Long-Term Care Requirements of Participation - Phase 2 Implementation Effective November 28, 2017

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The revised Phase 2 Requirements of Participation for long-term care facilities will go into effect November 28, 2017. While multiple provider groups have requested a delay of some of the rule's provisions to allow time for additional revisions, officials at the Centers for Medicare and Medicaid Services ("CMS") have indicated that they will not act on those requests at this time and plan to move forward with the November 28, 2017 implementation date for Phase 2.

CMS has, however, delayed the enforcement of remedies for violations of certain Phase 2 requirements. CMS will provide a one-year restriction of enforcement; it will not utilize civil money penalties, denial of payment, and/or termination sanctions should a facility be found to be out of compliance with certain provisions within the new Phase 2 requirements. Rather, CMS plans to use this year-long period to educate facilities about certain new Phase 2 quality standards by requiring a directed plan of correction or additional directed in-service training. Enforcement for other existing standards (including Phase 1 requirements) will follow the standard enforcement process.

Implementation of Phase 2 is scheduled to occur simultaneously with a new, computer-based long-term care survey system. In this new computer-based survey system, CMS is incorporating the new regulatory requirements while combining the Traditional and Quality Indicator Survey processes. To help with this transition, CMS issued new Survey Pathways and a new Long-Term Care Survey Process Procedure Guide.

Additionally, CMS has issued a revision to the State Operations Manual in an Advance Appendix PP containing detailed revisions to its guidance effective with the start of Phase 2, including the revised F-tags. Here is a high-level review of a few of the significant regulatory provisions that go into effect with Phase 2 and some of the new guidance contained in the Advance Appendix PP.

Resident Rights, Required Notices (F574)

Residents must be given written or oral notice of the following:

- contact information for the California Department of Public

Health, the Long-Term Care Ombudsman, Disability Rights California, the Aging and Disability Resource Center (or other No Wrong Door Program), and the Medicaid Fraud Control Unit; and
- information regarding Medicare and Medicaid eligibility and coverage.

Reporting of Reasonable Suspicion of a Crime (F608)

A provider who receives at least $10,000 in Federal funds during the preceding year must have written policies and procedures that ensure the reporting of certain crimes. The policies and procedures must include:

- annual notification to any owner, operator, employee, manager, agent, or contractor of the facility of his or her obligation to report to the State Agency and law enforcement any reasonable suspicion of a crime against a resident within 2 hours after forming the suspicion if the events result in serious bodily injury or within 24 hours if they do not;
- posting conspicuous notice of employee rights as required under 42 USC § 1320b-25; and
- prohibiting and preventing retaliation.

Transfer and Discharge Requirements (F622)

A physician must document the basis for the transfer or discharge in the medical record and the facility must ensure when transferring a resident that the receiving provider gets appropriate information about the resident, including at least: the contact information of the responsible practitioner and the resident representative, any advance directive, special instructions or precautions for care, comprehensive care plan goals, all other information necessary to ensure a safe and effective transition, including a copy of the discharge summary. When discharging a resident the facility must also send a discharge summary as outlined in F661. Advance Appendix PP contains additional information regarding the requirements during emergency transfers and residents' rights to return and remain in the facility.

Baseline Care Plan (F655)

Providers must develop and implement a baseline care plan for each resident within 48 hours of the resident's admission. This baseline care plan must have instructions to provide effective and specific care for that resident and include initial goals, physician orders, dietary orders, therapy orders, social services, and where applicable, PASRR recommendations. The provider must give the resident and his or her representative a summary of the baseline plan that includes; (1) initial goals, (2) a summary of the medications and dietary orders, (3) services and treatments, (4) updates as necessary. The facility may continue to develop a comprehensive care plan instead, as long as it includes everything required under the baseline plan and is completed within the 48 hour time period.

Behavioral Health Services (F740-745)

The provider must ensure the provision of necessary behavioral health care and services. The provider must have sufficient, competent staff with the ability to implement non-pharmacological interventions for its residents. With regard to residents exhibiting signs of, or diagnosed with, dementia a provider must ensure those residents receive appropriate treatment and services to maintain their highest well-being. Guidance specific to dementia residents (see F744) requires continual, in depth IDT review and planning for residents living with dementia. Finally, the provider must provide rehabilitative services for mental disorders and intellectual disability, if required by the residents' comprehensive care plan.

Freedom from Unnecessary Psychotropic Medication/PRN Use (F758)

Based on the comprehensive assessment the provider must ensure that residents who haven't used psychotropic drugs are not given them unless necessary to treat a diagnosed and documented condition. Providers must also ensure that residents using psychotropic drugs receive gradual dose reductions and interventions to try to discontinue these drugs. Residents may not receive psychotropic drugs on a PRN basis unless necessary to treat a diagnosed and documented condition with prescriptions for 14 days duration (unless the physician documents a reason for extension). The Advanced Appendix PP makes clear that CMS is looking for limited PRN use and only where the use is necessary. Where the medication is an anti-psychotic drug, a prescription may not be extended past 14 days unless the physician evaluates the resident.

Facility Assessment (F838)

The provider must document an annual facility-wide assessment of what resources are necessary for day-to-day operations and emergencies. This assessment must be updated and reviewed at least annually and any time there is a change that would require a substantial modification. The assessment must include such areas as the resident population, community resources, and risks. According to the Advance Appendix PP, the overall intent of this F tag is "for the facility to evaluate its resident population and identify the resources needed to provide the necessary care and services the residents require."

QAPI (F865)

Every provider must develop, implement, and maintain a comprehensive Quality Assurance and Performance Improvement (QAPI) program. In conjunction with Phase II's implementation every facility is required to develop a QAPI plan and present its plan to federal and state surveyors at each annual recertification survey, upon request during any other survey, and to CMS upon request. According to the Advance Appendix PP, the QAPI plan is intended to "describe how the facility will conduct its required QAPI and QAA committee functions."

Infection Prevention and Control (F880) and Antibiotic Stewardship Program (F881)

The facility must implement written standards and policies for its infection prevention and control program, which must include an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.

As can be seen from the Phase 2 implementations above, CMS is highly focused on analysis and assessment with the updates to its Requirements of Participation. Be prepared for the California Department of Public Health to be assessing these new additions during post-dated surveys. Taking steps now to assess, analyze, and implement these changes will put facilities on the right track for the upcoming year. As always the requirements of the regulations being implemented under Phase 2 are fact dependent. Providers should seek counsel if questions arise as to its specific compliance with, and obligations under, the new rules.

For further information see the CMS guidance, located here: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html

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