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Cleaning House: CMS Proposes Sweeping Reform of Requirements for Long Term Care Facilities

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On July 16, 2015, the Centers for Medicare & Medicaid Services (CMS) published a proposed rule that would substantially reorganize and revise the requirements currently codified at 42 C.F.R. Part 483, Subpart B that long term care facilities must follow in order to participate in the Medicare and Medicaid programs (the Proposed Rule). CMS has extended the comment deadline to October 14, 2015.

The Proposed Rule emphasizes "competency-based" approaches to care improvement, and implements changes required by The Patient Protection and Affordable Care Act of 2010, as amended (the Affordable Care Act) and the Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act). The most substantial changes to the current regulations can be categorized as follows:

- Formal implementation of a compliance and ethics program
- Training requirements
- Establishment of a quality assurance and performance improvement (QAPI) program
- Annual facility assessment
- Pharmacy services and the use of psychotropic drugs
- Patient centered care planning
- Requirements related to discharge and transitions of care

Compliance and Ethics Program

The substantive requirements of what comprises an effective compliance program generally tracks the "seven elements" of compliance programs as articulated in the March 2000 Office of the Inspector General's (OIG) guidance to nursing facilities[1], and its further supplemental guidance that was issued in September 2008[2]. The Proposed Rule does establish some additional requirements for long term care providers.

The operating organization of the SNF or NF must establish a compliance program which meets the requirements of the regulations no later than one year after the Proposed Rule is finalized. In addition, organizations that operate five or more facilities would be required to designate a specific Compliance Officer, while smaller organizations could delegate compliance program responsibilities to a staff member without designating them the "Compliance Officer." Finally, the compliance programs of organizations operating five or more facilities must also require mandatory annual compliance training, and must designate a "compliance liaison" at each operating facility.

Training Requirements

The Proposed Rule sets forth specific training requirements that must be part of every facility's training

program for new and existing staff, individuals providing services under a contractual arrangement, and volunteers. The exact amount and types of training are to be determined by the facility based on their self-assessment, but training topics must include the following: (i) effective communication methods for direct care staff, (ii) rights of residents and responsibilities of the facility, (iii) activities that constitute abuse, neglect, exploitation and misappropriation of resident property, and how to report such incidents, (iv) the goals and elements of the QAPI program, (v) infection prevention and control, (vi) required in-service training for nurse aides, (vii) required training for feeding assistants, and (viii) behavioral health training.

QAPI Program

Each facility must submit a detailed QAPI plan to their applicable State agency or federal surveyor at their first annual recertification survey that occurs at least one year after the regulations are finalized. The facility must then present their QAPI plan at each annual recertification survey and to CMS upon request.

CMS identified five critical elements that should be addressed in a successful QAPI program: (i) design and scope, (ii) governance and leadership, (iii) feedback, data systems and monitoring, (iv) performance improvement projects, and (v) systematic analysis and systemic action.

Annual Facility Assessment

The Proposed Rule adds a requirement that facilities must conduct an annual facility assessment. The assessment must be updated as necessary but at least annually. The assessment must address (i) factors and needs of the facility's resident population, (ii) staff competencies that are necessary to provide certain levels and types of care, (iii) needs of the physical environment and equipment of the facility, (iv) ethnic or cultural factors that could impact care, (v) services provided, (vi) personnel and the training provided to staff, (vii) contracts and arrangements with third parties to provide services or equipment, and (viii) health information technology resources.

Pharmacy Services and Use of Psychotropic Drugs

The Proposed Rule states that the facility must ensure that psychotropic drugs are only administered if "necessary to treat a specific condition as diagnosed" and that gradual dose reductions are applied to discontinue use. In addition, the use of "PRN orders" will be limited to 48 hours unless a physician documents a rationale for continuation. The Proposed Rule adopts a broad definition of "psychotropic drugs" to include (i) antipsychotics, (ii) antidepressants, (iii) anti-anxiety, (iv) hypnotic, (v) opioid analgesic and (vi) any other drug "that results in effects similar" to the drugs listed in the definition.

CMS will require the pharmacist to report in a separate, written report any "irregularities" noted during the monthly drug regimen review. A definition of "irregularity" is being proposed to mean a drug used (i) in an excessive dose, or (ii) for an excessive duration, or (iii) without adequate monitoring, or (iv) without adequate indications for its use, or (v) in the presence of adverse consequences that indicate reduction or discontinuation, or (vi) any combination of these characteristics.

Care Planning

CMS proposes that facilities develop a "baseline interim care plan" for each resident which must be completed within 48 hours of admission. The baseline plan must address at least the following areas: (i) initial care goals, (ii) physician orders, (iii) dietary orders, (iv) therapy services, (v) social services, and (vi) any necessary PASARR recommendations.

Discharge and Transitions of Care

The Proposed Rule requires that facilities develop and implement an effective discharge planning process, which must result in a discharge plan for each resident that includes referrals to other community-based entities.

A change to the transfer requirements involves information that must be provided to the receiving provider, which includes acute care hospitals, as well as long term care hospitals, psychiatric facilities, another SNF, hospice, home health or community based providers or practitioners. Eighteen specific data elements are set forth in the Proposed Rule that must be included in the transfer documentation.

Finally, the Proposed Rule requires that an in-person evaluation of a resident be conducted by a physician, physician assistant, nurse practitioner or clinical nurse specialist prior to an unscheduled

transfer of a resident to a hospital.

Long term care providers in should take advantage of the extended comment period offered by CMS to provide feedback to the agency regarding the practical implications of such comprehensive reforms. As reimbursement dollars continue to be stretched, and the number of patients requiring long term and skilled nursing care continues to increase, it will be vital for nursing facilities to both advocate for meaningful improvements for patient care, and to provide input and seek clarity on how to operationalize and monetize the new reforms put into place.

[1] 65 Fed. Reg. 14, 289 (March 16, 2000).
[2] 73 Fed. Reg. 56,832 (Sept. 30, 2008).

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