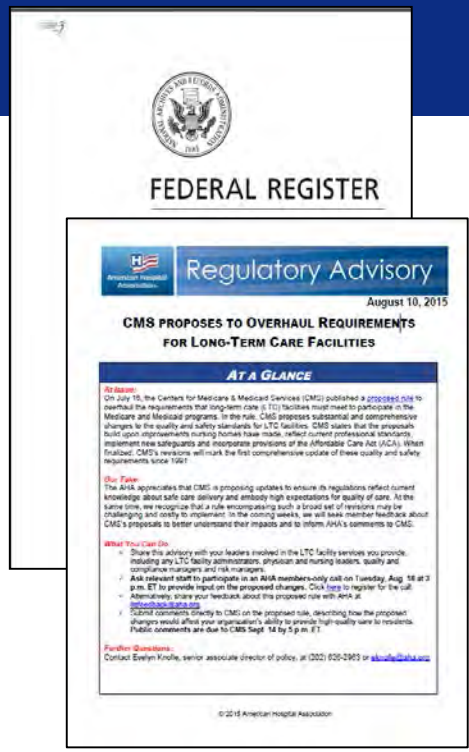
CMS Proposed Rule:
Revising the Requirements for Long-Term Care Facilities

American Hospital Association

Key Dates and Facts



- CMS published the rule in the *Federal Register* on July 16, 2015.
- The proposed rule updates requirements for long-term care (LTC) facilities to participate in Medicare.
- Comments: due by 5 p.m. on **Sept. 14** and may be submitted electronically at http://www.regulations.gov. **Please refer to file code CMS–3260–P.**
- Share your feedback about this proposed rule with AHA at **ltcfeedback@aha.org.**

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CMS Cost and Time Estimates

CMS Cost Estimates.

Aggregate:

- First Year: $729 million
- Second year and thereafter: $638 million

Per Facility:

- First Year: $46,491 per facility
- Second year and thereafter: $40,685 per facility

Implementation timeframe. What is the appropriate timeframe for implementation of the proposed revisions? CMS anticipates that it may take longer than 12 months to implement the provisions once the rule is finalized.

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Key Themes

- ✓ Bringing the regulations up to date with current quality standards
- ✓ Person-centered care
  - ❖ Empowerment/control
  - ❖ Services
  - ❖ Protection
- ✓ Competency-based approach
- ✓ Behavioral/mental health emphasis

Highlights of the proposed rule follow.

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Quality Assurance and Performance Improvement

Quality Assurance and Performance Improvement (QAPI).

CMS proposes that each LTC facility must develop, implement and maintain an effective, ongoing, comprehensive, data-driven and well-documented QAPI program. CMS envisions that:

- facilities will adopt a systematic approach to quality improvement, using data to study and continually make improvements to operations and services.
- a facility's QAPI program would address its full range of care and services (including those under contract) and reflect its complexities and the unique care it provides.
- facilities would use the best available evidence to develop quality indicators and facility goals that incorporate processes known to promote good outcomes.

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Quality Assurance and Performance Improvement

Quality Assurance and Performance Improvement (QAPI). Under the specific provisions of the proposed rule, facilities must:

- have policies and procedures to obtain feedback from staff and residents that identify problems that are high-risk, high-volume or problem-prone;
- collect and use data from all departments;
- develop and monitor performance indicators; systematically track, investigate and analyze adverse events and implement preventive actions; and
- engage in performance improvement activities and monitor success.

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Quality Assurance and Performance Improvement

Performance Improvement Projects (PIPs).

The facility also must conduct distinct PIPs.

- The number and frequency of PIPs would reflect the scope and complexity of the facility's services and available resources, as represented in the facility assessment.
- At least annually, the facility must undertake a project that focuses on high-volume, high-risk or problem-prone areas identified through the data collection and analysis.
- CMS specifically asks for comment on whether it should require a specific number of PIPS or establish mandatory PIPs (and thus require facilities to implement at least one PIP selected from the mandatory PIPs.)

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Quality Assurance and Performance Improvement

QAPI Leadership.

The proposed rule tasks the governing body and/or executive leadership with QAPI program oversight. It holds the governing body accountable for ensuring that the QAPI program:

- is effectively implemented;
- maintained during transitions in leadership/staffing; and
- adequately resourced, among other requirements.

QAPI Presentation to Surveyors.

Facilities would be required to present the QAPI programs to:

- state agency surveyors at the first annual recertification;
- state or federal surveyors at subsequent annual recertification surveys or upon request during other surveys; and
- CMS upon request.

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Quality Assurance and Performance Improvement

Quality Assessment and Assurance Committee.

The QAA committee would consist at a minimum of:

- the director of nursing services;
- the medical director or his/her designee;
- at least three other members of the facility's staff (at least one of whom must be the administrator, owner, a board member or other individual in a leadership role);
- and the infection control and prevention officer.

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Quality Assurance and Performance Improvement

QAA Committee (cont'd).

The QAA committee would:

- report to the governing body;
- meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program;
- develop and implement appropriate plans of action to correct identified quality deficiencies; and
- regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.

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Infection Control

Infection Control – Overview

In the rule, facilities must establish and annually update infection prevention and control programs (IPCPs).

These programs must include a system for:

- preventing,
- identifying,
- reporting,
- investigating and
- controlling

infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement.

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Infection Control

Infection Control – Specifics. IPCPs would need to have:

- **written standards, policies and procedures** that address: surveillance, reporting procedures, standard and transmission-based precautions, isolation, hand hygiene, and limitations for employees with communicable diseases/infected skin lesions;

- **an antibiotic stewardship program**;

- **a system for recording incidents** identified under the facility's IPCP and the corrective actions taken by the facility;

- **an infection prevention and control officer (IPCO).**
  - a clinician who works there at least part-time,
  - has specialized training in infection prevention and control beyond his/her initial professional degree.

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Transitions of Care

Transitions of Care.

For transfers and discharges, CMS would require facilities to ensure that appropriate information is communicated to the receiving health care institution or provider. Information provided to the receiving provider must address 18 elements, such as:

- Demographic information
- Resident representative info
- Advance directive info
- History of present illness
- Past medical/surgical history
- Active diagnoses
- Laboratory tests
- Functional status
- Psychosocial assessment
- Social supports
- Behavioral health issues
- Medications
- Allergies
- Immunizations
- Smoking status
- Vital signs
- Unique device identifier(s)
- Comprehensive care plan goals

CMS does not propose a specific form or format for this communication and recognizes that limited information may initially be sent in an emergency.

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Discharge Planning

Discharge Planning.

CMS would require that facilities develop and implement an effective discharge planning process that will:

- identify the discharge needs and goals for each resident;
- result in the development of a discharge plan for each resident;
- include regular re-evaluation of residents and updating of discharge plans as needed;
- involve the IDT in developing discharge plans as well as residents and their representatives;

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Discharge Planning

Discharge Planning (cont'd)

- consider caregiver/support person availability and capacity;
- address residents' care goals and treatment preferences; and
- document that residents have been asked about their interest in receiving information about returning to the community.
  - *If discharge to the community is deemed unfeasible, the facility must document who made the determination and why*.

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Training

Training Requirements.

Facilities must develop, implement and maintain effective training programs for:

- all new and existing staff;
- individuals providing services under contractual arrangements; and
- volunteers, consistent with their expected roles.

Each facility would determine the amount and types of training necessary based on the facility assessment.

However . . .

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Training

Training Topics.

Training topics must include the following:

- communications (for direct care/direct access personnel);
- residents' rights;
- the prevention of abuse, neglect and exploitation;
- QAPI;
- infection control;
- compliance and ethics;
- required in-service training for nurse aides; and
- behavioral health.

The rule retains a requirement that paid feeding assistants must successfully complete a state-approved training program for feeding assistants.

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Facility Assessments – Overview.

CMS would establish a new requirement for an annual facility assessment.

LTC facilities would conduct and document facility-wide assessments to determine the resources needed to care for residents competently in both day-to-day operations and emergencies.

Facilities would be expected to update their assessments:

- annually,
- as necessary, and
- whenever there are changes that would require a substantial modification to any part of the assessment.

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Facility Assessments – Specifics.

Assessments would need to address areas such as:

- # of residents and resident capacity;
- the care required by the resident population and the staff competencies necessary to provide that care;
- the physical environment, equipment, services and other physical plant considerations that are necessary;
- any ethnic, cultural or religious factors that may potentially affect the care provided by the facility;
- the facility's resources, such as all buildings and/or other physical structures and vehicles; equipment;

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Facility Assessments – Specifics.

Assessments would need to address areas such as:

- services provided;
- all personnel, including managers, staff, and volunteers, as well as their education and/or training;
- contracts, memorandums of understanding or other agreements with third parties;
- health information technology resources; and
- a facility-based and community-based risk assessment, utilizing an all-hazards approach.

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Physician Services

Allowing Physicians to Delegate.

CMS would allow a physician to:

- delegate to a qualified dietitian or other clinically qualified nutrition professional the task of writing dietary orders, to the extent the dietitian or other clinically qualified nutrition professional is permitted to do so under state law, and

- delegate to a qualified therapist, consistent with proposed § 483.65 (the revised section on “Specialized Rehabilitative Services”), the task of writing therapy orders, to the extent that the therapist is permitted to do so under state law.

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Physician Services

Immediate Care Needs.

- CMS would allow a physician, a physician assistant, a nurse practitioner, or a clinical nurse specialist to provide orders for the resident's immediate care and needs after admission, until a comprehensive assessment and care planning is completed.

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Compliance Programs

Compliance Programs – Overview.

CMS proposes that operating organizations be required to develop, implement and maintain effective compliance and ethics programs, and that these programs be reviewed annually.

Operating organizations would need written compliance and ethics standards, policies and procedures

> *that are reasonably capable of reducing the prospect of criminal, civil and administrative violations under the SSA.*

<u>The written policies should</u>:

- designate a compliance and ethics program contact;
- identify an alternate way to anonymously report suspected violations; and
- describe disciplinary standards for staff, contractors and volunteers for violations.

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Compliance Programs

Compliance Programs – Specifics.

Among other provisions, the proposed rule would require that operating organizations:

- assign “high-level personnel” with the responsibility for oversight of the compliance program;
- provide those individuals with adequate human and financial resources and authority;
- carefully select individuals to whom they delegate substantial discretionary authority;
- effectively communicate standards, policies and procedures to the operating organization’s entire staff;
- ensure programs employ reasonable measures to achieve compliance with standards, policies and procedures.

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Compliance Programs

Operating Organizations with Five+ Facilities.

CMS proposes additional requirements for operating organizations with five or more facilities. They would need to:

- provide a mandatory annual **training program** about the organization's compliance and ethics program;
- designate a **compliance officer** for whom the operating organization's compliance and ethics program is a major responsibility. This person:
  - must report directly to the operating organization's governing body and
  - cannot be subordinate to the general counsel, chief financial officer or chief operating officer;
- designate **compliance liaisons** at each facility.

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Resident Rights & Facility Responsibilities

Resident Rights and Facility Responsibilities.
CMS would expand current resident rights and delineate facility responsibilities pertaining to resident rights separately.

Resident Rights:
Exercise of Rights
Planning & Implementing Care
Choice of Attending Physician
Self-determination
Access to Information
Privacy and Confidentiality
Communication
Safe Environment
Grievances
Respect and Dignity

Facility Responsibilities:
Exercise of Rights
Planning & Implementing Care
Attending Physician
Self-determination
Information and Communication
Privacy and Confidentiality
Contact with External Entities
Safe environment
Grievances

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Resident Rights & Facility Responsibilities

Resident Representative.

The rule defines “resident representative” as:

> *an individual of the resident’s choice who has access to information and participates in healthcare discussions or a personal representative with legal standing, such as a power of attorney, legal guardian, or health care surrogate appointed or designated in accordance with state law. If selected as the resident representative, the same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated.*

CMS would clarify that residents may retain the ability to exercise those rights not delegated to a representative.

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Resident Rights & Facility Responsibilities

Care Planning.

CMS would maintain residents' rights to be fully informed about their health status in languages they understand.

The agency would require that residents be informed in advance:

- about care to be furnished;
- the disciplines involved; and
- the risks and benefits of proposed care and alternative treatment options.

Residents also would have the right to participate in the establishment and implementation of a person-centered plan of care.

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Resident Rights & Facility Responsibilities

Visitation.

Under the rule:

- Residents would have the right to receive visitors of their choosing at the time of their choosing, subject to a resident's right to deny visitation, and in a manner that does not impose on the rights of another resident.

The proposed rule would require facilities to:

- have written visitation policies and procedures, including any necessary or reasonable limitations;
- inform residents/representatives of their visitation rights (and any limitations);
- ensure visitors have full and equal visitation privileges consistent with resident preferences.

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Resident Rights & Facility Responsibilities

Selection of Attending Physician.

CMS would maintain the right of the resident to choose an attending physician.

The facility would need to:

- Ensure that the attending physician is licensed and meets the credentialing requirements of the facility.
- If the physician chosen by the resident does not meet such requirements, the facility may seek alternative physician participation to ensure the resident receives adequate care.
- However, it must discuss alternative physicians with the resident and honor the resident's wishes with regard to options.

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Resident Rights & Facility Responsibilities

Information about Medicare/Medicaid and Facility Services. Under the rule, facilities would be required to:

- provide notice to residents as soon as reasonably possible when changes in coverage are made to items and services covered by Medicare and/or the Medicaid state plan.

- inform residents at least 60 days prior to changes in charges for other items and services offered by the facility.

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Resident Rights & Facility Responsibilities

Grievances.

Under the rule, facilities would need to:

- make information available about how to file a grievance or complaint;
- make prompt efforts to resolve grievances; and
- establish a grievance policy to be provided to residents upon request.

The grievance policy must include numerous specific elements outlined in the proposed regulation, such as:

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Resident Rights & Facility Responsibilities

- notifying residents of the right to file and how to file grievances, and of the right to obtain a written decision regarding a grievance;
- identifying a Grievance Official who is responsible for overseeing the grievance process;
- as necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
- taking appropriate corrective action in accordance with State law; and
- immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, to the administrator; and as required by State law.

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Care Planning

Comprehensive Person-centered Care Planning.

Under current requirements, facilities must create a comprehensive care plan for residents within 21 days of admission. ***CMS would expand the interdisciplinary team (IDT) that creates this plan to include a nurse aide, social worker, and food/nutrition staff member.***

CMS also would require that facilities complete a baseline interim care plan for each resident within 48 hours of admission that includes, at a minimum:

- initial goals,
- physician orders,
- dietary orders,
- therapy services,
- social services and
- PASARR recommendations, if applicable.

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Quality of Care and Quality of Life

Quality of Care and Quality of Life.

Under the new heading, “Quality of Care and Quality of Life,” CMS would require, among other provisions, that:

- care needed to maintain or improve, as practicable, a resident’s abilities to perform his or her activities of daily living, is provided. The facility must ensure that those abilities do not diminish for avoidable reasons (other than an individual’s clinical condition);

- staff can provide basic life support (including cardiopulmonary resuscitation) to residents who require it before the arrival of emergency medical personnel;

- bed rails are correctly installed, used and maintained; and

- trauma survivors receive culturally competent, trauma-informed care to eliminate or mitigate triggers that may re-traumatize the resident.

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Behavioral Health

New Section on Behavioral Health Services.

Facilities would need to provide each resident the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

Facilities must have staff:

- who are competent to care for residents with mental illness, psychosocial disorders or a history of trauma and/or post-traumatic stress disorder; and
- who can implement non-pharmacological interventions.

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Behavioral Health

Behavioral Health Services (cont'd).

CMS wants to ensure that residents receive appropriate treatment, including those residents:

- with mental or psychosocial adjustment difficulties or
- who have a history of trauma and/or post-traumatic stress disorder

Facilities would need to ensure that residents without mental or psychosocial adjustment difficulties or documented histories of trauma and/or post-traumatic stress disorder do not display:

a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that development of such a pattern was unavoidable.

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Specialized Rehabilitative Services

Addition of Respiratory Therapy Services.

Currently, facilities must provide or obtain specialized rehabilitative services for residents if required by their comprehensive care plans:

- physical therapy,
- speech-language pathology,
- occupational therapy, and
- mental health rehabilitative services for mental illness and intellectual disability.

CMS would add **respiratory therapy** to this list.

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Physician Services

Non-emergency Transfers.

- CMS would require that before an unscheduled transfer of a resident to a hospital, a physician, physician assistant, nurse practitioner or clinical nurse specialist must conduct an in-person evaluation shortly after the potential need for a transfer is identified.

  - *Except for emergency situations*

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Pharmacy Services

Pharmacy Services.

CMS proposes that a pharmacist be required to review the resident's medical chart along with the drug regimen review at least every six months and when:

1) the resident is new to the facility;

2) the resident returns or is transferred from a hospital or other facility; and

3) during each monthly drug regimen review when the resident has been prescribed or is taking a psychotropic drug, an antibiotic or any drug the quality assessment and assurance (QAA) committee has requested be included in the pharmacist's monthly drug review.

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Food and Nutrition Services

Food and Nutrition Services.

CMS would make a number of changes, such as:

- expanding some staff qualifications;
- requiring that menus reflect the religious, cultural and ethnic needs of the residents, as well as input received from residents and resident groups, be updated periodically, and be reviewed for nutritional adequacy;
- adding a requirement for facilities to have policies regarding the use and storage of foods brought to residents by visitors to ensure safe and sanitary storage, handling and consumption; and
- enhancing the requirements for frequency of meals and snacks to align more with resident preferences or needs.

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Administration

Binding Arbitration Agreements.

Under the proposed rule, facilities must ensure that binding arbitration agreements are explained to residents in a form and manner they understand and that residents acknowledge that they understand the agreements. Further, the agreements:

- must be separate from other paperwork;
- must be entered into by the resident voluntarily, provide for the selection of a neutral arbiter, and provide for selection of a venue convenient to both parties; and
- cannot include language that prohibits or discourages the resident or anyone else from communicating with federal, state or local officials.

A facility cannot make admission to the facility contingent upon signing the agreement.

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Discussion Questions

- **Overall Reaction:** What is your overall reaction to the proposed rule?
- **Implementation timeframe:** How much time would you need to implement these provisions?
- **Cost:** Will cost be an issue in adopting these changes?
- **Specific reactions:** What provisions will be the most challenging to implement?
- **Suggested changes:** How should CMS modify any of its proposals?

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