APRIL 2011

SHORTS ON LONG TERM CARE
for the North Carolina LTC Community from Poyner Spruill LLP

CMS Throws Providers a Couple of Bones in New Regulation Governing SNF Survey-Related Civil Money Penalties

by Ken Burgess

On March 18, 2011, the Centers for Medicare and Medicaid Services (CMS) issued its long-awaited final rule implementing portions of the federal Patient Protection and Affordable Care Act (the health care reform law) governing the imposition and collection of civil money penalties (CMPs) against nursing facilities found to have deficiencies during surveys. CMS published a proposed rule on this issue in July 2010, spawning an outcry from provider organizations.

In its final rule, CMS took note of some of those concerns and tossed providers a couple of "bones." However, overall, the regulation dramatically alters how and when CMPs are collected, distributed and used by CMS. According to CMS, the rule has four major goals:

- Establish an escrow account where CMPs can be placed until all administrative appeals of survey deficiencies involving CMPs are completed
- Allow for reductions in CMP amounts of 50% for providers and deficiencies meeting certain specified conditions
- Create an independent informal dispute resolution process providers may elect to use in cases where CMPs are levied against providers that are subject to being placed in the new "escrow account"
- Improve the extent to which CMPs collected from Medicare-certified facilities can be used to benefit residents

The Escrow Requirement

Under the regulation, CMPs that are assessed against providers may be placed by CMS in an escrow account and held there until all appeals are exhausted. This would include appeals filed with an administrative law judge by a provider and further appeals of the Administrative Law Judge (ALJ) decision to the Departmental Appeals Board (DAB) by either the provider or CMS. At the end of the appeals, if the provider has lost, CMS keeps the funds. If the provider has won in whole or part (which is increasingly rare in these appeals), the CMP must be returned to the provider, with interest. **The effective date of this rule is January 1, 2012,** allowing CMS and the State Survey Agencies time to develop systems to accommodate the escrow provisions and to develop the independent IDR process (discussed more on the next page).

The escrow requirement applies to both "per instance" and "per day" CMPs. The CMPs will be collected and placed in escrow on the earlier of 1) the date on which an independent informal dispute resolution (IDR) is completed if one is requested, or b) 90 days from the CMS notice of imposition of CMPs that are subject to being escrowed.

(continued on page 2)

p.s. Poyner Spruill LLP
ATTORNEYS AT LAW

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

CMS Throws Providers a Few Bones
(continued from page 1)

CMS will collect and place in escrow all CMPs that have accrued up to the time of collection and then may undertake additional collections for additional CMPs that continued to accrue after that date, until the facility achieves substantial compliance or is terminated from the Medicare program. The stated purpose of the escrow provision is to keep providers from avoiding the sting of CMPs, thus delaying their impact on the facility, while appeals proceed through the ALJ and sometimes DAB levels, which can take up to two years in some cases.

CMS has retained the right to implement a different, longer CMP collection process of up to 12 months, where it finds that immediate collection would place an undue and substantial financial hardship on the provider. No guidelines or definitions of those terms are included in the final rule. If a facility fails to remit CMPs for collection and escrowing when due, CMS can deduct the amount due from amounts owed to the facility under Medicare.

Independent IDR

The rule also creates an alternative to the traditional IDR called an "independent IDR." Providers may not utilize both IDR processes except in cases where a regular IDR was requested and completed before CMS notified a provider that CMPs were being imposed that were subject to being collected and placed in escrow. CMS must notify a provider in such cases of their right to request an independent IDR, which must be completed within 90 days from the notice of imposition of CMPs. The interplay between the timing of requesting a normal IDR (10 days from receipt of CMS 2567) and the independent IDR in the rule's text is confusing. In comments to the rule, CMS says providers will have 10 days from receipt of notice of imposition of a CMP to request an independent IDR. That notice will come to providers either in the letter transmitting the CMS 2567 or in the CMS letter notifying a provider of the imposition of CMPs. So, providers wishing to use this process will need to carefully review all correspondence from the North Carolina Division of Health Service Regulation and CMS and begin counting the 10 days from whatever correspondence first includes notice of imposition of a CMP. The independent IDR must be completed within 60 days of the provider's request for one.

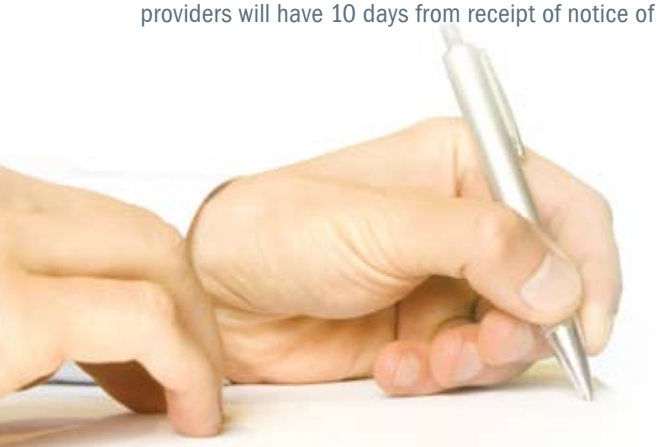
CMS is leaving many details of the independent IDR to future development and says it will incorporate such details into the State Operations Manual (SOM). Some things we know now...

The State Ombudsman and a representative of the resident(s) affected by the deficiency have a right to participate in the independent IDR, at least via submission of written comments.

The State Survey Agency may not be the entity that conducts the independent IDR. Instead, another entity such as "an independent entity with a specific understanding of Medicare and Medicaid," or a component of a state umbrella agency that is "organizationally separate" from the State Survey Agency, must conduct the IDR. It's not altogether clear at this point what other divisions of a state umbrella agency may qualify. However, CMS retains the right to approve any entity designated by a state for this purpose.

CMS backed off a proposal in the draft regulations to charge providers for the cost of the independent IDR. This proposal, affectionately dubbed the "pay to play" clause by provider organizations, is not included in the final rule, but CMS says it wants to study this issue further. So, this could resurface in the future.

Survey findings that have already been contested in a regular IDR cannot be challenged again in an independent IDR unless the provider received notice that the deficiency would result in a CMP after completion of the normal IDR.



Reductions in CMPs

The rule also provides for a 50% reduction in total CMP amounts assessed where:

1. The provider waives its right to a hearing;
2. The provider has not already received a 35% reduction in the applicable CMP for waiving a hearing, which is allowed under current law (e.g., a provider may receive only one CMP reduction, not a total 85% reduction);
3. The provider has self-reported the deficiency to CMS or the State agency before it was reported to CMS or the state as a complaint lodged by someone other than an official representative of the facility;
4. Correction of the deficiency occurred by whichever of the following dates occurs first: a) 15 calendar days from the incident that later resulted in a finding of noncompliance, or b) 10 calendar days from the date the CMP was imposed;
5. The deficiency did not constitute a pattern of harm (e.g., E, H or K on the CMS enforcement grid), or immediate jeopardy or result in the death of a resident;
6. The deficiency was not a "repeat deficiency," as defined under existing regulations for which a CMP has already been reduced by waiver of a hearing; and
7. The facility has met any mandatory reporting obligations for the incident under state or federal law (e.g., the obligation to report resident abuse, neglect or misappropriation of property).

How CMPs May Be Used

If there's a bright spot in this rule, it's the new provisions that prevent states from using their share of CMP money to fund State Survey Agency operations, including payment of surveyor salaries. North Carolina, for example, has dipped into the CMP fund for the past two years to pay surveyor salaries. Under the final regulation, this practice would be prohibited. Instead, 10% of CMP collections will go to the U.S. Treasury and 90% must go to activities that benefit residents. CMS plans to issue further guidance as to what sort of activities it views as benefitting residents, but some of the examples given in the rule include:

- Support and protection of residents of a facility that closes
- Certain limited expenses of residents relocating to another facility or to a home- or community-based setting when a facility is closed or downsized
- Projects that support resident and family councils and other consumer involvement in assuring quality of care
- Facility improvement initiatives approved by CMS, such as joint training of facility staff and surveyors or technical assistance for facilities implementing quality assurance programs where the facility has been cited for related deficiencies

CMS stresses in comments to the rule that these funds may not be used to fund obligations that facilities may have under existing law, or CMS or state survey program activities for which Congress has already allocated funds, and warns that it will not approve uses of CMP money that either do or may appear to create the impression of an ongoing revenue stream sufficient to potentially affect the judgment of the state or CMS in imposing CMPs.

We anticipate further guidance from CMS via the SOM on various aspects of this rule, as well as many questions from providers. We will continue to track the implementation of this rule and the issuance of CMS guidance and keep *Shorts* readers posted on both.

Ken Burgess advises clients on a wide range of legal planning issues arising in the SNF setting, assisted living setting and other aspects of long term care. He may be reached at 919.783.2917 or kburgess@poynerspruill.com.

POYNER SPRUILL IS GOING GREEN — In an effort to be more environmentally conscious, we also issue *Shorts* by email. To sign up for an email subscription to *Shorts*, please send an email request to alerts@poyners.com with *Shorts* in the subject line. Save a tree!

CMS Promises Future Guidance on Elder Justice Act Requirement for SNF Owners and Employees to Report Crimes

By Ken Burgess

In a March 11, 2011 letter, a key official from CMS has announced CMS's plans to issue future guidance on Section 1150B of Title VI, Subtitle H of the Elder Justice Act. That provision requires that certain employees and owners of SNFs that receive federal funding (including Medicare and Medicaid) report to the Secretary of the U.S. Department of Health and Human Services and to local law enforcement any "reasonable suspicion" of a crime occurring in the facility.

The law's breadth has left most long term care providers and government officials wondering how it can be implemented and precisely what is required. Many of the terms in the statute are undefined, but the penalty for failing to report reasonable suspicion of a crime occurring in a long term care facility includes enormous civil money fines that attach to the individual failing to report suspicion of a crime. A number of providers and provider organizations around the country have inquired of their State Survey Agency and various CMS Regional Offices about the law, whether implementation has been delayed, to what crimes the law will apply and to whom these "reasonable suspicions" should be reported.

CMS has stopped short of saying that enforcement of the law has been delayed. However, in his March 11, 2011, letter, Thomas Hamilton, Director of CMS's Survey and Certification Group, stated that "at the present time we are formulating the necessary procedures and communications" to implement the law. He also stated that "we plan to issue guidance in the near future."

We are hoping that CMS will issue guidance that narrows the potentially enormous scope of this law and answers some of the lingering questions for which, frankly, there are currently no answers. We will continue to monitor developments regarding this part of the Elder Justice Act and report to *Shorts* readers as further guidance becomes available.

Ken's Quote of the Month

"What lies behind us and what lies ahead of us are tiny matters compared to what lives within us."

~ Henry David Thoreau

Poyner Spruill LLP
ATTORNEYS AT LAW