the past three years (unless they were cited as past noncompliance),
  - ◊ The facility has a history of achieving compliance before the first revisit, and/or
  - ◊ The facility has a history of no repeat deficiencies.
- CMS clarifies that when a per day CMP is initially imposed, a per instance CMP cannot be imposed within the same noncompliance cycle for subsequent deficiencies.
- CMS clarifies that a per day CMP can begin prior to the first day of the current survey if the first day of noncompliance can be documented by the survey team. The guidance even goes so far as to indicate by way of example, that if a survey team is able to document that immediate jeopardy began on April 1 and the survey begins on May 1, the civil money penalty start date is April 1.

- The guidance clarifies that the CMS Regional Office cannot adjust the baseline civil money penalty amount calculated using its new tool, any more than 35%, up or down.
- The guidance also indicates that facilities will be affirmatively notified if penalties may be reduced by 50% under recently effective provisions of the Affordable Care Act applicable to self-reported deficiencies. The guidance does not expressly state that a finding of "past noncompliance" is a precursor to obtaining a 50% reduction in civil money penalties, although the facility must have self-reported its noncompliance and corrected it 15 days from the date of the self-reported incident (or 10 calendar days from the date of CMS' notice of imposition of CMPs, whichever is earlier).
- The calculation tool provides specific dollar amounts that should be imposed under various scenarios.
- CMS will reevaluate its guidance and the corresponding calculation tool by the end of 2013.

If a facility believes that it will be assessed a civil money penalty, it is a useful exercise to calculate the anticipated civil money penalty using CMS' new tool. Likewise, after a CMP is imposed, facilities should check the imposed amount against the tool to determine whether CMS has followed applicable guidelines and whether the CMP is reasonable, prior to assessing appeal or settlement options. Likewise, the rollout of this tool further emphasizes the need to carefully consider whether challenges to cited deficiencies should be considered, given potential increases in CMPs as a result of this guidance.

Adjustments to State Survey Tasks May Mean Fewer Surveys – S&C: 13-23-ALL (April 5, 2013)

On April 5, 2013 CMS released a memo describing adjustments that it plans to make to its survey priorities as a result of sequestration budget reductions **effective immediately**. For nursing facilities, the memo highlights three changes in particular.

- Revisit surveys
  - ◊ Importantly, the OLC will have to seek approval from the CMS Regional Office in Philadelphia before conducing any second revisit survey after a first revisit determines the provider is still not back in substantial compliance with conditions of participation. Until now, the OLC did not have to seek regional office approval until the third revisit.
  - ◊ If a third revisit (or even a fourth) is necessary, the OLC must seek prior approval from CMS' central office in DC.
  - ◊ Longer wait times between revisits may occur.

Longer wait times between revisits means providers risk not clearing the survey cycle before mandatory remedies (such as denial of payment for new admissions) go into effect. It also means increased per day civil money penalties if CMS chooses to impose this remedy. **Providers need to be more prepared than ever for surveys**.

- Special Focus Facilities (SFF)
  - ◊ Any SFF that has been on the SFF list for more than 18 months and has failed to improve will have a "last chance" survey. If OLC and the Regional Office believe appropriate improvement has not occurred or that no "major development" indicates that enduring and timely improvement in quality or safety are very likely, a termination notice may be issued.
  - ◊ Any SFF that has been on the list for more than 12 months will be discussed by the Regional Office and OLC to plan further action.
  - ◊ No new SFFs will be selected when a current SFF rolls off the list as a result of either termination or improvement.

There is a low risk of being placed on the SFF list if not currently designated, and an enhanced opportunity for removal from the list if an SFF-designated facility is demonstrating improvement.

- Life Safety Code Surveys
  - ◊ If a nursing facility is fully sprinkled and has a consistently good track record of Life Safety Code compliance, a "short form survey" will be made available at the state's option.
  - ◊ CMS will provide a list to each state survey agency of the facilities that may qualify for the short form survey. See also S&C 13-22-NH (April 5, 2013)

Expect fewer life safety code surveys and faster completion of that portion of the survey cycle.

National Background Check Program Work Group Report Defines Direct Patient Access Employees – S&C: 13-24-NH (April 12, 2013)

The Affordable Care Act established the National Background Check program to identify procedures for national background checks on prospective "direct patient access employees." States who wished to participate were awarded grants to do so.

In March 2011 the OIG published a report showing that *92% of nursing facilities employed one or more individuals with a history of criminal conviction.* In response, the OIG recommended that CMS define employee classifications that are direct patient access employees and work with participating States to develop a list of convictions that disqualify an individual from nursing facility employment. A work group made up of CMS employees and 11 state agency volunteers has published a report addressing the OIG's recommendations.

The Work Group is recommending that a "direct access employee" be broadly defined as follows:

> An individual who has direct access to a resident or beneficiary through ownership, employment or a contract/ agreement with a LTC facility or provider.

While this suggested definition neither includes students or volunteers (unless they perform unsupervised patient functions); nor does it include "contractors performing repairs, deliveries or installations … for the facility," it does include contractors such as pharmacy, hospice, therapy providers and even facility owners.

The Work Group is recommending that "direct access" be defined as:

> Having or expecting to have duties that involve one-on-one contact with a resident or beneficiary, *or access to the resident or beneficiary's property, personally identifiable information or financial information*.

These two definitions, if ultimately adopted, would widen the categories of individuals for whom facilities must conduct criminal background checks, and create a need to review compliance plans and other facility policies and procedures to ensure compliance.

The Work Group also suggested categories of crimes that would constitute barriers to employment for direct access employees such as: 1) crimes against care-dependent or vulnerable individuals, 2) crimes against the person, 3) crimes against property, and 4) crimes related to unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

CMS is considering the recommendations of the work group, so no changes are imminent, but these developments bear close watching, along with corresponding developments in state-specific law.

Note for Virginia facilities: The Virginia Code includes barrier crimes in the first three categories identified by the Work Group but does not include the fourth. If the Work Group recommendations are adopted by CMS, Virginia facilities may be barred from hiring employees or contracting with individuals who have convictions dealing with controlled substances. Virginia Senator John Edwards introduced Senate Bill 868 in the 2013 General Assembly session to further define barrier crimes to include crimes dealing with controlled substances, but the bill was passed over indefinitely by the Committee for Courts of Justice. HDJN will continue to monitor legislative changes in this area.

If you have questions or need assistance, please contact Mary Malone (mmalone@hdjn.com), Jeannie Adams (jadams@hdjn.com), Emily Towey (etowey@hdjn.com), or Berkeley Horne (bhorne@hdjn.com). In addition to email, they can be reached by phone at (866) 967-9604. Additional information about Hancock, Daniel, Johnson & Nagle, P.C. is available on the firm's website at www.hdjn.com.