CMS PROPOSES COMPREHENSIVE REVISION OF LTC REQUIREMENTS FOR PARTICIPATION: REVIEW OF NEW REGULATIONS FOR FACILITIES

INTRODUCTION

CMS has proposed a comprehensive revision of the requirements for participation for long-term care facilities (the "Requirements") for the first time since 1991. The proposed regulations reflect the significant changes in technology, resident care and facility demographics since 1991. CMS states the proposed regulations are designed to optimize resident safety, reflect current professional standards, focus on evidence-based outcomes and resident-centered care, reduce unnecessary hospitalizations and rehospitalizations and reduce health care-associated infections, as well as improve the logical flow of the regulations.

These changes will have an estimated financial impact of $729,495,614 for all long-term care facilities (a "Facility") in the first year of implementation. CMS estimates the ongoing costs for Facilities to comply with the proposed regulations at $628,386,760 per year thereafter.

Comments on the proposed regulations are being accepted by CMS until September 14, 2015. Below is a brief description of new regulations added to the Requirements. A more detailed review of all the proposed changes will be available soon. If you would like to submit comments to these or any of the proposed changes, contact any of the Hall Render attorneys listed at the end of this article.

FACILITY RESPONSIBILITIES (§483.11)

CMS is proposing a new regulation titled "Facility Responsibilities." The goal of the proposed regulation is to improve the logical organization of the existing provisions currently found in the Resident Rights and Quality of Life Requirements. This proposed regulation is consistent with other recently proposed rules that focus on the individuality of the resident by providing services in a "person-centered" manner.

The proposed regulation creates a new section titled "Exercise of Rights." While this is a new section of the Requirements, much of the language exists in the current Resident Rights regulation. One fairly significant change relates to decisions being made by patient representatives. While the Facility must treat decisions of the resident's representative as those of the resident to the extent allowed by law or court order, the Facility should be careful not to extend more authority to the resident's representative than is permitted by law or court order. CMS expressed concern that a Facility may defer decisions to resident representatives that exceed the scope of the resident representatives' authority.

Self-Administration of Treatment. The proposed regulation retains existing language that the resident be informed of and participate in his/her own care to the extent practicable, including the self-administration of drugs. This proposed rule goes one step further and allows the resident to "...self-administer or take part in other health care practices, such as dialysis." CMS expects the Facility to address whether additional self-administration is appropriate through the interdisciplinary team ("IDT") and care planning.

Physician Credentialing. The proposed regulation requires the Facility to inform the resident of all health care providers responsible for the resident's care, including the resident's physician, nurse practitioner or clinical nurse specialist. CMS is also proposing that the Facility ensure the resident's attending physician is appropriately credentialed. If the attending physician is not appropriately credentialed, the Facility can seek another physician but only after discussing with the resident. The resident is also allowed to seek out an alternate physician that the Facility must honor if that physician meets the credentialing requirements.

Visitation Rights. The proposed regulation addresses and expands visitation rights consistent with the recent revisions to the hospital Conditions of Participation. The Facility would also be required to develop policies and procedures addressing visitation rights. CMS is firm in its belief that open visitation helps residents by providing a better support system and homelike environment.

Payment for Hospice Services. The proposed regulation prohibits the Facility from charging the resident for hospice services elected by the resident that are paid for by Medicare or Medicaid. This would apply if the services are provided directly by the Facility or under an agreement with a hospice provider.
Resident Communication. With the exception of medical records, CMS proposes to expand the form and manner that a resident may receive information in a manner that he/she can understand. CMS stated in the proposed regulation that a resident may prefer to access information via the internet rather than be provided with a paper copy. With regard to a blind or visually impaired resident, CMS may request an audio file of the information requested. CMS stated in the proposed regulation that it would provide Facilities with “flexibility” in implementing this requirement.

Access to Surveys. As required by the Affordable Care Act (“ACA”), CMS would allow resident access to Facility surveys and corresponding plans of correction for the preceding three years.

Posting of Notices. The proposed regulation requires the Facility to post a notice providing information on how residents would contact various client advocacy agencies, state survey agencies and Medicaid Fraud Control Units. This information is already required in the written resident rights information, but CMS believes posting a notice will ensure that resident representatives and others visiting the Facility will be on notice of the various agencies it may contact.

Filing Grievances. The proposed regulation requires the Facility to have a policy to ensure prompt resolution of grievances and also appoint a Grievance Officer. The Facility would be required to produce a copy of the grievance policy upon request. The proposed regulation also identifies a number of specific actions the Facility must take in response to a grievance.

COMPREHENSIVE PERSON-CENTERED CARE PLANNING (§483.21)

As part of the reorganization of the existing Requirements, CMS has removed the requirements for comprehensive care plans from section 483.20 and proposes a new section 483.21 - Comprehensive Person-Centered Care Planning. The proposed section significantly expands the requirements for comprehensive care plans. CMS estimates the cost to Facilities for implementation of this section will be $118,184,092 per year.

Baseline Interim Care Plan. Recognizing current regulations permit up to 21 days for a Facility to develop a comprehensive care plan, CMS proposes a new requirement for a Facility to develop a baseline interim care plan within 48 hours of admission for every resident.

The baseline interim care plan must include, at a minimum, the initial resident goals based on admission orders, the physician orders, dietary orders, therapy and social services and PASARR recommendations.

In the alternative, a Facility may complete a comprehensive care plan within 48 hours of admission instead of the baseline interim care plan.

Revised Comprehensive Care Plan Requirements. CMS is proposing revisions to the comprehensive care plan requirements to encourage person-centered care, provide clarity and promote resident safety.

A new requirement for a resident care plan is the inclusion of any specialized services or specialized rehabilitation services that a Facility would provide pursuant to a PASARR recommendation. If a Facility disagrees with the findings of the PASARR, it must indicate this disagreement and the reasons for it in the resident's medical record.

The proposed regulations include a requirement for discharge assessment and planning to be included in the comprehensive care plan. CMS is focusing on maximizing every opportunity for residents to attain their highest quality of life, including returning to the community.

In the proposed regulations, the IDT responsible for developing the comprehensive care plan will expand to include "other appropriate staff" to be determined based on the resident's specific needs. In addition, a nursing aide, a member of the food and nutrition services staff and a social worker will be required on the IDT.

To the extent possible, the proposed regulations also require the resident or the resident representative to participate on the IDT for care planning. Should the IDT decide not to include the resident or the resident representative, this decision must be documented in the resident's medical record.

The comprehensive care plan must ensure that the services provided by the Facility are culturally competent and trauma-informed. Cultural competency includes language, culture preferences and other cultural concerns applicable to the resident. Trauma-informed approaches should help to minimize triggers and re-traumatization, as well as address the unique care needs of Holocaust survivors and other trauma survivors. CMS states these approaches are an important aspect of person-centered care.
Finally, CMS is strongly encouraging integration of certified health IT systems to support robust care plans that can be shared with other providers.

**Discharge Planning.** In order to improve the continuity of care during transitions to other providers and to support CMS’s initiatives for reduced rehospitalizations and unnecessary hospitalizations, the proposed regulations strengthen current discharge planning requirements.

The proposed regulations reflect the recent additions from the IMPACT Act of 2014, which required post-acute providers, home health agencies, SNFs, IRFs and LTCHs to report standardized patient assessment data, data on quality measures and data on resource use and other measures. Under the IMPACT Act, this information must be standardized and interoperable to allow for the exchange of data amongst different providers.

Facilities will be required to develop and implement an effective discharge planning process that ensures the discharge goals and needs of each resident are identified. Additionally, Facilities will be required to assist residents in selecting other providers by utilizing the standardized data sets implemented by the IMPACT Act and present the information to the resident and his/her representative in an accessible and understandable format.

A Facility will have to provide the resident with a discharge summary that includes a post-discharge plan of care and document arrangement for follow-up care and any post-discharge medical and non-medical services required. The discharge summary will have to include a reconciliation of all medications, both prescription and non-prescription, in order to ensure residents avoid unnecessary medications and drug interactions and to assist in transitions of care.

Similar to the comprehensive care planning, CMS will require the resident to assist in the development of the post-discharge plan to the extent possible.

**BEHAVIORAL HEALTH SERVICES (§483.40)**

In an attempt to ensure that all residents of Facilities receive the necessary behavioral health care and services they need, the proposed regulations would add new requirements for behavioral health services and Facility staffing qualifications.

Under the proposed regulations, Facilities are required to have sufficient direct care staff with the appropriate competencies and skills to provide nursing and related services to ensure resident safety and attain or maintain the highest practicable well-being of each resident in accordance with the resident's plan of care. These appropriate competencies and skills include knowledge and training for caring for residents with mental illness, psychosocial issues or a history of trauma. Staff must also be trained in implementing non-pharmacological interventions.

The proposed regulations require a Facility to ensure that a resident who displays or is diagnosed with mental or psychological adjustment difficulty receives appropriate treatment and services to correct the issue or attain the highest practicable well-being. Further, the proposed regulations require a Facility to ensure that residents without a mental or behavioral health disorder identified in their assessment do not display patterns of decreased social interaction and/or increased withdrawn, angry or depressive behaviors, unless the behavior is unavoidable given the resident's clinical condition.

**LABORATORY, RADIOLOGY AND OTHER DIAGNOSTIC SERVICES (§483.50)**

In order to increase resident access to care and avoid delays in treatment, CMS proposes to expand the ability of physician assistants, nurse practitioners and clinical nurse specialists, in accordance with state scope of practice limitations, to order laboratory, radiology and other diagnostic tests in Facilities. Further, unless required otherwise by Facility standards or the order, the ordering practitioner must be promptly notified of test results that fall outside of clinical reference or expected "normal" ranges.

**QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT. (§483.75)**

The long-awaited quality assurance and performance improvement ("QAPI") regulations are included in the proposed regulation. The proposed regulations largely mirror the guidance CMS has issued in past publications on SNF QAPI programs. The QAPI requirement was included in the ACA, but enforcement has been delayed until CMS publishes regulations. CMS anticipates the implementation of a QAPI program will cost Facilities $118,419,977 the first year and $47,402,511 each year thereafter.

With this proposed regulation, Facilities will be required to develop, implement and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life.
The Facility will be required to present the QAPI plan at the first annual recertification survey, each subsequent survey and upon request by CMS or during any other survey event.

Under the proposed regulation, the State or the Secretary may not require the disclosure of the records of the QAPI committee except so far as required to ensure the committee is in compliance with the regulations. Good faith attempts by the QAPI committee to identify and correct quality deficiencies will not be used as the basis for sanctions.

**COMPLIANCE AND ETHICS PROGRAM (§483.85)**

As CMS reiterates throughout the proposed regulation, the current regulations governing Facilities do not address a compliance and ethics program as required by the ACA. The ACA requires Facilities to have in place a compliance and ethics program that is effective in preventing and detecting criminal, civil and administrative violations and in promoting quality of care.

Under the proposed regulations, Facilities are required to have a compliance and ethics program in place one year after the effective date of the regulations.

CMS proposes that a Facility's compliance and ethics program contains, at a minimum, the following elements:

1. Established written standards, policies and procedures that include, without limitation, a designated compliance and ethics program contact to whom individuals may report suspected violations and disciplinary standards for committing such violations that apply to all employees, contracted individuals and volunteers.

2. Assignment of specific high-level personnel with oversight responsibility to ensure compliance with the operating organization's standards, policies and procedures.

3. Sufficient resources and authority given to the specific high-level personnel mentioned above to reasonably ensure compliance.

4. Due care to not delegate substantial discretionary authority to individuals who the operating organization knew had a propensity to engage in criminal, civil and administrative violations.

5. Effectively communicate standards, policies and procedures of compliance and ethics program to entire staff, including contracted practitioners and volunteers. Such requirements would include mandatory training and orientation.

6. Reasonable steps to achieve compliance with compliance program such as using monitoring and auditing systems to detect violations, implementing a reporting system and having a process for ensuring the integrity of any reported data.

7. Consistent enforcement of its policies and procedures through a disciplinary mechanism.

8. Reasonable steps taken to respond to a violation once it is detected and to prevent similar violations from occurring.

Additionally, CMS proposes requiring an annual review of the compliance and ethics program and revising the program as needed. Additional requirements are proposed for operating organizations that operate five or more Facilities.

**TRAINING REQUIREMENTS (§483.95)**

The proposed regulation would impose a number of training requirements on Facilities. Facilities would be required to develop, implement and maintain an effective training program. Training must be provided to new and existing staff, individuals providing services under contract and volunteers.

*Communication Training.* CMS will require communication training for all direct care personnel. CMS believes communication breakdowns lead to adverse events, which in turn lead to rehospitalizations. CMS cites numerous resources that Facilities may utilize to train direct care staff. Importantly, CMS is not setting forth a specific amount of time or content that must be devoted to communication training.

*Resident’s Rights Training and Abuse, Neglect and Exploitation Training.* Under the proposed regulation, CMS requires Facilities to conduct resident’s rights training for staff members with an emphasis on abuse, neglect and exploitation.

*QAPI Training.* QAPI training will be required for all staff. Staff must be trained on the elements and goals of the QAPI program and how the Facility intends to implement and monitor the program.
Infection Control Training. Facilities will be required to train staff on how to prevent infections and infection control policies and procedures.

Compliance and Ethics Training. Facilities will be required to conduct compliance and ethics training. Noteworthy is the fact that if the operator has five or more Facilities, compliance training must occur annually.

Nurse Aide Training on Dementia Management and Abuse Prevention. Due to the high number of dementia and Alzheimer's residents residing in Facilities, along with increased life expectancy, CMS is proposing nurse aide training on dementia management. CMS noted that many industry professionals do not believe nurse aide training adequately addresses dementia training.

PRACTICAL TAKEAWAYS
1. The proposed regulations are very comprehensive and add many new requirements. If you have comments on the proposed regulations, exercise your right to comment prior to September 14, 2015.

2. Keep in mind that while the regulations are just being proposed, many, if not most, will be implemented as proposed, so it is best to start preparing now. For example, the proposed QAPI regulation mirrors what has been passed for other health care providers, so Facilities should start implementing their programs now.

3. The same could be said for the long-awaited Compliance and Ethics Program proposed regulation. This proposed regulation was mandated by the ACA, so the likelihood it will be changed drastically is remote. Therefore, Facilities that do not have compliance programs will need to implement one, and those that do will need to ensure their compliance program conforms to the proposed regulation.

4. While many of the proposed regulations are just re-designations and revisions to current regulations, Facilities should be mindful that many of the proposed regulations have subtle changes that could have an impact on Facility operations.

If you have any questions or would like additional information about this topic, please contact:

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