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Legally Speaking

QUESTIONABLE SURVEY ENFORCEMENT POLICIES REQUIRE HEIGHTENED PREPARATION[1]

Paula G. Sanders, Esquire[2]

Long term care facilities across the Commonwealth are reeling from the impact of several new survey enforcement policies: federal civil money penalties (CMPs) are accumulating at staggering rates that easily pass $500,000, and immediate jeopardy (IJ) citations are being issued for deficiencies that previously would have been cited at a much lower scope and severity, if at all. Facilities are surprised to hear surveyors apologize when they cite immediate jeopardy, repeating the refrain, "All G's are now IJ's." And as a special New Year's gift to the industry from the Department of Health, any "facility with a Division of Nursing Care Facilities (Division) survey exit date on or after January 1, 2017, may be subjected – when warranted – to civil penalties (CP) calculated on a per violation, per day basis" of up to $500 per violation.

Given the heightened risks of six to seven figure CMPs, and citations of IJ and substandard quality of care, facilities need to understand the new environment and improve their survey readiness. When the Department announced the new CP guidelines, the Secretary wrote, "the purpose of this is to impress upon long-term care facilities the need to provide quality care to the residents of their facilities." Together and individually, facilities need to correct the misperception that the industry has not been, and is not currently, providing high quality care to their residents. LeadingAge PA, PHCA and PA-CAH are working collaboratively on finding a solution to the current crisis, but the Centers for Medicare and Medicaid Services (CMS) and the Department do not appear in a hurry to concede there is a problem.

I. Inflation Has Caught Up with Federal CMPs

The Federal Civil Penalties Inflation Adjustment Act Improvements Act, which amended the Federal Civil Penalties Inflation Adjustment Act of 1990, was designed "to improve the effectiveness of civil monetary penalties and to maintain their deterrent effect." The Act required certain agencies with CMP authority to update penalties based on their value in the last update prior to 1996 and the change in the CPI between that date and October 2015. Although agencies were given discretion to increase one or more penalties covered by these provisions by less than the new formula -- upon a finding that increasing the penalty by required amount would have a negative economic impact or that the social costs outweigh the benefits -- the Secretary of the US Department of Health and Human Services (DHHS) did not make such a finding, and the CMS CMPs were increased effective August 1, 2016.

Facilities that have been hit with the new CMPs may question how anyone could determine that the higher CMPs would not have a negative impact. The Category 2 CMPs (for deficiencies less than IJ) have increased from a per-day range of $50 - $3,000/day to **$103 - $6,188/day** and from a per-instance range of $1,000 - $10,000/ instance to **$2,063 - $20,628/ instance**. Under the new enforcement policies, an IJ citation is subject to a mandatory and immediate Category 3 CMPs. The Category 3 CMPs have increased from a per-day range of 3,050-$10,000/ day to **$6,291 - $20,628/day** and from a per-instance range of $1,000 - $10,000/ instance to **$2,063 - $20,628/instance**.

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The potentially devastating impact of the increased CMPs is compounded when CMS applies "retroactive" per-day CMPs that start to accrue on the first identified date of noncompliance, rather than on the survey exit date. CMS began using retroactive per-day CMPs in June 2014, and explained the methodology in its Civil Money Penalty Analytic Tool and Guidance. The most dramatic effect of this retroactive per-day CMP policy is that facilities are receiving per-day CMPs that start to accrue for incidents that happened months before the survey has started. In the past, under the former enforcement policy, per-day CMPs would never accrue for more than 180 days because a facility that was out of compliance for six months would be terminated from the Medicare and Medicaid programs; now, however, facilities are receiving CMPs that start to accrue for sometimes 300 days before the survey. Often, facilities do not even know they will be charged for a retroactive CMP until well after the survey.

While most facilities are familiar with the concept of being fined for past noncompliance, they do not expect to have per day CMPs starting to accrue before the date they were notified by the surveyors that they were out of compliance, especially for incidents that were self-reported to the Department through the on-line Event Reporting System (ERS). Facilities are finding themselves facing retroactive CMPs for a deficient practice, such as an avoidable pressure ulcer or a failure to prevent accidents, that the surveyors identify as having begun long before the start of the survey in question, but not having been corrected. The Analytic Tool Guidance clearly states:

> A PD CMP should begin on the first day noncompliance at the sited scope and severity level is documented, even if that date precedes the first day of the current survey, unless the facility can demonstrate that it corrected the noncompliance prior to the current survey (past noncompliance). If the team cannot document the first day of noncompliance, then the CMP should start on the day the noncompliance was observed and documented at the time of the current survey.

CMP Analytic Tool Guidance at 6 (emphasis added).

Facilities are well advised to note that surveyors will be looking for documentation of the beginning of a deficient practice. If the surveyors do not find specific documentation, the facility may still be at risk for retroactive per-day CMP that starts prior to the exit date, if the date the noncompliance was observed is earlier than the exit.

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CMS has instructed its analysts to calculate the start date for the proposed CMP with the first supportable date of noncompliance, as determined by the evidence documented by surveyors in the statement of deficiencies (CMS form 2567). State surveyors are instructed that they must "determine the earliest date for which supportable evidence shows that the noncompliant practice began" when performing surveys and making recommendations for a per-day CMP to CMS. Additionally, if there is ambiguity, meaning the start date of the deficient practice is not clearly identified and supportable, the CMS analyst is instructed to contact the state survey agency to see if such a date can be determined. The analysts are also required to document their discussions and conclusion with the state agency. If the start date cannot be determined, then the per-day CMP would start on the first day during the survey on which the survey team identified the noncompliant practice. Id. at 22.

The CMP Analytic Tool also provides additional information about the "add-on" factors that CMS considers. These factors include: history of noncompliance; repeated deficiencies; substandard quality of care (SQC); total number of SQC tags; and facility culpability. According to the CMP Analytic tool, the facility culpability add-on is warranted at both a base level and a failure to act level. Culpability includes "neglect, indifference, or disregard for resident care, comfort or safety. A facility may be held responsible and culpable for the actions of its management and staff, and contract staff." (Emphasis added.)

Facilities should pay careful attention to the failure to act culpability amount. The analyst is instructed to add an additional amount, up to $500, if it can be documented that management officials, e.g., administrator, director of nursing, facility owners, and/or the facility's governing body knew of problems but failed to act." Id. at 12. (Emphasis added.)

II. A New Interpretation of Immediate Jeopardy

Since the middle of November, 2016, the Department has been issuing IJ citations without applying the guidelines for determining IJ that are set forth in the State Operations Manual, Appendix Q, Guidelines for Determining Immediate Jeopardy. As a result, facilities are receiving deficiencies at a scope and severity level of J, K or L which, before this new interpretation, would have been cited at a scope and severity level of G, H or I, respectively.

We understand that the Department is applying this new interpretation under oral instruction from CMS that when it makes determinations of immediate jeopardy, the Department should not consider whether jeopardy to residents is, in fact, immediate because that term does not appear in the regulatory definition of "immediate jeopardy" found at 42 C.F.R. § 488.301. That regulation provides:

Immediate jeopardy means a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

42 C.F.R. § 488.301. CMS has also orally directed the Department to disregard Appendix Q, allegedly because CMS has recently determined that Appendix Q is inconsistent with the regulatory definition of "immediate jeopardy" found at 42 C.F.R. § 488.301. CMS has not explained how they reached this determination or how they think it complies with the express language of the Social Security Act regarding immediate jeopardy. CMS has so far refused to give the Department written guidance on how the new interpretation is to be applied.

Without proper guidance from CMS, and unable to rely on the traditional interpretation of when to cite IJ, surveyors are consistently citing IJ at a scope and severity level of J or higher in almost every situation where there has been an isolated instance of actual harm that in the past would have been cited at a scope and severity level of G. Many of these cases involve events that were timely self-reported to the Department through the on-line ERS portal, sometimes months before the survey that has just declared IJ. Sometimes the Department cites the facility for a corrected past noncompliant IJ, but in other situations declares that there has been and continues to be an on-going IJ until the facility implements an effective corrective action to ameliorate it.

One of the more unusual twists of this new policy is that a facility can be in IJ for more than 23 days, even though at its most elemental level, an IJ situation is so extreme that a facility is supposed correct the IJ within 23 days or be terminated from the Medicare and Medicaid programs. The "immediacy" of IJ seems to have disappeared, to be replaced by crippling CMPs that range from $6,291 - $20,628/day or $2,063 - $20,628/instance.

III. Adapting to the New Environment

A. Return to the Basics

CMS, in the new Requirements of Participation (RoPs) that went into effect on November 28, 2016, has stated that the RoPs are "an integral part of our efforts to achieve broad-based improvements both in the quality of health care furnished through federal programs, and in patient safety." Id. It goes without saying that facilities should be reviewing the RoPs and updating their policies and procedures to ensure compliance with the new regulations. As a whole, the industry needs to improve documentation of their efforts to assure high quality care.

Directors of nursing (DONs), in particular, should be champions of a return to the basics. Take advantage of stand-up and morning meetings to remind staff about such basics as: always follow the care plan; a two person assist requires two people; never leave a resident unattended in a shower chair; call the physician if an order is confusing or contradictory; always report suspected abuse or neglect. These are such rudimentary nursing concepts that they are sometimes taken for granted, just as one assumes drivers know that they are supposed to stop at a red light.

In this new enforcement environment, it is not safe to take basic knowledge for granted. Instead, DONs and other nurse leaders should constantly remind staff about the basics. Routine reinforcement should be documented, even when the principles discussed are as fundamental as where to find resident care plans.

B. Treat Every Serious Event as a Deficiency

One of the keys to surviving a potentially catastrophic survey is to be able to

demonstrate that the problem was self-identified and corrected, particularly if the survey is focused on an incident that was self-reported through the ERS. CMS will reduce a CMP by 50% for past noncompliance if a facility self-reported the noncompliance to CMS or the State before it was otherwise identified by or reported to one or the other; as long as correction of the self-reported noncompliance occurred within 15 days of the incident. 42 C.F.R. § 488.438

CMS and the Department expect proof of the corrections for self-reported incidents to be comprehensive. The way to provide this is to treat any incident that results in reporting to the Department as if had already been cited as a deficiency on the CMS Form 2567 Statement of Deficiencies. This includes developing a corrective action and documentation of monitoring and auditing for ongoing compliance. Depending on the severity of injury that may have been involved, full house staff education (all shifts and all units) should be considered. In some cases, the education should be required before staff can return to the floor. Be prepared to give the surveyors evidence at the time of the survey that a quality assurance and process improvement plan was implemented and maintained to assure continued compliance.

C. Beware the "Kangaroo Survey"

The Department is conducting on-site surveys for more than 95% of all complaints it receives. It is also conducting on-site surveys for ERS-reported incidents that have resulted in harm. Not surprisingly, surveyors are in facilities with a higher frequency than ever before. One of the unintended consequences of the Department's heightened on-site scrutiny is that when surveyors are returning to conduct re-visit surveys to determine whether a plan of correction has been implemented and old deficiencies cleared, they often bring with them other complaints and/or incidents to investigate.

Facilities that have concentrated on their plan of correction are delighted to hear that the revisit has cleared the prior deficiencies. That moment of euphoria evaporates quickly however, when they learn that they are the subject of a "kangaroo survey," so-called because the surveyors seemingly pull out of a kangaroo pouch complaints and incidents that have accumulated since the last survey and find new deficiencies. Many facilities are being cited for new deficiencies that were unrelated to the revisit, and these new deficiencies are extending their survey cycle. Picture the new deficiencies coming out of a kangaroo pouch, and the kangaroo kick that follows when the revisit clears but new tags keep the clock open.

One strategy to reduce the likelihood of a kangaroo survey is to be survey ready 24/7. Do not have a myopic focus on the plan of correction to the exclusion of monitoring compliance with the RoPs. More importantly, work with your staff, residents and families to improve communications and reduce the number of complaints that go to the Department. A complaint addressed in-house is one less potential on-site survey and deficiency.

D. Challenge Deficiencies

In the past, many facilities were afraid to file requests for independent dispute resolutions (IDRs). Now, surveyors are often telling facilities that is what they should do, particularly if they have been cited for IJ. Facilities need to examine their statements of deficiencies very carefully to look for potential factual inaccuracies and legal challenges to the citations. In many cases, the facility will not know whether CMS is going to impose a retroactive or extended per-day CMP until it receives the official letter from CMS. Often that is well after the time for filing an IDR with the Department has passed.

An IDR can directly challenge scope and severity for IJ and SQC citations. When it issued the new RoPs, CMS changed and added a number of regulations that can result in an SQC citation. CMS released a revised SOM, Appendix PP on November 9, 2016, that incorporates the new RoPs into existing F-tags. The old SQC regulatory groupings (Resident Behavior and Facility Practices: 42 CFR §483.13; Quality of Life: 42 CFR §483.15; and Quality of Care: 42 CFR §483.25) no longer exist. Instead, SQC will be found in citations at a scope and severity level of F, H, I, J, K or L in any of the following F-tags: F221-226, F240-258 and F309-334.

Consulting with experienced health care counsel is a wise investment when the stakes are high. CMS has stated that it "is not CMS's intent to impose CMPs that could, in and of themselves, put providers out of business." Providers can file "compelling evidence of financial hardship," which CMS "is willing, in the interest of the Medicare and Medicaid programs and their beneficiaries, to consider." A successful request may result in the reduction of the CMP or in an extended payment plan that usually will not be longer than twelve months.

While this may sound promising, the underlying instructions to CMS analysts provide that in determining whether a facility's financial condition is a factor which would support lowering the CMP amount, the analyst is instructed to select one of only two alternatives. The CMS analyst must document whether the facility's documentation proves that: (1) "the facility lacks sufficient assets to pay the CMP without having to go out of business," or (2) the facility does not lack sufficient assets to pay the CMP without having to go out of business."

[1]This article does not offer specific legal advice, nor does it create an attorney-client relationship. You should not reach any legal conclusions based on the information contained in this article without first seeking the advice of counsel.

[2]Ms. Sanders is a Principal and Co-Chair of the national health law practice of Post & Schell, P.C. She may be reached at psanders@postschell.com and 717-612-6027.

[3]The Department issued this announcement on December 19, 2016. See, Description of the Civil Penalty Assessment Guidelines, available at https://sais.health.pa.gov/CommonPOC/content/FacilityWeb/attachment.asp?message-id=3271&filename=CP+Guideline+Explanation + DOH + logo + 161219%2Epdf&attachmentnumber=1

[4]Section 701 of the Bipartisan Budget Act of 2015, Pub.L. 114-74, entitled "The Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015, (signed by President Obama on November 2, 2015), available at https://www.congress.gov/bill/114th-congress/house-bill/1314/text?overview=closed

[5]CMS Survey & Certification Memo, "Civil Money Penalty (CMP) Analytic

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Tool and Submission of CMP Tool Cases, S&C: 15-16-NH (Dec. 19, 2014).

[6]See, 42 U.S.C. § 1395i-3(h).

[7]81 Federal Register 68688 (Oct. 6, 2016).

[8]Facilities do have an opportunity to file a federal independent IDR when they receive notice of the federal CMP.

[9]CMS Survey & Certification Memo, "Advance Copy - Revisions to State Operations Manual (SOM), Appendix PP-Revised Regulations and Tags," S&C: 17-07-NH (Nov. 9, 2016).

Federal Scope and Severity Grid

Scope and Severity	Isolated	Pattern	Widespread
Immediate Jeopardy To Resident Health Or Safety	J	K	L
Actual Harm That Is Not Immediate Jeopardy	G	H	I
No Actual Harm With Potential For More Than Minimal Harm That Is Not Immediate Jeopardy	D	E	F
No Actual Harm With Potential For Minimal Harm	A	B	C

Civil money penalty ranges:

IJ Per Day: $6,291 - $20,628 **Non-IJ Per Day: $103 - $6,188**

IJ Per Instance: $2,063 - $20,628 **Non-IJ Per Instance: $2,063 - $20,628**

Substandard Quality of Care: Any deficiency in these regulatory groupings at scope and severity of F, H, I, J, K, L -- F221-226, F240-258 and F309-334