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Client Alert

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CMS Issues Proposed Rule Revising the Nursing Home Civil Monetary Penalty System

In mid-July, the Centers for Medicare and Medicaid Services ("CMS") published a proposed rule which would modify the current civil monetary penalty ("CMP") system for nursing homes. The modifications are required by the federal health reform law (the Patient Protection and Affordable Care Act ("PPACA")). The proposed rule includes the following:

- The provision of a fifty percent (50%) reduction of CMPs for nursing homes that self-report issues of noncompliance with the federal Medicare/Medicaid conditions of participation and promptly correct such noncompliance;
- Establishes an independent informal dispute resolution process for the purpose of allowing nursing homes to challenge findings of noncompliance;
- Creates an escrow account arrangement for CMP payments; and
- Identifies acceptable uses of CMPs paid to CMS, with such uses generally being limited to activities which benefit the residents of nursing homes.

Information and details about each of these elements of the proposed rule are provided below.

50% Reduction in CMPs for Nursing Homes That Self-Report and Promptly Correct Noncompliance

In sections 6111 (a) and (b) of PPACA, Congress authorized CMS to reduce a CMP by up to 50% to incentivize nursing homes to report and promptly correct their noncompliance. CMS included several conditions in the proposed rule that must be satisfied in order for a nursing home to qualify for the reduction in its CMP:

- The facility must be the original source of the noncompliance information. That is, the facility must self-report the noncompliance before it is identified by CMS or Medicaid in a survey and before it was reported by means of a complaint; and
- The facility must have corrected the noncompliance within ten (10) calendar days of the date the facility identified the noncompliance; and
- The facility must waive its right to a hearing.

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This 50% reduction does not apply to instances of noncompliance that constitute immediate jeopardy to resident health or safety, or that constitute either a pattern of harm or widespread harm to facility residents, or that resulted in a resident's death. Further, the 50% percent reduction is not available when a facility has a repeated instance of the same deficiency; if a facility received a reduction for the same deficiency in the previous year, the facility is not eligible for the reduction the following year.

Notably, CMS clarified that, if a facility receives the 50% reduction, the facility will not also be eligible to receive the traditional 35% reduction in the CMP for waiving the right to a hearing.

Independent Informal Dispute Resolution Process

The proposed rule established an independent informal dispute resolution process for nursing homes that wish to challenge a finding of noncompliance. This proposed process differs from the existing informal dispute resolution process available to nursing homes in several ways:

- The new process is available only in cases where a CMP is actually imposed, as opposed to being available for non-CMP remedies such as denial of payment for new admissions.
- The nursing home is required to pay a fee, the amount of which will depend on complexity of the case.
- The process may be conducted by an independent state agency, a Quality Improvement Organization, or state survey agency (as long as the participants had no involvement in the citation of the deficiency at issue).

The proposed rule states that nursing homes must request independent informal dispute resolution within 30 days of notice of the CMP, and the process must be completed within 60 days of the imposition of the CMP. A written record of the process will be made available to the facility prior to the collection of the CMP.

Notably, if a resident was involved in the incident(s) of noncompliance, resident or a representative must be notified of the process and given the opportunity to provide written comment. The state ombudsman may also be given an opportunity to comment.

Establishment of an Escrow Account for CMP Payments

Currently, nursing homes may avoid paying a CMP while they exhaust all of their administrative appeals, and the appeal process can take years. Section 6111(a) and (b) of PPACA permits the collection and placement of CMPs into an escrow account pending the resolution of any formal appeal filed by the nursing home. The CMP would not be collected until the completion of the independent informal dispute resolution process (if elected by the facility) or 90 days has passed since the notice of imposition of the CMP (whichever is earlier). However, a per-day CMP can begin to accrue as early as the date the facility is determined to be noncompliant or be retroactive to the date of the occurrence underlying the noncompliance.

The procedures included in the proposed rule would place CMPs into escrow accounts pending the resolution of the facility's formal appeal. If the facility is ultimately successful in its appeal, the CMP amount held in escrow will be returned to the facility, with interest, following the expiration of the time for CMS to appeal the Administrative Law Judge's ("ALJ") decision or, if CMS does appeal, the Departmental Appeals Board's affirmation of the ALJ's reversal of the CMP.

Acceptable Uses for CMP Money

Section 6111 of PPACA limited the acceptable uses for CMPs collected by CMS. Accordingly, in the proposed rule, CMS proposes that 50% of the Medicare portion of collected CMPs be used for activities that benefit nursing home residents (with a specific prohibition on the use of the funds for survey and certification functions), but only if such activities are approved by CMS. The rule indicates that CMS should issue guidance outlining approved uses of CMP funds that will not require case-by-case approval from CMS. The remaining 50% of the CMP will be deposited to the Department of the Treasury.

When distinguishing between Medicare and Medicaid proportions of CMP collections, CMS will return funds to the state Medicaid program in proportion to the relative number of Medicare and Medicaid beds at the facility actually in use by residents covered by those programs on the date the CMP began to accrue.