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CLIENT ADVISORY

CMS Proposes New Rules for Civil Monetary Penalties

The Centers for Medicare & Medicaid Services (“CMS”) and states’ use of Civil Monetary Penalties (“CMPs”) – and the threat of CMPs – encourage nursing facilities to comply with Medicare and Medicaid participation requirements. CMS currently imposes a per instance or, more frequently, a per diem CMP for each instance or day of substantial non-compliance. The recently enacted health reform legislation (collectively, the “PPACA”), specifically, PPACA Section 6111, provides new authority to CMS to reduce the CMP (in certain limited circumstances) to encourage self reporting and speedy correction of deficiencies. Section 6111 also requires new regulations to improve collection of CMPs and streamline the informal process for appealing a non-compliance determination. It will impact provider appeal decisions once in force.

On July 12, 2010, CMS proposed new rules to implement PPACA Section 6111 and expand and revise the current Medicare and Medicaid regulations for the imposition and collection of CMPs by CMS. The proposed rules would allow CMS to hold CMP funds until the completion of the administrative appeal process. In the proposed rules, CMS also outlines its new authority to reduce a CMP by 50% when a facility self-reports and promptly corrects its noncompliance. CMS further defines the new PPACA authorized “independent” informal dispute resolution process. Finally, CMS describes its plan to use a portion of collected CMPs to benefit nursing facility residents. CMS is accepting comments on the proposed rules until August 11, 2010.

CMP Escrow Accounts Established; Delaying Payment Until the End of the Appeal Process Eliminated

A nursing facility’s ability to drag out CMP payments through appeal is eliminated by PPACA. Under the current regulations, some nursing facilities can avoid paying CMPs for years, if at all; because the lengthy administrative appeals process. Section 6111 of the PPACA provides CMS the authority to collect and place CMPs into an escrow account pending the resolution of any formal appeal.

In the new rules, CMS proposes that it will not collect applicable CMPs until either an independent informal dispute resolution process is completed or until 90 days has passed since issuance of a CMP notice, whichever is earlier. CMS further proposes that it will not disperse the escrowed funds until the nursing facility either waives or exhausts its formal appeals process. In the event of a nursing facility’s successful appeal,



the CMP held in escrow will return to the nursing facility, with interest. In instances where a nursing facility successfully challenges a part of the compliance determination resulting in a reduced or adjusted CMP, the difference is refunded.

The new escrow regulations will discourage nursing facility appeals of deficiencies in questionable cases. Declining to specify how these new escrow requirements would operate, CMS postpones additional guidance for inclusion in the State Operations Manual following further comment and collaboration from interested stakeholders. CMS expects the initial collection of the CMP from the effective date of the penalty through the date of collection will be placed in an escrow account along with periodic additional collections until the full balance is paid. A final collection may occur to cover any balance as of the date the nursing facility achieved substantial compliance or was terminated from the Medicare or Medicaid program.

Fifty Percent Reduction of CMPs Available in Certain Cases for Self Reporting and Prompt Correction

Under the PPACA, CMS may reduce a CMP by up to 50% “where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause not later than 10 calendar days after the date of such imposition.” In its proposed rule, CMS requires that before a nursing facility can benefit from the 50% reduction of the imposed CMPs, the nursing facility must have self-reported the noncompliance to CMS or the State survey office before it was identified and reported to CMS or the State by means of a complaint. CMS further requires the correction of the noncompliance must have occurred within ten (10) calendar days of the date that the nursing facility identified the deficient practice, that the same deficiency did not recur from a prior survey, and that the nursing facility was not the beneficiary of a similar 50% CMP reduction for the same deficiency within the previous year. The proposed rule prohibits a 50% CMP reduction when the noncompliance constitutes immediate jeopardy, a pattern of harm or widespread harm, or results in a resident’s death, despite self reporting and prompt correction. The 50% reduction will not be available unless the nursing facility waives its right to a hearing.

Under the proposed rule, the nursing facility may elect to receive either the current 35% reduction for waiving its right to a hearing or the 50% reduction for self-reporting and promptly correcting, as well as waiving its right to a hearing. However, both reductions are mutually exclusive. There is no information on how this rule might affect CMS’ willingness to negotiate reductions in CMPs for cases settled on appeal.



An “Independent” Informal Dispute Resolution Process will be Available, For a Fee

Section 6111 of the PPACA requires CMS to provide a requesting nursing facility with the opportunity to participate in an independent informal dispute resolution process when CMPs have been imposed on it. The law requires that informal dispute resolution process must be offered within thirty (30) days after imposition of the CMP and requires a written record prior to the collection of the penalty and notice to an involved resident and the local ombudsman.

CMS proposes the new independent informal dispute resolution process as an additional option for nursing facilities, expanding on the current informal dispute resolution process requirements in 42 CFR § 488.331. Although the PPACA requires an informal hearing when CMPs are imposed, each state may choose to make the independent process applicable to a wider array of situations. For these nursing facilities dissatisfied with the current IDR process before the Health Commissioner’s Adjudication Officer and interested in pursuing the independent process, there is a catch: CMS proposes that the requesting facility pay the expense of the new independent informal dispute resolution process, possibly through each state’s system of user fees.

CMS notes that the current informal dispute resolution process will continue to be available to nursing facilities at no charge. Likewise, Virginia’s administrative appeals process for Medicaid decisions will remain in place. However, providers may elect to use the proposed informal dispute resolution process because of a guaranteed faster review time and a decision prior to CMP escrow. Virginia already has a rarely used, statutory-based, independent review. See Va. Code § 32.1-135. Future appeal choices will be interesting, as the PPACA and proposed rules raise more questions than they answer.

Patient Care Uses of Civil Money Penalties Collected by CMS

Section 6111 of the PPACA expressly provides that “a portion” of the collected CMPs be used to promote quality care and the well being of nursing facility residents. Examples of activities that Congress considered as appropriate uses for CMP funds include: (i) assistance to support and protect residents of a nursing facility that closes or is decertified; (ii) projects that support resident and family councils and other consumer involvement in assuring quality care in nursing facilities; and (iii) CMS approved nursing facility improvement initiatives such as joint training of nursing facility staff and surveyors, technical assistance for nursing facilities implementing quality assurance programs, the appointment of temporary management firms, and other activities approved by CMS. Currently, funds collected from Medicare facilities attributable to Medicare are deposited into the Treasury.



Therefore, CMS proposes that 50% of the collected CMP amounts be used for activities that would benefit nursing facility residents and that the remaining 50% of collected funds applicable to Medicare would continue to be deposited to the Treasury. In order to avoid the appearance of conflicts, CMS proposes prohibiting the use of collected CMP funds for state and federal survey and certification operations.

The Comment Process

Comments concerning these proposed new rules must be received by CMS no later than 5 p.m. EST on August 11, 2010. Comments may be submitted electronically following the instructions at <http://www.regulations.gov> or by regular or overnight mail. Comments may also be submitted by hand delivery to CMS's offices in Washington, D.C. and Baltimore, Maryland.

Conclusion

As the new federal health reform legislation is implemented via the regulatory process, providers should expect additional opportunities to comment on new proposed rules. If our firm can be of assistance in this comment stage of the rule process or provide further interpretation of the proposed new rules, please let Peter Mellette, Harrison Gibbs or Nathan Mortier know.