Center for Medicare Advocacy

The National CONSUMER VOICE for Quality Long-Term Care formerly NCCNHR

JUSTICE IN AGING
FIGHTING SENIOR POVERTY THROUGH LAW

MAKING IT REAL: USING THE REVISED FEDERAL NURSING FACILITY REGULATIONS IN YOUR ADVOCACY

January 25, 2018

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Agenda

- **Introductions**

  Robyn Grant, Director of Public Policy & Advocacy, Consumer Voice

- **Overview**

  Toby Edelman, Senior Policy Attorney, Center for Medicare Advocacy

- **Case Scenarios**

  Eric Carlson, Directing Attorney, Justice in Aging

  Toby Edelman, Senior Policy Attorney, Center for Medicare Advocacy

- **Q & A**
- **Closing**

  Robyn Grant, Director of Public Policy & Advocacy, Consumer Voice

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Overview, Requirements of Participation

- Revised Requirements of Participation (RoPs), 81 Fed. Reg. 68688 (Oct. 4, 2016), replace RoPs published Sep. 26, 1991, 56 Fed. Reg. 48826.

Overview

- CMS describes reasons for comprehensive revisions:
  - Nursing home population is more diverse, more clinically complex
  - Substantial advances have been made in theory and practice of service delivery
  - “[E]liminate or significantly reduce those instances where the requirements are duplicative, unnecessary, and/or burdensome” (page 68689)
  - Align with HHS Quality Initiatives (high quality of care, improved care, lower cost)

Three Phases to Implementation of Final Rules

- Phase One: Nov. 28, 2016
- Phase Two: Nov. 28, 2017
- Phase Three: Nov. 28, 2019

Phase One

- Phase 1: Nov. 28, 2016
  - RoPs from existing RoPs, which CMS redesignates and frequently revises (pp. 68825-68831)
  - Includes most residents' rights; admission, transfer, discharge; care planning; quality of life; quality of care; physician services; nursing services; pharmacy services; dental; food and nutrition; administration; infection control
    - Important point: Most of this language is identical to prior Requirements (in effect for 25 years), or very similar, or moved from surveyor guidance – These are NOT NEW requirements for facilities.

Phase Two

- Phase 2: Nov. 28, 2017
  - New RoPs and more complex issues

- Includes
  - Baseline care plan
  - Facility assessment process to determine number and competency of needed staff
  - Behavioral health services
  - Medical chart review in pharmacy
  - Facility policy for replacing dentures
  - Antibiotic stewardship (infection control)

Phase Three

- Phase 3: Nov. 28, 2019
  - Completion of implementation
  - Includes
    - Trauma-informed care
    - Quality Assessment and Performance Improvement (QAPI), required by Affordable Care Act (ACA) to be implemented by CMS by Dec. 31, 2011, and by facilities, by Dec. 31, 2012
    - Compliance and Ethics Programs, required by ACA to be implemented by facilities 2013
    - Call system for each resident bedside
    - New training requirements

Requirements Were Not Repealed in Their Entirety

- Under Congressional Review Act, 5 U.S.C. § § 801-808, Pub. L. 104-121 (part of Gingrich's Contract with America), § 251
  - Allows Congress/President to overturn major rules; 60 legislative days
  - "Joint resolution of disapproval" (signed by President)

- But CMS is proposing to repeal some Requirements and has undermined enforcement

CMS (Current Administration) Requirements of Participation

- NPRM to allow pre-dispute mandatory arbitration, 82 Fed. Reg. 26649 (Jun. 8, 2017)(reversing prohibition in revised Requirements published Oct. 2016).

- Announces review of Requirements in annual update to Medicare SNF reimbursement, 82 Fed. Reg. 21014, 21089 (May 4, 2017), specifically
  - Grievance process, 42 C.F.R. § 483.10(j)
  - Quality Assurance and Performance Improvement, § 483.75
  - Discharge notices, § 483.15(b)(3)(i)

- Delays enforcement of Phase 2 Requirements for a year, S&C: 17-36-NH (Jun. 30, 2017) ("Revisions to State Operations Manual (SOM) Appendix PP for Phase 2, F-Tag Revisions, and Related Issues"), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-36.pdf.

While the Rules Are Here . . .

- We'll use them as much as we can
  - Both the specifics of what the rules say, with new emphases on
    - Person-centered care, meaning resident choice, control, preferences
    - Professional standards of practice (facilities cannot rely on corporate policy); and
  - what surveyor guidance (State Operations Manual, Appendix PP) says. SOM is subregulatory, but official, guidance from CMS, explaining what law and regulations mean.

PROBLEM: RESIDENT SEEMS TO SIGN AWAY RIGHTS IN ADMISSION AGREEMENT

No Waiver of Rights

- Admission agreement cannot waive federal, state, or local law.
  - Includes rights to coverage under Medicare and Medicaid.
  - Includes (new language) no waiver of facility's responsibility for resident's personal property.
    - 42 C.F.R. § 483.15(a).

Can’t Misstate Law

- Admission agreement cannot conflict with federal nursing facility law.
  - 42 C.F.R. § § 483.10(g)(18)(v).

No Third-Party Guarantee Agreements

- Third-party guarantees cannot be required or requested.
  - 42 C.F.R. § 483.15(a)(3).

Arbitration

- Regulations prohibit mandatory pre-dispute arbitration agreements.
  - 42 C.F.R. § 483.70(n).

- But implementation of regulation enjoined by federal court in Mississippi.
  - Also, CMS now has put out proposed language which would reverse prohibition and instead establish standards for facility to require arbitration.

Disclosure of Characteristics and Limitations

- Facility must disclose special characteristics or service limitations.
  - 42 C.F.R. § 483.15(a).

- Failure to disclose limitations should be cited if facility subsequently claims that it cannot meet resident's needs.

PROBLEM: NO CARE PLAN FOR SEVERAL WEEKS AFTER ADMISSION

Baseline Care Plans

- New “baseline care plan” must be developed and implemented within 48 hours of admission. Must include:
  - Initial goals;
  - MD orders;
  - Dietary orders;
  - Therapy services;”
  - Social services; &
  - PASARR.

PROBLEM: RESIDENT HAS LITTLE CONTROL OVER DAY-TO-DAY ACTIVITIES AND SCHEDULE

Care Planning

- Facility must develop and implement a comprehensive person-centered care plan for each resident."
  - 42 C.F.R. § 483.21(b)(1).

Is Care Really “Person-Centered”?

- “Person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.”
  - 42 C.F.R. § 483.5.

Addressing Resident Preferences

- Resident has the “right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.”
  - 42 C.F.R. § 483.10(e)(3).

Comprehensive Care Plan

- Within 7 days of assessment.

- Interdisciplinary team includes, “[t]o the extent practicable, the participation of the resident and the resident's representative(s).”
  - An explanation must be included in a resident's medical record if “the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.”
    - 42 C.F.R. § 483.21(b).

Interdisciplinary Team

- Must also include:
  - Attending MD.
  - RN with responsibility for resident.
  - CNA with responsibility for resident.
  - Member of food and nutrition staff.
  - Other appropriate staff, based on resident's need or as requested by resident.

PROBLEM: RESIDENT NEVER IS ABLE TO RETURN HOME

Care Plan Contents

- Services needed for resident's highest practicable well-being.
- Resident's goals and desired outcomes.
- Resident's preference and potential for future discharge.
- Discharge plans, as appropriate.
  - 42 C.F.R. § 483.21(b).

Possibility of Returning Home

- Default to discharge – if discharge to community is deemed not feasible, facility must document who made the determination and why.

- Discharge plan:
  - Considers caregiver support and availability post-discharge.
  - Documents resident offered information about interest in returning to community.
    - 42 C.F.R. § 483.21(c).

PROBLEM: RESIDENT IS SEDATED TO MAKE HER MORE MANAGEABLE

Antipsychotic Drugs

- Moved from quality of care (where antipsychotic drugs were addressed under unnecessary drugs, § 483.25(l)(2)),to pharmacy services; but content remains identical:
  - Residents who haven't used these drugs shouldn't get them unless they are necessary to treat the resident's diagnosed and documented medical condition
  - If resident takes antipsychotic drug, there must be gradual dose reduction and behavioral interventions in effort to discontinue use of the drugs
- 42 C.F.R. § 483.45(d)

PRN (As-needed) Antipsychotic Drugs

- PRN orders limited to 14 days and “cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.” 42 C.F.R. § 483.45(e)(5).

Antipsychotic Drugs

- BUT National Partnership to Improve Dementia Care (2012) is over for facilities that reduced antipsychotic drugs by 30% (from 23.9% to 15.7%) (still more than 200,000 receiving these drugs, most, inappropriately)

Psychotropic Drugs

- Unnecessary drugs broadened to include psychotropic drugs (anti-psychotic, anti-depressant, anti-anxiety, and hypnotic drugs); same protections as for anti-psychotics
  - Residents who haven't used these drugs shouldn't get them unless they are necessary to treat the resident's diagnosed and documented medical condition
  - If resident takes antipsychotic drug, there must be gradual dose reduction and behavioral interventions in effort to discontinue use of the drugs

- 42 C.F.R. § 483.45(c)(3)

PRN Psychotropic Drugs

- PRN orders limited to 14 days, but may be extended beyond 14 days if attending physician or prescribing practitioner documents rationale for extension and duration of extension. 42 C.F.R. § 483.45(e)(4)

Unnecessary Drugs, SOM

- Cites Inspector General's 2014 report, Adverse Events in Skilled Nursing Facilities: National Incidence among Medicare Beneficiaries, OEI-06-11-00370 (37% of adverse events related to medications)

- Expresses concern that psychotropic drugs not be used to replace declining use of antipsychotic drugs

- Stresses importance of facilities' first attempting non-pharmacological approaches before using antipsychotic and psychotropic medications

PROBLEM: RESIDENT DOESN'T GET NEEDED THERAPY SERVICES

Rehabilitation Services

- Facilities must provide “specialized rehabilitative services” to any resident who needs them.

- Important to advocate for therapy for residents
  - who are not in Medicare Part A stay (advocate for therapy in care plan)
  - who are not improving. *Jimmo* confirms that maintenance therapy is covered by Medicare.
  - 42 C.F.R. § 483.65

Respiratory Therapy

- Identified for first time in regulatory language, but not further defined or discussed in preamble. 42 C.F.R. § 483.65(a).

- Also discussed in quality of care rule, Respiratory care. 42 C.F.R. § 483.25(i), (with its own F-tag F695)

Case Example

- Quality of care, 42 C.F.R. § 483.25(i)
- Respiratory services, 42 C.F.R. § 483.65
- Neglect, 42 C.F.R. § 483.12 (free from neglect, defined at 42 C.F.R. § 483.5 as failure to provide services that a resident needs to avoid physical harm, pain, mental anguish, or emotional distress)
- Transfer and discharge protections, 42 C.F.R. § 483.15 (discuss later)

PROBLEM: FACILITY WON'T LET FAMILY VISIT BEFORE NOON

Right to Accept Visitors

- Resident has right to “immediate access” to visits by relatives or non-family visitors.

- Non-family visitation is “subject to reasonable clinical and safety restrictions.”
  - 42 C.F.R. § 483.10(f)(4).
    - Does this strengthen visitation rights for family, by suggesting that family visits are not subject to restriction?

What Are “Clinical and Safety Restrictions?”

- Non-exclusive list in Surveyor’s Guideline to section 483.10(f)(4):
  - Infection-related restrictions.
  - Denying access if person
    - Is suspected of abusing resident, until investigation is completed or if allegation is confirmed.
    - Is found to have stolen or have committed another criminal act.
    - Is drunk or disruptive.

PROBLEM: RESIDENT IS MOVED OUT OF MEDICARE-CERTIFIED ROOM

New Limits on Transfers within Facility

- Resident can refuse intra-facility transfer if the purpose is:
  - To move the resident out of a Medicare-certified room.
  - "Solely for the convenience of staff."
    - E.g., according to surveyor's guidelines, putting residents together because they have similar care needs.

- Written notice, including reason for change, before change in room or roommate.
  - 42 C.F.R. § 483.10(e)(6), (7).

PROBLEM: RESIDENT IS FORCED OUT FOR BEING “NON-COMPLIANT”

Justifications for Involuntary Transfer/Discharge

- Same as before, but with some changes in wording.
  - “Safety of others” justification now limited to endangerment from resident’s “clinical or behavioral status.”
  - Nonpayment does not occur if resident has submitted necessary paperwork for third-party reimbursement.
    - 42 C.F.R. § 483.15(c).

Some New Protections

- No transfer/discharge while appeal is pending, absent documented endangerment to health or safety of resident or others.

- Facility must send copy of transfer/discharge notice to LTC ombudsman program.
  - Resident consent not required. 81 Fed. Reg. at 68,734.

- Facility must assist resident in “completing the form and submitting the appeal hearing request.”
  - Facility’s failure to do this might be useful defense.
  - 42 C.F.R. § 483.15(c)(1)(ii), (3)(i), (5)(iv).

Involuntary = Facility-Initiated

- Resident-initiated when resident (or rep) “has given written or verbal notice of their intent to leave the facility.”

- But not:
  - Resident’s expression of general desire or goal to return to home or the community, or
  - Elopement of a cognitively-impaired resident.
    - Surveyor’s Guideline to 42 C.F.R. § 483.15(c).

Facility-Initiated After Medicare-Funded Rehabilitation

- "Discharges following completion of skilled rehabilitation may not always be a resident-initiated discharge. In cases where the resident may not object to the discharge, or has not appealed it, the discharge could still be involuntary and must meet all requirements of this regulation."
  - Surveyor's Guideline to 42 C.F.R. § 483.15(c).

PROBLEM: RESIDENT ISN'T ALLOWED BACK AFTER HOSPITALIZATION

Returning to Facility After Hospitalization

- Facility must give notice of bed-hold policy.

- Facility also must allow return to next available room.
  - If resident eligible for Medicaid or Medicare coverage of NF care.
  - Must be previous room, if available.
    - 42 C.F.R. § 483.15(e).

Resident Allowed to Return Pending Hearing

- If facility “determines that a resident who was transferred with an expectation of returning to the facility cannot return to the facility,” the facility must comply with transfer/discharge requirements.

- Surveyor’s Guidelines: “the resident must be permitted to return and resume residence in the facility while an appeal is pending.”

PROBLEM: CMS AND NURSING HOME INDUSTRY ARE TRYING TO ROLL BACK REQUIREMENTS

Challenges to Requirements, Survey, and Enforcement

- From CMS, Congress, nursing home trade associations (both American Health Care Association and LeadingAge)

- Even if the Requirements of Participation largely or partially survive, CMS has already gutted enforcement through subregulatory guidance (two Survey & Certification Letters replacing surveyor guidance issued by Obama Administration)

CMS Changes to Enforcement: Immediate Imposition of Remedies

- S&C: 18-01-NH (Oct. 27, 2017), "Revised Policies regarding the Immediate Imposition of Federal Remedies – FOR ACTION," https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-18-01.pdf:
  - Limits imposition of CMPs for some immediate jeopardy deficiencies, excludes from immediate penalties instances of "past" noncompliance, reduces enforcement against Special Focus Facilities, and makes other changes limiting CMPs.

- Proposes to replace S&C: 16:31-NH, "Mandatory Imposition of Federal Remedies and Assessment Factors Used to Determine the Seriousness of Deficiencies for Nursing Homes," https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-16-31.pdf

CMS Changes to Enforcement: CMP Analytic Tool

- CMS, "Revision of Civil Money Penalty (CMP) Policies and CMP Analytic Tool," S&C: 17-37-NH (Jul. 7, 2017), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-37.pdf.
  - Replaces tool issued in Dec. 2014.
  - Makes per instance CMPs the default, rather than per day CMPs.
  - Discourages Regional Offices from starting per day CMP before "the start date of the survey."

- "As Sought By Nursing Home Industry, CMS Changes Guidance to Reduce Civil Money Penalties for Nursing Facility Deficiencies" (CMA Alert, Jul. 2017), http://www.medicareadvocacy.org/cma-alert-snf-update-comments-on-reimbursement-civil-money-penalties-weakened/

CMS PRESENTATION AT ANNUAL MEETING OF STATE SURVEY AGENCY DIRECTORS

- Karen Tritz and Evan Shulman of Nursing Home Division described updates and planned changes (Aug. 23, 2017). Slide 41, Enforcement:
  - Revised Civil Money Penalty (CMP) Analytic Tool
  - Evaluating other policies:
    - Immediate Imposition of Remedies
    - Multiple tags for same noncompliance (AKA “stacking”)
  - Clarifying requirements for Nurse Aide Training Competency and Evaluation Programs
  - Exploring improving care through other remedies (e.g., DPOC)
  - Phase II Enforcement:
    - Focus on education for phase II requirements (e.g., facility assessment, antibiotic stewardship, etc.) such as Directed Plan of Correction or directed in-service training
    - Enforcement of Phase I requirements remains unchanged
  - **Long term: Revise SOM Chapter 7**
- http://ahfsa.org/resources/Pictures/CMS%20Update_AHFSA_%20AUG2017-AHFSAonly.pdf

CMS Implements Recommendations of Nursing Home Industry

- Accomplished so far
  - NPRM to allow mandatory pre-dispute arbitration agreements in contracts
  - Delay in enforcement of Phase 2 Requirements
  - CMP Analytic Tool for CMPs replaces Obama Tool
  - Changes to loss of nurse aide training rules
  - “Retroactive” CMPs (meaning cited noncompliance that began before survey)

- More changes are coming
  - Changes to multiple tags for deficiencies
  - Revisions to Requirements of Participation

Question and Answer

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