DOH SANCTIONS: A NEW ERA

PACAH 2018 SPRING CONFERENCE
April 26, 2018

LATSHA DAVIS & MCKENNA

ATTORNEYS AT LAW

Presented by
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INCREASE IN DOH OVERSIGHT OF NURSING HOMES

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. § 448.817

OVERVIEW OF RECENT SURVEY AND ENFORCEMENT ISSUES CON'T.

- DOH Civil Penalty Assessment Guideline – 12/19/16:
  - 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.

- Updated DOH Civil Penalty Assessment Guideline – 3/30/18:

  - Any facility with a survey exit date on or after 1/1/2017, may be subjected, when warranted, to civil penalties calculated on a ***per instance*** or per day basis, ***or both***, pursuant to 35 P.S. § 448.817.

OVERVIEW OF RECENT SURVEY AND ENFORCEMENT ISSUES CON'T.

- Updated DOH Civil Penalty Assessment Guideline – 3/30/18:
  - When determining whether civil penalties are warranted, DOH will consider the facility's compliance history, including but not limited to the following:
    - Whether the facility's violations resulted in harm or death to a resident;
    - The facility's most current deficiency report;
    - The threat or potential threat to resident health and safety;
    - The number of residents at risk or affected by the noncompliance;
    - The facility's plan of correction;
    - Similar survey findings where sanctions were imposed; and
    - Repeat noncompliance in the same or similar regulatory categories.

OVERVIEW OF RECENT SURVEY AND ENFORCEMENT ISSUES CON'T.

DOH CIVIL PENALTIES IMPOSED*

Year	Range of Civil Penalties	Total Amount of CP's for the year
2014	$1,500 - $9,000	$62,000
2015	$1,500 - $12,000	$170,050
2016	$1,000 - $60,800	$412,200
2017	$1,500 - $675,750	$2,019,750

*Chart based on sanctions disclosed on DOH's website as of 4/11/18.

OVERVIEW OF RECENT SURVEY AND ENFORCEMENT ISSUES CON'T.

- DOH website listing sanctions for nursing homes updated on 4/12/18:
  - List of 2017 DOH Civil Penalties Modified
    - Range of civil penalties: $1,500 - $21, 250
    - Total amount of civil penalties: $794,500
    - List of 2017 DOH civil penalties subject to further modification after resolution of pending appeals
  - List of 2018 DOH Civil Penalties to Date - $1,500 imposed during the time period of 1/1/18 thru 2/22/18

PREPARING FOR A SURVEY

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

- Three Parts to New LTC Survey Process:
  - Initial Pool Process
  - Sample Selection
  - Investigation

NEW LTC SURVEY PROCESS

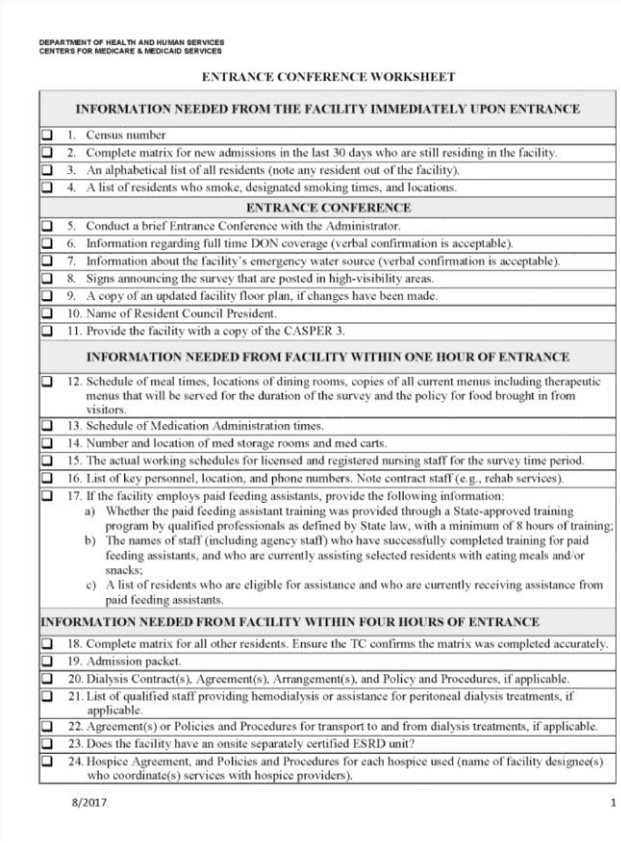
- Survey Team Coordinator – Offsite Preparation
  - CASPER 3 report for pattern of repeat deficiencies
  - Results of last standard survey
  - Compilation since last standard survey
  - Facility Reported Incidents (FRI)

NEW LTC SURVEY PROCESS

- Facility Entrance
  - Team Coordinator coordinates an Entrance Conference
    - Entrance Conference Worksheet
    - Matrix
  - Initial brief visit to kitchen
  - Surveyors go to assigned areas

NEW LTC SURVEY PROCESS

- Entrance Conference Worksheet

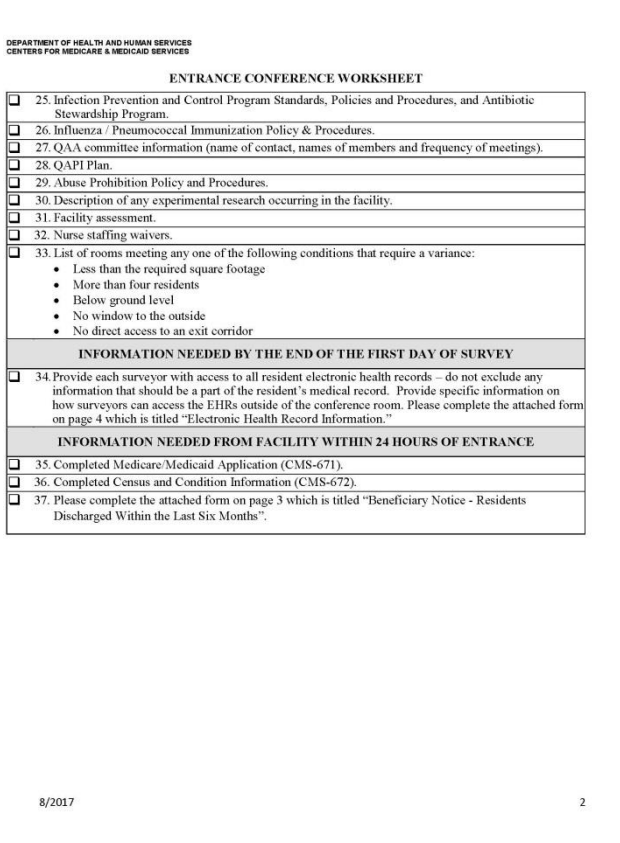


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

ENTRANCE CONFERENCE WORKSHEET

INFORMATION NEEDED FROM THE FACILITY IMMEDIATELY UPON ENTRANCE
❑ 1. Census number
❑ 2. Complete matrix for new admissions in the last 30 days who are still residing in the facility.
❑ 3. An alphabetical list of all residents (note any resident out of the facility).
❑ 4. A list of residents who smoke, designated smoking times, and locations.
ENTRANCE CONFERENCE
❑ 5. Conduct a brief Entrance Conference with the Administrator.
❑ 6. Information regarding full time DON coverage (verbal confirmation is acceptable).
❑ 7. Information about the facility's emergency water source (verbal confirmation is acceptable).
❑ 8. Signs announcing the survey that are posted in high-visibility areas.
❑ 9. A copy of an updated facility floor plan, if changes have been made.
❑ 10. Name of Resident Council President.
❑ 11. Provide the facility with a copy of the CASPER 3.
INFORMATION NEEDED FROM FACILITY WITHIN ONE HOUR OF ENTRANCE
❑ 12. Schedule of meal times, locations of dining rooms, copies of all current menus including therapeutic menus that will be served for the duration of the survey and the policy for food brought in from visitors.
❑ 13. Schedule of Medication Administration times.
❑ 14. Number and location of med storage rooms and med carts.
❑ 15. The actual working schedules for licensed and registered nursing staff for the survey time period.
❑ 16. List of key personnel, location, and phone numbers. Note contract staff (e.g., rehab services).
❑ 17. If the facility employs paid feeding assistants, provide the following information: a) Whether the paid feeding assistant training was provided through a State-approved training program by qualified professionals as defined by State law, with a minimum of 8 hours of training; b) The names of staff (including agency staff) who have successfully completed training for paid feeding assistants, and who are currently assisting selected residents with eating meals and/or snacks; c) A list of residents who are eligible for assistance and who are currently receiving assistance from paid feeding assistants.
INFORMATION NEEDED FROM FACILITY WITHIN FOUR HOURS OF ENTRANCE
❑ 18. Complete matrix for all other residents. Ensure the TC confirms the matrix was completed accurately.
❑ 19. Admission packet.
❑ 20. Dialysis Contract(s), Agreement(s), Arrangement(s), and Policy and Procedures, if applicable.
❑ 21. List of qualified staff providing hemodialysis or assistance for peritoneal dialysis treatments, if applicable.
❑ 22. Agreement(s) or Policies and Procedures for transport to and from dialysis treatments, if applicable.
❑ 23. Does the facility have an onsite separately certified ESRD unit?
❑ 24. Hospice Agreement, and Policies and Procedures for each hospice used (name of facility designee(s) who coordinate(s) services with hospice providers).

8/2017 1



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

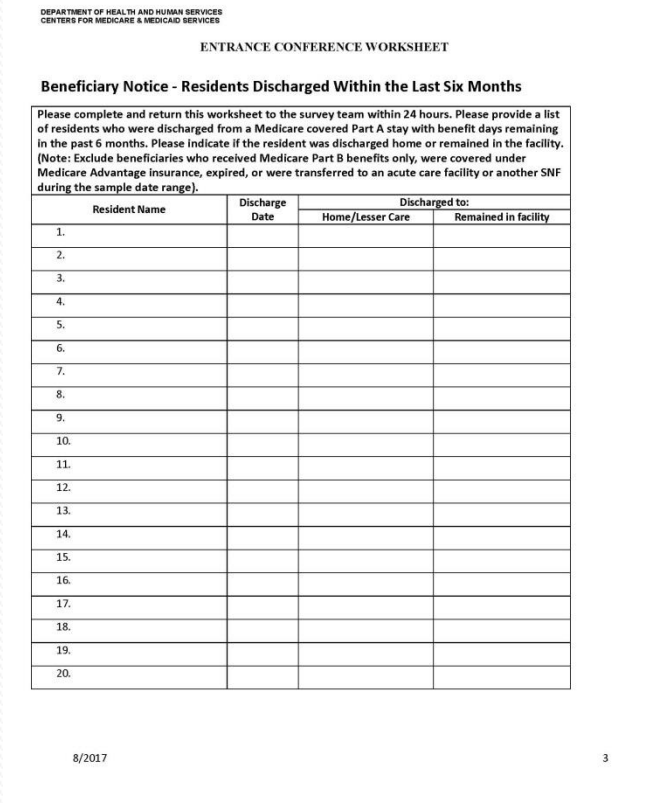
ENTRANCE CONFERENCE WORKSHEET

❑ 25. Infection Prevention and Control Program Standards, Policies and Procedures, and Antibiotic Stewardship Program.
❑ 26. Influenza / Pneumococcal Immunization Policy & Procedures.
❑ 27. QAA committee information (name of contact, names of members and frequency of meetings).
❑ 28. QAPI Plan.
❑ 29. Abuse Prohibition Policy and Procedures.
❑ 30. Description of any experimental research occurring in the facility.
❑ 31. Facility assessment.
❑ 32. Nurse staffing waivers.
❑ 33. List of rooms meeting any one of the following conditions that require a variance: • Less than the required square footage • More than four residents • Below ground level • No window to the outside • No direct access to an exit corridor
INFORMATION NEEDED BY THE END OF THE FIRST DAY OF SURVEY
❑ 34. Provide each surveyor with access to all resident electronic health records – do not exclude any information that should be a part of the resident's medical record. Provide specific information on how surveyors can access the EHRs outside of the conference room. Please complete the attached form on page 4 which is titled "Electronic Health Record Information."
INFORMATION NEEDED FROM FACILITY WITHIN 24 HOURS OF ENTRANCE
❑ 35. Completed Medicare/Medicaid Application (CMS-671).
❑ 36. Completed Census and Condition Information (CMS-672).
❑ 37. Please complete the attached form on page 3 which is titled "Beneficiary Notice - Residents Discharged Within the Last Six Months".

8/2017 2

NEW LTC SURVEY PROCESS

- Entrance Conference Worksheet



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

ENTRANCE CONFERENCE WORKSHEET

Beneficiary Notice - Residents Discharged Within the Last Six Months

Please complete and return this worksheet to the survey team within 24 hours. Please provide a list of residents who were discharged from a Medicare covered Part A stay with benefit days remaining in the past 6 months. Please indicate if the resident was discharged home or remained in the facility. (Note: Exclude beneficiaries who received Medicare Part B benefits only, were covered under Medicare Advantage insurance, expired, or were transferred to an acute care facility or another SNF during the sample date range).

Resident Name	Discharge Date	Discharged to:	
		Home/Lesser Care	Remained in facility
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
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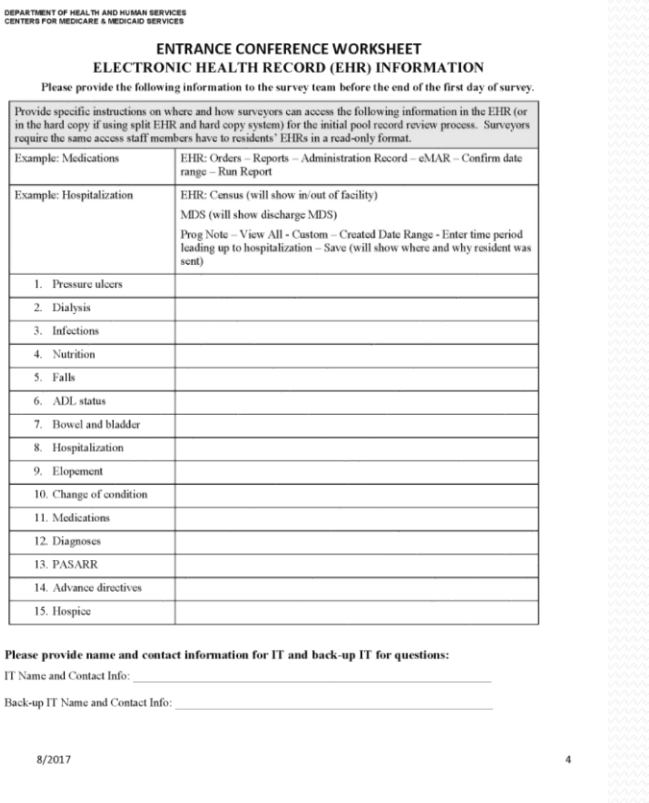
20.			

8/2017 3



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

ENTRANCE CONFERENCE WORKSHEET
ELECTRONIC HEALTH RECORD (EHR) INFORMATION

Please provide the following information to the survey team before the end of the first day of survey.

Provide specific instructions on where and how surveyors can access the following information in the EHR (or in the hard copy if using split EHR and hard copy system) for the initial pool record review process. Surveyors require the same access staff members have to residents' EHRs in a read-only format.	
Example: Medications	EHR: Orders – Reports – Administration Record – eMAR – Confirm date range – Run Report
Example: Hospitalization	EHR: Census (will show in/out of facility) MDS (will show discharge MDS) Prog Note – View All - Custom – Created Date Range - Enter time period leading up to hospitalization – Save (will show where and why resident was sent)
1. Pressure ulcers	
2. Dialysis	
3. Infections	
4. Nutrition	
5. Falls	
6. ADL status	
7. Bowel and bladder	
8. Hospitalization	
9. Elopement	
10. Change of condition	
11. Medications	
12. Diagnoses	
13. PASARR	
14. Advance directives	
15. Hospice	

Please provide name and contact information for IT and back-up IT for questions:

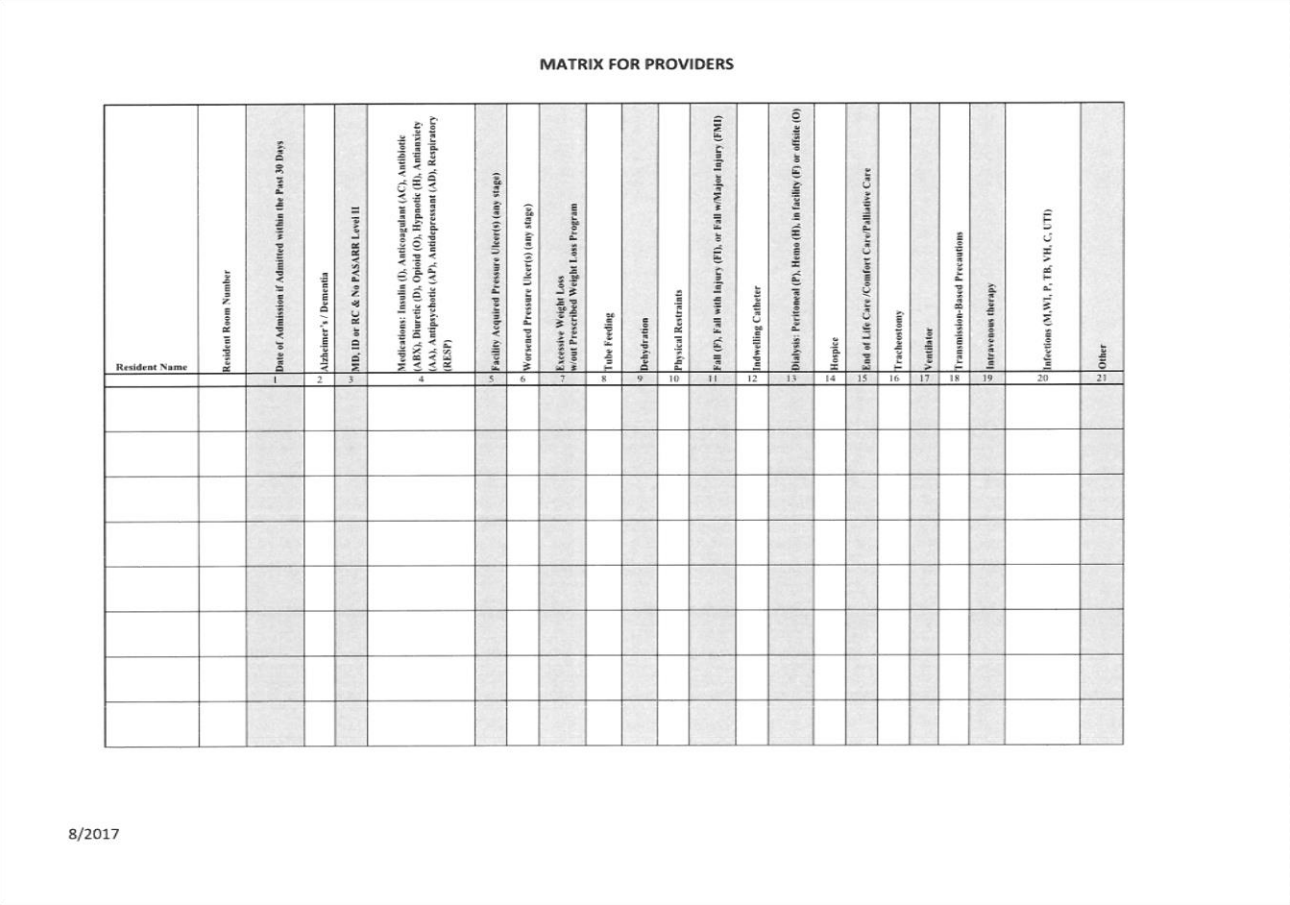
IT Name and Contact Info: _____

Back-up IT Name and Contact Info: _____

8/2017 4

NEW LTC SURVEY PROCESS

- Matrix for Providers



MATRIX FOR PROVIDERS

Resident Name	Resident Room Number	1 Date of Admission if Admitted within the Past 30 Days	2 Alzheimer's / Dementia	3 MD, ID or RC & No PASARR Level II	4 Medications: Insulin (I), Anticoagulant (AC), Antibiotic (ABX), Diuretic (D), Opioid (O), Hypnotic (H), Antianxiety (AA), Antipsychotic (AP), Antidepressant (AD), Respiratory (RESP)	5 Facility Acquired Pressure Ulcer(s) (any stage)	6 Worsened Pressure Ulcer(s) (any stage)	7 Excessive Weight Loss w/out Prescribed Weight Loss Program	8 Tube Feeding	9 Dehydration	10 Physical Restraints	11 Fall (F), Fall with Injury (FI), or Fall w/Major Injury (FMI)	12 Indwelling Catheter	13 Dialysis: Peritoneal (P), Hemo (H), in facility (F) or offsite (O)	14 Hospice	15 End of Life Care /Comfort Care/Palliative Care	16 Tracheotomy	17 Ventilator	18 Transmission-Based Precautions	19 Intravenous therapy	20 Infections (M,W1, P, TB, VH, C, UTI)	21 Other

8/2017

NEW LTC SURVEY PROCESS

- Initial Pool Process
  - 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 for larger facilities

NEW LTC SURVEY PROCESS

- Initial Pool Process
  - First 8-10 hours onsite primarily spent completing initial pool process
  - Surveyors screen all residents in facility and narrow down to an initial pool of about 8 residents per surveyor
  - Surveyors complete an observation, interview (if appropriate) and limited record review for the initial pool residents to help identify those residents who should be in the sample

NEW LTC SURVEY PROCESS

- Sample Selection
  - After completing the initial pool process, survey team chooses residents from initial pool to include in the sample based on concerns identified from the interview, observation and/or limited record review, and consideration of resident-specific data

NEW LTC SURVEY PROCESS

- Investigation
  - After selecting the sample, the team spends the rest of the survey investigating all concerns that required further investigation for every resident in the sample. Facility task and closed record investigation are also conducted (although dining is observed the first day)
  - When investigations are complete, the team makes citation, severity and scope decisions for every tag identified by each surveyor.

NEW LTC SURVEY PROCESS

- Facility Tasks to be Completed with all Surveys

  - Dining
  - Infection Control
  - SNF Beneficiary Protection Notification Review
  - Kitchen
  - Medication Administration and Storage
  - Resident Council Meeting
  - Sufficient and Competent Nurse Staffing
  - QAA/QAPI

NEW LTC SURVEY PROCESS

- 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/GuidanceforLawsAndRegulations/Nursing-Homes.html)

CMS FINAL RULE REGARDING CHANGES TO SURVEY TEAM COMPOSITION & INVESTIGATION OF COMPLAINTS

- On August 4, 2017, CMS published a final rule[1] 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 1819 and 1919 of the Social Security Act.

[1](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 HCP Influenza Vaccination Immunization Reporting Measure in the ESRD QIP for PY 2020 which can be accessed via the following link: https://www.federalregister.gov/documents/2017/08/04/2017-16256/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities

CMS FINAL RULE REVISION CON'T.

- Survey Team Composition
  - Regulatory provision clarifies that only surveys conducted under sections 1819(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.

TEMPORARY ENFORCEMENT DELAYS FOR PHASE 2 F-TAGS AND CHANGES TO NURSING HOME COMPARE (S&C-18-04NH (11-24-17))

- CMS issued an 18-month moratorium on the imposition of CMPs, discretionary denial of payment for new admissions and discretionary termination for the following Phase 2 F Tags:
  - F655 (Baseline Care Plan) §483.21(a)(1)-(a)(3)
  - F740 (Behavioral Health Services) §483.40
  - F741 (Sufficient/Competent Behavioral Health Staff) §483.40(a)(1)-(a)(2)
  - F758 (Psychotropic Medications – related to PRN limitations) §483.45(e)(3)-(e)(5)
  - F838 (Facility Assessment) §483.70(e)
  - F881 (Antibiotic Stewardship Program) §483.80(a)(3)
  - F865 (QAPI Program and Plan – related to the development of the Plan) §483.75(a)(2)
  - F926 (Smoking Policies) §483.90(i)(5)

TEMPORARY ENFORCEMENT DELAYS FOR PHASE 2 F-TAGS AND CHANGES TO NURSING HOME COMPARE (S&C-18-04NH (11-24-17)) CON'T.

- Health rating scores under Five-Star Quality Rating System on Nursing Home Compare will be frozen from 11/28/17 until 11/27/18

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 improvements
  - Address any compliance issues

HELPFUL LINKS:

New Survey Process - https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html

Revised F Tags - https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/List-of-Revised-FTags.pdf

Appendix PP of SOM - https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf

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")

- Generally – The Federal Certification Survey Process provides an informal process to dispute survey findings with the State survey agencies. 42 C.F.R. §488.331.
- 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 CON'T.

- 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

STATE IIDR CON'T.

- 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

- Federal IIDR Recommendation and Final Decision con't.
  - 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 if warranted by CMS policy
    - Annotate deficiency(ies) citations 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; and
    - Provide written notice of the final decision to the facility

OVERVIEW

IDR	State IIDR	Federal IIDR
Submitted within same 10 calendar days that facility has to submit POC	Submitted within same 10 calendar days that facility has to submit POC	Submitted within 10 calendar days of the receipt of the CMS letter imposing CMP's
No Fee	Fee-for-Service basis	No Fee
Can only dispute federal deficiencies	Can dispute state and federal deficiencies	Can only dispute federal deficiencies
NO NOTICE to and NO OPPORTUNITY for comment by resident/resident's representative	NO NOTICE to and NO OPPORTUNITY for comment by resident/resident's representative	NOTICE to and OPPORTUNITY for comment by resident/resident's representative
DOH Reviews IDR	Quality Insights of PA reviews State IIDR but DOH is final decision-maker	Independent entity within the DOH reviews IIDR, but if SSA disagrees, CMS is final decision-maker

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 CON'T.

- 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

CMS APPEAL

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

CMS APPEAL

Appeal Process con't.

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

CMS APPEAL

Appeal Process con't.

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.

CMS APPEAL

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

CMS APPEAL

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.

CMS APPEAL

Appeal Considerations con't.

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

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