July 19, 2019

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CMS Announces Proposed Rule that would Revise Requirements of Participation for LTC Facilities

On July 16, 2019, the Centers for Medicare & Medicaid Services (CMS) announced ***a proposed rule***, "Medicare & Medicaid Programs; Requirements for Long-Term Care Facilities: Regulatory Provisions to Promote Efficiency and Transparency" The proposed rule would remove requirements for participation identified as unnecessary, obsolete, or excessively burdensome on long-term care (LTC) facilities.

In order to give facilities enough time to respond to these proposed changes, CMS also proposes to delay the implementation of certain phase 3 QAPI and compliance and ethics related requirements that are directly impacted by the proposed changes in the regulation to one year following the effective date of this proposed rule, if finalized. The revised LTC facility requirements for participation set forth in the October 2016 final rule are being implemented in three phases. Phases 1 and 2 were implemented in November of 2016 and 2017 respectively. Phase 3 includes additional regulatory provisions that could be implemented as early as November 28, 2019.

Summary of Major Provisions

a. Requirements for Participation

Resident Rights (§483.10)
CMS proposes to revise the requirement for facilities to ensure that residents remain informed of the name and specialties of the physician and other primary care professionals responsible for their care, and is provided with their contact information. Specifically, CMS proposes to reduce burden by revising the provision to require facilities to provide residents with their primary care physician's name and contact information upon admission, with any change, or upon a resident's request.

In addition, CMS proposes revisions to the grievance policy requirements. Proposed revisions include clarifying that general feedback may not rise to the level of an official grievance, removing the specific duties required of the grievance official, removing prescriptive requirements related to written grievance decisions, and reducing the amount of time that facilities must retain evidence demonstrating the results of grievances from 3 years to 18 months.

Admission, Transfer, and Discharge Rights (§483.15)
CMS proposes to revise the requirement for facilities to send discharge notices to State LTC Ombudsman by applying this requirement to "facility-initiated involuntary transfers and discharges" only.

Quality of Care (§483.25)
CMS proposes to modify requirements to focus on the appropriate "use" of bed rails and eliminate references to the "installation" of bed rails. These revisions would provide clarity and address stakeholder concerns regarding the purchase of beds with bed rails already in place with no practical means of removal.

Nursing Services (§483.35)
CMS proposes to reduce the timeframe that LTC facilities are required to retain posted daily nursing staffing data from 18 months to 15 months, or as required by state law.

Behavioral Health (§483.40)
CMS proposes to remove requirements that are duplicative of other LTC requirements in other sections of the regulation, and improve clarity.

Pharmacy Services (§483.45)
CMS proposes to remove the existing requirement that PRN, or as needed, prescriptions for anti-psychotics cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This proposed revision would increase flexibility by allowing each facility to allow for PRN orders of all psychotropic medications to be extended beyond 14 days if the attending physician or prescribing practitioner believes it appropriate and documents his or her rationale in the resident's medical record and indicates the duration for the PRN order.

Food and Nutrition Services (§483.60)
CMS proposes to revise the required qualifications for a director of food and nutrition services to provide that those with several years of experience performing as the director of food and nutrition services in a facility could continue to do so. CMS proposes that at a minimum an individual designated as the director of food and nutrition services would receive frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional; and would either have 2 or more years of experience in the position of a director of food and nutrition services, or have completed a minimum course of study in food safety that includes topics integral to managing dietary operations such as, but not limited to, foodborne illness, sanitation procedures, food purchasing/ receiving, etc. This proposal would help to address concerns related to costs associated with training for existing staff and the potential need to hire new staff.

Administration (§483.70)
CMS proposes to clarify that data collected under the facility assessment requirement can be utilized to inform policies and procedures for other LTC requirements. In addition, CMS proposes to remove duplicative requirements and revise the requirement for the review of the facility assessment from annually to biennially.

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Quality Assurance and Performance Improvement (§483.75)
CMS proposes to revise the requirement for facilities to implement a Quality Assurance and Performance Improvement (QAPI) program by removing prescriptive requirements to allow facilities greater flexibility in tailoring their QAPI program to the specific needs of their individual facility.

Infection Control (§483.80)
CMS proposes to remove the requirement that the infection preventionist (IP) work at the facility "part-time" or have frequent contact with the infection prevention and control program (IPCP) staff at the facility. They will instead require that the facility must ensure that the IP has sufficient time at the facility to meet the objectives of its IPCP.

Compliance and Ethics Program (§483.85)
CMS proposes to remove many of the requirements from this section not expressly required by statute. Proposed revisions include removing the requirements for a compliance officer and compliance liaisons and revising the requirement for reviewing the program from annually to biennially.

Physical Environment (§483.90)
CMS proposes to allow older existing LTC facilities to continue to use the 2001 Fire Safety Equivalency System (FSES) mandatory values when determining compliance for containment, extinguishment, and people movement requirements. This proposal would allow older facilities who may not meet the FSES requirements in the recently adopted 2012 Life Safety Code (LSC) to remain in compliance with the older FSES without incurring substantial expenses to change their construction types, while maintaining resident and staff safety. In addition, CMS proposes to revise the requirements that newly constructed, re-constructed, or newly certified facilities accommodate no more than two residents in a bedroom and equip each resident room with its own bathroom that has a commode and sink. Specifically, they propose to only apply this requirement to newly constructed facilities and newly certified facilities that have never previously been a nursing home. This would remove unintended disincentives to purchase facilities or make upgrades to existing facilities.

b. Survey, Certification and Enforcement Procedures

Informal Dispute Resolution and Independent Informal Dispute Resolution (§488.331 and §488.431)
CMS proposes to revise the informal dispute resolution and independent informal dispute resolution processes to increase provider transparency by ensuring that administrative actions are processed timely, and that providers understand the outcomes of results.

Civil Money Penalties: Waiver of Hearing, Reduction of Penalty Amount (§488.436)
CMS proposes to eliminate the requirement for facilities to actively waive their right to a hearing in writing and create in its place a constructive waiver process that would operate by default when CMS has not received a timely request for a hearing. The accompanying 35 percent penalty reduction would remain. This proposed revision would result in lower costs for most LTC facilities facing civil money penalties (CMP)s, and would streamline and reduce the administrative burden for stakeholders.

Phase 3 Implementation of Overlapping Regulatory Provisions
The revised LTC requirements for participation are being implemented in three phases. Phases 1 and 2 were implemented in November of 2016 and 2017, respectively. Phase 3 includes additional regulatory provisions that are scheduled to be implemented on November 28, 2019.

Of the Phase 3 provisions, this regulation proposes revisions that, if finalized, would have an impact on provisions that fall into three primary areas— (1) designation and training of the infection preventionist (§483.80), QAPI (§483.75), and compliance and ethics program (§483.85). CMS proposes to ***delay implementation*** of some of these Phase 3 provisions until 1 year following the effective date of this regulation.

CMS will accept comments on the proposed rule until September 16, 2019. Comments may be submitted electronically here: https://www.federalregister.gov/documents/2019/07/18/2019-14946/medicare-and-medicaid-programs-requirements-for-long-term-care-facilities-regulatory-provisions-to

For a copy of the CMS proposed rule: http://polaris-group.com/news_releases.asp

CMS Announces Final Rule for Revision of Requirements for Long-Term Care Facilities Arbitration Agreements

On July 16, 2019, the Centers for Medicare & Medicaid Services (CMS) announced a ***final rule***, "Medicare and Medicaid Programs; Revision of Requirements for Long-Term Care Facilities: Arbitration Agreements". The final rule revises the requirements for arbitration agreements when they are used by long-term care (LTC) facilities to resolve disputes with their residents.

This final rule repeals the prohibition on LTC facilities entering into pre-dispute, binding arbitration agreements with their residents, as proposed.

Final Rule Revisions to Arbitration Requirement

- The facility must not require that a resident or his or her representative sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. According to CMS, this ensures that no resident or his or her representative will have to choose between the resident obtaining the skilled nursing care he or she needs and signing an agreement for binding arbitration.
- The facility must ensure that the agreement is explained to the resident or his or her representative in a form and manner that he or she understands, including in a language that her or she understands, and that the resident or his or her representative acknowledges that he or she understands the agreement. According to CMS, these two requirements ensure that the arbitration agreement is transparent and the resident or his or her representative understand what he or she is agreeing to.

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- The facility must ensure that the agreement provides for the selection of a neutral arbitrator agreed upon by both parties and a venue that is convenient to both parties. According to CMS, these requirements help to ensure that the arbitration process is fair to both parties, especially the residents.
- The facility must ensure that the agreement does not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including Federal or state surveyors, other federal or state health department employees, or representatives of the Office of the State Long-Term Care Ombudsman. According to CMS, this protects the resident and his or her representative from any undue influence by the LTC facility to not discuss the circumstances surrounding a concern, complaint, or grievance.
- The facility must retain copies of the signed agreement for binding arbitration and the arbitrator's final decision for five (5) years following the resolution of any dispute resolved through arbitration with residents, and make these documents available for inspection upon request by CMS or its designee. According to CMS, this will ensure that CMS will be able to obtain information on how the arbitration process is being used by LTC facilities and on the outcomes of the arbitrations for residents.

For a copy of the CMS Final Rule: http://polaris-group.com/news_releases.asp

Polaris Group Solution Center Hotline Q&A "Where No Question Goes Unanswered!"

Question:
We had a skilled resident with a primary diagnosis of Sepsis/ UTI, but the resident is no longer on antibiotics but is still skilled. Would the primary diagnosis continue to be Sepsis for billing and would Sepsis still be on the MDS?

Answer:
For billing, the answer would be yes, since the principal diagnosis is the condition established after study to be chiefly responsible for the admission. For the MDS, the answer would be if they meet the RAI criteria for coding on the MDS. The RAI says the following: "Determine whether diagnoses are active: Once a diagnosis is identified, it must be determined if the diagnosis is active. Active diagnoses are diagnoses that have a direct relationship to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. Do not include conditions that have been resolved, do not affect the resident's current status, or do not drive the residents' plan of care during the 7-day lookback period, as these would be considered inactive diagnoses". It is likely the decline related to sepsis still impacts ADLs/Care Planning.

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Oct 22-24 Las Vegas, NV

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