

Medicare Termination: It Could Happen to You

Dan M. Peterson and Melissa (Lisa) Thompson, Fulbright & Jaworski LLP, Washington, DC

With increased transparency in healthcare, a hospital now faces a greater risk that a complaint will suddenly put it on a track to be terminated from the Medicare program. The Centers for Medicare and Medicaid Services (CMS) may receive a complaint from almost anywhere—a patient, a hospital employee, the state, the media, an accrediting agency, a competitor, or a plaintiff’s lawyer—and send surveyors knocking at the hospital’s door. The hospital itself may be required to self-report in some instances, or it may be unlucky enough to receive a random validation survey even without a complaint being filed.

No matter the complaint’s source, it can prompt a survey by Medicare to determine whether the hospital is in compliance with the Medicare Conditions of Participation.¹ The potential consequences of a finding of noncompliance include termination of the hospital from participation in the Medicare and Medicaid programs. That termination may in turn jeopardize managed care contracts, bonds, or financing agreements. In short, termination from Medicare can be a death blow to a hospital. Even if termination ultimately is avoided, negative publicity during the termination proceedings can seriously damage a hospital’s reputation and business.

Medicare surveys are normally carried out by the designated state agency (SA), typically the state licensing agency. For Medicare survey purposes, the SAs work under the general direction of the CMS Regional Offices (ROs), which are responsible for oversight of the survey process. Because the state surveyors wear two hats, one federal and one state, they may find violations of federal requirements during state monitoring activities and vice versa.

When a complaint raises a “substantial allegation of noncompliance” with a Condition of Participation, the SA will conduct a survey, focusing on the allegations in the complaint. At the completion of the complaint survey, if a hospital is out of compliance with even one Condition of Participation, the RO will place the hospital on a track for termination from Medicare.² If “immediate jeopardy” to patient safety is found, the entire termination process may be completed in as few as 23 days. Immediate jeopardy is defined in the federal regulations as “a situation in which the provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a [patient].”³

This article will focus on termination of accredited hospitals from Medicare for violations of the general hospital Conditions of Participation.⁴ Because of the high stakes involved, and the sometimes compressed time schedules, counsel for hospitals should understand the Medicare survey and termination process in advance, and know the strategies

that work, in order to guide their clients through what can be a very difficult time.

The Medicare Conditions of Participation

To participate in the Medicare program, a hospital must meet the hospital Conditions of Participation. Conditions are composed of “standards,” which in turn have multiple “elements.” For example, the “Patient’s Rights” Condition states that: “A hospital must protect and promote each patient’s rights.”⁵ The Patient’s Rights Condition comprises the following standards:

- » Privacy and Safety
- » Exercise of Rights
- » Notice of Rights
- » Confidentiality of Patient Records
- » Restraint or Seclusion
- » Restraint or Seclusion: Staff Training Requirements
- » Death Reporting Requirements

The Privacy and Safety standard contains the following three elements:

- (1) The patient has the right to personal privacy;
- (2) The patient has the right to receive care in a safe setting; and
- (3) The patient has the right to be free from all forms of abuse or harassment.⁶

Whether there is compliance with a particular Condition of Participation depends upon the manner and degree to which the hospital satisfies the standards within each Condition.⁷ According to CMS guidance, this is based on the “nature (how severe, how dangerous, how critical, etc.) and extent (how prevalent, how many, how pervasive, how often, etc.) of the lack of compliance.”⁸

Because these criteria are highly subjective, survey results are prone to variability depending on the survey team and the CMS region. As federal regulations acknowledge, surveyors use their “judgment, in concert with Federal forms and procedures, to determine compliance.”⁹ With that judgment comes the potential for different treatment.

CMS has attempted to make the process more objective by developing survey methods, procedures, and federal forms for state surveyors.¹⁰ These are principally set forth in the *State Operations Manual*, CMS Publication No. 100-07, a CMS policy document that contains sections on topics such as the complaint survey process, termination actions, the hospital Conditions of Participation, and immediate jeopardy.¹¹

The Complaint Survey—Accreditation Readiness Is Not Enough

The Medicare program does not itself ordinarily conduct the routine, periodic surveys on which participation in the program is based. Instead, a facility is “deemed”¹² to meet the hospital Conditions of Participation for Medicare if it is accredited by The Joint Commission, or by the American Osteopathic Information Association (AOIA).¹³ Hospitals typically devote much energy to preparing for accreditation surveys. But sometimes they give less attention to the real potential for a Medicare survey. This can be a serious oversight, because a Medicare survey uses different evaluation criteria (the Conditions of Participation) than are used by The Joint Commission or the AOIA.

If information received about a hospital raises a substantial allegation of noncompliance with a Condition of Participation, the RO usually directs the SA to conduct a complaint survey at the hospital, focusing primarily on the areas related to the allegations (although the RO can conduct an investigation itself).¹⁴ At the close of the complaint survey, the state surveyors submit their findings and recommendations to the RO, and the RO makes the final decision regarding the nature and seriousness of any violations.

Medicare surveys are unannounced. Typically, two to four surveyors will show up at the door and remain on-site for a period ranging from a single day to a week. Appropriate hospital personnel should be instructed to immediately inform the administrator-in-charge of the arrival of any surveyors on-site. Without delay, the hospital should assemble its survey response team. The surveyors will conduct an entrance conference to explain the process, describe the purpose and scope of the survey, introduce the survey team members, and propose a date and time for an exit conference. The surveyors will ask for general background information on the hospital and its patients, medical staff, and employees.¹⁵ Depending upon the nature of the survey, the surveyors most often will review medical records. The surveyors also may ask to see relevant portions of personnel files, credentials files, maintenance records, staffing documents, policies, procedures, and contracts.

Failure to provide surveyors with access to the documentation they need can itself be grounds for termination.¹⁶ Often the surveyors will request photocopies of records they have reviewed. The hospital should make an additional copy of those records, so that it will know during subsequent proceedings exactly what is in the surveyors’ possession. It should also secure and safeguard the original records.¹⁷ In addition to reviewing records, the surveyors may observe patient care, treatment areas, and physical plant. They also may interview patients, staff, family members, or other individuals, either in person or by telephone.

During the survey, one or more members of the hospital team should accompany the surveyors, and should ask to sit in on any interviews with employees, patients, or physicians. They should inquire frequently regarding any alleged violations found, and particularly whether the surveyors

have identified any possible bases for a finding of immediate jeopardy. If a potential for immediate jeopardy is identified, the hospital should take immediate steps to remove or correct those circumstances. It should document the measures taken, explain the corrective action to the surveyors, and provide them with documentary proof at the earliest possible time.

The surveyors ordinarily will conduct an exit conference, which the hospital has a right to record. The hospital’s survey team should attend and, depending on the anticipated severity of the findings, the hospital should consider involving legal counsel. The hospital should use the conference to obtain a clear understanding of alleged deficiencies, including any findings of immediate jeopardy. It should inquire about the “level” of any deficiencies (e.g., “Condition” level or “standard” level). If the hospital believes that the proposed findings are based on erroneous information, it should provide the surveyors with the correct information. Before the surveyors leave, the hospital should ask what the next steps will be, and the timing of those actions.

The Statement of Deficiencies (CMS Form 2567)

After the survey, the RO will send the hospital a Statement of Deficiencies (CMS Form 2567), which provides specific factual findings and lists the Conditions of Participation alleged to have been violated. It also will state whether “immediate jeopardy” has been found. The SA also may send a separate form, detailing alleged violations of state requirements. A cover letter usually issues along with the 2567. Both documents must be carefully reviewed. The cover letter will provide a fairly short time frame for the hospital to respond. It will typically include additional information, such as the date the hospital will be terminated from Medicare if the hospital is not found to be in compliance prior to that date, and information regarding public notice of the termination.

Rather than simply waiting for the 2567 to arrive, the hospital should begin or continue to implement corrective action based upon the findings stated orally at the exit conference. The hospital also should give serious consideration to contacting the RO by telephone, in writing, or both. This can be particularly important if the hospital believes that a Statement of Deficiencies will issue based on erroneous findings. These may include factual mistakes or misunderstandings, medical judgments made by surveyors who are not qualified, or incorrect interpretation of CMS regulations or policies. Communicating with the RO can sometimes prevent a Statement of Deficiencies from issuing altogether, or may result in a less onerous document. Effective communications also can establish credibility and help to create an ongoing working relationship. On the downside, providing the RO with additional information may allow the RO to construct a Statement of Deficiencies that is harder for the hospital to challenge. On balance, however, communication is usually a good idea.

When the 2567 is received, there are three main (and separate) avenues down which further proceedings may go. First,

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if only standard-level deficiencies are found, the RO should not proceed to termination, and the hospital should be able to continue to participate in Medicare if it submits an acceptable plan of correction for achieving compliance within a reasonable time. Standard-level deficiencies typically are violations that do not jeopardize the health and safety of patients and do not substantially limit the hospital's capacity to render adequate care.¹⁸

Second, if the RO cites even one Condition-level violation, an accredited hospital will lose its "deemed" status under Joint Commission or AOIA accreditation, and survey jurisdiction will shift to the state agency. The hospital will be placed on a 90-day termination track unless, as discussed below, there is immediate jeopardy, in which case the termination track will be shorter.¹⁹ The state agency will then conduct a full Medicare survey, looking at all of the hospital Conditions of Participation.²⁰

Third, where noncompliance poses immediate jeopardy, the RO will put the hospital on a 23-day track and, as provided in the *State Operations Manual*, the state agency will usually conduct a resurvey after the hospital submits an acceptable plan of correction.²¹

Immediate Jeopardy—a Crisis Situation

CMS considers immediate jeopardy a crisis situation in which the health and safety of one or more individuals are at risk because of provider noncompliance.²² Significantly, actual harm is not required—potential harm to even a single patient can be enough.

When state surveyors identify a potential case of immediate jeopardy, they are supposed to consider, among other factors, whether actual or potential harm was caused by the hospital's noncompliance, the likelihood of repetition, and the culpability of the hospital:

- » Did the hospital thoroughly investigate the circumstances?
- » Did the hospital implement corrective measures?
- » Has the hospital re-evaluated the measures to ensure the situation was corrected?²³

CMS guidance documents on immediate jeopardy provide several case studies.²⁴ In one case, immediate jeopardy was found to exist and Medicare termination initiated when an elderly patient with a history of dementia and refusing to eat was admitted as a hospital inpatient with orders to withhold nutrition and hydration. The surveyors found insufficient documentation of advance directives from the patient and her authorized representative. The social worker familiar with the case did not know why the orders had been given and, further, the patient's representative disagreed with the orders.

In another case, immediate jeopardy was not found when an outsider entered a facility by cutting through a window screen and sexually assaulted a resident who had a diagnosis of advanced dementia. Although the patient had suffered actual, serious harm, the facility had no indication or warning prior

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to the incident and acted appropriately after the incident—conducting a thorough investigation, calling the police, hiring a security service to patrol the grounds, and checking all doors and windows.

Plan of Correction—the Hospital's Response to the Statement of Deficiencies

The Plan of Correction (POC) is a detailed outline of a hospital's plan for correcting deficiencies. The goal is to produce a POC that is acceptable to CMS. What the surveyors and the RO expect in that regard will vary somewhat by region. The hospital also may seek to rebut the factual or legal findings on which the 2567 is based.

A POC will include corrective actions made to date, outline the plan for the future, and, where appropriate, contain ongoing corrective actions. The POC should address problems at their core, and this may involve multiple solutions across several disciplines. Completion dates in the POC should be realistic, giving the hospital the leeway it needs to complete the corrective action within a time frame that is sufficient to avoid termination. By necessity, most completion dates will be very short in an immediate jeopardy situation. The POC should designate individuals (by title) and departments responsible for implementation, and describe the monitoring mechanisms the hospital will use to confirm the corrective actions.

Submitting a letter from the hospital along with the POC can be a good mechanism to provide a point-by-point refutation of any erroneous findings, and to argue that citations should be removed or modified. To the extent supported by the facts and the law, the hospital could make arguments such as: (1) some of the factual allegations included in the 2567 are erroneous, and therefore do not support a finding of a violation; (2) even if certain facts are true, they do not warrant a finding of immediate jeopardy or of a Condition-level violation; and (3) any immediate jeopardy was removed prior to the close of the survey.

The Resurvey

With Condition-level violations, if the POC submitted by the hospital is acceptable to the RO, the SA will conduct up to two

resurveys during the 90-day termination track.²⁵ The hospital should be prepared to present evidence of its corrective actions and monitoring results at the resurvey. If substantial noncompliance at the Condition level remains, the RO either will continue the 90-day track or, if the violations involve only new Conditions, may sometimes restart the clock.

In immediate jeopardy cases, if the RO receives a “credible allegation” of compliance, the state surveyors will ordinarily revisit, and termination will be rescinded if no immediate jeopardy and no Condition-level violations exist.²⁶ If there are Condition-level violations remaining, but no immediate jeopardy, the RO often will convert the termination to a 90-day track.²⁷ Under these circumstances, the state surveyors, if authorized by the RO, may conduct one or more additional revisits.

Resurveys (other than full surveys conducted after deemed status is lost) normally focus on the prior deficiencies and corrective actions, but this may not always be the case. If additional violations are found, they will be cited. These can be especially problematic if found during the final survey prior to the proposed termination date. Once compliance with all Conditions of Participation is verified during a resurvey, termination is rescinded.²⁸

Notice and Right to Appeal

CMS usually must give a hospital at least 15 days’ written notice prior to termination, and at the same time publish public notice in a newspaper in the hospital’s geographic area. For certain immediate jeopardy situations, however, the notice period can be two to four days.²⁹ The hospital should try to get the RO to postpone notice as long as possible, given the real potential for reputational harm if notice is published. Sometimes, rescission of the termination track can be accomplished before notice is published.

The decision to terminate a provider is an “initial determination” appealable to an administrative law judge (ALJ).³⁰ A hospital must file its appeal within 60 days.³¹ The issue of untimely filing often is raised by CMS and also can be raised independently by the ALJ. Although the ALJ may extend the deadline for good cause, an extension can be very difficult for the hospital to obtain. Accordingly, all documentation sent to the hospital during a Medicare termination process should be closely scrutinized by legal counsel so the hospital does not forfeit any appeal rights. The next level of appeal is with the Department of Health and Human Services (HHS) Departmental Appeals Board, and then the federal court system.³²

Alternative Remedies

CMS sometimes contends that it cannot impose any remedy for hospital noncompliance other than termination. The Social Security Act and the regulations state, however, that CMS “may” terminate a provider agreement.³³ The regulations also provide that CMS “may reopen” a termination decision within 12 months of notice and make a revised determination.³⁴ There is nothing in the regulations precluding CMS from reconsid-

ering a decision to terminate, if a hospital makes a compelling case. That may be particularly true where the hospital has new information, there were errors or omissions regarding the facts, or patient safety objectives have been substantially achieved.

Depending on the circumstances, CMS also may agree to special measures such as on-site monitoring to assure safety and quality, extending the time of the termination track, or conducting additional resurveys. At times, the hospital may need to take more drastic measures to avoid termination, such as closing a hospital unit; discontinuing a service, treatment, or procedure; adopting high staffing ratios; or replacing key personnel.

Although CMS guidance documents can give the impression that only a certain number of surveys are permitted before termination must occur, in practice this is not always the case. In some situations, the ROs have put hospitals on and off termination tracks for years.³⁵ This is consistent with the regulations and decisions on appeal.³⁶

The willingness of CMS to work with a hospital to craft an alternative remedy may depend on a variety of factors. Certainly the seriousness of any remaining violations, the good faith and credibility demonstrated by the hospital, and the importance of the hospital in the community may all play a role.

The legal posture of the case also may have an effect. The hospital can seek an expedited hearing with the ALJ. Even though the appeal is not likely to be heard for at least a couple of months after appeal, the prospect of impending ALJ review may encourage CMS to be more flexible. If supported by the facts and the law, the hospital also can attempt to obtain a temporary restraining order and/or a preliminary injunction in federal court. This can be a difficult hurdle, because the government will argue that the federal courts lack jurisdiction before the HHS administrative appeals process is completed, and because of the deference traditionally accorded to CMS in termination actions.³⁷ Nevertheless, hospitals have sometimes prevailed in federal court actions, and a lawsuit can provide the opportunity for an alternative solution to be reached by the parties.


Conclusion

Hospitals need to take steps to ensure they comply with all of the requirements for participation in the Medicare program, including the hospital Conditions of Participation. Joint Commission and AOIA readiness is not enough. The hospital should designate a Medicare survey response team in advance. The team should have a working knowledge of the requirements for Medicare participation and understand how to handle a survey. If it appears that CMS may initiate a termination action, the hospital should expand the team to include in-house or outside legal counsel experienced with the Medicare survey and termination process.

A hospital client in the midst of termination will be faced with challenges on multiple fronts and may have to deal simultaneously with CMS, the state surveyors, The Joint Commission or AOIA, the press, potential lawsuits, personnel actions,

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employee morale issues, effects on major contracts, and potential decreases in patient census and revenue. The best strategy often is a multi-pronged approach, utilizing a hospital Medicare survey team, public relations team, clinical care leadership, the governing body, upper-level management, and legal counsel.

If the hospital does not take effective measures on all fronts, there is a risk of being caught in the vortex of a downward spiral, in which regulatory agencies, the media, accreditation bodies, and perhaps malpractice counsel each reinforce the negative actions taken by the others. The hospital must take immediate steps to address incidents when they happen, and to fix what is wrong, while maintaining its public image and employee morale, limiting collateral damage, and ultimately avoiding termination—all while continuing to provide quality care. Throughout, the hospital needs to maintain credibility and continue to foster positive relationships with the regulatory authorities. 

Dan Peterson is a partner in the Washington, DC office of Fulbright & Jaworski LLP. He concentrates his practice in the field of healthcare law, focusing principally on representation of clients in federal court litigation and in contested proceedings before federal and state administrative agencies. He has handled dozens of Medicare termination matters. He also represents a broad range of healthcare clients in regulatory, business, compliance, and operational matters. Mr. Peterson can be reached at (202) 662-4610 and dpeterson@fulbright.com.

Melissa (Lisa) Thompson is a Senior Counsel in the Washington, DC office of Fulbright & Jaworski LLP, where she focuses her practice on healthcare and life sciences. Ms. Thompson has advised hospitals, medical device and pharmaceutical companies, pharmacies and pharmacy companies, physicians, and other clients on a broad range of corporate, regulatory, and transactional matters. She has represented clients in state and federal court litigation matters and administrative agency appeals, including Medicare terminations and PRRB appeals. Ms. Thompson can be reached at (202) 662-0398 and ltompson@fulbright.com.

Endnotes

- 1 The Medicare Conditions of Participation for hospitals are set forth in 42 C.F.R. Part 482 (2009).
- 2 42 U.S.C. § 1395cc(b) (2009); 42 C.F.R. § 489.53 (2009).
- 3 42 C.F.R. § 489.3 (2009). See *CMS State Operations Manual, Appendix Q – Guidelines for Determining Immediate Jeopardy*, § II (2004).
- 4 This article will not address requirements other than general hospital Conditions of Participation in Part 482 (e.g., requirements for specialized hospital services at psychiatric hospitals, transplant centers and rehabilitation hospitals, and requirements pursuant to the Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd (1986)).
- 5 42 C.F.R. § 482.13 (2009).
- 6 42 C.F.R. § 482.13(c)(1)-(3) (2009).
- 7 42 C.F.R. § 488.28 (2009).
- 8 *CMS State Operations Manual, Appendix A—Survey Protocol, Regulations and Interpretive Guidelines for Hospitals* (2009).

- 9 42 C.F.R. § 488.26(c)(3) (2009).
- 10 42 C.F.R. § 488.26(c) and (d) (2009).
- 11 See generally *CMS State Operations Manual, Chapter 5—Complaint Procedures* (2006), Chapter 3 – *Additional Program Activities* (2007) (adverse actions including termination), *Appendix A—Survey Protocol, Regulations and Interpretive Guidelines for Hospitals* (2009), and *Appendix Q – Guidelines for Determining Immediate Jeopardy* (2004).
- 12 See 42 U.S.C. §§ 1395x(e) (2009) and 1395bb(a) (2009). Exceptions to the “deemed” status include the utilization review (UR) condition and two special conditions for psychiatric hospitals. 42 C.F.R. § 488.5(a) (2009); *CMS State Operations Manual § 5100.1* (2006).
- 13 AOIA, an association founded by the American Osteopathic Association, replaced the American Osteopathic Association as an accrediting entity and was approved by CMS. Letter from Patricia Chmielewski, Deputy Director, Division of Acute Care Services, Centers for Medicare and Medicaid Services, to George Reuther, Chief Operating Officer of HFAP, American Osteopathic Association (Sept. 3, 2008).
- 14 42 C.F.R. § 488.7(a) (2009); *CMS State Operations Manual § 5100.1* (2006).
- 15 The surveyors are instructed to request detailed census information on current inpatients; contact information for department heads; a copy of the hospital’s organizational chart; a list of other hospital locations having the same provider number; the hospital’s infection control plan; a list of employees; the medical staff bylaws, rules and regulations; a list of contracted patient services; and a copy of the facility’s floor plan with the location of patient care and treatment areas marked. See *CMS State Operations Manual, Appendix A—Survey Protocol, Regulations and Interpretive Guidelines for Hospitals* (2009).
- 16 42 C.F.R. § 489.53 (2009).
- 17 *Id.*
- 18 42 C.F.R. § 488.28(a)-(c) (2009).
- 19 See 42 C.F.R. § 488.7(d) (2009).
- 20 42 C.F.R. § 488.7(a)(3) and (d) (2009).
- 21 *CMS State Operations Manual § 5100.2* (2006).
- 22 *CMS State Operations Manual § 3010* (2007) and *Appendix Q – Guidelines for Determining Immediate Jeopardy*, § I (2004).
- 23 See *id.*, Appendix Q, at § V.
- 24 See *id.*, at § V.
- 25 *CMS State Operations Manual § 3012* (2007).
- 26 *Id.* at §§ 3010B (revisit performed prior to termination “if possible”) and 3038A.
- 27 See *id.* at § 3038A (2007) and at Appendix Q, § VII B (2004).
- 28 See *id.* at §§ 3010 (2007) and 5100 (2006).
- 29 42 C.F.R. § 489.53 (d) (2009) and *CMS State Operations Manual § 3022* (2007).
- 30 The determination that a deficiency is Condition-level is reviewable, as is the decision regarding whether termination was justified. *CSM Home Health Servs., Inc.*, DAB No. 1622 (1997). Neither the existence of standard-level violations nor the determination that a facility has lost its “deemed” status by failing to meet a Condition of Participation are appealable. 42 C.F.R. § 498.3(d) (2009).
- 31 42 C.F.R. §§ 498.5 and 498.40 (2009).
- 32 42 C.F.R. §§ 498.82 and 498.90 (2009).
- 33 Social Security Act § 1866(b)(2), 42 U.S.C. § 1395cc(b)(2) (2009) and 42 C.F.R. § 489.53(a)(3) (2009).
- 34 42 C.F.R. §§ 498.30 and 498.32 (2009); *Carmel Convalescent Hosp.*, DAB No. 1584 (1996) (CMS may reopen and revise any initial determination within 12 months after the date of the initial determination).
- 35 See, e.g., *Evelyn V. v. Kings County Hosp. Ctr.*, 956 F. Supp. 288 (E.D.N.Y. 1997).
- 36 Surveyors have the responsibility to “[r]esurvey providers or suppliers as frequently as necessary to ascertain compliance and confirm the correction of deficiencies.” 42 C.F.R. § 488.20 (2009). Medicare termination is intended to protect the health and safety of program beneficiaries and is not a punishment. *ACT of Health*, CR1177 (2004), *aff’d ACT of Health*, DAB No. 1972 (2005) (authority that Social Security Act confers on CMS to terminate Medicare participation is “remedial and not punitive”); see *CSM Home Health Servs., Inc.*, CR440 (1996); *Comprehensive Professional Home Visits*, CR1097 (2003).
- 37 See *Shalala v. Ill. Council on Long Term Care*, 529 U.S. 1, 21, 25 (2000) (citing 42 U.S.C. § 405(h)).