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Reform of Long-Term Care Facility Requirements: CMS's Landmark Final Rule Poses New Challenges

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In response to care and quality innovations in the long-term care industry, the Center for Medicare & Medicaid Services (CMS) published a 713 page final rule on Sept. 28, 2016. *The Reform of Requirements for Long-Term Facilities* was the largest revision to regulations governing long-term care facilities in over 30 years. Although the final rule implemented comprehensive regulatory reform, many long-term care facilities likely already comply with most of the new requirements. CMS focused the final rule on modernizing the regulatory structure and codifying regulations instituting patient-centered care.

Under the Social Security Act (SSA), the Secretary of the Department of Health and Human Services is permitted to establish any requirements relating to the health, safety and well-being of skilled nursing facilities (SNFs) and nursing facilities (NFs). Additionally, the secretary may establish rights to protect and promote the rights of each resident. Facilities must meet requirements set forth by CMS to qualify as a SNF in the Medicare program and a NF in the Medicaid program. If a facility fails to meet these requirements, it is no longer eligible for Medicaid and Medicare funding. State survey agencies determine whether facilities meet the standards through a survey conducted by qualified health professionals. State survey agencies are currently surveying for compliance with regulations included in Phase I of the revised requirements, which went into effect Nov. 28, 2016. Phase II regulations will go into effect on Nov. 28, 2017, and, finally, Phase III regulations will go into effect on Nov. 28, 2019.

The final rule is projected to cost about $831 million in the first year and $736 million per year in subsequent years. Specifically, CMS estimated the average cost per facility for compliance with these new regulations to fall at $62,900 for the first phase and $55,000 for all subsequent years. Benefits from the reforms were not monetarily quantifiable, but CMS said it believes the final rule creates new efficiencies and added flexibility for facilities that are likely to reduce injury costs, improve care quality and create a positive business environment for facilities. CMS explained these extensive changes were necessary to reflect the increasing complexity of long-term care facility operation over the years. Therefore, CMS implemented these regulations in an effort to improve resident services, reflect current professional standards and improve the flow of the regulations overall.

Prior to enacting this regulation, CMS published its proposed revisions for public comment. Due to the extensive revisions included in the proposed rule, CMS extended the usual 60-day public comment period by 30 days. CMS included responses to many of the comments submitted when it published the final rule.

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The BIG Provision: CMS Attempts to Ban Pre-Dispute Arbitration Agreements (42 CFR 483.70(n))

Most significantly, the final rule prohibited predispute arbitration agreements between facilities and

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residents. CMS received more than 9,800 comments on the rule as a whole, almost 1,000 of which were in response to the proposed arbitration ban. Hundreds of comments were submitted both for and against the ban. Long-term care lobbyists strongly opposed the provision while the American Association for Justice along with advocacy groups such as AARP, the Fair Arbitration Now Coalition and the National Consumer Voice for Quality Long-Term Care supported the new provision. Commenters opposing the rule argued that the Federal Arbitration Act favors arbitration and requires that arbitration agreements are enforced unless the contract is unconscionable. As part of the first phase of regulations, the arbitration ban was set to take effect on Nov. 28, 2016. However, pre-dispute arbitration agreements are still permitted.

Specifically, the final rule stated that facilities that participate in Medicare or Medicaid ''must not enter into a predispute agreement for binding arbitration with any resident or resident's representative nor require that a resident sign an arbitration agreement as a condition of admission.'' CMS determined this regulation was within the scope of the secretary's statutory authority. The U.S. District Court for the Northern District of Mississippi, however, disagreed. Before the provision even went into effect, four plaintiffs, including the American Health Care Association, sued to enjoin the arbitration ban. Plaintiffs argued that CMS exceeded its statutory authority by enacting the regulation banning arbitration agreements. On Nov. 7, 2016, the court granted a preliminary injunction, staying implementation of the ban.

The court made no final ruling on the merits of the case but found that the plaintiffs' would likely succeed in the case against CMS because the pre-dispute arbitration ban likely exceeded the agency's statutory authority. First, the court found CMS did not make the requisite efforts to prove that nursing home arbitration had the negative effects that the commenters contended it did. Although CMS did not establish a strong basis in fact for the arbitration ban, the court noted it is possible CMS could have done so by focusing on specific issues pre-dispute arbitration agreements present in more detail. As an example, the court discussed the questionable mental competency of residents when entering into pre-dispute arbitration agreements. To develop a stronger factual record, CMS could have focused on the legal basis for restricting arbitration agreements by residents who likely have weak mental states, it said.

Even if CMS established a strong basis for the predispute arbitration ban, the court held it is still likely inconsistent with the secretary's statutory authority to promulgate regulations. CMS argued the secretary could issue this regulation under the general statutory authority under sections 1819 and 1919 of the SSA. Even though CMS's statutory authority to establish regulations for long-term care facilities is broad, the court determined CMS ''seemed to be forcing the tie'' between the arbitration ban and its authority to make regulations on general policy grounds. While the court was sympathetic to the public policy concerns cited by CMS, it placed greater importance on the separation of powers between Congress and an agency of the executive branch. Additionally, legislative history showed that Congress has expressly granted certain federal agencies the authority to regulate or prohibit arbitration agreements with clear and direct language. Here, Congress has not given the HHS that specific grant of power. As a result, the court held the arbitration ban is likely an overreach of the secretary's established statutory authority.

Finally, the court noted CMS had allowed binding arbitration agreements for the past 30 years. Such a major policy change should be done by the legislature, not an agency, the court suggested. Not only did CMS fail to appeal the order, the agency issued a memorandum on Dec. 9, 2016, informing all state survey agency directors that enforcement of the provision was suspended until and unless the injunction is lifted. CMS specifically ordered surveyors not to survey facilities for compliance with this new provision until further notified. While facilities are currently permitted to use predispute arbitration agreements, this regulation should be carefully monitored for any change in the law.

Smaller Regulation Changes

Expansion of Resident Rights (42 CFR 483.10)—Phase I Implementation. Other regulations codify the importance of resident-centered care and ensure residents are in high quality facilities. Expanded resident rights in the final rule include: equal access to quality care regardless of diagnosis, severity of condition or payment source; treatment of same-sex spouses the same as opposite-sex spouses; participation in the care planning process; designated staff responsible for providing assistance and responding to resident or family needs; and access to internal and external communication, including access to telephone services and internet to the extent available. Facilities are not required to rebuild or refurbish to accommodate these requirements, but any new facilities must comply with the additional regulations.

Comprehensive Person-Centered Care Plan (42 CFR 483.21)—Phase I & II Implementation. As part of Phase II, another new regulation in the final rule will require facilities to develop a baseline care plan for each resident within 48 hours of facility admission. A comprehensive plan can be developed in place of the baseline plan if it is done within the 48 hour time period and meets all comprehensive care plan requirements. In addition to the current requirements, a nurses aide and a member of the food and nutrition service staff must be added to each resident's plan. In Phase I, facilities must also have developed and implemented a discharge planning process that focuses on the resident's discharge goals and prepares residents to be active partners in the discharge process. Facilities must document and update a resident's goals for discharge and assess the potential for future discharge. The facility must then involve and inform the resident concerning this process and document that the resident has been asked about his or her interest in receiving information concerning return to the community. If discharge to the community is determined not to be feasible, the facility must document how that determination was made.

Compliance and Ethics Program (42 CFR 483.85)—Phase I & II Implementation. Although many facilities are already operating under a compliance and ethics program, the final rule codifies standards for a compliance and ethics program consistent with the Affordable Care Act requirement. By Nov. 28, 2017, in Phase II, any fa-

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cility's compliance and ethics program must have written standards, policies and procedures to reduce the prospect of criminal, civil and administrative violations. Additionally, new requirements are included for staff training programs. Organizations operating five or more facilities must develop, implement and maintain an effective training program for all new and existing staff, contract employees and volunteers by Nov. 28, 2017.

Dietary Services (42 CFR 483.60)—Phase I & III Implementation. Facilities are now explicitly required to meet residents' nutritional needs and preferences, including cultural and ethnic needs. Additionally, facilities have five years from Nov. 28, 2016, to ensure a qualified dietitian or other clinically qualified professional is included on staff. The following titles will satisfy this requirement: certified dietary manager; certified food service manager; similar national certification for food service management from a national certifying body such as the Association of Nutrition and Foodservice Professionals, the International Food Service Executives Association or the Food Management Professional certification through the National Restaurant Association; or an associate or higher degree in food service management or hospitality. CMS estimated that 10 percent of facilities will need to hire a director of food and nutrition services as a result of the new regulation. Finally, the new regulations clarify that residents are not prohibited from consuming foods not procured by the facility and requires facilities to develop a policy regarding the use and storage of foods brought to residents by family and visitors.

Going Forward

As discussed, CMS's final rule included the most expansive revision to long-term care regulations in over 30 years. Extensive additional modifications and clarifications were included in the major overhaul. Facilities must implement any new required policies and procedures to ensure they are in compliance with Phase II regulations by November 2017 and Phase III regulations by November 2019. Pre-dispute binding arbitration agreements are currently permitted and will not be evaluated on state surveys. This decision was solidified beyond the preliminary injunction by the memorandum sent by CMS to state survey agency directors. Because this action is the result of only a preliminary injunction and not a ruling on the merits of the case, facilities must monitor this regulation for future changes. Proactive action to ensure facilities are complying with all new regulations will avoid legal issues and potential loss of federal funding.