WHAT YOU NEED TO KNOW ABOUT PREPARING FOR SURVEYS AND RESPONDING TO AN ADVERSE SURVEY/LICENSURE ACTION

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Presented by
Kimber L. LaBish, Esq.
Tanya Daniels Harris, Esq.

PREPARING FOR A SURVEY

OVERVIEW OF RECENT SURVEY AND ENFORCEMENT ISSUES

- Performance Audit of DOH Regulation and Oversight of Nursing Facilities July 26, 2016
  - Staffing
  - Disposition of Complaints
  - Inadequate Civil Money Penalties
OVERVIEW OF RECENT SURVEY AND ENFORCEMENT ISSUES

• DOH Civil Penalty Assessment Guideline – 12/19/16:
  • Factors to be considered when issuing civil penalties:
    • Statutory provisions authorizing civil penalties under HCFA
    • Recommendations contained in PA Auditor General’s Performance Audit Report (July 2016)
    • DOH’s interest in effective regulation to promote the highest possible quality of care and services for LTC residents in PA
  • Any facility with a survey exit date on or after 1/1/2017 may be subject, when warranted, to civil penalties calculated on a per violation per day basis pursuant to 35 P.S. § 448.87

OVERVIEW OF RECENT SURVEY AND ENFORCEMENT ISSUES CON’T.

• DOH Civil Penalty Assessment Guideline
  • Guidance from the Secretary of Health preserves DOH’s “discretion to take into consideration other mitigating or aggravating circumstances.” If mitigating or aggravating circumstances warrant deviating from the Secretary’s guidance, the Division of Nursing Care Facilities will be able to propose an alternative civil penalty with a special committee formed by the Secretary.

OVERVIEW OF RECENT SURVEY AND ENFORCEMENT ISSUES CON’T.

• Immediate Jeopardy Citations
  • Issue of DOH making immediate jeopardy (IJ) determinations that were inconsistent with guidance under Appendix Q during time period of approximately 11/15/2016 until 12/20/2016.
  • Susan Williamson (Director, Division of Nursing Care Facilities) issued clarifying information to the field offices on 12/20/2016 instructing field offices to follow Appendix Q when making IJ determinations.
NEW LTC SURVEY PROCESS

• New LTC Survey Process (Effective November 28, 2017)
  • One unified survey process that will utilize strengths from both the Traditional survey process and Quality Indicator Survey (QIS) process
  • Goal of being more effective and efficient
  • Focus is resident-centered
  • New survey process provides structure to ensure consistency while allowing surveyors autonomy
  • New survey process will be an automated process (i.e., computer software-based).

NEW LTC SURVEY PROCESS

• Sample Selection
  • Sample size is determined by the facility census
  • 70% of the total sample is MDS pre-selected residents and 30% of the total sample is selected onsite by the survey team
  • Maximum sample size is 35 residents

PREPARING FOR A SURVEY

• CMS released new long-term care survey forms and updated investigative protocols to be used for the new survey process:
  • Survey Preparation Worksheet - Provides a list of information that a facility must provide to surveyors immediately upon entrance, within one hour and within four hours of entrance, by the end of the first day of survey and within 24 hours of entrance.
  • Facility Map - Utilized to identify pertinent care categories for 1) newly admitted residents in the last 30 days who are still residing in the facility and 2) all other residents.
  • Critical Element Pathways - Pathways provide guidance to surveyors during the investigation process to determine compliance with the LTC Requirements of Participation. (NOTE: LTC Survey Pathways (total of 41) can be accessed via the following CMS website: https://www.CMS.gov/Medicare/Provider-Enrollment-and-Certification/Downloadable-Laws-Rules-Regulations-Nursing-Homes.pdf)
CMS FINAL RULE REGARDING CHANGES TO SURVEY TEAM COMPOSITION & INVESTIGATION OF COMPLAINTS

- On August 4, 2017, CMS published a final rule that clarifies the regulatory requirements for team composition for complaint surveys and aligns the regulatory provisions for investigation of complaints with the statutory requirements found in sections 1869 and 1919 of the Social Security Act.

MEDicare Program: Prospective Payment-System and Consolidated Billing for Skilled Nursing Facilities (SNF) for FY 2018, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, Survey Team Composition, and Correction of the Performance Period for the NHSN HEP Influenza Vaccination Immunization Reporting Measure in the ESRD QIP for FY 2016 which can be accessed via the following link: https://www.aspe.hhs.gov/medicare-prog/program-prospective-payment-system-consolidated-billing-skilled-nursing-facilities

CMS FINAL RULE REVISION CON’T.

- Survey Team Composition
  - Regulatory provision clarifies that only surveys conducted under sections 1891(g)(2) and 1919(g)(2) of the Social Security Act ("Act") are subject to the requirement at §488.314 that survey teams include a registered nurse.
  - Regulatory provision also clarifies that complaint surveys and surveys related to on site monitoring, including revisit surveys, are subject to the requirements of 1819(g)(4) and 1919(g)(4) of the Act and §488.332 which allows for the use of a specialized investigative team that may include appropriate healthcare professionals but need not include a registered nurse.

MINIMUM DATA SET (MDS) FOCUSED SURVEYS

- In November 2016, CMS issued a Survey & Certification Letter (Ref: S&C: 17-06-NH) addressing Minimum Data Set (MDS) focused surveys.
- The S&C Letter discussed OIG and subsequent CMS surveys aimed at assessing the accuracy of nursing facility self-reported data on resident assessments, as required by 42 C.F.R. § 483.20.
- It cited evidence that 47% of SNFs misreported assessment information in 2012, causing Medicare to overpay the facilities.
- CMS indicated they plan to continue to conduct MDS focused surveys through fiscal year 2017.
- The Pennsylvania Department of Health has recently begun conducting such surveys, focusing on resident assessment accuracy.

MINIMUM DATA SET (MDS) FOCUSED SURVEYS CONT.

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MINIMUM DATA SET (MDS) FOCUSED SURVEYS

• Adverse survey outcomes with respect to resident assessment accuracy can impact SNFs financially and may require remedial action.

  • A survey finding a deficiency stemming from resident assessment inaccuracy can result in civil monetary penalties.

  • Inaccurate resident assessments, which affect MDS scores and RUG classifications, can result in Medicare overpayments to the facility.

  • If a survey cites resident assessment inaccuracies with respect to specific residents, the facility will likely have an obligation to determine whether Medicare overpayment results from those inaccuracies.

  • If a survey cites widespread assessment inaccuracies, the facility most likely will need to determine whether those errors have resulted in Medicare and/or Medicaid overpayments.

STEPS TO PREPARING FOR A SURVEY

• Understand new LTC survey process

• Review LTC Final Rule (effective 11/28/16) and revised interpretative guidance under Appendix PP of the State Operations Manual (effective 11/28/17)

• Ensure policies/procedures comply with LTC Final Rule

• Educate/train facility staff regarding policies/procedures

• Train staff on what to expect during a survey

STEPS TO PREPARING FOR A SURVEY

• Conduct Mock Surveys

  • Facility staff vs. outside consultant

  • Utilization of new Entrance Conference Worksheet, Facility Matrix and Critical Element Pathways as tools to assess compliance with LTC Final Rule and identify any systems, procedures and/or processes of care that need improvement.

  • Address any compliance issues.
Responding to an Adverse Survey/Licensure Action

APPEAL OPTIONS

- IDR
- State IIDR
- Federal IIDR
- DOH Appeal
- CMS Appeal
- DAB Appeal
- Federal Court

INFORMAL DISPUTE RESOLUTION (“IDR”)

- Purpose – To challenge one or more deficiencies on the CMS-2567 that the facility believes was cited in error.
- Timeline – Must submit IDR within the same 10-calendar day period the facility has for submitting an acceptable Plan of Correction.
- Other – Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility.
IDR PROCESS
• Facilities may not use the IDR process to challenge:
  • Scope and severity (unless substandard quality of care or immediate jeopardy)
  • Remedy(ies) imposed by the enforcing agency
  • Failure of the survey team to comply with a requirement of the survey process
  • Alleged inconsistency of the survey team in citing one or more deficiencies among facilities; or the
  • Alleged inadequacy or inaccuracy of the IDR process

IDR PROCESS
• Documentation to support IDR
• IDR submitted to Department of Health for review
• Decision of DOH final – no appeal of final decision
• If IDR results in elimination of one or more deficiencies, the following applies:
  • Facility will receive a "clean" (new) CMS-2567
  • Any enforcement action imposed solely as a result of one or more deficiencies will be rescinded.

STATE INDEPENDENT INFORMAL DISPUTE RESOLUTION ("STATE IIDR")
• Pennsylvania’s Long-term Care Nursing Facility Independent Dispute Resolution Act (Effective 4/20/2012)
• Establishes an independent informal review process for long-term care nursing facilities to dispute
  state and federal survey deficiencies
• Quality Insights of Pennsylvania conducts the State IIDR process
• State IIDR process conducted on a fee-for-service basis (currently $95/hour)
STATE IIDR CONT’D.
- Timeline – State IIDR must be submitted within the same 10 calendar days that facility has to submit the POC
- To request a State IIDR, the nursing facility must submit:
  - Written IIDR request that identifies the deficiencies disputed and the reasons for the IIDR request
  - Supporting documentation
  - Copy of 2567
  - Indicate type of review requested: Desk review, telephone review or in-person review

QIP reviews the IIDR/supporting documentation and submits a written recommendation to the facility, with a copy to DOH, within 45 days of receipt of the IIDR request.
- If QIP sustains the deficiency, then QIP’s written determination shall include the rationale for its decision and provide recommended action that the facility can implement to achieve compliance.
- If QIP reverses the deficiency and DOH disagrees, DOH has authority to nullify QIP’s decision.

FEDERAL INDEPENDENT INFORMAL DISPUTE RESOLUTION (“FEDERAL IIDR”)
- Federal IIDR applicable if:
  - The Centers for Medicare and Medicaid Services (“CMS”) imposes civil money penalties against the nursing facility; and
  - The penalties are subject to being collected and placed in an escrow account pending a final administrative decision.
- CMS may collect and place imposed civil money penalties in an escrow account on whichever of the following occurs first:
  - The date on which the IIDR process is completed, or
  - The date which is 90 calendar days after the date of the notice of imposition of the civil money penalty

NOTE: If a facility utilizes the IDR or State IIDR process to challenge the survey findings, the facility cannot also utilize the federal IIDR process for the same survey unless the IDR or State IIDR process (whichever is applicable) was completed prior to the imposition of the civil money penalty.
FEDERAL IIDR

Timeline:
- A request for a Federal IIDR must be submitted within 10 calendar days of the receipt of the letter from CMS regarding the imposition of the civil money penalties.
- The Federal IIDR shall be completed within 60 calendar days of a facility's request.

(Note: The Federal IIDR is deemed completed when a final decision from the IIDR process has been made, a written record has been generated and the State survey agency has sent written notice of this decision to the facility. The IIDR process is also considered to be completed if a facility does not timely request or chooses not to participate in the IIDR process.)

FEDERAL IIDR

- During the Federal IIDR process, a facility may not challenge other aspects of the survey process, such as:
  - Scope or severity (unless substandard quality of care or immediate jeopardy)
  - Remedy(ies) imposed
  - Alleged failure of the survey team to comply with a requirement of the survey process
  - Alleged inconsistency of the survey team in citing deficiencies among other facilities; or the
  - Alleged inadequacy or inaccuracy of the IDR or IIDR process

FEDERAL IIDR

- Request for Federal IIDR must include:
  - Copy of CMS letter indicating facility is eligible for an IIDR review
  - Written IIDR request that identifies the deficiencies disputed and reasons for the IIDR request
  - Supporting documentation
  - Names and contact information for residents involved in the deficiencies for which the facility seeks an IIDR review or the appropriate resident representative(s)
FEDERAL IIDR

• Opportunity for Resident or Resident’s Representative to comment:
  • Once a facility requests a Federal IIDR, the State must notify the involved resident or resident representative, as well as the State’s long-term care ombudsman, that they have an opportunity to submit written comment.

FEDERAL IIDR

• The notice to the resident/resident’s representative, at a minimum, must include:
  • A brief description of the findings of noncompliance for which the facility is requesting the IIDR, a statement about the CMP imposed based on those findings, and reference to the relevant survey date
  • Contact information for the State survey agency, or the approved IIDR entity or person regarding when, where and how potential commenters must submit their comments
  • A designated contact person to answer questions/concerns
  • For residents and/or resident’s representatives, contact information for the State’s long-term care ombudsman.

FEDERAL IIDR

• Written Record re: Federal IIDR
  • The IIDR entity or person must generate a written record as soon as practicable but no later than within 10 calendar days of completing its review
  • Written record shall include:
    • List of each deficiency or survey findings that was disputed
    • A summary of the IIDR recommendation for each deficiency or finding at issue and the justification for that result
    • Documents submitted by the facility to dispute a deficiency
    • Any comments submitted by the State long-term care ombudsman and/or residents or resident representatives.
FEDERAL IIDR

- Federal IIDR Recommendation and Final Decision
  - Upon receipt of the IIDR written record, the State Survey Agency ("SSA") will review the IIDR recommendations and:
    - If SSA agrees with IIDR recommendations and no changes will be made to the disputed survey findings, the SSA will send written notice of the final decision to the facility within 10 calendar days of receiving the written record from the IIDR entity/person.
    - If SSA disagrees with one or more of the recommendations of the IIDR entity/person, the complete written record will be sent to the applicable CMS Regional Office for review and final decision. SSA will then send written notice of final decision to the facility within 10 calendar days of receiving CMS' final decision.

- Federal IIDR Recommendation and Final Decision cont’d.
  - If SSA agrees with IIDR recommendation(s) or has received a final decision from the CMS Regional Office and changes will need to be made to the disputed survey findings, the SSA will, within 10 calendar days of receiving the written record:
    - Change deficiency(ies) citation content findings as recommended.
    - Adjust scope and severity assessments as warranted by CMS policy.
    - Annotate deficiency(ies) citation as "deleted" or "amended" where appropriate.
    - Have a SSA manager/supervisor sign and date revised CMS-2567.
    - Promptly recommend to CMS that any enforcement action(s) imposed solely because of deleted or altered deficiency citations be reviewed, changed or rescinded as appropriate.
    - Provide written notice of the final decision to the facility.

OVERVIEW

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<tr>
<th>IIDR</th>
<th>State IIDR</th>
<th>Federal IIDR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submitted within same number of calendar days that facility has to submit POC</td>
<td>Submitted within same number of calendar days that facility has to submit POC</td>
<td>Submitted within 10 calendar days of the receipt of the CMS letter imposing CMPs</td>
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<tr>
<td>No Fee</td>
<td>Fee for Service basis</td>
<td>No Fee</td>
</tr>
<tr>
<td>Can only dispute federal deficiencies</td>
<td>Can dispute state and federal deficiencies</td>
<td>Can only dispute federal deficiencies</td>
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<tr>
<td>NO NOTICE to and NO OPPORTUNITY for comment by resident/resident’s representative</td>
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<tr>
<td>Quality Insights of PA reviews State IIDR but DOH is final decision-maker</td>
<td>Independent entity within the DOH reviews IIDR, but if SSA disagrees, CMS is final decision-maker</td>
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DOH APPEAL

- Possible Sanctions:
  - CMP
  - Provisional License

- Appeal of Adverse State Orders
  - File appeal within 30 days of the date of mailing of the Order
  - Appeal of sanction does not act as an automatic supersedeas
  - Must specifically deny the allegations

DOH APPEAL CONT’D.

- Appeal of Adverse State Orders (continued)
  - Appeal filed with Health Policy Board
  - Hearing Officer to conduct hearing
  - Practical considerations
    - Possible admissions?
    - Probability of success

CMS APPEAL

- Possible Sanctions
  - CMP
  - Denial of Payment for New Admissions or All Individuals
  - Loss of NATCEP
  - Termination
The facility must appeal within 60 days of receipt of notice of imposition of remedies from CMS. Procedural elements of the appeal process are as follows:

1. Notice of Appeal and request for hearing
2. Pre-hearing Procedural Order
   a. Case readiness report
   b. Document and witness exchange
   c. Must identify evidence in exchange

3. Scheduling of hearing
   a. CMS Motions to Dismiss
   b. Timing
4. Hearing before Administrative Law Judge ("ALJ")
   a. Preparation – clinical documentation
   b. Physical evidence
   c. Witnesses, identification of expert witnesses
   d. Oral and written summation
   e. Use of hearsay
   f. Burden of proof

5. Decision of ALJ
6. DAB Appeal
7. Specificity of Appeal. In order to preserve factual issues, appeals should be specific, including which survey and Tag numbers are being contested. The specific grounds for the dispute should be included and explanations of why the conclusions are incorrect. The focus should be on the alleged deficient practice in comparison to the regulatory requirement. Issues of timing, dates, chronological order should be noted.
What is Subject to Appeal

1. Only actual remedies – not deficiencies alone
2. Severity and scope if related to IJ, Substandard Quality of Care, Loss of nurse aide training
3. Cannot appeal proposed or withdrawn remedies

Appeal Considerations

1. Nature of proposed remedy
   a. Immediate Jeopardy
   b. Resident death, abuse, serious injury
   c. Second consecutive S/S “G”
   d. Second revisit with any deficiencies (including new deficiencies) and 6 month mandatory termination date is approaching
   e. Termination proposed.

Appeal Considerations cont’d.

2. Waiver of appeal in exchange for 35% discount on Civil Monetary Penalty
3. Can you win on merits?
4. Cost