You Can’t Always Get What You Want: Appealing CMS Enforcement Actions

By Alan C. Horowitz, JD, RN

Many of the country’s 15,400 skilled nursing facilities live in almost mortal fear of a survey that results in enforcement actions by the Centers for Medicare & Medicaid Services. When surveyors determine that noncompliance exists, CMS has a veritable quiver of arrows at its disposal to target the allegedly offending SNF. CMS is authorized by the statute (the Social Security Act) and its implementing regulations at 42 CFR Part 498 to impose one or more “sanctions” (euphemistically referred to as “remedies” but more accurately described as “enforcement actions”) when a SNF is not in “substantial compliance” with Medicare’s Requirements for Participation (ROP) found at 42 CFR Part 483. Substantial compliance is defined by the applicable federal regulation as “an isolated instance of the potential for more than minimal harm” (42 CFR 488.301). On the corresponding “scope and severity grid” (CMS, “Nursing Home Enforcement Reports Through December 31, 2014,” June 3, 2016, https://go.cms.gov/3svOEoY) such an allegation would be a D-level deficiency.

When a provider receives a CMS “Imposition Notice” informing it of one or more sanctions, the clock starts ticking. CMS may impose sanctions for any deficiency from levels D to L. And,

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AMDA Establishes Behavioral Health Council

By Richard Juman, PsyD, and Lea Watson, MD, MPH

When the Centers for Medicare & Medicaid Services describes the mission of nursing homes, it notes that “each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being” (42 CFR § 483.40). The majority of residents living in post-acute and long-term care communities have one or more psychiatric diagnoses, and all are by definition contending with a major life transition. This makes PALTC a behavioral health care environment, not just a medical care environment as has been the traditional service model.

As co-chairs of the new Behavioral Health Council of AMDA – The Society for Post-Acute and Long-Term Care Medicine, we are eager to bring behavioral health expertise, training, and care delivery models from the sidelines into the center of care, where Society members get more of what they need to succeed. We plan to accomplish this with an interdisciplinary council focused on promoting integration of behavioral health with medical health, eliminating the false dichotomy, and supporting person-centered well-being.

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The Foundation for Post-Acute and Long-Term Care Medicine is thrilled to report that in December 2019 the Foundation Board voted to develop a new excellence award to recognize the interdisciplinary roles within the membership of AMDA – The Society for Post-Acute and Long-Term Care Medicine. The Clinician of the Year Award was developed to honor a licensed health care provider who is directly involved in the treatment and care of older adults. Dr. Heidi White, MD, MEd, CMD, member of the Foundation Board, chaired the subcommittee, and the other committee members were Jamyl Walker, MSN, APRN, AGNP-C; Patricia L. Bach, PsyD, MS, RN; and Eric Hasemeier, DO, MBA, CMD. The plan is to present the first award in 2022, whether in person or online. As with other Society awards, this award will be presented at a General Session during the Society’s Annual Conference. The following includes the purpose and criteria for the award.

Purpose: The Clinician of the Year Award recognizes a practitioner in the PALTC continuum who embodies excellence in patient/resident care.

Eligibility Criteria
• Settings of practice: Can be a skilled facility, private practice/practice management group, assisted living, or Program of All-Inclusive Care for the Elderly (PACE) program.
• Society member in good standing.
• Licensed practitioner providing direct care in PALTC settings including mental health practitioner, advanced practice nurse, or physician.

Nomination or Evaluation Criteria
• High level of professional competence, including ethical and social issues.
• Recognized as a strong advocate for patients/residents.
• Excellent collaborator with members of the interdisciplinary team.

Nominee is someone who is recognized as a role model by his or her peers.
• High level of exemplary interaction with patients/residents and families.
• Community involvement in community medical services, professional organizations, and/or other contributions to the community.

The AMDA Foundation Board would like to take the opportunity to encourage members to consider nominees for this award. The award itself acknowledges the interdisciplinary nature of the Society and the importance of recognizing all members of the interdisciplinary team. The Foundation has long worked to support care to older adults across all post-acute settings via inclusion of all providers in Foundation-supported activities such as the Futures Program and a variety of supported research and quality improvement projects.

Given the advent of COVID-19, the need for all members of the interdisciplinary team and expert clinicians has been amplified. For all of us working in this industry, we have had to balance the 24-hour-a-day management of keeping patients/residents free of infection as well as trying to optimize their quality of life. Although accolades have more frequently gone to those working in acute care settings rather than those of us working in the PALTC arena, we have all seen heroes at work.

Please take a minute to think about these individuals and identify the exemplary clinicians in your settings or organizations. This type of award can serve as an important thank you to those individuals. We anticipate accepting applications soon after the 2021 Annual Meeting. We hope to see you all there!

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Enforcement

What If the Surveyors and CMS Got it Wrong?

When a provider receives a CMS “Imposition Notice” informing it of one or more sanctions, the clock starts ticking. The provider has only 60 calendar days (not 61 or more) to take one of two possible actions: it must either waive its right to an appeal (in writing) and receive the mandatory 35% discount on the CMP, or file a formal appeal with the Health and Human Services Departmental Appeals Board (DAB). An appeal merely stating “We disagree with CMS’s allegations” will not be heard and is not worth the paper it is written on; at a minimum, an appeal must satisfy the regulation’s requirements, which means it must articulate the reason it disagrees with the CMS findings for each and every challenged deficiency and state the basis for such disagreement.

The formal appeal is the first time a federal Administrative Law Judge (ALJ) sees a glimpse of what the case is all about, and as the old adage goes, it’s hard to get a second chance at a first impression. So the initial appeal, or the “Request for Hearing” as it is also referred to, must be comprehensive, cogent, and legally persuasive. It must lay out a road map of the defense and succinctly explain why the CMS allegations are factually and/or legally insufficient as a basis to impose one or more sanctions. More specifically, a provider must describe the findings of fact and conclusions of law with which it disagrees, and the basis for such disagreement.

Notably, not every action CMS takes is subject to an appeal. For example, when CMS designates a nursing facility as a “Special Focus Facility” (SFF), that action may not be appealed. CMS defines a Special Focus Facility as one that has serious deficiencies constituting substandard care and a “yo-yo” history of compliance. CMS allows each state to designate a set number of facilities as Special Focus Facilities, which among other things means (1) those facilities will have full on-site annual surveys twice a year, and (2) if they do not “graduate” from the SFF program, typically within 18 months, they will be terminated from Medicare.

Likewise, if CMS imposes a sanction and then rescinds it, a provider may not appeal even if the Statement of Deficiencies remains uncorrected and the alleged deficiencies are not removed from the Statement of Deficiencies. A provider’s right to appeal is nullified once CMS rescinds a sanction, even if CMS refuses to correct the Statement of Deficiencies; this raises a question of fundamental fairness and due process because those alleged deficiencies will adversely affect a provider’s CMS Five-Star Quality Rating and likely damage its reputation. Nevertheless, under the current regulatory scheme, being designated a SFF or having a sanction removed — but not the underlying alleged deficiencies on the Statement of Deficiencies — are not appealable actions. Under the current federal regulations, only “initial determinations” (e.g., CMPs, DPNA, terminations, etc.) may be appealed.

The Appeal

There are three levels of appeal for CMS enforcement actions. The first two move with the speed of a turtle stuck in molasses.

As a threshold matter, the legal standard is that CMS must first establish a prima facie case that its enforcement actions are predicated on violations of one or more federal regulations at 42 CFR Part 483 (ROP for SNFs). Most ALJs simply accept the Statement of Deficiencies as sufficient for CMS to meet its burden. Once CMS has met that burden of establishing its prima facie case, the burden then shifts to the provider to establish by a preponderance of the evidence that CMS is incorrect.

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Another example of the time involved in an appeal is found in the case of Golden Living – Mountainview v. HHS (6th Cir. No. 19-3755) (October 27, 2020). That appeal began with a survey on March 31, 2014, and a CMS enforcement notice in April 2014. CMS alleged immediate jeopardy-level deficiencies and imposed a CMP of $621,250. The provider filed a timely appeal to the ALJ. The ALJ upheld the CMS determination. The provider next appealed to the DAB, which affirmed the ALJ decision. Undaunted, the provider then appealed to the U.S. Court of Appeals for the Sixth Circuit. After reviewing the evidence in the administrative record (i.e., the ALJ and DAB hearings and all related documents) on October 27, 2020, the court reversed the DAB decision (and, by extension, the ALJ) and remanded the case. Thus, the CMS enforcement action from 2014 is still being appealed in 2021. Whoever said justice moves swiftly must not be familiar with appeals of CMS enforcement actions: sadly, the Mountainview case is the rule rather than the exception.

As has been said, “Justice delayed is justice denied.” As currently constituted, the appeals process is in need of reform. At least regarding the years it takes to have a final resolution. If HHS had the budget to hire more ALJs, it would certainly help this sluggish process, but that ball is in the hands of Congress.

After an Appeal to the ALJ

When one of the roughly half-dozen ALJs who decide all nursing home cases finally renders an opinion, the side that did not prevail has 60 calendar days to appeal to the DAB. I say “finally” because it is not uncommon for it to take two years or longer from the date an appeal is filed to decide the appeal by the ALJ. That is not to impugn the ALJs in any manner. They hear myriad cases beyond just CMS enforcement actions that have gone to appeal, there has not been a successful provider appeal at the ALJ level or DAB level in years. It would take a certain level of naiveté to believe that surveyors — and, by extension, CMS — get it right 100% of the time while providers get it wrong 100% of the time concerning a CMP directly to the U.S. Court of Federal Claims (i.e., the ALJ and DAB hearings and all related documents) on October 27, 2020, the court reversed the DAB decision (and, by extension, the ALJ) and remanded the case. Thus, the CMS enforcement action from 2014 is still being appealed in 2021. Whoever said justice moves swiftly must not be familiar with appeals of CMS enforcement actions: sadly, the Mountainview case is the rule rather than the exception.

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Spotlight on Policy: Amid COVID-19 CMS Holds Physicians Harmless From Up to 9% of MIPS Penalties

Earlier this year, the Centers for Medicare & Medicaid Services announced it will hold physicians harmless from up to 9% Merit-Based Incentive Payment System (MIPS) penalties due to the significant disruptions of the COVID-19 public health emergency on physician practices’ performance in 2020. Your MIPS eligibility status is specific to each practice you’re associated with. AMDA – The Society for Post-Acute and Long-Term Care Medicine advocated for this automatic relief from MIPS penalties and applauds CMS for ensuring PALT C clinicians will not be unduly penalized during the pandemic.

The Extreme and Uncontrollable Circumstances (EUC) Hardship Exception policy will be automatically applied to all MIPS-eligible clinicians who do not submit any MIPS data for the 2020 performance period and avoid a 2022 payment penalty. CMS is also reopening the hardship exception application for group practices, virtual groups, and alternative payment model (APM) entities who missed the previous 2020 deadline. The reopened application deadline was March 31, 2021. Note that groups and eligible clinicians who submitted data in at least two MIPS categories will override the hardship exception and be eligible to earn a bonus from the exceptional performance bonus pool or potentially be subject to a penalty.

Those Who Haven’t Submitted Data
Individual MIPS-eligible clinicians: You don’t need to take any additional action to qualify for the automatic EUC policy. You will be automatically identified and will receive a neutral payment adjustment for the 2022 MIPS payment year unless (1) you submit data as an individual in two or more performance categories, or (2) your practice reports as a group, by submitting data for one or more performance category.

Groups: You don’t need to take any further action if you’re not able to submit data for the 2020 performance period. Group participation is optional, and your individual MIPS-eligible clinicians qualify for the automatic EUC policy. They will have all four performance categories reweighted to 0% and receive a MIPS final score and MIPS payment adjustment for the 2022 MIPS payment year unless (1) you submit data for another performance category, or (2) your group submits data for one or more performance category.

Groups and virtual groups who have submitted data for a single or two or three performance categories:
If you’re not able to complete data submission for other performance categories, you can submit an application to request reweighting in all four performance categories (CMS, “About QPP Exceptions,” http://bit.ly/38cXwL). If you didn’t submit an application, your group will be scored in all performance categories unless you are eligible for reweighting in one or more performance categories.

If your application is approved and data aren’t submitted for another performance category, your MIPS eligible clinicians will receive a neutral payment adjustment for the 2022 MIPS payment year.

Groups and virtual groups who have submitted data for two or three performance categories:
Your MIPS-eligible clinicians will receive a MIPS final score and MIPS payment adjustment for the 2022 MIPS payment year.

Your group will be scored in all performance categories unless you qualify for reweighting in one or more performance categories.

For more information, please visit https://bit.ly/3euH2u.

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If it would have a devastating financial impact on a facility — as is often the case when a CMP is imposed on a relatively small company is well over $1 million.

The often-overlooked benefit of this practice comes with successful appeals. If a provider prevails at an appeal, CMS must refund the escrowed CMP funds plus interest. (Even a partial victory will result in CMS paying interest on a pro rata basis.) About four years after I prevailed in a case, CMS had to return more than $600,000 it had escrowed in addition to $53,000 in interest it was forced to pay the provider.

Residents deserve the best and highest quality care possible. Clearly, when the deficiencies are factually accurate, the best course of action is to pay the CMP (less the 35% discount) and, more importantly, learn what went wrong so that future adverse incidents can be avoided. On the other hand, if, as I often see, there is no factual and/or legal basis for the alleged deficiencies, providers may wish to appeal. Patience is necessary waiting for an ALJ decision to be rendered; currently it takes more than two years.

Each case and every fact pattern is unique, and an aggrieved provider will have to carefully consider the pros and cons of filing an appeal. Just do not expect a quick resolution, unless the counsel for CMS sees how strong a provider’s case is and how weak the government’s case is. Such an epiphany by CMS counsel can lead to CMS withdrawing a CMP or termination from Medicare action — or at least agreeing to a favorable negotiated settlement.

Mr. Horowitz is a partner at Arnall Golden Gregory LLP. His practice involves regulatory compliance concerning skilled nursing facilities, hospices, and home health agencies. Prior to joining the firm, he served as Assistant Regional Counsel at the U.S. Department of Health and Human Services and represented the Centers for Medicare & Medicaid Services. Mr. Horowitz also has extensive experience as health care provider.

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