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PHCA Webinar
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New CMS Survey Initiatives Require Immediate Attention

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Survey Overview

- Receive statement of deficiencies (2567)
- 10 days to file plan of correction
  - Include disclaimer language
- 10 days to file state informal dispute resolution (IDR) or state independent IDR (IIDR)

Sanction Letters

- PA Department of Health (DOH) imposes sanctions against license and recommends sanctions to Centers for Medicare &Medicaid Services (CMS)
- CMS imposes sanctions against certification, often after time for state IDR has passed
- Challenges to federal civil money penalty (CMP) must include escrow of CMP

Sanction Letters

- Ability to file federal IIDR within 10 days of receipt of CMS CMP letter (often sent by certified or regular mail—keep envelope)
- Federal IIDR will include contact of affected residents
- Waiver of appeal rights gets 35% reduction of CMP
  - File notice within 60 days

Historical CMPs

- At exit, center advised of potential deficiencies
- 2567 sent along with recommendation of federal sanctions and possible state sanctions
- Typically federal per day CMPs (PD CMPs) begin at date of exit; rarely in 6 figure range
- Entering a new era of CMPs

New CMS CMP Analytic Tool

- New approach to federal per day (PD) CMPs
- Begin CMP on 1st day noncompliance is documented, *even if that date precedes the first day of the current survey*
  - Unless center can demonstrate that it corrected the noncompliance prior to the current survey (past noncompliance)

CMS Survey & Certification Memo, "Civil Money Penalty (CMP) Analytic Tool and Submission of CMP Tool Cases, S&C: 15-16NH (Dec. 19, 2014)

Starting the PD CMP

- 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)"

- Surveyors instructed to "determine the earliest date for which supportable evidence shows that the non-compliant practice began"

Ambiguity About Start of Deficient Practice

- CMS analysts will contact state agency if start date is ambiguous or not clearly identified and supportable, to see if start date can be determined

- CMS analysts required to document their discussions and conclusion with the state agency

If Start Date Not Determinable

- If start date cannot be determined, then PD CMP would start on 1st day during the survey on which the survey team identified the noncompliant practice

- 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

Hypothetical F314 Deficiency S/S G

- Feb. 5 progress note identifies reddened area on R1 sacrum
- Feb. 12 weekly wound report identifies Stage 4 preventable pressure ulcer on R1 sacrum
- Aug. 4 survey identifies documentation error
- Surveyor interviews with DON and wound care nurse confirm that facility is unable to provide documentation that R1's pressure ulcer was timely identified or that physician notified
- Pressure ulcer unresolved at exit on Aug. 5

F314 Hypo

- SNF regains compliance Sept. 5

- Days of noncompliance under old analytic tool
  - Exit date to compliance
  - 30 days at $500 per day = **$15,000**

- Days of noncompliance under new analytic tool
  - First documented evidence to compliance
  - 212 days at $500 per day = **$106,000**

CMP Culpability Add-Ons

- Neglect, indifference, or disregard for resident care, comfort or safety
  - SNF responsible and culpable for actions of its management and staff, and contract staff

- Failure to act culpability amount up to $500
  - If management officials, e.g., administrator, director of nursing, facility owners, and/or the facility's governing body knew of problems but failed to act

CALCULATING CMPs

Base CMP	
Per Day CMP	$50 - $5,050
Per Instance	$1,200 - $5,500

Add –Ons	
History of Noncompliance	$100 - $500
Repeated Deficiencies	$50 - $150
Repeated Substandard Quality of Care (SQC)	$50 - $2,500
Total SQC Tags	$0 - $550
Facility Culpability (Base Amount)	$100 - $2,250
Facility Culpability (Failure to Act)	$1 - $500

Total CMP Limits	
Immediate Jeopardy (IJ)	≤ $10,000 per day
Immediate Jeopardy (IJ)	≤ $10,00 per instance
Non-IJ with no repeat deficiencies	≤ $3,000 per day
Non-IJ with a repeat deficiency	> $3,000 per day

Financial Hardship Requests

- "[N]ot 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."

CMS Hardship Documentation Requirements

- Written, dated request specifying the reason financial hardship is alleged within 15 days of CMP letter
- Brief summary listing the supporting documents that are being submitted
- Current balance sheet, income statements and cash flow statements

CMS Hardship Documentation Requirements

- Most recent full year audited financial statements prepared by an independent accounting firm (including footnotes)
- Most recent full year audited financial statements of the home office and/or related entities (including footnotes)
- Disclosure of expenses and amounts paid/accrued to the home office and/or related entities

CMS Hardship Documentation Requirements

- Schedule showing amounts due to/from related companies, or individuals, included in the balance sheets
  - Schedule should list the names of related organizations, or persons, and indicate where the amounts appear on the balance sheet (e.g., Accounts Receivable, Notes Receivable, etc.)

CMS Hardship Documentation Requirements

- If requesting an extended payment schedule of more than twelve (12) months duration, must submit a letter from a financial institution denying the provider's loan request for the amount of the CMP

Financial Hardship Requests

- Possible reduction of CMPs or 12 month repayment plan

- Analytic tool options: 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."

Survey Strategy

- Reevaluate how you approach survey
  - Surveyors may reject any documents not provided at time of survey
  - Where are your critical documents
  - What do your medical records look like
  - How up to date is your filing

- *Review 2567 carefully and prepare IDRs for any factual inaccuracies*

Genesis of the New Focused Surveys

- Goal: assess MDS coding practices in relation to resident care, as well as staffing levels
- OIG 2013: SNFs reported inaccurate information, not supported or consistent with medical record, on at least one MDS item for 47% of claims
- OIG 2012: 99% of assessments of residents receiving atypical antipsychotic drugs missed at least one requirement

Genesis of the New Focused Surveys

- Look for evidence of involvement by a professional qualified in relevant care area to conduct a comprehensive assessment, such as a mental health professional
  - OIG: 46% of records, RN was solely responsible for conducting resident assessment, even though residents may have had mental health conditions that needed to be assessed by qualified health professionals

New MDS and Staffing Focused Surveys

- New survey will be in addition to annual Medicare certification surveys
- 2-day survey focused on MDS accuracy and staffing
- Deficiencies will be cited and sanctions issued if warranted
  - May result in a complaint survey

Pilot Program Findings

- Pilot program in 5 states (IL, MD, MN, PA, VA)

- 25 SNFs -- 96% error rate
  - Inaccurate staging and documentation of pressure ulcers
  - Lack of knowledge re classification of antipsychotic drugs
  - Poor coding regarding use of restraints

Pilot Program Findings

- MDS assessment disagreements with medical records
  - 25% for falls
  - 18% for pressure ulcers
  - 17% for restraints other than side rails
  - 15% for late loss ADLs (including bed mobility, toileting, transfer and eating)

Areas Examined

Timing of MDS completion

RN coordination of MDS

Antipsychotic medications

Clinical conditions

Pressure ulcers

Late loss ADL status

Indwelling catheters

Urinary tract infections

Problems with Pressure Ulcers

- Proper identification of pressure ulcer
  - Presence
  - Worsening
  - Staging

- CMS conclusion: errors in staging likely stemmed from a lack of an accurate clinical assessment and failure of staff to accurately stage pressure ulcers in the clinical record

Collateral Issues

- Potential repayment
  - Obligation to repay within 60 days of identification of known overpayment
- PA Preventable Serious Adverse Events (PSAE) Act
  - Preventable stage 3 & 4 pressure ulcers
- Changes in 5 star

Prepare Now

- Ongoing review of MDS accuracy with heightened attention to ADLs
- Engage your medical director and attending physicians
- Reevaluate wound care protocol
- Review MDS RAI Manual – CMS not prepared to issue any additional guidance

Questions?

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CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality /Survey & Certification Group

Ref: S&C: 15-16-NH

DATE: **December 19, 2014**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Civil Money Penalty (CMP) Analytic Tool and Submission of CMP Tool Cases

Memorandum Summary

- **Civil Money Penalty Analytic Tool Case Submissions** - The Centers for Medicare & Medicaid Services (CMS) is issuing the following guidance to notify States that CMS Regional Offices (ROs) are required to continue to use the CMP Analytic Tool and guidance in establishing CMPs, but are no longer required to submit Civil Money Penalty (CMP) Analytic Tool cases to the CMS Central Office.

- **Use of Civil Money Penalty Analytic Tool** - On March 22, 2013, CMS issued guidance that all CMS ROs were required to use this guidance and CMP Analytic Tool as a guide to choose the appropriate type of CMP to be imposed and to calculate the baseline CMP amount, for all new enforcement cases when the CMS RO determines that a CMP is an appropriate enforcement remedy.

- **Enhanced Enforcement Consistency** – CMS issued the CMP Analytic Tool and guidance to promote more consistent application of enforcement remedies for skilled nursing facilities (SNFs), nursing facilities (NFs), and dually-certified facilities (SNF/NFs) (collectively referred to as "nursing homes" or "facility(ies)").

Background

The CMS ensures that nursing home residents receive appropriate care by setting health, safety and quality requirements that facilities must meet in order to participate in the Medicare and Medicaid programs. The CMS has agreements with States to routinely inspect nursing homes to ensure compliance with the requirements of participation. Congress has authorized CMS to impose certain enforcement remedies in order to promote a facility's compliance with these

requirements. Sections 1819(h)(2)(B) and 1919(h)(3)(C) of the Social Security Act (the Act) provide that sanctions should be designed to minimize the time between the identification of violations and the final imposition of sanctions. CMS and States[1] may use a variety of remedies to encourage compliance. These remedies range from directing the specific actions and timeframes needed to correct a deficiency under a directed plan of correction to those that impose a monetary fine through the CMP for review and analysis.

Beginning on April, 1, 2013, CMS ROs began piloting the CMP Analytic Tool. In an effort to monitor and evaluate the usefulness and effectiveness of this tool, ROs were asked to submit their final completed worksheets to CMS Central Office. As a follow up, in early 2014, the CMS held a conference call with each RO to discuss the efficiency, consistency and application of the CMP tool guidance and instructions. We discussed the usability and the need for additional training and/or clarification. Based on this feedback we made a number of changes and provided additional policy clarification and instructions. The CMP Analytic Tool was revised at the conclusion of the pilot and distributed to the CMS ROs on June 16, 2014. We found that the use of this Tool helped with nationally consistent application and imposition of CMPs and will help shape the language of future proposed guidance related to CMPs and other enforcement remedies.

Selecting Enforcement Remedies: (refer to 42 CFR §488.404 and section 7400 in Chapter 7 of the State Operations Manual (SOM))

The ROs must evaluate each case and consider whether or not to impose an enforcement remedy or multiple remedies as appropriate. When choosing enforcement remedies, CMS and the State must consider the following:

- The Scope and Severity (S/S) of the deficiency(ies);
- The relationship of one deficiency to other deficiencies resulting in noncompliance;
- A facility's prior history of noncompliance; and
- The likelihood that the selected remedy(ies) will achieve correction and continued compliance.

The severity of the remedy should increase with the severity of the deficiency(ies), (see 42 CFR §488.408 through §488.414). For example, for noncompliance that is cited at the immediate jeopardy level, S/S levels J, K, and L, the regulations require that either a facility is terminated within 23 days or temporary management is imposed to remove the immediate jeopardy within 23 days. Additionally, CMPs from $3,050 to $10,000 per day or $1,000 to $10,000 per instance of noncompliance may also be imposed.

Similarly, noncompliance that is actual harm (S/S levels G, H, and I), require one or a combination of the following remedies:

- Temporary management;
- Denial of Payment for New Admissions (DPNA);

[1] In addition to Federal remedies, some States have the authority to impose State sanctions under state licensure.

- Per day CMP of $50 to $3,000; or
- Per instance CMP of $1,000 to $10,000 per instance of noncompliance.

In addition to these required remedies, additional remedies may be imposed for noncompliance that is actual harm. For example, depending on the severity of the deficiency and a facility's compliance history, a combination of state monitoring, DPNA, and a CMP may be imposed.

For cases in which the State Survey Agency fails to recommend a CMP, the RO must evaluate whether or not a CMP remedy is warranted. In such cases, the RO must review the survey findings and impose the appropriate remedy(ies) regardless of a State's recommendation or failure to make a recommendation.

Use and Imposition of CMPs as an Enforcement Remedy

We are issuing both the attached CMP Analytic Tool User's Guide as an attachment specifically when a CMP is one of the selected remedies. All ROs must use the CMP Analytic Tool when the RO has determined that a CMP is an appropriate enforcement remedy. The CMP Tool itself is internal CMS software. The CMP Analytic Tool User's Guide (attached) describes the requirements regarding the use of the tool and the instructions on proper use of the Tool.

The ROs must evaluate each case and consider whether or not to impose a CMP in addition to or instead of other remedies for deficiencies with a Scope and Severity (S/S) of "G," or above, and for deficiencies with a S/S of "F" when Substandard Quality of Care (SQC) is cited. For deficiencies cited at other S/S levels, the RO should consider imposing alternative remedies other than a CMP as appropriate.

The ROs must use this tool in the calculation of each new or changed[2] CMP imposed on a facility within a noncompliance cycle[3]. Each time a survey is conducted within an already running noncompliance cycle and a CMP is imposed, the facility is given appeal rights and may exercise its waiver of right to a hearing (refer to section 7526 of the State Operations Manual (SOM), Chapter 7). This tool is not intended to yield an automatic, immutable end result in the calculation of a CMP. It does not replace professional judgment or the application of other pertinent information in arriving at a final CMP amount. However, it does provide logic, structure, and defined factors for mandatory consideration in the determination of CMPs. The tool should be used with the CMP Analytic Tool User's Guide, which more fully explains factors and policies that lead to final CMP amounts.

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[2] A CMP is changed when the circumstances initiating the original CMP imposed have changed and an increase or decrease to the original CMP may be warranted. For example, a facility has corrected some but not all of the original deficiencies and is still within its noncompliance cycle and the remaining deficiencies warrant an increase or decrease in the original CMP imposed. See section 7516.3 of the SOM.

[3] A noncompliance cycle begins with a recertification, complaint or temporary waiver revisit survey that finds noncompliance and ends when substantial compliance is achieved or the facility is terminated (or voluntarily terminates) from the Medicare and Medicaid programs. The noncompliance cycle cannot exceed 6 months. Once a remedy is imposed, it continues until the facility is in substantial compliance (and in some cases, until it can demonstrate that it can remain in substantial compliance), or is terminated from the programs.

If you have any questions regarding this memorandum, tool, or guidance, please contact Akosua Ghailan at (410) 786-8047 or at Akosua.Ghailan2@cms.hhs.gov.

Effective Date: Immediately for all enforcement cases when the CMS RO determines that a CMP is an appropriate enforcement remedy. This guidance should be communicated to all RO and State Survey Agency survey, certification and enforcement staff, their managers and the State/RO training coordinators within 30 days of this memorandum.

/s/
Thomas E. Hamilton

Attachment- CMP Analytic Tool User's Guide

cc: Survey and Certification Regional Office Management

Centers for Medicare & Medicaid Services
Center for Clinical Standards & Quality
Survey & Certification Group
Division of Nursing Homes

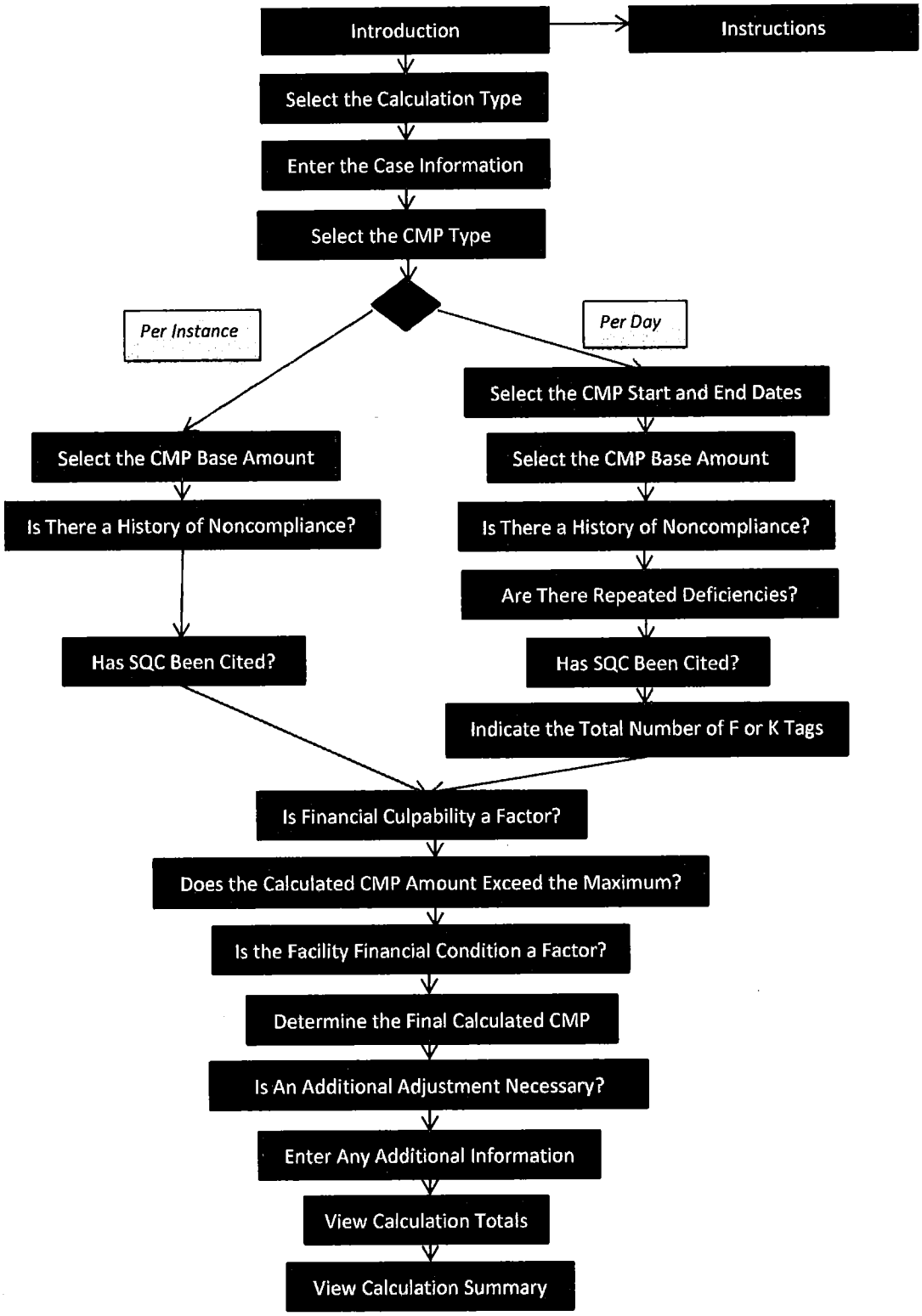
CMP Analytic Tool

User's Guide

Version 1.0

Contents

1 Overview


Introduction
Instructions
Select the Calculation Type
Enter the Case Information
Select the CMP Type
Per Instance
Per Day
Select the CMP Start and End Dates
Select the CMP Base Amount
Select the CMP Base Amount
Is There a History of Noncompliance?
Is There a History of Noncompliance?
Are There Repeated Deficiencies?
Has SQC Been Cited?
Has SQC Been Cited?
Indicate the Total Number of F or K Tags
Is Financial Culpability a Factor?
Does the Calculated CMP Amount Exceed the Maximum?
Is the Facility Financial Condition a Factor?
Determine the Final Calculated CMP
Is An Additional Adjustment Necessary?
Enter Any Additional Information
View Calculation Totals
View Calculation Summary

2 CMP Analytic Tool

2.1 Introduction Section

2.1.1 Instructions

All CMS Regional Offices (ROs) are required to use the following CMP Analytic Tool and Instructions: (1) to choose the appropriate type of CMP to be imposed; and (2) to calculate the CMP amount, when the RO determines that a CMP is an appropriate remedy to impose. The RO must complete all sections of the tool that apply to the type of CMP selected. Please refer to the CMP Analytic Tool User's Guide for information about using this tool.

Note: Use a separate calculation for each Life Safety Code (LSC) CMP, Health Survey CMP, or any new or changed CMP within a noncompliance cycle. Always use the tool at this link (save in your bookmarks/favorites) for the most current version. Required fields are marked with an asterisk.*

2.2 "Select the Calculation Type" Section

2.2.1 Input

Field	Input	Detailed Instructions	Error Messages
Calculation Type (Required)	• Preliminary • Final	Select "Final" if in compliance or terminated.	Please select a calculation type.

2.3 "Enter the Case Information" Section

2.3.1 Input

Field	Input	Detailed Instructions	Error Messages
CCN (Required)	Text	N/A	Please enter a CCN.
Confirm CCN (Required)	Text	N/A	Please enter the CCN again. The CCN does not match, please try again.
Provider Name (Required)	Text	N/A	Please enter a Provider Name.
Analyst Name (Required)	Text	Enter full name (first and last name).	Please enter the Analyst Name.
Cycle Start Date (Required)	Text	Enter the date in mm/dd/yyyy format.	Please enter a Cycle Start Date. Please enter a valid date in mm/dd/yyyy format.

2.4 "Select the CMP Type (Per Day or Per Instance)" Section

2.4.1 Instructions

Section 1819(h)(2)(B)(ii) of the Social Security Act.

The factors to consider in this tool for each type of CMP are intended to determine amounts for each CMP to be imposed. Also, if a Life Safety Code (LSC) deficiency is the basis for the CMP, the whole Tool algorithm applies to the LSC deficiencies, not the health deficiencies.

Note: This tool is to be used to calculate an amount for each new or changed CMP imposed against a facility within a noncompliance cycle.

2.4.2 Input

Field	Input	Detailed Instructions	Error Messages
CMP Type (Required)	• Per Day CMP (PD) • Per Instance CMP (PI)	For each instance where a CMP will be imposed for a facility, select only one CMP Type to be used: Per Day or Per Instance. Always choose a PD CMP if none of the PI factors is present. Select a PI CMP ***only*** when one or more of the associated factors are present (check all applicable factors).	Please select a CMP Type.
CMP Per Instance Factors	• Finding of noncompliance that is a singular event of actual harm at a S/S at "G" or "J" • Findings of current/ongoing noncompliance at a S/S of "G" or above, or SQC findings at "F" but where a facility has a good compliance history • Findings of past noncompliance when dates of noncompliance *cannot* be determined at a S/S of "G" or above or SQC findings at a S/S of "F".	N/A	Please select one or more factors for the selected CMP Type.

2.5 "Select the CMP Start and End Dates (Only for Per Day CMPs)" Section

2.5.1 Instructions

PD CMP Start Date - A PD CMP should begin on the first day noncompliance at the cited S/S 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 date the noncompliance was observed and documented at the time of the current survey.

PD CMP End Date - Except in cases when IJ is removed on the same date that it was identified, do not include the day on which IJ is removed, the day the S/S is lowered, thereby lowering the CMP amount to another level or substantial compliance is achieved when calculating the final PD CMP.

2.5.2 Input

Field	Input	Detailed Instructions	Error Messages
CMP Start Date	Text	Enter the date in mm/dd/yyyy format.	Please enter a CMP Start Date. Please enter a valid date in mm/dd/yyyy format. Please select a CMP Type of Per Day for this field. Please select a start date that is on or before the end date.
CMP End Date	Text	Enter the date in mm/dd/yyyy format.	Please enter a CMP End Date. Please enter a valid date in mm/dd/yyyy format. Please select a CMP Type of Per Day for this field. Please select a start date that is on or before the end date.

2.6 "Select the CMP Base Amount" Section

2.6.1 Instructions

Select the highest S/S level for the base Calculated CMP Amount.

2.6.2 Input

Field	Input	Detailed Instructions	Error Messages
CMP Base Amount (Required)	• Per Day - Regional Office Discretion - $50 • Per Day - Regional Office Discretion - D - $100 • Per Day - Regional Office Discretion - E - $150 • Per Day - Potential for More than Minimal - F - $200 • Per Day - Actual Harm - S/S Level G - $250 • Per Day - Actual Harm - S/S Level H - $600 • Per Day - Actual Harm - S/S Level I - $1000 • Per Day - Immediate Jeopardy - S/S Level J - $3050 • Per Day - Immediate Jeopardy - S/S Level K - $4050 • Per Day - Immediate Jeopardy - S/S Level L - $5050 • Per Instance - Potential for More than Minimal - S/S Level F - $1,200 • Per Instance - Actual Harm - S/S Level G - $1,500 • Per Instance - Actual Harm - S/S Level H - $2,000 • Per Instance - Actual Harm - S/S Level I - $2,500 • Per Instance - Immediate Jeopardy - S/S Level J - $3500 • Per Instance - Immediate Jeopardy - S/S Level K - $4500 • Per Instance - Immediate Jeopardy - S/S Level L - $5500	Select the highest S/S level for the base Calculated CMP Amount.	Please select a CMP Base Amount.
Abated IJ	Yes	N/A	N/A

2.7 "Is There a History of Facility Noncompliance?" Section

2.7.1 Instructions

42 CFR §488.438(f)(1).

If a facility has a history and/or a pattern of noncompliance at a S/S of "G" or above for surveys (standard, complaint, or revisit) conducted in the past 3 calendar years, add an amount indicated below based on the S/S pattern/trend of a facility's noncompliance history.

2.7.2 Input

Field	Input	Detailed Instructions	Error Messages
Facility Noncompliance Amount Added	Number	Enter a dollar amount (no cents) to add to the Calculated CMP Amount. Do not add less than $100 or more than $500.	Please enter a positive dollar amount (no cents) from 100 to 500.

2.8 "Are There Repeated Deficiencies? (Only for Per Day CMPs)" Section

2.8.1 Instructions

42 CFR §488.438(d)(2)(3).

"Repeated Deficiencies" are deficiencies within the same regulatory grouping of requirements under which deficiencies were cited at the last survey, subsequently corrected, and cited again at the next survey.

2.8.2 Input

Field	Input	Detailed Instructions	Error Messages
Repeated Deficiencies Amount Added	• Per Day - S/S Level F - Add $50 • Per Day - S/S Level G, H, I - Add $100 • Per Day - S/S Level J, K, L - Add $150	Select the amount to add to the Calculated CMP Amount based on the highest S/S level of the repeat deficiencies.	Please select a CMP Type of Per Day for this field.

2.9 "Has a Substandard Quality of Care (SQC) Been Cited?" Section

2.9.1 Instructions

42 CFR §488.438(d)(2)(3).

SQC is defined for deficiencies cited at a S/S "F", "H", "I", "J", "K", or "L" within the regulatory groupings of 42 CFR §483.13 (Tags F221-F226), 42 CFR §483.15 (Tags F240-F258), or 42 CFR §483.25 (Tags F309-F333).

2.9.2 Input

Field	Input	Detailed Instructions	Error Messages
Repeated Deficiencies Amount Added	• Per Day - S/S Level F - Add $50 • Per Day - S/S Level H, I - Add $100 • Per Day - S/S Level J, K, L - Add $500 • Per Instance - S/S Level F - Add $500 • Per Instance - S/S Level H, I - Add $1,000 • Per Instance - S/S Level J, K, L - Add $2,500	Select the amount to add to the Calculated CMP Amount based on the highest SQC S/S level.	N/A

2.10 "Indicate the Total Number of "F" or "K" Tags Cited that Contributed to the CMP (Only for Per Day CMPs)" Section

2.10.1 Instructions

42 CFR §488.438(d)(2)(3).

SQC is defined for deficiencies cited at a S/S "F", "H", "I", "J", "K", or "L" within the regulatory groupings of 42 CFR §483.13 (Tags F221-F226), 42 CFR §483.15 (Tags F240-F258), or 42 CFR §483.25 (Tags F309-F333).

2.10.2 Input

Field	Input	Detailed Instructions	Error Messages
Total Number of Tags Cited Amount Added	• Per Day - 1-6 F or K Tags - S/S Level F at SQC- Add $0 • Per Day - 1-6 F or K Tags - S/S Level G, H, I - Add $50 • Per Day - 1-6 F or K Tags - S/S Level J, K, L - Add $400 • Per Day - 7-10 F or K Tags - S/S Level F at SQC- Add $0 • Per Day - 7-10 F or K Tags - S/S Level G, H, I - Add $100 • Per Day - 7-10 F or K Tags - S/S Level J, K, L - Add $450 • Per Day - 11-19 F or K Tags - S/S Level F at SQC- Add $0 • Per Day - 11-19 F or K Tags - S/S Level G, H, I - Add $150 • Per Day - 11-19 F or K Tags - S/S Level J, K, L - Add $500 • Per Day - 20+ F or K Tags - S/S Level F at SQC- Add $50 • Per Day - 20+ F or K Tags - S/S Level G, H, I - Add $200 • Per Day - 20+ F or K Tags - S/S Level J, K, L - Add $550	Select the number of tags and the amount (if any) to add to the Calculated CMP Amount based on the highest S/S level. Do not include deficiencies for which the S/S set the base amount - use the next highest S/S level.	Please select a CMP Type of Per Day for this field.

2.11 "Is Facility Culpability a Factor?" Section

2.11.1 Instructions

42 CFR §488.438(f)(4).

Add an amount indicated below if culpability is a factor, this can include 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.

2.11.2 Input

Field	Input	Detailed Instructions	Error Messages
Base Culpability Amount Added	Number	Enter a dollar amount (no cents) to add to the Calculated CMP Amount based on the highest S/S level cited: • "F" at SQC - Add $100-$250 • "G", "H", "I" - Add $300 - $1,000 • "J", "K", "L" - Add $1,250 - $2,250	Please enter a positive dollar amount (no cents) from 100 to 2,250.
Failure to Act Culpability Amount Added	Number	Enter a dollar amount (no cents) to add to the Calculated CMP Amount. 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 - Add up to $500.	Please enter a positive dollar amount (no cents) from 1 to 500.
Facility Culpability Rationale	Text	N/A	N/A

2.12 "Does the Calculated CMP Amount Exceed the Maximum Regulatory Amount?" Section

2.12.1 Input

Field	Input	Detailed Instructions	Error Messages
Reduced Calculated CMP Amount	• Per Day - Calculated CMP Amount for IJ Case > $10,000 - Reduce Calculated CMP Amount to $10,000 • Per Day - Calculated CMP Amount for Non-IJ Case > $3,000 - Reduce Calculated CMP Amount to $3,000 • Per Day - Calculated CMP Amount for Non-IJ Case > $3,000 and a repeat deficiency - No change • Per Instance - Calculated CMP Amount Exceeds $10,000 - Reduce Calculated CMP Amount to $10,000	Select the highest permissible CMP amount.	N/A

2.13 "Is the Facility Financial Condition a Factor?" Section

2.13.1 Instructions

42 CFR §488.438(f)(2).

A facility is responsible for notifying CMS of hardship and providing financial documentation.

2.13.2 Input

Field	Input	Detailed Instructions	Error Messages
Lower Calculated CMP Amount	Number	Enter a dollar amount (no cents). Select an option below if applicable.	Please enter a positive dollar amount (no cents).
Lower Calculated CMP Amount Selection	CMS reviewed the financial information and determined that facility documentation proves (select one): • The facility lacks sufficient assets to pay the CMP without having to go out of business. • The facility does not lack sufficient assets to pay the CMP without having to go out of business.	N/A	N/A

2.14 "Determine the Final Calculated CMP Amount" Section

2.14.1 Instructions

The Final Calculated CMP is determined according to CMP Type:

- The lowest Calculated CMP Amount is determined: lowest of Calculated CMP Amount, Reduced Calculated CMP Amount (adjusted for exceeding the maximum regulatory amount), and Lower Calculated CMP Amount (adjusted for facility financial condition).
- Final Calculated CMP Amount, Per Day: The lowest Calculated CMP Amount multiplied by the Total CMP days, less any Discount.
- Final Calculated CMP Amount, Per Instance: The lowest Calculated CMP Amount, less any Discount.

2.14.2 Input

Field	Input	Detailed Instructions	Error Messages
Discounts Applied to Final Calculated CMP Amount	• No Discount • Discount for Waiving Appeal (35%) • Discount for Self-reporting and Waiving Appeal (50%)	N/A	Please select an option above so the final amount may be calculated. Please select a CMP Type, Start and End Dates if Per Day CMP, and a Base CMP Amount before selecting this option.

2.14.3 Output

Field	Description
Final Calculated CMP Amount	N/A

2.15 "Is An Additional Adjustment to the Final Calculated CMP Amount Necessary?" Section

2.15.1 Instructions

The Final Calculated CMP Amount may be adjusted by no more than 35%. If an Adjusted Final Calculated CMP Amount is entered, provide a rationale below. If the RO believes that the Final Calculated CMP Amount should be adjusted by more than 35%, they must consult with and obtain prior approval from the CO before making any further adjustment using this tool.

2.15.2 Input

Field	Input	Detailed Instructions	Error Messages
Adjusted Final Calculated CMP Amount	Number	Enter a dollar amount (no cents). Adjust the Final Calculated CMP Amount (which is the total amount for Per Instance or Per Day) and enter above. Note: The amount entered should reflect the total amount (not a Per Day amount).	Please enter a positive dollar amount (no cents). Please select an option above to calculate the Final Calculated CMP Amount first.
Adjusted Final Calculated CMP Amount Rationale	Text	N/A	Please provide a rationale.

2.16 "Enter Any Additional Case-Related Information (Optional)" Section

2.16.1 Input

Field	Input	Detailed Instructions	Error Messages
Additional Information	Text	N/A	Please provide a rationale.

2.17 "View Calculation Totals" Section

2.17.1 Output

Field	Description
Calculated CMP Amount	The Calculated CMP Amount is the sum of CMP Base Amount and Facility Noncompliance Amount, Repeated Deficiencies Amount (Per Day only), Substandard Quality of Care Amount, Total Number of Tags Cited Amount (Per Day only), Base Culpability Amount, and Failure to Act Culpability Amount, if any.
Reduced Calculated CMP Amount	The Reduced Calculated CMP Amount is the amount after the adjustment for exceeding the maximum regulatory amount, if any.
Lower Calculated CMP Amount	The Lower Calculated CMP Amount is the amount after the adjustment for facility financial condition, if any.
Total CMP Days	The Total CMP Days for Per Day is the total number of days from the CMP Start Date to the CMP End Date.
Discounts Applied to Final Calculated CMP Amount	The Discounts Applied to Final Calculated CMP Amount include one of the following options: No discount, 35% discount if waiving appeal, or 50% discount for self-reporting and waiving appeal.
Final Calculated CMP Amount	The Final Calculated CMP Amount for Per Day is the lowest Calculated CMP Amount multiplied by the Total CMP days, less any Discount. Note: This is a total amount, not a Per Day amount. The Final Calculated CMP Amount for Per Instance is the lowest Calculated CMP Amount, less any Discount.
Adjusted Final Calculated CMP Amount	The Adjusted Final Calculated CMP Amount is the amount after the adjustment to the Final Calculated CMP Amount. Note: This is a total amount, not a Per Day amount.
Total Final CMP Amount	The Total Final CMP Amount is the Adjusted Final Calculated CMP Amount if an adjustment was made, otherwise the Final Calculated CMP Amount.

2.18 "View Calculation Summary" Section

2.18.1 Input

Field	Input	Detailed Instructions	Error Messages
Display Calculation Summary	N/A	Note: If changes are made to any of the fields above, display Calculation Summary again.	Please correct the errors above then display the Calculation Summary again.
Begin a New Case	N/A	N/A	N/A

2.18.2 Output

Field	Field (Continued)
Calculation Type	Total Number of Tags Cited Selection
CCN	Total Number of Tags Cited Amount Added
Provider Name	Base Culpability Amount Added
Analyst Name	Failure to Act Culpability Amount Added
Cycle Start Date	Facility Culpability Rationale
Current Date	Calculated CMP Amount
CMP Type	Reduced Calculated CMP Amount Selection
CMP Per Instance Factors	Reduced Calculated CMP Amount - Maximum Exceeded
CMP Start Date	Lower Calculated CMP Amount - Financial Condition
CMP End Date	Lower Calculated CMP Amount Selection
Abated IJ	Discounts Applied to Final Calculated CMP Amount
CMP Base Amount Selection	Total CMP Days
CMP Base Amount	Final Calculated CMP Amount
Facility Noncompliance Amount Added	Adjusted Final Calculated CMP Amount
Repeated Deficiencies Selection	Rationale for Adjusted Final Calculated CMP
Repeated Deficiencies Amount Added	Total Final CMP Amount
Substandard Quality of Care Selection	Additional Information
Substandard Quality of Care Amount Added	

3 Instructions

3.1 Instructions for Use and Completion of the Civil Money Penalty (CMP) Analytic Tool

All CMS Regional Offices (ROs) are required to use the following instructions and CMP Analytic Tool: (1) to choose the appropriate type of CMP to be imposed; and (2) to calculate the CMP amount, when the RO determines that a CMP is an appropriate remedy to impose. The RO must complete all sections of the tool that apply to the type of CMP selected.

ROs must evaluate each case and consider whether or not to impose a CMP in addition to or instead of other remedies for deficiencies with a Scope and Severity (S/S) of "G," or above, and for deficiencies with a S/S of "F" when Substandard Quality of Care (SQC) is cited. For deficiencies cited at other S/S levels, the RO should consider imposing alternative remedies other than a CMP as appropriate.

For cases in which the State Survey Agency fails to recommend a CMP, the RO must evaluate whether or not a CMP remedy is warranted. In such cases, the RO must review the survey findings and impose the appropriate remedy(ies) regardless of a State's recommendation.

ROs must use this tool in the calculation of each new or changed[1] CMP imposed on a facility within a noncompliance cycle[2]. Each time a survey is conducted within an already running noncompliance cycle and a CMP is imposed, the facility is given appeal rights and may exercise its waiver of right to a hearing (refer to section 7526 of the State Operations Manual (SOM), Chapter 7).

This tool is not dispositive, and does not replace professional judgment or the application of other pertinent information in arriving at a final CMP amount. However, it does provide logic, structure, and defined factors for mandatory consideration in the determination of CMPs. The tool should be used with this protocol, which more fully explains factors that lead to final CMP amounts.

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[1] A CMP is changed when the circumstances initiating the original CMP imposed have changed and an increase or decrease to the original CMP may be warranted. For example, a facility has corrected some but not all of the original deficiencies and is still within its noncompliance cycle and the remaining deficiencies warrant an increase or decrease in the original CMP imposed. See section 7516.3 of the SOM.

[2] A noncompliance cycle begins with a recertification, complaint or temporary waiver revisit survey that finds noncompliance and ends when substantial compliance is achieved or the facility is terminated (or voluntarily terminates) from the Medicare and Medicaid programs. The noncompliance cycle cannot exceed 6 months. Once a remedy is imposed, it continues until the facility is in substantial compliance (and in some cases, until it can demonstrate that it can remain in substantial compliance), or is terminated from the programs.

3.2 Choosing the Type of CMP to be Imposed

After making a determination that a CMP will be imposed, ROs must use the Tool and the following guidance to decide whether to impose a Per Instance (PI) CMP versus a Per Day (PD) CMP, regardless of the State Survey Agency's recommendation.

PD CMP – Always choose a PD CMP if none of the PI factors is present. A PD CMP is generally used when the noncompliance lasts for two or more days. CMS regulations specify a per day CMP range from $50 to $10,000 for each day a facility is noncompliant: from $50 to $3,000 for non-immediate jeopardy noncompliance, and $3,050 to $10,000 for immediate jeopardy (IJ) noncompliance.

PI CMP – Choose a PI CMP ONLY when one or more of the following factors are present:

1. Finding of noncompliance that is a singular event of actual harm at a S/S at "G" or "J";
2. Findings of current/ongoing noncompliance at a S/S of "G" or above, or SQC findings at "F" but where a facility has a good compliance history; and/or
3. Findings of past noncompliance when dates of noncompliance **CANNOT** be determined at a S/S of "G" or above or SQC findings at a S/S of "F".

Per instance[3] CMPs range from $1,000 to $10,000 per instance of noncompliance. While multiple per instance CMPs can be imposed for deficiencies identified during a survey, the total amount of the CMP imposed for a survey cannot exceed $10,000.

NOTE: The PD and the PI CMP cannot be used simultaneously during a specific survey (i.e., standard, revisit, complaint), but both types of CMPs may be used during a noncompliance cycle if more than one survey takes place and the PD CMP was not the CMP initially imposed. However, when a PD CMP is the CMP initially imposed, a PI CMP cannot be imposed on a subsequent survey within the same noncompliance cycle.

Factors to consider when determining "a good compliance history" might include but are not limited to:

- The facility is not a Special Focus Facility;
- The facility has not had findings at a S/S of "G" or above within the past three (3) calendar years, unless they were cited as past noncompliance;
- The facility has a history/pattern of achieving compliance prior to or at the time of the first revisit; and/or

[3] Unlike for PD CMPs, CMS does not specify a particular PI CMP amount range for cases of immediate jeopardy. An "instance" is a single deficiency identified by the tag number used as a reference on the CMS-2567 and in Appendix PP of the SOM.

- The facility has a history/pattern of sustaining compliance with previously cited deficiencies (i.e., no repeat deficiencies).

3.3 Choosing the PD CMP Start Date

A PD CMP should begin on the first day noncompliance at the cited S/S 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 date the noncompliance was observed and documented at the time of the current survey.

For example, a survey begins on May 1 and on that date the survey team finds evidence of immediate jeopardy. If the survey team is able to document that the immediate jeopardy began on April 1, the CMP start date is April 1. However, if the survey team is unable to document the first day of noncompliance at the immediate jeopardy level, the CMP would start on May 1.

3.4 Guidance on Determining the Dates of a PD CMP

PD CMP Start Date[4] - In all possible cases, the RO analyst shall 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).

Therefore, in performing the survey and when making a recommendation for a PD CMP to CMS, the State Survey Agency must determine the earliest date for which supportable evidence shows that the noncompliant practice began.

If this start date is not clearly identified and supportable, then the RO should contact the State Survey Agency to see if such a date can be determined and should document this discussion and conclusion. If the start date cannot be determined, the PD CMP would begin on the first day during the survey on which the survey team identified the noncompliant practice.

PD CMP End Date - Except in cases when IJ is removed on the same date that it was identified, do not include the day on which IJ is removed, the day the S/S is lowered, thereby lowering the CMP amount to another level or substantial compliance is achieved when calculating the final PD CMP. See 42 C.F.R. §488.440(h), penalties accrue until the date of correction. The RO analyst will input the resulting number of days into the CMP Analytic Tool.

[4] A CMP may not include days prior to the date of the last standard survey.

3.5 CMPs for Past Noncompliance

Past noncompliance identified during the current survey means a deficiency citation at a specific survey data tag (F-tag or K-tag) (with a S/S at "G" or above, or SQC findings at a S/S at "F") that meets **all** of the following three criteria:

1. The facility was not in compliance with the specific regulatory requirement(s) (as referenced by the specific F-tag or K-tag) at the time the situation occurred;
2. The noncompliance occurred after the exit date of the last standard (recertification) survey and before the survey (standard, complaint, or revisit) currently being conducted; and
3. There is sufficient evidence to determine that the facility corrected the noncompliance and is in substantial compliance at the time of the current survey for the specific regulatory requirement(s), as referenced by the specific F-tag or K-tag.

Additional information regarding past noncompliance can be found in the State Operations Manual, Appendix P, Section E, "Determining Citations of Past Noncompliance at the Time of the Current Survey."

3.6 Required Central Office Prior Approval for Any Adjustment to Final Calculated CMP Amount of More than Thirty-five Percent (35%)

If the RO believes that the circumstances involved in the specific case require an adjustment to the CMP amount which was calculated using this Tool, the RO may increase or reduce the CMP by NO MORE THAN 35 percent. **If the RO makes such an adjustment, in each instance, it must provide a rationale for that adjustment when completing the tool.** An adjustment to the CMP is not the same thing as imposing a different CMP based on different or new deficiencies. Whenever such an adjustment is made, the analyst will annotate the tool when calculating the original CMP to explain why an adjustment was made. For a newly imposed or revised CMP within the same noncompliance cycle, a separate tool is to be completed.

NOTE: If the RO believes that a calculated CMP should be adjusted by **more** than 35 percent, it must consult with and obtain prior approval from CMS Central Office before making the adjustment. Requests for prior approval should be sent to Akosua Ghailan.

A 35 percent adjustment that the RO may make is not the same as, and does not affect, the 35 or 50 percent reductions made to the total CMP amount based on §§488.436 and 488.438. The facility will receive a 35 percent reduction if it timely waives its right to an Administrative Hearing. The facility should be notified that it will receive a 50 percent reduction if **all** of the following conditions are met:

- The facility must have self-reported the noncompliance to CMS or the State before it was identified by CMS or the State and before it was reported to CMS or the State by means of a complaint lodged by a person other than an official representative of the nursing home;
- Correction of the noncompliance must have occurred on the earlier of either 15 calendar days from the date of the self-reported circumstance or incident that later resulted in a finding of noncompliance or 10 calendar days from the date (of CMS' notice to the facility) that a CMP was imposed;
- The facility waives its right to a hearing;
- The noncompliance that was self-reported and corrected did not constitute a pattern of harm, widespread harm, immediate jeopardy, or result in the death of a resident;
- The CMP was not imposed for a repeated deficiency that was the basis of a CMP that previously received a reduction; and
- The facility has met mandatory reporting requirements for the incident or circumstance upon which the CMP is based as required by Federal and State law.

If you have any questions regarding the memorandum, Tool or guidance, please contact Akosua Ghailan at (410) 786-8047.

Effective Date: Immediately for all enforcement cases when the CMS RO determines that a CMP is an appropriate enforcement remedy. This guidance should be communicated to all RO and State Survey Agency survey, certification and enforcement staff, their managers and the State/RO training coordinators within 30 days of this memorandum.

3.7 For Training and General Examples ONLY[5]

The following information provides some examples of situations in which the Departmental Appeals Board (DAB)[6] and/or the DAB Administrative Law Judges (ALJs) determined that there was facility culpability.

Physical Environment: 42 C.F.R. §483.70

1. Life Safety Code (LSC) and/or maintenance issues considered detrimental to the health, safety and welfare of the residents. DAB CR3000

Quality of Care: 42 C.F.R. §483.25

[5] Note this information is provided only by way of providing some examples in which the DAB found culpability in the past.
[6] DAB website

1. Repeated failure to timely follow or clarify doctor's treatment orders (including for pressure sores). DAB 2390 and 2299
2. Repeated failure to notify doctor of significant changes. DAB 2479 and 2304
3. Repeated failure to notify physician of change which exposed resident to high likelihood of suffering grave harm. DAB 2304 and 2300
4. Repeated failure to properly assess pressure sores. DAB 2426
5. Multiple residents with severe weight loss (> 5% in a month) not detected or addressed despite care plan. DAB 2511
6. Repeated failure to timely provide testing, care, treatment & services for residents receiving anticoagulant therapy. DAB 2411
7. Repeated failure to closely monitor resident with compromised respiratory status, or failure to have necessary oxygen equipment. DAB, 2511, 2344, 2327, and 2299
8. Failure to administer CPR to "full code" resident. DAB 2396 and 2336
9. Repeated failure to implement interventions and supervise to prevent falls for resident with history of falls. DAB 2470, 2380, and 2357
10. Repeated failure to adequately supervise resident with known choking problems to provide prompt intervention. DAB 2520 and 2192
11. Repeated failure to provide blood sugar monitoring and care as ordered as ordered by physician. DAB 2375
12. Repeated failure to supervise residents with known history of elopement. DAB 2450, 2446, 2434, and 2288
13. Repeated transfer of residents by one aide despite care plan requiring two aides for transfer. DAB CR1863

Resident Behavior and Facility Practices: 42 C.F.R. §483.13

1. Staff failure to promptly report physical, verbal or sexual abuse. DAB 2256

Quality of Life: 42 C.F.R. §483.15

1. Egregious dignity issues. DAB 2513