

CMS Releases Final Rule Overhauling Long-Term Care Facility Requirements

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The **Centers for Medicare & Medicaid Services (CMS)** recently released its [final rule](#) overhauling *long-term care (LTC) facility* participation requirements for **Medicare** and **Medicaid** (“Final Rule”). This much anticipated rule represents the first major update of these regulations in 25 years – setting new staffing, patient protections, and compliance requirements for LTC facilities. CMS estimates that these changes will not necessarily be inexpensive for facilities, costing an average of \$62,900 per facility in the first year and \$55,000 in each subsequent year. In response to the estimated financial burden and the complexity of the Final Rule, CMS has adopted a phased approach for the rollout, spreading out implementation of the various requirements over the next three years. The implementation dates are November 28, 2016 for Phase 1, November 28, 2017 for Phase 2, and November 28, 2018 for Phase 3. The three phases have been categorized based on CMS’s assessment of each revision’s complexity and the extent to which interpretive guidance and survey processes will need to be revised.

We highlight key provisions of the Final Rule below:

Prohibition against Pre-Dispute Binding Arbitration Agreements

In an effort to strengthen resident rights, under the Final Rule, CMS will prohibit LTC facilities from entering into pre-dispute binding arbitration agreements with residents or their legal representatives. While the initial [Proposed Rule](#) set forth specific criteria to be met by LTC providers seeking to make use of pre-dispute binding arbitration agreements, the Final Rule bans them altogether. CMS cites doubts about residents’ ability to understand the implications of such agreements as well as concerns about the arbitration process in general. In response to comments regarding CMS’s legal authority to ban arbitration agreements, the agency clarified that the Final Rule would have no effect on existing pre-dispute arbitration agreements between LTC facilities and residents, and that any such existing agreements could still be enforced. The prohibition against pre-dispute binding arbitration agreements is included in Phase 1.

Attending Physician Delegation to Qualified Dietitians and Therapists

Under the Final Rule, attending physicians may delegate responsibility for writing dietary orders to qualified dietitians and other qualified nutritional professionals. Similarly, attending physicians may delegate responsibility for writing therapy orders to qualified therapists. In both cases, the delegation of responsibilities is limited by the relevant state scope of practice laws for the professionals. CMS expressed the hope that this change will allow for greater responsiveness to resident needs as these professionals have more opportunities to interact with and observe residents. While this change will likely allow for some flexibility in the use of attending physicians' time, CMS has made it clear that the attending physician remains responsible for overseeing the full spectrum of the resident's care. This provision is also included in Phase 1.

Compliance and Ethics Program

The final rule implements the Affordable Care Act requirement that organizations operating LTC facilities must establish a compliance and ethics program. Even though this is a new regulatory requirement, many facilities are already operating under some type of compliance and ethics program. Nonetheless, organizations have until November 28, 2018 to develop new compliance and ethics programs or to bring their current programs into compliance. Under the Final Rule, this program must include written policies and procedures to reduce criminal, civil, and administrative violations and must be reviewed and revised annually. CMS imposes additional requirements on operating organizations with five or more facilities. These compliance and ethics programs must include annual training, a compliance officer, and a designated liaison located at each facility.

Pharmacy Services

Under current rules, LTC facilities are required to have a pharmacist conduct a monthly drug regimen review (DRR). The Final Rule expands this review to require the pharmacist to review the medical record for each resident concurrently with the monthly DRR. These new requirements will be phased in during Phase 2. Further, pharmacists must report irregularities to the facility's medical director, in addition to the director of nursing and the attending physician. The Final Rule also establishes requirements targeting the unnecessary use of psychotropic drugs, which will be implemented in Phase 2 as well.

Comprehensive Person-Centered Care Planning

The Final Rule updates the care plan and discharge planning requirements with a focus on person-centered planning. First, CMS is requiring that facilities develop and implement a baseline care plan, in addition to the comprehensive person-centered care plan. The baseline care plan must be established within 48 hours of a resident's admission. Further, in response to comments, CMS updated the Final Rule requiring facilities to provide residents and their representatives with a summary of their baseline care plan. Facilities can skip the baseline care plan and only develop the comprehensive care plan, so long as it is established within 48 hours. CMS also expanded the required members of the interdisciplinary team (IDT), who are responsible for developing the comprehensive person-centered care plan, to include a nurse aide and a member of the food and nutrition services staff. Also of note, the Final Rule requires that facilities develop and implement a discharge planning processes as part of the person-centered care plan. With some exceptions, the new requirements for comprehensive person-centered care planning are included in Phase 1. Implementation of the baseline care plan requirement will be included in Phase 2.

Conclusion

The September 28, 2016 CMS [press release](#) announcing the Final Rule correctly indicated these “Revisions mark [the] first major rewrite of the conditions of participation for long-term care facilities since 1991.” Many of the new requirements come as no surprise to those familiar with the LTC industry. Nonetheless, the scope of the revisions and their complexity is staggering. Time will tell if the phased-in roll out and future interpretive guidance will help ease the transition.

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