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Client Alert

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CMS's Proposed Rules for Home Health Surveys and Enforcement Signal Major Changes to Come

On July 13, 2012, the Centers for Medicare & Medicaid Services (CMS) published a proposed rule addressing home health survey processes and new penalties for survey deficiencies. 77 Fed. Reg. 41,548, (July 13, 2012). The proposed rule also describes reductions in home health payments for 2013 and hospice quality reporting requirements. Comments must be submitted by September 4, 2012. Proposed subpart I details survey and certification guidelines, while subpart J outlines new intermediate sanctions for home health agencies (HHAs) that are not in substantial compliance with Medicare conditions of participation (COPs). This article highlights key provisions in subpart I that HHAs should note. A second discussion to appear in next week's Healthcare Authority will focus on the proposed enforcement penalties. Home health providers should evaluate both sections of the proposed rules and consider submitting comments to inform the rule-making process.

CMS first proposes to codify by regulation the following definitions: "standard," "abbreviated standard," "extended," "partial extended," "complaint," "condition-level deficiency," "deficiency," "non-compliance," "standard-level deficiency," "substandard care," and "substantial compliance."

As proposed, a HHA will be subject to a standard survey no later than 36 months after the last day of its previous standard survey. Standard surveys will review a stratified case mix sample of patients according to select standards and COPs mostly linked to quality of care, and will include visits to homes of sampled patients only if patients consent to surveyor visits. Telephone calls to patients may also be used. Notably, surveyor determinations of deficiencies will remain valid even if the survey agency fails to follow its own procedures, such as not forwarding a statement of deficiencies to a provider within 10 days after an exit conference.

A partial extended survey will be conducted where a standard survey has been unable to fully determine whether deficiencies exist. At that time, at a minimum, additional standards under the HHA COPs will be assessed. If non-compliance is identified that substantially limits the provider's capacity to furnish adequate care, or which adversely affects the health or safety of patients, a condition-level deficiency will be found. Thereafter, an extended survey will be conducted within 14 days after the completion of the standard survey that identified substandard care, which will include a review of the HHA's policies, procedures, and practices which contributed to the deficient practice.

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All surveys must be unannounced and scheduled so that they are "as unpredictable in their timing as possible." Civil monetary penalties of up to $2,000 may be assessed against an individual (presumably a survey agency employee) who notifies an HHA of the time or date for a survey.

A standard survey or an abbreviated standard survey also may be conducted within 2 months of a change in ownership, administration or management of an HHA, and is required to be conducted within 2 months of a significant number of complaints reported to CMS, the State, State or local agency hotline or other appropriate government agency.

The proposed rules require surveyors to successfully complete a CMS-sponsored Basic Home Health Agency Surveyor Training Course. Surveyors who have conflicts of interest are disqualified, and the following potential conflicts are noted: the surveyor works for or has worked for the HHA to be surveyed within the past 2 years, either as a direct employee or through a staffing agency; the surveyor is an officer, consultant or agent for the agency; the surveyor has a financial or ownership interest in the HHA; a surveyor's family member has a relationship with or is a patient of the HHA. Agencies appealing survey deficiencies should seek to determine whether surveyors in fact met the training and no conflicts requirements, as a failure to do so may be useful in any appeal. Despite the fact that the proposed rules specify, as noted earlier, that a failure by surveyors to follow procedures will not invalidate otherwise legitimate deficiencies, a wholly unqualified surveyor should be a factor to be weighed on appeal.

The proposed rule also establishes a new informal dispute resolution (IDR) process by which an HHA can seek to refute a surveyor's deficiency finding(s). The HHA's request for an IDR must be in writing to the State or CMS, specify the deficiencies that are disputed, and must be submitted within the same 10 calendar days that the HHA has for submitting its plan of correction. The proposed rule establishes that the initiation of an IDR will not delay the effective date of any enforcement action, and does not specify whether an IDR process will allow representation of counsel or a face-to-face meeting with the surveyor or surveyor's supervisor; presumably such details of the IDR process will be left for each state's determination. Providers should request face-to-face IDR meetings and use the IDR process as a means to learn additional information about the surveyor's concerns, to make a favorable impression on the decision-maker, and to emphasize the impact of sanctions on the agency.

Although the IDR process is new and the codification of definitions is helpful, much of the remaining survey process detailed in subpart I is familiar ground already established by CMS policy. However, the intermediate sanctions laid out in the proposed rule are a drastic change from the current rules, where termination from the Medicare program is the only sanction available to CMS following survey deficiencies. Part II of this analysis will examine the proposals for intermediate HHA sanctions, including appointment of temporary managers, suspension of payment for new admissions and episodes, civil monetary penalties, directed plans of correction and directed in-service training, as well as the broad discretion granted to survey agencies in the enforcement process.