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**From:** theknapps4@verizon.net
**To:** DH, LTCRegs
**Subject:** [External] Comments to proposed DOH LTC Regulations
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**Attachments:** DOH.docx 10-20.docx

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Foulkeways at Gwynedd
1120 Meetinghouse Road
Gwynedd, PA 19436

**Re: Commonwealth of Pennsylvania proposed Long Term Care Regulations comments by Foulkeways at Gwynedd**

This document responds to the proposed regulations as the regulations apply to the three Nursing Homes in the Commonwealth of Pennsylvania that do not accept Medicare or Medicaid funds for the delivery of care to their Residents. Foulkeways at Gwynedd, Dallastown Nursing Home and Linden Hall deserve their minority voices to be heard.

Currently, the Pennsylvania Department of Health has responded to our grave concerns about being subject to massive regulatory changes with the attitude, *they are probably already doing this.* These assumptions are wrong.

**Foulkeways Experience with Medicare Reimbursement Regulations**

Foulkeways at Gwynedd (Foulkeways) never participated in Medicaid because our Residents self-fund other Residents who "spend down" their assets over time through personal donations to assistance funds. Foulkeways did participate in the Medicare program since its inception because every Nursing Home did so. After careful analysis Foulkeways withdrew from the Medicare Part A program in 2017 in order to allow our staff to provide care to Residents rather than sit at a computer documenting for Medicare reimbursement. We know what impact the proposed DOH regulations had on us and we don't want that non-Medicare funded regulatory burden anymore now than when we participated in Medicare.

What has been the impact of withdrawing from Medicare and its reimbursement related compliance regulations?

- More time with Residents, less time documenting for Medicare reimbursement and associated regulations.
- Ongoing DOH annual licensure surveys that are deficiency free with and without Medicare regulations.
- Quality of Care Outcomes that are the same with and without Medicare regulations.
- No DOH complaint surveys with and without Medicare regulations.
- Staff that can better fulfill their professional mission to provide quality care to people rather than documenting for Medicare regulatory compliance.
- DOH surveyors that still spend as much time onsite site assessing for quality under current DOH licensure regulations.
- Less hard-earned Resident money spent on Medicare related reimbursement regulations that produce no benefit to their wellbeing or health.

**Why All Self-Funded/Private Pay Nursing Homes should be Exempt from Proposed DOH Medicare reimbursement related compliance Regulations**

The following points need to be considered when the regulatory burden on Older Adults who are paying privately for their care are about to be dramatically affected by increased costs and government interference where it does not exist:

- Although these organizations do not accept or are dependent on government funds, all are currently licensed in the Commonwealth to provide quality care for Older Adults who have the same care needs as residents in Medicare and Medicaid Certified facilities.
- Each organization has been surveyed annually using the same survey method the Pennsylvania Department of Health (DOH) uses for all Medicare and Medicare Certified Facilities including an annual and/or complaint investigations that are unplanned, usually 2-3 days onsite by 2-3 Medicare/Medicaid federally survey qualified surveyors, however, we have not had to adhere to Medicare related reimbursement regulations.
- The DOH surveyors use the same stringent survey methods (assessment of medication drug pass, wound care observation, food safety, etc.) as all other government funded nursing facilities.
- The DOH surveyors have demonstrated no difficulty applying the state DOH licensure regulations for years in all of these facilities rather than massive Federal regulations
- The Residents in these facilities have demonstrated no different quality outcomes of care related to payor sources
- Facility staff meet the same professional licensure standards as all government funded facilities
- Facility staff must receive salary and benefits comparable to facilities that receive government funds in order to remain competitive in today's market
- The occupancy in these facilities is small in order to provide quality, resident focused care
- The actual Residents self-fund these organizations in order to be able to have direct control over their care outcomes.
- If the Resident consumer is dissatisfied with care, they or their family's self-discharge
- While these facilities do not accept Medicaid and Medicare funds, they are still required to pay for ***not*** accepting these government funds in the form of annual per licensed bed taxes in Pennsylvania known as the "Granny Tax"
- The cost of care will go up personally for Residents as our Nursing Facility care is Resident funded. For instance, under the proposed DOH regulations we would have to add a Registered Nurse to do Medicare paperwork. That RN would have to certify the accuracy of the MDS for Medicare funding that we do not receive. This person is difficult to recruit and would cost at least $125,000 annually for salary and benefits. This additional cost was NOT calculated in the DOH fiscal impact on our self-funded/private pay Nursing Homes.
- The lack of a real, accurate fiscal analysis by DOH has not been demonstrated, for instance in order to comply with regulations as proposed the cost of meeting additional paperwork compliance has not been calculated.

So, what is the difference between these three facilities and all other Medicare and Medicaid certified facilities? The major difference is:

- The Private Pay/Self-Funded Nursing Homes have purposely declined government funds in order to provide quality care under essentially the same care provisions requirements without the regulations that are in place to insure Medicare and Medicaid funding compliance. In other words, Medicare **and Medicaid funding attaches regulations to nursing homes that are strictly related to insuring that those organizations are in *fiscal* compliance with taxpayer funds.**

IRRC Initial Analysis

We are in full agreement with the Independent Regulatory Review Commission (IRRC) Assessment as referenced below, DOH did not answer and has not answered whether the regulation is in the public interest; Protection of the public health, safety, and welfare; Reasonableness question or provided an accurate final impact statement on self-funded/private pay Nursing Homes.

## Department of Health Regulation #10-224 (IRRC #3343)
## Long-Term Care Nursing Facilities
## July 27, 2022

"Determining whether the regulation is in the public interest; Protection of the public health, safety, and welfare; Reasonableness.

We ask the Department to explain the reasonableness of applying 42 CFR Part 483 to facilities which are not seeking Medicare reimbursement.

We appreciate the Department's attempt to estimate the fiscal impacts of the proposed regulation on long-term care nursing facilities. A commenter states that the Department ignores the potential impacts on small businesses. The commenter asserts that the three private-pay facilities are likely to be considered small businesses, and failing to consider the significant impact on these facilities seems to be an egregious omission. Throughout the RAF, the Department states that "any costs to these three facilities are outweighed by the need for consistency in the application of standards to all long-term care nursing facilities, regardless of whether they participate in Medicare or MA." We ask the Department to address the fiscal impacts on small businesses in the Preamble and RAF to the final regulation. ratios that are more stringent than. The commenter asserts that it is particularly unreasonable to assume that the private-pay long-term care nursing facilities will be able to implement immediately Federal regulations with which they need not currently comply"

The three Nursing Homes that are currently not accepting government funds in the form of Medicare and Medicaid should ***not*** be subject to onerous, excessive reimbursement related compliance regulations. These three nursing homes, and future nursing homes that choose not to accept government funds, should be **EXEMPT** from government fiscally related Medicare and Medicaid compliance regulations.

DOH has also proposed and exemption/exception process. Exemption and exception are often confused due to the similarity in their forms and morphology, clarity is required when applied to long standing ***existing*** DOH licensed Nursing Homes that are in the minority.

There is some difference between exemption and exception that is critically important at this point in time when a huge number of federal Medicare and Medicaid fiscally regulations are now going to be imposed on Nursing Homes that do not accept Medicare and Medicaid funds. The DOH proposal to remove the following federal preamble from State regulations (listed below), does ***not*** remove the initial or current federal regulations that are imbedded throughout the regulations specially related to Medicare and Medicaid funding:

§ 483.1 Basis and scope.

(a) *Statutory basis.*

(1) Sections 1819(a), (b), (c), (d), and (f) of the Act provide that -

(i) Skilled nursing facilities participating in Medicare must meet certain specified requirements; and

(ii) The Secretary may impose additional requirements (see section 1819(d)(4)(B)) if they are necessary for the health and safety of individuals to whom services are furnished in the facilities.

(2) Section 1861(l) of the Act requires the facility to have in effect a transfer agreement with a hospital.

(3) Sections 1919(a), (b), (c), (d), and (f) of the Act provide that nursing facilities participating in Medicaid must meet certain specific requirements.

(4) Sections 1128I(b) and (c) require that -

(i) Skilled nursing facilities or nursing facility have in operation a compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative violations.

(ii) The Secretary establish and implement a quality assurance and performance improvement program for facilities, including multi-unit chains of facilities.

(5) Section 1150B establishes requirements for reporting to law enforcement crimes occurring in federally funded LTC facilities.

(b) *Scope.* The provisions of this part contain the requirements that an institution must meet in order to qualify to participate as a Skilled Nursing Facility in the Medicare program, and as a nursing facility in the Medicaid program. They serve as the basis for survey activities for the purpose of determining whether a facility meets the requirements for participation in Medicare and Medicaid.

Words Matter

The word 'exemption' is used in the sense of 'freedom' or 'exclusion'. On the other hand, the word 'exception' is used in the sense of 'omission'. The three long standing, currently DOH licensed privately funded, as well as future Nursing Homes that refuse government funds should be **EXEMPT** from regulations associated with fiscal compliance or federally specific regulations and interpretations of those regulations as part of the DOH licensure regulations.

**There is no Public Interest in subjecting self-funded/private pay Nursing Homes to Federal Medicare and Medicaid Related Reimbursement Regulations. There are additional costs and paperwork burdens with no associated Medicare and Medicaid revenue. The DOH has ignored or dismissed these burdens that fall directly on our Residents in the proposed regulations.**

The following Regulatory Burdens need to be **EXEMPTED** from DOH regulations as they apply to Non-Medicare/Medicaid funded Nursing Homes:

- Minimum Data Set (MDS)
- Medicare and Medicaid reimbursement compliance regulations

**Minimum Data Set (MDS)**

According to the Centers of Medicare and Medicaid (CMS):

The Balanced Budget Act of 1997 included the implementation of a Medicare Prospective Payment System (PPS) for skilled nursing facilities (SNFs) and hospitals with a swing bed agreement, consolidated billing, and a number of related changes. The PPS system replaced the retrospective cost-based system for SNFs under Part A of the program (Federal Register Vol. 63, No. 91, May 12, 1998, Final Rule). Effective with cost reporting periods beginning on or after July 1, 2002, SNF-level services furnished in rural swing bed Hospitals are paid based on the SNF PPS instead of the previous, cost-related method (Federal Register Vol. 66, No. 147, July 31, 2001, Final Rule).

The SNF PPS is the culmination of substantial research efforts beginning as early as the 1970s that focus on the areas of nursing home payment and quality. In addition, it is based on a foundation of knowledge and work by a number of States that developed and implemented similar case mix payment methodologies for their Medicaid nursing home payment systems. The current focus in the development of State and Federal payment systems for nursing home care is based on recognizing the differences among residents, particularly in the utilization of resources. Some residents require total assistance with their activities of daily living (ADLs) and have complex nursing care needs. Other residents may require less assistance with ADLs but may require rehabilitation or restorative nursing services. The recognition of these differences is the premise of a case mix system.

Reimbursement levels differ based on the resource needs of the residents. Residents with heavy care needs require more staff resources and payment levels should be higher than for those residents with less intensive care needs. In a case mix adjusted payment system, the amount of reimbursement to the nursing home is based on the resource intensity of the resident as measured by items on the Minimum Data Set (MDS). Case mix reimbursement has become a widely adopted method for financing nursing home care. The case mix approach serves as the basis for the PPS for skilled nursing facilities and swing bed hospitals and is increasingly being used by States for Medicaid reimbursement for nursing homes.

The MDS is the source for determining Medicare and Medicaid case mix reimbursement in Nursing Homes. The federal regulations associated with the MDS completion, electronic submission, timeframes associated with data collection and certification are voluminous.

For instance, a Registered Nurse Assessment Coordinator (RNAC) tis required to review the assessments performed by physical therapists, occupational therapist, speech pathologists, social workers, licensed nurses, certified nursing assistants, dieticians, recreational therapist, respiratory therapist and any discipline that documents in the MDS in order to “certify” accuracy for reimbursement. This role is a full-time position.

DOH proposes to exclude “data submission” for the three privately funded nursing homes but does not exclude the unnecessary, reimbursement related RNAC position from the regulations. This position alone would add approximately $125,000 for salary and benefits to the budgets of the three nursing homes that do not need this position. In addition, the recruitment of a RNAC is currently almost impossible. Of note, this position was not included in the what can generously be described as incomplete and inaccurate in the most current proposed financial impact of the regulations on the three self-funded nursing homes.

Regulation Exemption

Only the current DOH licensure regulation related to the MDS as an assessment tool should apply to non-Medicare and Medicaid certified nursing homes for PA DOH licensure regulations:

**Medicare and Medicaid Regulatory References**

All references to Medicare and Medicaid that are imbedded in the Federal regulations should be **EXEMPTED s**uch as but not limited to:

483.5 Definitions

Distinct Part definition. [Referred for cost reporting of Medicare and Medicaid therefore inapplicable to self-funded nursing facilities.]

483.10 Resident Rights

(i) A facility must provide access to any resident by (A) Any rep. of Secretary. [Would not apply to non-Medicare or Medicaid facilities since Secretary refers to HHS Sec.]
(B) Allocation of Resident Funds- [requirements are based on residents whose care is funded by Medicaid. Not relevant to self-funded private pay nursing facilities.]
(iv)Notice of certain balances. [Notification of each resident that receives Medicaid benefits.]
(11) charges of personal funds of a resident for services which payment is made under Medicare or Medicaid.
(i) Services included in Medicare or Medicaid payment. During the course of a covered Medicare or Medicaid stay, facilities must not charge a resident for the following items:

Nursing services
Food and Nutrition
Activities
Room/bed maintenance.

(iii) Requests for Services

(C) facility must inform orally and in writing the resident requesting a service in which a charge will be made, and what the charge will be.

All the above starting with subsection (i) are not applicable to non-MA facilities as it addresses what can and cannot be charged to residents that have their care paid for by Medicare or Medicaid.
(11) The facility must-

(ii) Have reports including surveys, certifications, complaint investigations, and corrective plans of actions [may not have all information because a non-MA facility wouldn't have 3 years of federal certifications (feds don't survey), would have state certifications.]

Change in resident rights under Federal or state law. [Federal law could include Medicare or Medicaid specific requirements.]
(17 and 18) Informing residents of Medicaid and Medicare eligibility at admission. [Wouldn't be applicable]

483.12 Freedom from abuse, neglect, and exploitation.

(5) reporting of crimes in federally funded LTC facilities (1150B of the ACT) [Section 1150B of the Social Security Act (the Act), as established by section 6703(b)(3) of the Patient Protection

and Affordable Care Act of 2010 (Affordable Care Act), requires specific individuals in applicable long-term care facilities to report any reasonable suspicion of crimes committed against a resident of that facility to State Survey Agencies (SAs) and Law. This is a Federal Law that only applies to Medicare and Medicaid facilities and is referenced in the certification regulations. The three self-funded private pay nursing facilities are already subject to State Law regarding abuse, neglect and exploitation regulations]

483.15 Admissions, Transfers, and discharge rights.

(2)(i) The facility must- requirements in subsection 4 through 5 regarding residents right to Medicare and Medicaid at admission. [Non-Medicaid and Medicare certified facilities would not need to notify of these rights as residents come to their facilities knowing they do not accept Medicare or Medicaid.]

(d) Notice of bed-hold policy and return- [In Medicare and Medicaid facilities, NF bed will be held when resident goes to hospital. PPFs use internal policies and resident contracts.]

483.20 Resident Assessment.

(e) Coordination of assessment with PASARR program under Medicaid [not applicable, EXEMPT all references to PASARR]

483.21 Comprehensive person-centered care planning.

(ii) Minimum healthcare information necessary to properly care for a resident including, but not limited to:

(F) Remove PASARR because it is Medicaid specific.

(2) Comprehensive Care plan must-

(i) Developed within 7 days after the completion of the comprehensive assessment. [Care plan timeline should be set by the facility nursing homes should be EXEMPT from care planning timelines that are associated with the MDS reimbursement instrument]

Only Current DOH Care Planning Licensure Regulations should apply:

*§ 211.11. Resident care plan.*

*(a) The facility shall designate an individual to be responsible for the coordination and implementation of a written resident care plan. This responsibility shall be included as part of the individual's job description.*

*(b) The individual responsible for the coordination and implementation of the resident care plan shall be part of the interdisciplinary team.*

*(c) A registered nurse shall be responsible for developing the nursing assessment portion of the resident care plan.*

*(d) The resident care plan shall be available for use by personnel caring for the resident.*

*(e) The resident, when able, shall participate in the development and review of the care plan.*

483.30 Physician Services

> (c) *Frequency of physician visits.* The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least 60 days thereafter. [Time line requirement should be removed as they are associated with Medicare and Medicaid certifications and funding and have no relation to resident needs or care. This would may require residents to pay for visits that would not be reimbursed by Medicare under physician compliance billing regulations. EXEMPT physician visit schedules]

Only Current DOH Physician Licensure Regulations should apply:

*§ 211.7. Physician assistants and certified registered nurse practitioners.*

*(a) Physician assistants and certified registered nurse practitioners may be utilized in facilities, in accordance with their training and experience and the requirements in statutes and regulations governing their respective practice.*

*(b) If the facility utilizes the services of physician assistants or certified registered nurse practitioners, the following apply:*

*(1) There shall be written policies indicating the manner in which the physician assistants and certified registered nurse practitioners shall be used and the responsibilities of the supervising physician.*

*(2) There shall be a list posted at each nursing station of the names of the supervising physician and the persons, and titles, whom they supervise.*

*(3) A copy of the supervising physician's registration from the State Board of Medicine or State Board of Osteopathic Medicine and the physician assistant's or certified registered nurse practitioner's certificate shall be available in the facility.*

*(4) A notice plainly visible to residents shall be posted in prominent places in the institution explaining the meaning of the terms ''physician assistant'' and ''certified registered nurse practitioner.''*

*(c) Physician assistants' documentation on the resident's record shall be countersigned by the supervising physician within 7 days with an original signature and date by the licensed physician. This includes progress notes, physical examination reports, treatments, medications and any other notation made by the physician assistant.*

*(d) Physicians shall countersign and date their verbal orders to physician assistants or certified registered nurse practitioners within 7 days.*

*(e) This section may not be construed to relieve the individual physician, group of physicians, physician assistant or certified registered nurse practitioner of responsibility imposed by statute or regulation.*

*§ 211.3. Oral and telephone orders.*

*(a) A physician's oral and telephone orders shall be given to a registered nurse, physician or other individual authorized by appropriate statutes and the State Boards in the Bureau of Professional and Occupational Affairs and shall immediately be recorded on the resident's clinical record by the person receiving the order. The entry shall be signed and dated by the person receiving the order. Written orders may be by fax.*

*(b) A physician's oral and telephone orders for care and treatments, shall be dated and countersigned with the original signature of the physician within 7 days of receipt of the order. If the physician is not the attending physician, he shall be authorized and the facility so informed by the attending physician and shall be knowledgeable about the resident's condition.*

*(c) A physician's telephone and oral orders for medications shall be dated and countersigned by the prescribing practitioner within 48 hours. Oral orders for Schedule II drugs are permitted only in a bona fide emergency.*

*(d) Oral orders for medication or treatment shall be accepted only under circumstances where it is impractical for the orders to be given in a written manner by the responsible practitioner. An initial written order as well as a countersignature may be received by a fax which includes the practitioner's signature.*

*(e) The facility shall establish policies identifying the types of situations for which oral orders may be accepted and the appropriate protocols for the taking and transcribing of oral orders in these situations, which shall include:*

*(1) Identification of all treatments or medications which may not be prescribed or dispensed by way of an oral order, but which instead require written orders.*

*(2) A requirement that all oral orders be stated clearly, repeated by the issuing practitioner, and be read back in their entirety by personnel authorized to take the oral order.*

*(3) Identification of all personnel authorized to take and transcribe oral orders.*

*(4) The policy on fax transmissions.*

483.70 Administration.

*(q) Mandatory submission of staffing information and (2) submission requirements.* [The required data for submission is to CMS and would not be applicable to non-Medicare and Medicaid facilities for Payroll Based Journal (PBJ) data. EXEMPT submission of staffing information to Federal government]

483.75 Quality assurance and performance improvement.
(2) present its QAPI plan to the state agency of Federal surveyor no later than 1 year following the promulgation of this regulation;
(3) present its QAPI plan to state or federal agency at each annual recertification survey and upon request.
(c) Program feedback, data systems and monitoring.

[QAQI plans do not need to be submitted based on Federal Medicare requirements]

483.85 Compliance and ethics program.

Compliance is based on receiving Medicaid and Medicare and an EXEMPTION should be given in regulation

(j) *Grievances.*

(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:

(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;

(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously; issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

[Too prescriptive under federal law. The requirements are related to Medicare and Medicaid reporting of grievances Grievance Official that is required under federal statue is subsidized by Medicare and Medicaid funds, no such funds exist in self-funded nursing facilities. The position will add costs. Self-funded facilities currently have QAPI policies and procedures, resident council, that address grievances without additional paperwork. If the Resident or family is dissatisfied, they self-discharge]

**Regulation Exemptions Summary**

Non-Medicare and Non-Medicaid Certified Nursing Facilities should be EXEMPT from:

- All federal MDS regulations, only current Pennsylvania Licensure regulations should apply

- Federal care planning regulations, only current Pennsylvania Licensure regulations should apply
- All federal regulations referenced by Medicare and Medicaid reimbursement such as bed hold agreements, PASARR screen should been exempted
- Only current Pennsylvania Licensure regulations should apply for physician and physician extender services including oral and telephone verbal orders
- Compliance and Ethics Program should be exempted because it relates to Medicare and Medicaid funding compliance
- Section 1150B of the Social Security Act (the Act), as established by section 6703(b)(3) of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) that only applies by statue to Medicare/Medicaid certified nursing facilities
- PBJ staffing reporting should be exempted
- All reporting to the "Secretary" should be exempted
- All additional staff positions such as the Grievance Official should be exempted

In conclusion, the minority self-funded/private pay Pennsylvania Licensed Nursing Homes should be specifically exempted from all Medicare and Medicaid related regulations for Pennsylvania DOH Licensure purposes.