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# Insights

## CMS Issues Proposed Rule Revising the Long-Term Care Facility Medicare and Medicaid Participation Requirements

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On July 16, 2015, CMS issued a proposed rule revising the Long-Term Care Facility Medicare and Medicaid participation requirements. These proposed revisions would serve as a widespread update to the participation requirements which have not been comprehensively reviewed and updated since 1991, despite substantial changes in LTC service delivery. These proposed revisions add new requirements where necessary, eliminate duplicative or unnecessary provisions, and reorganize the regulations as appropriate.

The key proposed revisions include (this list is not all-inclusive of the proposed changes):

- Updating resident rights for organization, clarity and innovation
- Adding a new section for “Facility Responsibilities” that parallels many residents’ rights provisions
- Specifying that facilities cannot employ individuals who have had a disciplinary action taken against their professional license by a state licensure body as a result of a finding of abuse, neglect, mistreatment of residents or misappropriation of their property. Adding a requirement that facilities must develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and mistreatment of residents or misappropriation of their property.
- Adding a new requirement that not only a transfer or discharge be documented in the clinical record, but also that specific information, such as history of present illness, reason for transfer and past medical/surgical history, be exchanged with the receiving provider or facility when a resident is transferred.
- Adding a new requirement that facilities must develop a baseline care plan for each resident, within 48 hours of their admission, which includes the instructions needed to provide effective and person-centered care that meets professional standards of quality care.
- Adding discharge planning requirements including: documenting in a resident’s care plan the resident’s goals for admission, assessing the resident’s potential for future discharge, including discharge planning in the comprehensive care plan, including a reconciliation of all discharge medications with the pre-admission medications in the resident’s discharge summary, and summarizing arrangements for follow-up care and any post-discharge medical and non-medical services.
- Requiring an in-person evaluation of a resident by a physician, a physician assistant, nurse practitioner, or clinical nurse specialist before an unscheduled transfer to a hospital.
- Allowing physicians to delegate dietary orders to dieticians and therapy orders to therapists.

- Adding drug regimen review requirements, including a requirement that a pharmacist review a resident's medical chart at least every 6 months and when the resident is new to the facility, a prior resident returns or is transferred from a hospital or other facility, and during each monthly drug regimen review when the resident has been prescribed or is taking a psychotropic drug, an antibiotic or any drug the QAA Committee has requested be included in the pharmacist's monthly drug review.
- Placing limitations on the use of psychotropic drugs.
- Clarifying that a physician assistant, nurse practitioner or clinical nurse specialist may order laboratory, radiology, and other diagnostic services for a resident in accordance with state law, including scope of practice laws.
- Prohibiting SNFs from charging a Medicare resident for the loss or damage of dentures determined to be the facility's responsibility.
- Adding requirements regarding binding arbitration agreements, including:
    - The facility and the agreement itself shall ensure that if a facility presents binding arbitration agreements to its residents that the agreements be explained to the residents and they acknowledge that they understand the agreement;
    - The agreements be entered into voluntarily;
    - Arbitration sessions be conducted by a neutral arbitrator in a location that is convenient to both parties;
    - Admission to the facility could not be contingent upon the resident or the resident representative signing a binding arbitration agreement
    - Agreement shall not prohibit or discourage the resident or anyone else from communicating with federal, state, or local health care or health-related officials, including representatives of the Office of the State Long-Term Care Ombudsman.
- Requiring all LTC facilities to develop, implement, and maintain an effective comprehensive, data driven Quality Assurance and Performance Improvement program that focuses on systems of care, outcomes of care and quality of life.
- Adding various training requirements.
- Requiring the operating organization for each facility to have in operation a compliance and ethics program that has established written compliance and ethics standards, policies and procedures that are capable of reducing the prospect of criminal, civil, and administrative violations in accordance with section 1128I(b) of the Act.

For a full list of the proposed changes, the Proposed Rule is available here.

CMS projects the costs of this rule would be $46,491 per facility for the first year, and $40,685 per facility for subsequent years.

CMS is accepting comments on the Proposed Rule until 5 p.m. on September 14, 2015. Due to the comprehensive nature of the changes, CMS has suggested the implementation time frame for the changes may be longer than 12 months.

If you have any questions or concerns, please feel free to contact Meghan M. Linvill McNab at mmcnab@kdlegal.com.