# CMS Proposes a Host of Changes to Nursing Home Requirements for Participation - Part One

Jennifer L. Hilliard

More than a year after soliciting feedback from stakeholders and the public on areas for reducing the regulatory burden on nursing facilities, the Centers for Medicare and Medicare Services (CMS) on July 18 released a proposed rule that the agency estimates will achieve annual savings of nearly $644 million for providers. The agency proposes a host of changes to the revised Medicare Requirements for Participation ("Requirements for Participation") that it promulgated in 2016 and an extension of the implementation deadline for certain of the Phase 3 requirements for a period of one year following issuance of a final rule.[1]

Specifically, the rule proposes changes in 12 sections of the Requirements for Participation. This article will cover the first seven sections, and a companion piece will cover the remaining sections.

- **Resident Rights** – Section 483.10[2]
  - **Choice of Attending Physician** – Section 483.10(d)(3) – A facility must ensure that a resident "remains informed" of the name and specialties of the physician and other primary care professionals, and provide the resident with their contact information. Given that nursing facility residents often receive care from multiple health care professionals, CMS proposes to revise this requirement to obligate the facility to provide such information at admission, with any change of such information, and upon the resident's request.
  - **Grievances** – Section 483.10(j) – Nursing facilities are required to establish a grievance policy, appoint a grievance official, and abide by specific procedural and recordkeeping requirements. CMS proposes the following changes with respect to the grievance process:
    - **Distinguishing general feedback from a grievance** – The proposed rule would add language that refers to "general feedback" as a means of clarifying what rises to the level of a grievance. Without a specific definition or concrete examples, however, the mere inclusion of a reference to general feedback does not differentiate a grievance from ordinary complaints. In its narrative, CMS states that general feedback or complaints stem from "issues that can typically be resolved by staff present at the time a concern is voiced, while grievances are more serious and generally require investigations into allegations regarding the quality of care." Further, CMS stated that it expects a facility's grievance policy to cover how the facility makes its determination as to whether it is dealing with a complaint or a grievance. Further muddying the waters, CMS states in its narrative that a facility's failure to address repeated complaints from the same resident or the same complaint from several residents would raise the concerns to that of a grievance.

1 The proposed rule also would make changes to CMS's Informal Dispute Resolution and Independent Informal Dispute Resolution processes, and would eliminate the requirement for nursing facilities to actively waive their right to a hearing in order to receive a 35 percent reduction in penalty amount. Rather, CMS would institute a constructive waiver process that would operate by default when CMS has not received a timely request for a hearing. AGG Partner, Alan Horowitz, provides further insight into these aspects of the proposed rule here.

2 All citations refer to various parts within Title 42 of the Code of Federal Regulations.

- **Duties of the grievance official** – CMS proposes to remove the specific duties required of the grievance official to provide facilities with greater flexibility in shaping their handling of grievances.
- **Written decision** – The rule calls for removing some of the specifics regarding information to be included in written grievance decisions, though CMS states in the narrative that it expects that those specifics to be included in the written decision as a "standard practice," so it would appear that this change offers little in the way of administrative relief for providers.
- **Records retention** - Reducing from three years to 18 months the record retention period. CMS reasons that 18 months would more than cover the longest possible interval between surveys for a facility.

- **Admission, Transfer, and Discharge Rights** – Section 483.15(c)(3)(i) – One of the more roundly criticized requirements of the 2016 revisions to the Medicare Requirements for Participation has been the obligation of nursing facilities to provide notice before resident transfer or discharge to the Office of the State Long-Term Care Ombudsman ("LTC Ombudsman"). Nursing facilities expressed concern about the administrative burden of providing such notice even in the case of resident-initiated transfers or discharges and emergency transfers to acute care facilities. LTC Ombudsman programs voiced concern over their ability to receive and review flood of notices from facilities in their effort to focus on potentially inappropriate transfers and discharges. These concerns prompted CMS in 2017 to issue a survey and certification memorandum[3] that attempted to clarify the notification requirement to provide some relief to both facilities and LTC Ombudsman programs. In this rule, CMS proposes to change the notification requirement to specify that facilities must send a copy of a transfer or discharge notice to the LTC Ombudsman program in their state only in the event of a facility-initiated involuntary transfer or discharge. It would not include resident-initiated transfers or discharges, or emergency transfers or discharges when a return to the facility is expected. CMS further clarified that a facility-initiated involuntary transfer or discharge is one to which the resident objects, did not originate through the resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences.

- **Quality of Care** – Section 483.25
  - **Bed Rails** – Section 483.25(n) – The rule proposes to focus the requirements of Section 483.25(n) on "use" rather than "installation" of bed rails because many beds come with the bed rails pre-installed by the manufacturer and many observed that removing them may present problems with the warranty.

- **Nursing Services** – Section 483.35(g) – This provision of the Requirements for Participation requires facilities to post in the facility daily nurse staffing data and to retain that data for a period of 18 months. Industry stakeholders commented to CMS that the payroll-based journal ("PBJ") provisions, which require nurse staffing data to be reported electronically and posted on the Nursing Home Compare website, accomplish the same goal and thus are redundant. CMS, however, disagrees, pointing out that the PBJ data are retrospective whereas the daily nurse staffing data present information in real time to keep residents and their families apprised of number of staff in the facility during each shift. While CMS, therefore, declined to eliminate the requirements of Section 483.35(g), the agency proposes to reduce the timeframe for the retention of the nurse staffing data from 18 months to 15 months. Such a reduction offers little in the way of burden reduction.

- **Behavioral Health** – Section 483.40
  - Generally - CMS proposes to remove duplicative language in Section 483.40(a) regarding care and services to attain or maintain residents' highest practicable physical, mental, and psychosocial well-being because it is duplicative of language in Section 483.35. Instead, if the proposed language is finalized, Section 483.40 will refer to Section 483.35. Accordingly, this change is inconsequential in terms of burden reduction and does not address the concerns of industry stakeholders that the requirements of Section 483.40 risk "turning [long-term care] facilities into mental health institutions."
  - Specialized rehabilitation services - The proposed rule would remove Section 483.40(c), which mandates that facilities provide or obtain from the outside specialized rehabilitation services for residents

3 Centers for Medicare & Medicaid Services, Center for Clinical Standards and Quality/Survey & Certification Memorandum No. S&C 18-08-NH (Dec. 22, 2017)

if called for by the care plan, because it is identical to Section 483.65(a), "Specialized Care Services." Like the change to Section 483.40(a), this proposed change would merely tighten up the language of the Requirements for Participation rather than effectuate substantive change.

- **Pharmacy Services** – Section 483.45
  - **PRN anti-psychotics** – Under Section 483.45(e)(4), PRN prescriptions for psychotropic medications are limited to 14 days. There is presently an exception that permits prescribers to extend medication orders beyond 14 days by documenting their rationale in the resident's medical record and specifying the duration of the PRN order. The exception, however does not presently extend to anti-psychotics unless the resident is evaluated for the appropriateness of the medication as required by Section 483.45(e)(5). This is largely because of the National Partnership to Improve Dementia Care in Nursing Homes initiative launched by CMS in 2012 to reduce the prevalence of anti-psychotic medications in long-stay nursing home residents. In its narrative CMS discusses the burdens presented by the current structure, particularly for small providers and rural facilities that have difficulty with access to physicians and other health care providers. CMS also notes that it heard from psychiatrists who reported that the limitations interfere with their ability to treat their patients who reside in nursing facilities. The agency also discusses the counter argument that anti-psychotics have been used as chemical restraints. As a result, CMS proposes to strike a balance in the competing priorities by revising subsections (4) and (5) of Section 483.45(e) to eliminate the distinction between anti-psychotics and other psychotropic medications. Also, the facility will need to take into consideration the individual resident's need for psychotropic medications. CMS reasons that the changes will simplify the survey process, reduce improper deficiency citations, and permit mental health professionals to provide appropriate care for their nursing home patients. Still, however, CMS is concerned about the potential for misuse of anti-psychotics and is asking for additional input regarding whether the proposed changes provide adequate protection for nursing home residents.

- **Food and Nutrition Services** – Section 483.60 – If a nursing facility does not employ a full-time qualified nutrition professional, facility must designate someone to serve as the director of food and nutritional services. Individuals designated as the director of food and nutritional services prior to the effective date of the Requirements for Participation on November 28, 2016, must meet certain credentialing requirements within five years after that effective date. In response to concerns that the credentialing requirements exacerbate workforce shortages and increase the financial burden on both facilities and experienced food service staff, CMS proposes to revise the qualifications of the individual serving in the position to require two or more years of experience in the position of director of food and nutrition services or completion of a minimum course of study in food safety that includes topics integral to managing dietary operations, such as but not limited to, foodborne illness, sanitations procedures, and food purchasing/receiving. Unlike some of the other changes that are more wordsmithing than substantive changes aimed at reducing burden on providers, this proposed revision provides protection to nursing home residents by ensuring that those serving as the director of food and nutrition services have a threshold level of experience or education while not crippling the ability of facilities, particularly smaller or rural facilities, to find qualified staff.

In the forthcoming companion piece to this article, proposed changes to the following sections of the Requirements for Participation will be discussed:

- Administration – Section 483.70
- Quality Assurance and Performance Improvement (QAPI) Program – Section 483.75
- Infection Control – Section 483.80
- Compliance and Ethics Program – Section 483.85
- Physical Environment – Section 483.90

Comments to the proposed rule must be submitted no later than 5:00 p.m. Eastern on September 16, 2019. Comments may be submitted electronically via the regulations.gov website. All comments should include reference to file code CMS-3347-P.

## Authors and Contributors

**Jennifer L. Hilliard**
Of Counsel, DC Office
202.677.4900
jennifer.hilliard@agg.com

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Atlanta, GA 30363

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