Surveys and Compliance: Using Your Compliance Program to Avoid Survey Sanctions

Robert W. Markette, Jr. CHC
Of Counsel
Hall, Render, Killian, Heath & Lyman P.C.
One American Square, Suite 2000
Indianapolis, IN 46282
E-mail: rmarkette@hallrender.com

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Intermediate Sanctions

Current Enforcement Environment
Survey Sanctions
How it Impacts Home Health
Preparing for the New Environment
Current Enforcement Environment

Surveys and Survey Sanctions

CMS continues to impose alternative sanctions in home health.

In Indiana in the past 12 months: per day fines, IJ, appointed manager and payment suspensions.

Per day fines can be significant.
Surveys and Survey Sanctions

Providers subject to alternative sanctions can find it hard to survive.

Similarly, providers subject to payment suspensions can find it difficult.

Surveys and Survey Sanctions

Increase in state level enforcement as well:

Apparent increase in licensure revocations.

ISDH considering survey history in enforcement decisions.
Repeat violations are especially significant.

Current Enforcement

Prior to revised authority, CMS only had one option: termination.

Tended to allow survey process to “run its course.”
Current Enforcement

This generally meant one or two resurveys after an initial “problematic” survey.

If agency achieved substantial compliance prior to resurvey, no decertification.

However, survey results are public and the initial finding could create some harm.

Intermediate Sanctions

Intermediate sanctions provide CMS with additional options and allow those options to be imposed earlier.

Given CMS perception of industry and OIG’s call for intermediate sanctions, enforcement environment about to change.
Intermediate Sanctions

Congress gave CMS authority to pursue intermediate sanctions as part of OBRA ’87.

CMS ignored that authority for many years.

Survey Guidance

In the Home Health 2013 rule, CMS revised the survey and enforcement rules to bring home health “in line” with other providers.

This was the implementation of the alternative sanctions.

Survey Guidance

A survey may be performed for changes in ownership, administration, or management. SA may perform an abbreviated standard survey.

Still not very common.
Survey Guidance

Complaints: regulation states standard or abbreviated standard survey must be performed within two months of a “significant number of complaints” being reported against the HHA.

Comments do not clarify what is a “significant number of complaints.”

Survey Guidance

Appears that one complaint is still sufficient to result in a survey.

Immediate Jeopardy

Prior to promulgation of new survey standards, CMS was encouraging state survey agencies to consider IJs against all provider types.

Home health IJs were infrequent prior the rule change.
Immediate Jeopardy

Comments to final rule noted that IJ is an extremely rare occurrence in home health – in 2011, only 11 HHA IJs in 5500 HHA Surveys.

More recent numbers: In 2014-2015, 16 IJs

Still relatively rare in home health.

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Immediate Jeopardy

Comments to final rule noted that IJ is an extremely rare occurrence in home health

2011: 5500 HHA Surveys.
   I.J.s: 11

2013: I.J.s: 13

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Immediate Jeopardy

2014 5,455 Surveys

I.J.s: 20

CMPs
8 - $899,000
Immediate Jeopardy

2015 – CMS not as willing to share data.
Trend from 2011 – 2014 shows IJ frequency climbing.
Also shows CMPs increasing.

Immediate Jeopardy

Regulation defines immediate jeopardy.

Immediate jeopardy: situation in which the provider’s non-compliance with one or more requirements of participation has caused, or is likely to cause, serious harm, impairment or death to a patient.

Immediate Jeopardy

CMS believes this definition is clear, based upon the previous guidance and clarification provided.

Limited number of IJ findings means many providers are unfamiliar with this process.
Immediate Jeopardy

If IJ identified, CMS immediately terminates provider agreement or must terminate within 23 days from the date of last survey.

Rules allow CMS to impose sanctions in addition to termination.

Two day notice required.

Immediate Jeopardy

Situation where IJ not identified until after surveyor exits. This seems problematic.

If IJ, why a delay?
Not obvious prior to exit?
Opportunity to address before exit?

Alternative Sanctions

When Conditional Level Compliance identified, but not IJ, CMS may either terminate or impose alternate sanctions.

IMPORTANT Alternate Sanctions still involve a termination track. Just six months instead of 90 days.
Alternative Sanctions

In all cases, but the imposition of CMPs (which can run from the exit date), CMS must provide advance notice. Advance notice is 15 days, except for IJ terminations.

If provider does not meet requirement for continuation of payment, CMS must terminate the provider agreement.

Alternative Sanctions

Regulations state CMS has authority to pursue “alternative sanctions”, termination, or both! Intermediate sanctions can only last for six months.

If not compliant within six months – provider is terminated.

Alternative Sanctions

CMS allows for imposition of alternative sanctions after the initial survey.

You may not get a second chance. Need to be compliant at time of first survey.
Intermediate Sanctions

This is a significant potential change to enforcement, as providers can run up penalties even as they struggle to achieve compliance.

Has proven extremely burdensome to providers.

Intermediate Sanctions

Intermediate sanctions may only be imposed for condition level deficiencies.

CMS notes in comments that in some cases, a single non-compliant standard may be cited as a condition.

Intermediate Sanctions

Factors CMS considers in determining sanctions:

1. Do the deficiencies amount to immediate jeopardy?
2. The nature, incidence, degree, manner and duration of non-compliance.
3. Were repeat deficiencies present?
4. Are the deficiencies related to failure to provide quality patient care?
Intermediate Sanctions

Factors CMS considers in determining sanctions (cont’d):

5. Is HHA part of larger organization with documented performance problems?

6. Do deficiencies indicate a system wide failure of providing quality care?

Intermediate Sanctions

Repeat deficiency: condition level deficiency cited on current survey that is substantially the same as or similar to a finding of standard level or condition level non-compliance cited on most recent prior survey or on any intervening survey since most recent standard survey.

Intermediate Sanctions

So What are Alternative Sanctions?

• Civil money penalties
• Suspension of payment for new admissions
• Temporary management of HHA
• Directed plan of correction
• Directed in-service training
Civil Money Penalties
May be imposed per instance of non-compliance or per day of non-compliance.
A CMP may be imposed for “each day” of immediate jeopardy.
A per-day and per-instance penalty cannot be imposed simultaneously.

CMS may consider the following factors when assessing a CMP:
- Factors at 488.415
- The size of an agency and its resources
- Accurate and credible resources that provide information on the agency’s operations and resources
- Evidence of agency QAPI program

After a resurvey CMS may increase penalties based upon findings of:
(1) inability or failure to correct deficiencies;
(2) “system wide failure” to provide care, or;
(3) IJ with actual harm.
Civil Money Penalties

After a resurvey CMS may decrease penalties based upon finding substantial and sustained improvements even if not yet in full compliance.

Civil Money Penalties

There are three penalty ranges:

Lower: $500 - $4,000
Middle: $1,500 - $8,500 per day
Upper: $8,500 - $10,000 per day

Civil Money Penalties

The Lower penalty range may be imposed for:

(1) repeated non-condition level deficiencies;

(2) condition level deficiencies, and;

(3) for repeated condition level deficiencies where these deficiencies are:
   (i) primarily process related and
   (ii) not patient care related.
Civil Money Penalties

The middle range of penalties are imposed for:

1. repeat deficiencies;
2. condition level deficiencies and;
3. repeat condition level deficiencies that do not constitute immediate jeopardy, but that are primarily related to poor quality patient care and outcomes.

Civil Money Penalties

The high end range of penalties are imposed for a condition level deficiency that amounts to immediate jeopardy.

Notice: The high end penalties are only for IJ cases.

Civil Money Penalties

High end penalty amount is tiered:

- $8,500 per day for isolated incident of non-compliance due to violation of HHA policy.
- $9,000 per day for IJ resulting in potential for harm.
- $10,000 per day for IJ resulting in actual harm.
Civil Money Penalties

CAP: Per day penalty may not exceed $10,000 a day.

IJ penalties will be steep. If you fix the IJ, penalties may continue at a lower rate.

Civil Money Penalties

Per Instance Penalties:

May be imposed for one or more singular events of non-compliance where non-compliance was corrected during the survey.

Per instance penalties are $1,000 - $10,000.

Civil Money Penalties

When imposing a sanction, CMS issues a notice to the provider. The Notice states the amount of the CMP being imposed, the basis for the CMP and the effective date.

NOTE: the effective date will be the last day of the survey that found the HHA out of compliance.
Civil Money Penalties
The penalty continues until either compliance is achieved or the provider is terminated. A per day penalty will last no more than 23 days in an IJ or six months in a non-IJ situation.

IMPORTANT: The penalties begin running as of the exit date, even if you do not learn about them until later.

Civil Money Penalties
The CMP may be appealed. A provider that timely waives its right to an appeal (within 60 days) will be given a 35% discount on the penalty. The amount of the penalty is due within 15 days.

Appealing does not delay the imposition of the penalty, it only delays collection. Interest will accrue.

Suspension of Payments
When Condition level non-compliance is identified, CMS may suspend payments for all new admissions.

Patients admitted prior to the effective date continue to be paid.

Immediate jeopardy is not necessary.
Suspension of Payments

Rule states CMS to consider this sanction for any deficiency related to poor patient care outcomes.

Patient care does not need to amount to IU.

Suspension of Payments

CMS may impose sanction anytime an HHA is found to be out of compliance.

Suspension remains in place until substantial compliance achieved or the agency is terminated.

Suspension of Payments

CMS will provide 15 days notice to agency. Notice specifies nature of non-compliance, effective date of sanction, right to appeal the determination.
Suspension of Payments
Agency may not charge newly admitted HHA patient who is a Medicare beneficiary when CMS suspends payment.

Suspension of Payments
NOTE: When compliance achieved, payments resume going forward. You will not get paid for the time the suspension was in effect.

Temporary Management
If CMS determines an HHA has condition level deficiencies and determines that either:

1. Management limitations, or;
2. the deficiencies themselves
are likely to impair the agency’s ability to correct the deficiencies, CMS may appoint temporary management.
Temporary Management

Process:
1. CMS notifies agency temporary manager being appointed;
2. Agency relinquishes control to the temporary manager or CMS terminates the agency’s provider agreement.

Temporary Management

Temporary management continues until:
1. Agency achieves compliance
2. CMS Terminates provider agreement
3. Agency resumes management without CMS approval and CMS initiates termination

Temporary Management

Temporary management will not exceed six months.

Agency must pay the temporary manager’s salary. Salary includes: prevailing salary determined from BLS wage data, additional reasonable costs, other costs incurred by person furnishing services or set by State.

Failure to pay the salary/costs = a failure to relinquish control.
**Directed Plan of Correction**

When an HHA has one or more deficiencies that “warrant directing HHA to take action” and HHA fails to submit an acceptable POC, CMS or a temporary manager may direct HHA to take specific corrective action. Correct within six months or CMS may impose other sanctions or terminate.

**Directed In-Service Training**

If CMS determines HHA has deficiencies that indicate non-compliance and education is likely to correct the deficiencies, CMS may require agency staff to attend in-service training. Such training must be conducted by “established centers of health education and training or consultants with background in education or training of Medicare HHAs.”

**Continuation of Payments**

CMS may continue payments to HHAs that have condition level deficiencies that do not constitute immediate jeopardy for up to six months from the day of the last survey if certain conditions are met.
**Continuation of Payments**

Requirements for continued payment:

1. HHA has received alternative sanction, but not termination;
2. HHA has submitted an approved POC;
3. HHA agrees to repay payments received if corrective action not taken.

CMS may terminate provider at any time if any of the prior criteria are not met.

If termination later imposed, or any of the prior criteria no longer met, HHA will no longer receive any payments for patients admitted to service after the last day of the last survey.

If compliance not achieved within six months of last day of previous survey, CMS will terminate provider.
Experience Thus Far

Immediate Jeopardy
As noted above, a number of agencies have had IJ findings since the sanctions went into effect.

Many agencies have achieved compliance.

Several agencies had significant sanctions imposed along with IJ. Very difficult to survive the added burden.

CMPs and other Sanctions

HHAs are seeing an increased frequency of survey penalties.

When alternative sanctions are imposed, CMPs are common.

Because the penalty is daily and can be several thousand dollars a day, six figure totals are quite common.

Penalty may already be steep by the time you receive notice.
CMPs and other Sanctions

If they can achieve compliance, most HHAs are waiving their appeal and taking the 35% discount. This is often the more cost effective solution.

SNF experience shows appeals are hard to win and CMS does not negotiate.

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CMPs and other Sanctions

If you waive the appeal, must pay quickly.

Payment plan: Pay what you can and CMS charges interest. They do not do a formal “payment plan.”

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CMPs and other Sanctions

Some agencies have had payment suspensions imposed.

These prevent you from submitting claims for reimbursement for patients admitted after the suspension date. Can place some strain on agency, but not as burdensome as CMPs.

The fact that you can continue to bill for current patients provides at least mitigates the harm.
Life in the World of Alternative Sanctions

Prepare

Because sanctions can start as of the exit date, they can become quite large quite quickly.

Providers will want to avoid non-compliance, rather than risk substantial fines or non-payment for services.

Prepare

Your compliance program and current QAPI efforts can be leveraged to help.

Need to make survey compliance a priority. Key areas of Compliance:

• Audit and Monitor
• Educate
• Respond
Auditing and Monitoring

This will require auditing and monitoring risk areas/areas of prior non-compliance.

You will want to find and correct problems before the state does.

Where to look for problems?

Auditing and Monitoring

This list of top ten conditional level deficiencies is a good place to start.

Surveyors are aware of these problems.

You should review this list and determine which ones you need to be auditing for compliance.

2015 Top Ten Survey Citations

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<th>% Surveys Cited</th>
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<td>0.85%</td>
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</tr>
<tr>
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<td>COMPLIANCE WITH FEDERAL, STATE, AND LOCAL LAWS</td>
<td>0.85%</td>
<td>7.20%</td>
</tr>
</tbody>
</table>
2015 Top Ten Survey Citations

Examples:

1. Annual evaluation: Agency cited for allowing Governing Body to perform evaluation in parts, at times not during normal board meeting.
2. Plan of Care: Agency failed to note in file it had communicated a reduction in visits to patient due to unexpected resignation of nurses.
3. Agency failed to document it faxed a lab result to physician.

4. Missed visits can be a significant source of citations for failing to follow plan of care. You may miss a visit, but need to document properly.
5. Failing to log complaints/failing to follow up on complaints
6. Employees fail to document care performed during a visit.

Revised Guidance

New/revised Survey interpretations:

1. Physician must state in physical form that individual is free from communicable diseases.
2. Physician's orders for related home health aide services.
3. Start of care, assessments and Medicaid PA.
Employee Physicals and Communicable Diseases

Recent Survey: Agency cited because physical form failed to include "a declaration the individual is free from communicable disease."

Regulation does not require this certification.

Employee Physicals and Communicable Diseases

Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner not more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients.

410 I.A.C. 17-12-1(h)

Employee Physicals and Communicable Diseases

Regulation addressed what must be documented, not how to document.
Employee Physicals and Communicable Diseases

ISDH has also been more aggressive with TB tests.

Issue: Negative test within prior 12 months. Some surveyors requiring "either a valid negative PPD skin test within prior 12 months AND a valid negative one-step TB skin test upon hire".

Regulation only requires the valid negative in the prior 12 months.

Employee Physicals and Communicable Diseases

Prior negative test. If your employee says they have a prior negative, a statement from the former employer will not suffice. ISDH expects to see a copy of the prior negative TB test.

Also expect to see this if you do a one-step based upon a prior negative.

ISDH also basing citations upon a TB control memorandum, not on regulations.

Related Services

Agencies have been cited for failing to include specifics of home health aide services on POC.

Surveyor cites agency for failing to obtain orders to prepare meals, etc.

Meal prep, light housekeeping, etc. seem to be outside the realm of services requiring orders.
Related Services

Related issue: If you receive orders to provide these services, failure to provide them is a failure to follow doctors orders.

This overcomplicates what is, in essence, supportive services that would, under any other circumstance, never be considered to require physician’s orders.

Start of Care and Medicaid PA

ISDH had raised this issue many years ago, but dropped it. It appears to be resurfacing.

Surveyors cite agency for performing assessment before “first billable visit.”

Agency must perform assessment to develop information needed for PA request. CANNOT SUBMIT WITHOUT.

Start of Care and Medicaid PA

Difficulty here is that you cannot submit PA without an assessment, but ISDH thinks you cannot perform an assessment that is not a “Billable visit.”

Seems to conflate billing issues with licensure issues.

Doctor can order care/assessment without need for payer/billable date.
Start of Care and Medicaid PA

Potential Response:

1. Licensure does not care about billable visits. Licensure does not have any consideration for payer source or payment.
2. Have to do a full assessment to prepare PA request.
3. Medicare considers a visit to determine patient eligibility and needs to be a billable visit, because of the nursing skill required. Medicare Benefit Policy Manual, Chapter 7, Section 70.2(c).

Start of Care and Medicaid PA

Start of Care Assessments and Medicaid PA.

IAHHC is pursuing this with ISDH, but no resolution.

Not everyone is being cited, seems to be somewhat surveyor dependent. If you are cited, do not argue with the surveyor. Submit an IDR. Your plan of correction, for now, may amount to performing two assessments.

Auditing and Monitoring

INCLUDE CONDITION OF PARTICIPATION ISSUES IN YOUR ANNUAL AUDITING AND MONITORING PLAN!!!
**Prepare**

A number of these tags are cited due to a failure of documentation.

Documentation needs to be clear, legible and describe what is done during a visit.

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**Auditing and Monitoring**

Almost half of surveys performed in 2015 cited Plan of Care issues:

- POC signed and dated?
- POC Followed? Missed visits, etc.
- Missing orders?
- Missing medications?
- Summary to doc?
- Verbal orders?

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**Auditing and Monitoring**

Surveyors do not know your patients. If it is not written down, a surveyor does not know that it happened.

Do not assume. Surveyors will not give you the benefit of the doubt.
Auditing and Monitoring

Examples:
- Visits made match frequency ordered?
- Missed visits documented/explained?
- Assessments documented?
- Sixty day summaries documented? Note showing they were sent?
- Complete, signed physician orders? Verbal orders logged – signed and dated - for changes?
- Update medication lists?

Auditing and Monitoring

Examples:
- Documentation that changes communicated to physician? Physician response to changes?
- Patient refusal documented?
- Know when to call 911.
- Proper record correction?
- Documentation of annual agency review? Board minutes? Resolutions? Approvals?
- Budget information?
- Complete personnel files?

Auditing and Monitoring

Other areas:
- Quality assurance?
- Group of professional personnel?
- Annual program review?
Auditing and Monitoring

Employees following policies on document submission?
Documents received timely?
EMR can fix.

SPECIAL CASE: EMPLOYEE SABOTAGE

Auditing and Monitoring

When preparing your annual auditing/monitoring plan, you need to be sure to consider these areas and to include any deficiencies from previous surveys as part of the plan.

Auditing and Monitoring

Auditing prior areas of non-compliance is important, because repeat standard level violations can lead to the imposition of penalties.

Furthermore, if an agency keeps making the same mistakes, the surveyor, the survey agency and CMS will conclude the agency is not competent.
Education and Training

Your staff needs to be educated on documentation requirements.

They need to be reminded why clear and accurate documentation is important.

Education and Training

Need to be aware of CoP requirements.

• Proper plan of care
• Proper corrections
• Proper way to handle verbal orders
• Etc.

Education and Training

If your auditing and monitoring identifies shortcomings, you need to take appropriate corrective actions.

Need to train staff on new policies, procedures and documentation.
Education and Training
Clinical Staff should know common survey issues.
Clinical Staff should know proper documentation.

Progressive Discipline:
Use progressive discipline with employees who don’t “get it.” A written warning and corrective action plan may help them to focus.
If not, will provide clear grounds for discharge.

Prepare for Survey
You should have staff who are prepared for survey process.
Administrator should be familiar with process.
Avoid “admitting” violations.
When talking to surveyor, less is more.
No need to argue with surveyor.
Prepare for Survey

Workspace for surveyor – isolated.
Administrator present and easily accessible.
Survey binder prepared.

Prepare for Survey

Many surveyors will “take the initiative” by going to your files and pulling the files they want. Avoid this at all costs. You want to pull the files for them.

Prepare

Pulling the files is important for several reasons:

1. You need to make an extra copy of everything you provide to the surveyor, so you can refer back to it later;
2. You need to pull your files, to prevent surveyor from losing your documentation.
Respond

If you have a survey with alternative sanctions you must respond.

1. Plan of Correction
2. IDR
3. Appeal

Plan of Correction

As with any survey that alleges a deficiency, need to submit a POC that is accepted.

Be thorough. Do not want to lose time by having your POC rejected.

Submit within 10 days.

IDR

Informal Dispute Resolution is not a new concept. It has been available in Indiana for many years. CMS Formalized as part of Alternative Sanctions.

IDR must be requested within same ten day window in which POC must be submitted.
IDR Process
IDR is not an appeal process. Formal appeal only available if CMS imposes sanctions.
IDR is an “informal review.” In comments, CMS describes it as an “opportunity to settle disagreements.”

IDR Process
Important to understand what it is and what it is not.
An IDR is not a hearing in front of a neutral third party.
An IDR does not toll any filing deadline.

IDR Process
An IDR is a chance to discuss findings with the survey agency and attempt to explain why you disagree with the citation.
Survey agency may or may not agree.
Agency will issue a revised survey report based upon the IDR.
IDR Process

If IDR results in change or removal of condition upon which enforcement actions are based, CMS will “adjust enforcement actions accordingly.”

NOTE: Failure of CMS or SA to conduct the IDR timely, does not delay the effective date of any enforcement action.

Appeal

Appeal to DAB.

Must be filed within 60 days. Fail to file timely = waiver of appeal.

Can be filed electronically.

Counsel recommended.

Appeal may not be best option:

- Appeals can be difficult to win.
- Relatively deferential standard of review.
- ALJ CANNOT STAY TERMINATION OR PENALTIES.
- Appeals are expensive.
Conclusion

The new intermediate sanctions have increased the stakes in the survey process. Many agencies may find the intermediate sanctions amount to an effective termination. This will make proactive compliance efforts more important than ever.

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Of Counsel
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One American Square, Suite 2000
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E-mail: rmarkette@hallrender.com