CMS Proposes New Rules for the Long Term Care Industry

The centers for Medicare and Medicaid services (CMS) recently released a 403-page proposed regulation intended to improve the quality of care provided to beneficiaries. The regulation, which was released on July 13, 2015, "would revise the requirements that long term care facilities must meet to participate in the Medicare and Medicaid programs." The proposed regulations are far reaching and include requirements that would directly affect facility operations, including staffing and patient care. A sampling of those proposed changes are included below.

The proposal would bring changes to certain staffing requirements. Under proposed Section 483.12, 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 misappropriations of their property. Further, proposed Section 483.21 would require long term care facilities to add a nurse aide, a member of the food and nutrition staff, and a social worker to the required members of the interdisciplinary team that develop each resident's comprehensive care plan. Section 483.35 would require a "competency requirement" for determining sufficient nurse staff based on facility assessment, which would include but not be limited to the number of residents, resident acuity, and the range of diagnoses found in the facility's patient population.

The proposed regulation would require not only that a patient transfer to another facility or discharge be documented in the clinical record, but also that the record include specific information such as history of present illnesses, reason for transfer, and past medical history. *See* Pr. Reg. § 483.15. This information must be exchanged with the receiving provider or facility when a resident is transferred or discharged. The new regulation would require an in-person evaluation of a resident by a physician, a physician assistant, nurse practitioner, or clinical nurse specialist before any unscheduled transfer to a hospital.

In regard to pharmacy services, the regulation would add the requirement that a pharmacist review a resident's medical chart at least every six months. Reviews also would be required when the resident is new to the facility or returns or is transferred from a hospital or other facility. Further, monthly reviews would be required when the resident is taking a psychotropic drug or any drug the Quality Assurance Committee has requested to be included in the pharmacist's drug review. *See* Pr. Reg. § 483.45. The pharmacist also would be required to document any "irregularities" noted during the drug regimen review that lists, at a minimum, the resident's name, the relevant drug, and the irregularity identified, and that the report be sent to the attending physician and the facility's medical director and DON. The attending physician then would be required to document in the resident's medical record that he/she has identified the irregularity and what, if any, action they have taken to address it. Most importantly, the proposed regulation would revise existing requirements regarding antipsychotic drugs and have them mirror the requirements relating to psychotropic drugs. A "psychotropic drug" would be defined as any drug that affects brain activities associated with mental processes and behavior, which is a broader definition than what currently exists. Further, PRN orders for psychotropic drugs would be limited to 48 hours. Orders could not be continued beyond that time unless the primary care provider reviewed the needs for the medications prior to renewal of the order and documented the rationale for the order in the resident's clinical record.

A number of facility assessment requirements are added in proposed regulation Section 483.70. Facilities would be required to conduct and document a facility-wide assessment to determine what

resources are necessary to care for its residents competently during both day-to-day operations and emergencies. This assessment must be reviewed and updated at least annually.

The proposed regulation would affect the use of arbitration agreements as well. It would place specific requirements on the facility and the arbitration agreement itself to ensure that if a facility presents binding arbitration agreements to its residents, that the agreements be explained to the residents and that the residents acknowledge that they understand the agreement. The proposed regulation states in broad terms that the agreements be entered into voluntarily and that arbitration sessions be conducted by a neutral arbitrator and at a location that is convenient for both parties. Admission to the facility would not be allowed to be contingent upon the resident or the resident's representative signing a binding arbitration agreement. Moreover, the agreement could not prohibit or discourage the resident or anyone else from communicating with federal, state, or local healthcare or health related officials, including representatives of the office of the state long term care ombudsman.

The proposed regulation itself admits that this will be an expensive endeavor for long term care facilities to carry out. It estimates that the total projected cost of the rule will be $729,495,614 in the first year. This results in an estimated first year cost of approximately $46,491 facility and a subsequent year cost of $40,685.00 per facility.

CMS notes that it is revising the LTC requirements because the regulations have not been comprehensively reviewed and/or updated since 1991. During that time period, the number of Medicare beneficiaries who access care in a skilled nursing facility increased by more than 1,000,000 enrollees. Moreover, the patient population in skilled nursing facilities have become much more clinically complex, including a mix of elderly individuals, younger residents with intellectual and developmental disabilities, residents who are chronically ill, and residents who are in need of post-acute rehab services. Some of these changes also have resulted in nursing homes having to care for many residents that generally have a higher acuity. To accommodate a more diverse population such as this, the current care and service delivery practices of LTC facilities have changed to meet these evolving service needs. CMS believes that this proposed regulation is necessary to keep up with the changing times.

The public comment deadline for these rules and regulations is September 6, 2015.