NURSING HOME 2024 LEGAL AND REGULATORY YEAR IN REVIEW

The following is our summary of significant nursing home legal and regulatory developments during 2024 of interest to nursing home providers and operators.

1. STAFFING MANDATE RULE.

The "Minimum Staffing Standards for Long Term Care Facilities" final rule was published in the Federal Register on May 10, 2024, establishing a phased implementation of a 3.48 hours per resident day ("HPRD") requirement, including 0.55 HPRD for registered nurses ("RNs") and 2.45 HPRD for nurse aides. The rule also finalized the proposed 24/7 onsite RN requirement. Implementation timelines vary, with rural facilities granted extended periods:

- Nursing homes in non-rural areas will implement standards within two years for the 24/7 RN requirement, and three years for the RN and nurse aide HPRD requirements.
- Nursing homes in rural areas will implement standards in three years for the 24/7 RN, and five years for the RN and nurse aide HPRD requirements.
- The 3.48 HPRD total nurse staffing requirement will be implemented with the 24/7 RN requirements.

Nursing homes will be required to post exemption status and the degree to which the nursing home is not compliant with staffing standards in a publicly available and easily visible location in the nursing home. Nursing homes will also be required to provide individual notice to current and prospective residents and ombudsmen of exemption status and degree of noncompliance, and the Centers for Medicare & Medicaid Services ("CMS") will post this information publicly on Care Compare.

The rule also expanded Facility Assessment requirements with an extended implementation timeline of 90 days, compared to the proposed 60-day timeline and Medicaid payment transparency requirements with a four-year implementation date as proposed. Currently, the regulations are being challenged in Federal Court.

2. CMS DETAILS CHANGE TO CARE COMPARE ON JULY 1, 2024.

CMS released memo QSO-24-14-NH on July 1, 2024, detailing updates to the staffing domain coming with the July 31 Care Compare refresh. Updates included changes to the staffing domain based on case mix methodology and turnover measure specifications. CMS also announced that they post facility-level Minimum Data Set data on the CMS data site beginning with the July 2024 refresh and will update consumer guides on the Care Compare site.

3. CMS ISSUES REVISIONS TO REVIEW AND APPROVAL OF PLANS OF CORRECTION.

In June 2024, CMS released a memo that restated to state survey agencies that Plans of Correction "are an element of the compliance review" but are ultimately no more than an allegation of compliance and signal the provider's readiness for revisit. With an increase in complaint surveys in recent years, CMS noted an increase in resource burden on both providers and CMS/state agencies based, in part, on the review and disapproval of multiple Plans of Correction. CMS clarified that if the state is unable to approve a Plan of Correction after two submissions, they should reach out to the provider to confirm readiness and intention to request a revisit. If the CMS location or the state agency believes a revisit should not be performed, the CMS location or state agency must notify CMS Survey and Operations Group.

4. SNF PROSPECTIVE PAYMENT – FY 2025 AND EXPANSION OF AUTHORITY FOR ENFORCEMENT OF CMPS.

The "Fiscal Year 2025 Skilled Nursing Facility Prospective Payment System" final rule finalized a 4.2% payment update for FY25, expanded enforcement authority with regard to civil money penalties ("CMPs"), updates to the wage index and policy changes for the SNF Quality Reporting Program and Value-Based Purchasing program.

In the rule, CMS finalized an expansion of authority for the enforcement of CMPs. CMS now has the authority to impose multiple per-instance CMPs for the same type of noncompliance, and to enforce both per-instance and per-day CMPs within the same survey. CMS also finalized an expansion of the look-back period for enforcing CMPs to the last three standard surveys, clarifying that under the revised policy, CMPs will

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potentially be enforced only for previously cited noncompliance.

The expanded look-back period does not give surveyors the ability to investigate and cite noncompliance during the look-back period that was not previously cited. However, complaints must be investigated without limitation of when the alleged event occurred.

5. NURSING HOME PROVISIONS IN THE CY2025 HOME HEALTH PROPOSED RULE.

On November 1, 2024, CMS released a final rule ("HHA Final Rule") that calls for Medicare-certified and Medicaid-certified nursing homes to electronically report information on acute respiratory illnesses, including influenza ("flu"), severe acute respiratory syndrome coronavirus 2 ("SARS-CoV-2")/coronavirus 2019 ("COVID") and respiratory syncytial virus ("RSV").

In the HHA Final Rule, CMS also finalized a new standard at 42 CFR § 484.105(i) that would require home health agencies to develop, implement and maintain an acceptance-to-service policy that is applied consistently to each prospective patient referred for home health care. CMS stated that the purpose of the new requirements is to address concerns regarding the referral and acceptance process and their implications for prospective and current patients.

6. OIG AUDIT REVEALS NONCOMPLIANCE WITH INFECTION PREVENTIONIST REQUIREMENTS.

In August 2024, the Office of Inspector General ("OIG") of the U.S. Department of Health and Human Services issued a report that detailed the results of an audit examining nursing homes' compliance with Infection Preventionist requirements. The report found that of the 100 for-profit nursing homes that were audited from July 2021 to June 2022, 24% failed to provide sufficient evidence of compliance with requirements to designate as Infection Preventionist at least one qualified individual who has completed specialized training.

7. OIG REPORTS IDENTIFY COMMON ISSUES IN NURSING HOME-INITIATED DISCHARGES.

In April 2024, two OIG reports were released identifying concerns about facility-initiated discharges in nursing homes. OIG found that most facility-initiated discharges involved residents with behavioral issues that put themselves or others at risk and were most often admitted for long-term care. OIG determined that more research is needed to determine how to effectively provide long-term care for individuals with mental health disorders. OIG's second report summarized an investigation of nursing home compliance with discharge requirements and found that while most facility-initiated discharges occurred for permissible reasons, nursing homes often failed to fully meet documentation or notification requirements.

8. OIG INDUSTRY SEGMENT-SPECIFIC COMPLIANCE PROGRAM GUIDANCE FOR NURSING FACILITIES.

On November 20, 2024, OIG issued new Industry Segment-Specific Compliance Program Guidance For Nursing Facilities ("Nursing Facility ICPG") for nursing home members of the health care compliance community. Motivating factors for issuing the Nursing Facility ICPG included long-standing issues such as staffing, infection control, emergency preparedness, background checks, adverse events experienced by residents, inappropriate use of medications and other compliance and quality issues.

The Nursing Facility ICPG describes risk areas for nursing facilities, recommendations and practical considerations for mitigating those risks, and other important information OIG believes nursing facilities should consider when implementing, evaluating and updating their compliance and quality programs. Nursing Facility ICPG, together with OIG's General Compliance Program Guidance issued in November 2023, serves as OIG's updated and centralized source of voluntary compliance program guidance for nursing facilities. Nursing facilities should use the Nursing Facility ICPG to help identify their risks and implement an effective compliance and quality program to reduce those risks. For more details, see our alert.

9. OWNERSHIP REPORTING FOR OFF-CYCLE REVALIDATIONS.

Effective October 1, 2024, CMS introduced significant updates to the CMS-855A form, specifically requiring a new "Skilled Nursing Facility ("SNF") Attachment" for every SNF. These changes, following the implementation of regulations finalized in November 2023, impact how SNFs disclose detailed ownership and management information. The adjustments stem from Section 1124(c) of the Social Security Act and aim to enhance transparency in Medicare and Medicaid programs. The revised CMS-855A form adds substantial complexity to the process for SNF providers, who must now navigate new disclosure and revalidation requirements. In its guidance, CMS continues to confirm the due date for all SNFs to submit the off-cycle revalidation information is May 1, 2025, unless an exception applies. For more details, see our alerts here, here and here.

10. CMS CLARIFIES UNANNOUNCED SITE VERIFICATION VISITS.

CMS provided additional details and information related to CMS provider enrollment site visits. On November 4, 2024, CMS issued a Quality

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and Safety Special Alert memo, "Clarification of CMS' Provider Enrollment Visits (all providers and suppliers) and Specific Disclosure Requirements for SNFs and NFs." CMS clarified that inspectors performing site visits will carry a photo identification and a CMS-issued, signed authorization letter that the provider or supplier may review. An inspector's inability to perform a site visit may result in denial of the Medicare enrollment application or revocation of Medicare billing privileges. For more details, see our alert.

If you have questions or would like assistance with any of these topics for your compliance programs and operations, please contact:

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