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**Key Provisions of the CMS Proposed Nursing Home Rule with Suggested Positions Identified by LeadingAge Wisconsin\***

1. **Quality Assurance and Performance Improvement (QAPI), s.483.75, p. 42265**

Proposed Regulation**:** It is at best unclear the level of access that the survey team will have to a facility’s QAPI documentation. The proposed regulation states that the surveyor will have access to: “systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events.”

Provider Comments Should Focus On: Our concern is that with access to this information, surveyors would be able to use the facility’s own documentation and identification of problems to cite the facility. Under state and federal law, documents are privileged from disclosure if they are generated by a facility’s quality assessment and assurance (QAA) committee and used in the facility's quality assurance processes. The rationale for this privilege is that QAA committees are key internal mechanisms that allow nursing homes opportunities to address quality concerns in a confidential manner that can help them sustain a culture of quality improvement. The proposed CMS rule may have a chilling effect on advancing QAPI efforts, and should be deleted or substantially modified.

1. **Infection Control, s.483.80, p. 42266**

Proposed Regulation: Extensive infection control requirement that involves significant staff training and additional “expertise.” Designation of an Infection and Prevention Control Officer (IPCO) to oversee the infection and control program and serve as a member of the facility’s quality assessment and assurance committee. CMS is proposing to require facilities to have a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under an arrangement based upon its facility and resident assessments that is reviewed and updated annually. In addition, CMS is proposing to require facilities to designate an infection prevention and control officer (IPCO) for whom the IPCP is their major responsibility and who would serve as a member of the facility’s quality assessment and assurance (QAA) committee.

Provider Comments Should Focus On: The proposed regulations set mandated qualifications for a number of positions including Infection Control Officer. This designation and the additional expertise that is being required to function in the position will increase facility costs. In rural and other areas where this expertise may not be available, compliance would be difficult, if not impossible. We believe that a more reasonable approach would be to better define the standards for infection control in a detailed manner, and allow the nursing home to make a determination as to whether the individual responsible for this function has the competency and expertise to function in the position.

1. **Physical Environment, s.483.90, p. 42268**

Proposed Regulation: CMS proposes to require facilities that receive approval of construction or reconstruction plans from state and local authorities or are newly certified after the effective date of the final rule would have to have a bathroom in each resident room that is equipped with a toilet, sink and shower. CMS has proposed to define “reconstruction” to mean that the facility undergoes reconfiguration of the space such that the space is not permitted to be occupied, or the entire building or an entire occupancy of the building, such as a wing of the building, is modified.

Provider Comments Should Focus On: It is the goal to offer all residents a private room with their own bathroom. However, some older facilities may not be able to meet this goal and yet desire to create separate resident rooms with a shared bathroom (i.e.,, one bathroom shard by two residents). CMS comments say if a facility undergoes “reconstruction” all rooms will need a separate bathroom. The proposed rule could stop a facility from undertaking renovation or remodeling projects to improve an older building because the cost of creating separate bathrooms could be prohibitive. Ask that this proposed rule be clarified to apply only to new construction.

1. **Nursing (s.483.35, p. 42260) and Administration (s.483.70, p. 42264)**

Proposed Regulation: require facilities 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. The facility must review and update that assessment, as necessary, and at least annually. Address in the facility assessment the facility's resident population (that is, number of residents, overall types of care and staff competencies required by the residents, and cultural aspects), resources (for example, equipment, and overall personnel), and a facility-based and community-based risk assessment.

Provider Comments Should Focus On: This section should be deleted since outcomes of existing requirements stand as evidence of adequate facility assessment. We question the need to spend precious time writing and documenting a facility-wide assessment that surveyors will use to interpret whether we have sufficient staff. The current regulations already appropriately require resident-centered and specific care plans designed to attain and maintain the resident’s highest practicable physical, mental and psycho-social well-being. This individualized planning and attention to each person’s needs is a more appropriate way to assess allocation of resources than another documentation endeavor. A general requirement of this nature invites a tremendous amount of subjectivity into the survey process when surveyors already have F-Tags and interpretive guidelines at their disposal to address insufficient staffing, substandard quality of care and a wide range of other issues that could arise during a facility inspection.

1. **Physician Services, s.483.30, 42259**

Proposed Regulation: CMS would require an in-person evaluation by a physician, a physician assistant  (PA), nurse practitioner (NP, or clinical nurse specialist (CNS) before an unscheduled resident transfer to a hospital that is not an emergency.

Provider Comments Should Focus On: This proposal is poorly thought out, unrealistic, and could in fact result in harm to our residents. Our region already is facing a shortage of physicians wishing to serve nursing home residents; this proposed regulation only serves to fuel this shortage. If this rule goes forward, residents may need to wait before necessary care and services can be provided. Some “non-emergency” transfers to the hospital could prove to be life saving. Please let the clinicians practice their professions. Ask CMS to drop this provision.

1. **Laboratory, Radiology and other Diagnostic Services, s.483.50, p. 42261**

Proposed Regulation: CMS proposes to clarify that the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialists, be notified of abnormal laboratory results when they fall outside of clinical reference ranges, in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician’s, physician assistant’s, nurse practitioner’s or clinical nurse specialist’s orders.

Provider Comments Should Focus On: We believe this proposed requirement will impose an undue burden on facility clinical staff and on the ordering physicians, physician assistants, nurse practitioners and clinical nurse specialists. Instead, we recommend that CMS consider amending this proposal to state that the ordering practitioner should be notified when results fall outside a critical value, which is defined by every laboratory based on the reference range. This will avoid calls to the ordering practitioner when a lab result falls outside the clinical reference range, but the trend of the result is going in the correct direction for the resident.

1. **Pharmacy Services, s.483.45, p. 42261**

Proposed Regulation: CMS has proposed to revise existing requirements regarding ‘‘antipsychotic’’ drugs to refer to ‘‘psychotropic’’ drugs. Psychotropic medications would include any psychoactive medication, including antidepressants and opioid pain medications. In addition, CMS proposes to require that facilities ensure residents who have not used psychotropic drugs not be given these drugs unless medically necessary. Residents who use psychotropic drugs would be required to receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue use of these psychotropic drugs. ‘‘Psychotropic drug’’ is proposed to mean any drug that affects brain activities associated with mental processes and behavior. Finally, CMS proposes that PRN orders for psychotropic drugs be limited to 48 hours. Orders could not be continued beyond that time unless the primary care provider (for example, the resident’s physician) reviewed the need for the medications prior to renewal of the order and documented the rationale for the order in the resident’s clinical record.

Provider Comments Should Focus On: Wisconsin ranks as the fifth best State in the country in terms of reducing the use of antipsychotic medications. We believe that CMS and the States already have the authority and have used the authority under existing regulations and F-Tag interpretive guidelines to cite facilities for the use any drug if the drug is deemed to be unnecessary or to not have an appropriate indication for its use. We do not believe CMS should go so far as to expand the definition of antipsychotic drugs to include any drug that affects brain activities associated with mental processes and behavior. Further, we disagree that PRN orders should be limited to 48 hours; if CMS believes a limit is necessary, then we recommend that the limit be 72 hours. This will provide both a reasonable amount of time for the clinical team to work together on alternate solutions, especially after a weekend, and a way for the resident to remain in the facility and not be transferred to an emergency room because of behavioral health symptoms that present a danger to the resident and/or others, including staff. Further, **if**CMS decides to finalize this proposal, then we request the following:

* Exclude antidepressants and opioids from the definition of psychotropic drugs. Discouraging the treatment of depression or pain using appropriate medications (antidepressants and opioids, respectfully) seems to be the opposite of what is needed.
* Expand the list of excluded diagnoses from the limited set of exclusions currently in use with regard to antipsychotic medications.

1. **Behavioral Health Services, s.483.40, p.42260**

Proposed Regulation: CMS proposes to require facilities to provide the necessary behavioral health care and services to residents in accordance with their comprehensive assessment and plan of care. Specifically, CMS proposes to require that the facility staff’s skill set include, but not be limited to, knowledge of and appropriate training and supervision for: (1) Caring for residents with mental illnesses and psychosocial disorders, as well as residents with a history of trauma or post-traumatic stress disorder……and (2) Implementing non-pharmacological interventions. CMS further proposes to require the facility to ensure that a resident who has a mental or psychological adjustment difficulty, or who has a history of trauma and//or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being, and that a resident who did not have such a diagnosis does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors unless the resident’s clinical condition demonstrates that this was unavoidable.

Provider Comments Should Focus On: Respectfully request that CMS clarify how this new section intersects with the current PASRR process, particularly with respect to the Level II screening when it results in a finding that a resident would require specialized behavioral health services. Historically, nursing homes have not been expected to admit residents with these needs and Medicaid per diem rates for the most part do not include payment to the nursing home for specialized behavioral health services. We believe caring for residents with psychiatric illnesses is complex and requires a thoughtful plan that does not rely solely upon nursing homes to fill in gaps in the behavioral health system of care for older adults.Ask CMS to drop this provision and work with State survey agencies and providers to address how residents with complex behavioral challenges can best be served.

1. **Specialized Rehabilitative Services, s.483.65, p. 42263**

Proposed Regulation: CMS would add respiratory services to specialized rehabilitative services; clarify what constitutes rehabilitative services for mental illness and intellectual disability; establish new health and safety standards for provision of outpatient rehabilitative therapy services; require facilities to conduct, document, and update annually and when needed an assessment to determine resources necessary to care for its residents competently during both day-to-day operations and emergencies.

Provider Comments Should Focus On: We believe a nurse with the appropriate training can provide the necessary respiratory services in most instances. It would be nearly impossible to find enough Respiratory Therapists to provide the services described in the proposed rule. It would also be cost prohibitive if in most cases a nurse could have provided the same services to the residents.

1. **Dental Services, s.483.55, p.42262**

Proposed Regulation: CMS would prohibit facilities from charging a Medicare resident for the loss or damage of dentures determined to be the facility’s responsibility.

Provider Comments Should Focus On: The rule should clarify the facility’s responsibility for lost dentures does not extend to loss of dentures resulting from resident actions and/or failure to (repeatedly) abide by the facility’s policies. Ask CMS to revise (clarify) or drop this provision.

1. **Interdisciplinary Team (IDT), s.483.21(b)(2)(ii), p. 42257**

Proposed Regulation: Require that a CNA, member of nutrition services, and social worker participate on the IDT.

Provider Comments Should Focus On: This requirement would add to the current duties of each of these staff members and, therefore, would be a new economic cost to each facility. The federally-prescribed composition of the IDT should remain unchanged. While we believe that input from direct-care staff is critical in the care of each resident, the individual facility should have the flexibility to determine how best to obtain this input in a manner that is not disruptive to resident care activities. For example, a facility could put into place a process that elicits input from direct-care staff and conveys the information about the resident outside of the formal IDT meetings. Mandating attendance of direct-care staff at the actual IDT meetings raises cost and logistical issues.

1. **Facility Responsibilities—Visitation,** s.483.11, p. 42249

Proposed Regulation: CMS proposes to revise visitation requirements to establish open visitation, similar to the hospital conditions of participation (CoPs).

Provider Comments Should Focus On: We believe there are some important distinctions between hospitals and nursing homes that should be considered. Most nursing homes do not employ distinct security personnel, or if they do employ security personnel, they are typically not present around the clock. It is more common for a nursing home to have a receptionist at the main entrance who welcomes and guides visitors. Generally, reception staff are present until early evening hours. Around the clock visitation would require increased staffing, at a minimum. This did not seem to be included in CMS’ estimate of costs per facility for implementation of the rules.

Another concern to voice is that the privacy and conditions of other residents must be a consideration in an open visitation environment. Currently, facilities accommodate visitors at any time in their facilities when a request is made or the clinical situation of the resident is such that the presence of visitors is essential. This provides everyone involved with the time to prepare and to accommodate everyone’s needs. Mandatory open visitation in what is both a home and a health care facility means there will be more unanticipated visitors, and this could lead to facility resources being diverted to quickly arrange for an appropriate visiting environment for all involved, as opposed to attending to other needs. Recommend that CMS reconsider the open visitation proposal and instead make it clear in this section of the rules that facilities must accommodate visits that are not restricted due to clinical or safety reasons and must inform residents and visitors that these accommodations are available.

1. **Transfer/Discharge, s.483.15(b), p. 42254**

Proposed Regulation: CMS proposed requiring facilities to exchange specific information/data elements (e.g., demographic information, history of present illness including active diagnoses, functional status, medications, reason for transfer and past medical/surgical history) with the receiving provider.

Provider Comments Should Focus On:This requirement will be difficult to meet in a time-effective and accurate manner without interoperable health information exchange. Unfortunately, the federal government has not provided any health information technology “meaningful use” incentives to nursing homes and other post- acute care providers. We do not see how this requirement could be met without either increasing staff or deploying an electronic medical record system with interoperability. The federal government should provide “meaningful use” incentives to nursing homes if this requirement is included in the final rule.

1. **Training Requirements , s.483.95, p. 42268**

Proposed Regulation: CMS proposes to add a new section that sets forth all the requirements of an effective training program that facilities must develop, implement, and maintain for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. The proposed training topics that would be required to be included are:

* **Communication:** CMS proposes to require facilities to include effective communications as a mandatory training for direct care personnel.
* **Resident Rights and Facility Responsibilities**: CMS proposes to require facilities to ensure that staff members are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents as set forth in the regulations.
* **Abuse, Neglect, and Exploitation**: CMS proposes to require facilities, at a minimum, to educate staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property, and procedures for reporting these incidents.
* **QAPI & Infection Control**: CMS proposes to require facilities to include mandatory training as a part of their QAPI and infection prevention and control programs that educate staff on the written standards, policies, and procedures for each program.
* **Compliance and Ethics**: In accordance with section 1128I of the Act, as added by the Affordable Care Act, CMS would require the operating organization for each facility to include training as a part of their compliance and ethics program. CMS proposes to require annual training if the operating organization operates five or more facilities.
* **In-Service Training for Nurse Aides**: In accordance with sections 1819(f)(2)(A)(i)(I) and 1919(f)(2)(A)(i)(I) of the Act, as amended by the Affordable Care Act, CMS proposes to require dementia management and resident abuse prevention training to be a part of the 12 hours per year in-service training for nurse aides.
* **Behavioral Health Training**: CMS proposes to require that facilities provide behavioral health training to its entire staff, based on the facility assessment at s.483.70(e).
* **Trauma-Informed Care:** CMS proposes staff training requirements would need to include culturally competent, trauma-informed care.

Provider Comments Should Focus On:We are seriously concerned about the fiscal and administrative burdens associated with such expansive requirements when it is already challenging to meaningfully address currently required topics. Facilities need flexibility to determine how to best train staff on these and a myriad of other issues. We suggest the list of added topics be evaluated by a provider-CMS workgroup and a staggered, 5-year phase-in of any new training requirements be considered.

**Please Offer Closing Personalized Comments Addressing:**

* Given the significant changes underway and the sheer magnitude of the proposed changes contemplated in this rule, **we strongly recommend a five-year phase- in** of the regulatory revisions, with prioritization of certain requirements based on the level of importance and facility/government preparedness for implementation.
* We are also **concerned about the cumulative compliance costs** associated with the many changes proposed in the regulations. The additional staffing, credentialing, training, systems and contractual relationships that will be required for compliance will add to the financial stresses that nursing homes are experiencing from ongoing Medicare and Medicaid cuts.
* Ironically, the proposed requirements could force facilities to divert limited financial and staffing resources from resident care to the **increased administrative requirements** this rule would impose.

Please send a copy of your comments to CMS to John Sauer: [jsauer@leadingagewi.org](mailto:jsauer@leadingagewi.org) and to Evvie Munley: [emunley@leadingage.org](mailto:emunley@leadingage.org) 202 508 9478.

**\*LeadingAge Wisconsin would like to thank LeadingAge (national), our sister Associations, LeadingAge New Jersey and LeadingAge New York, and the staff at Cedar Community, West Bend, and Brookside Care Center, Kenosha, for their assistance in developing this document.**