Topic 1: Streamline Regulatory Requirements

1A. Are there existing regulatory requirements (including those issued through regulations but also rules, memoranda, administrative orders, guidance documents, or policy statements), that could be waived, modified, or streamlined to reduce administrative burdens without compromising patient safety or the integrity of the Medicare program?

1. Exercise statutory authority to waive the 3-day prior hospitalization requirement for purposes of Medicare coverage of skilled nursing facility (SNF) care. 42 CFR § 409.30(a) and 42 U.S.C. 1395d(f)

Rationale: Pursuant to Social Security Act § 1861(i), beneficiaries must have a prior inpatient hospital stay of at least three consecutive days to be eligible for Medicare coverage of SNF care. This requirement harms both Medicare beneficiaries and the Medicare program. In some cases, patients are admitted to the hospital and are ready for discharge prior to completion of a 3-day stay, but have a clinically compelling need for post-acute SNF care. Hospitals and patients are placed in the untenable position of prolonging a hospital stay or discharge without coverage of SNF care. Discharging hospital patients without medically-necessary post-acute care raises the risk of readmission and unnecessarily drives up Medicare costs. In other cases, a beneficiary's condition could be treated through SNF care without a hospital admission. Given risks of hospital readmission in the absence of SNF post-acute care, and shortages of hospital beds in many communities, the 3-day stay requirement does not make clinical or fiscal sense.

Federal law at 42 U.S.C. 1395d(f) allows Medicare to pay for SNF services without a 3-day qualifying stay if the Secretary of Health and Human Services finds that doing so will not increase total payments made under the Medicare program or change the essential acute-care nature of the SNF benefit. We recommend the expanded use of such waiver authority, especially in instances when the beneficiary is otherwise eligible and clinically qualified to receive covered SNF services and is deemed at risk of hospitalization or rehospitalization.

2. Eliminate nursing home minimum staffing standards. 42 CFR §§ 483.35(b) and (c)

Rationale: The Minimum Staffing Standards for Long-Term Care Facilities final rule, adopted on May 10, 2024, sets unfunded, one-size-fits-all staffing standards that fail to take into account the varying needs of residents and the array of professionals and paraprofessionals that serve them. The federal regulation requires nursing homes to: (i) have a registered nurse (RN) on-site 24/7 in every nursing home; (ii) provide 3.48 hours per resident per day of total nurse staffing, including 0.55 hours per resident per day of RN services and 2.45 hours per resident per day of nurse aide services. The regulation sets a minimum baseline for nurse and aide hours regardless of the assessed needs of the residents. The regulation imposes these requirements despite a nationwide shortage of nurses and nurse aides and the absence of additional funding to support recruitment and retention of additional staff. It also exceeds the statutory requirement to provide 24-hour licensed nurse services sufficient to meet the needs of residents and to use the services of a RN at least eight consecutive hours per day, seven days per week. And, it ignores the therapy, social work, recreation, and other staff that care for residents. The staffing regulation was vacated by a U.S. District Court Judge Matthew Kacsmaryk as a result of a lawsuit filed by the American Health Care Association and LeadingAge, upon a finding that the Centers for Medicare & Medicaid Services (CMS) had exceeded statutory authority in regulating these minimum staffing standards.

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New York's has adopted similar, but not identical, staffing requirements, that likewise impose minimum nurse, aide and overall hours per resident day requirements without regard for the assessed needs of residents. Based on CMS PBJ data for the 4th Quarter of CY 2024 (the most recent quarter available), 66% of all nursing homes in New York State were unable to meet the state staffing mandates and they face harsh per day penalties. Among our not-for-profit and public members, efforts to come close to staffing standards have caused nursing homes to limit admissions, take beds offline, or close entirely. This has created barriers to care for older adults seeking skilled nursing or long-term care and back-ups in hospitals.

We ask that CMS withdraw this regulation to allow nursing homes to staff at levels tailored to residents' needs, based on requirements for sufficient and competent staff.

3. Narrow the scope of Enhanced Barrier Precautions requirements, which detract from resident quality of life and dignity. State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities, Survey Tag F880, citing 42 CFR § 483.80

Rationale: Enhanced Barrier Precautions (EBP) in nursing homes are an infection control intervention intended to reduce the transmission of multidrug-resistant organisms (MDROs). EBP involves the targeted use of gowns and gloves during resident care activities characterized as high- contact. A March 2024 CMS directive, QSO-24-08-NH, requires the use of EBP for residents with chronic wounds or indwelling medical devices during resident care activities, such as dressing, transferring, providing hygiene, and changing linens. For many of our members, this represents more than half of their residents. This requirement applies for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device, even if there is no evidence of MDRO infection or colonization. The requirement was included in the November 2024 updates to the Long-Term Care Surveyor Guidance, Appendix PP of the State Operations Manual. As such, these guidelines are now enforceable under Infection Control requirements at 42 CFR 483.80.

The guidance on the use of EBP is broad and interferes with the quality of life and dignity of many residents. For example, the guidance provides that, outside the resident's room, EBP should be followed when "working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility." By the same logic, it appears to many nursing home leaders that they must follow EBP when conducting therapy activities in facility hallways or common areas where residents practice ambulating and transferring. Moreover, EBP requires the placement of large bins in resident rooms for the disposal of PPE, the storage of large amounts of PPE in close proximity to the resident rooms, and the posting of some marker on the room indicating that the resident is under EBP.

All of these measures create an institutional atmosphere in nursing homes and detract from the homelike environment desired by residents and families. Residents have expressed that the use of PPE during high contact care activities is humiliating and alienating. Some residents can become frightened or otherwise distressed when their caregivers are donning personal protective equipment. Accordingly, the EBP guidance conflicts with regulations at 42 CFR § 483.10, requiring nursing homes to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.

It does not appear that the use of EBP for this broad array of residents and activities is justified by the risk of transmission of infections. Indwelling devices and wounds are covered and are unlikely to emit droplets through

dressings or pads and clothing. Moreover, CDC has failed to produce evidence that the use of EBP prevents serious negative outcomes, such as hospitalization or death, among nursing home residents. Under the circumstances, the risk of individuals who are not actively infected or colonized transmitting an infection to a staff member seems low and insufficient to justify the negative effects of the broad-based EBP.

In order to strike a better balance between infection control and resident quality of life, the CMS EBP guidance (QSO-24-08-NH) and accompanying modifications to Tag F880 should be rescinded. Instead, CMS and nursing homes should rely on longstanding regulations and guidance requiring nursing homes to implement an ongoing infection prevention and control program to prevent, recognize, and control the onset and spread of infection to the extent possible. As part of this program, nursing homes are required to implement the appropriate level of infection prevention precautions (e.g., standard, contact, droplet, airborne, enhanced barrier) based on the pathogen and route. The use of EBP should be resident-centered and determined by the resident's condition and the nature of the resident care activity.

1B. Which specific Medicare administrative processes or quality and data reporting requirements create the most significant burdens for providers?

1. **Increase the Medication Regimen Reviews (MRR) timeframe to 90 days for long-term nursing home residents.** State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities, Survey Tag F605, citing 42 CFR § 483.45(c)

Rationale: The regulations at 42 CFR § 483.45(c) and the interpretive guidance require the nursing home pharmacist to review every resident's medication regimen at least once a month in order to identify irregularities and to identify clinically significant risks and/or actual or potential adverse consequences which may result from or be associated with medications. In 2016, a requirement was added for the pharmacist performing the monthly MRR to also review the resident's medical record to monitor the medication regimen and ensure that the medications each resident receives are clinically indicated. These requirements apply regardless of the resident's clinical condition or the length of the resident's stay in the nursing home.

The regulation and State Operations Manual guidance should be revised to lengthen the MRR review interval from 30 days to 90 days for stable long-stay residents. For these residents, a monthly MRR is unnecessary and diverts pharmacist resources from residents who require closer monitoring. In the event that a long-stay resident experiences a change in condition, transition in care, or fall, an immediate MRR would be triggered. This revision would better enable pharmacists and other team members to focus their efforts on residents for whom more frequent or immediate reviews are needed.

2. **Eliminate duplicative civil money penalties (CMPs) for the same incident or violation in nursing homes.** 42 CFR § 488.430

Rationale: Nursing homes can be cited for noncompliance with regulations known as the Requirements of Participation (ROPs) through the survey and certification process. As a result of findings of noncompliance, CMS and/or the state may impose financial penalties on a nursing home in an effort to ensure a return to, and maintenance of, compliance. Under the regulations at 42 CFR § 488.430 that existed prior to the publication of the final rule at 89 FR 64048, effective October 2024, the State and/or CMS would select either a per day (PD) or per instance (PI) civil monetary penalty (CMP) when considering whether a CMP will be used as a remedy. A PD

CMP is imposed for each day a facility is not in compliance until the facility corrects the noncompliance and achieves substantial compliance, while a PI CMP is imposed for each instance in which a facility is not in substantial compliance. The October 2024 final rule modified the prior regulation by authorizing the imposition of: (i) both types of CMPs during the same survey; and (ii) multiple per instance CMPs for instances of the same deficiency on different days during a survey, regardless of whether or not the deficient practice constituted immediate jeopardy.

The imposition of multiple penalties for the same violation creates barriers to quality improvement in affected nursing homes. When nursing homes are assessed large fines for noncompliance, even when the violation was promptly corrected, they have less money available for the care and services residents depend on. This means fewer resources are available to recruit and retain staff, implement quality improvement initiatives, or make improvements to the physical environment such as renovating outdated physical structures to improve indoor air quality and improve resident quality of life.

Nursing homes facing financial hardship may even be forced to make changes to operations including the need to reduce resident programs, close units, or close entirely, creating access issues for older adults seeking nursing home care. Eliminating this authority to impose duplicative penalties will facilitate quality improvement and the correction of deficient practices, as opposed to prioritizing penalties that merely deplete struggling facilities of needed resources.

3. **Exercise greater enforcement discretion or expand waiver authority to allow nursing homes cited with deficiencies to continue their nurse aide training programs (NATPs).** 42 CFR §§ 483.151(b)(2) and (c) and SSA § 1819(f)(2)

Rationale: SSA § 1819(f)(2) and CMS regulations generally prohibit states from approving a nursing home's NATP program, and require suspension of prior approval, if the facility, within the previous two years was: (1) operating under a waiver for coverage by licensed nurses; (2) subject to an extended survey or partial extended survey; (3) been assessed a Civil Money Penalty (CMP) of at least $13,343 (2024 figure); or (4) has been subject to imposition of a denial of payment, temporary manager, or termination.

There is a staffing crisis in nursing homes and other long-term care services, and facilities are having great difficulty attracting and retaining enough CNAs. Amid this crisis, many facilities continue to receive remedies from surveys that result in the termination of their NATPs or the prohibition of a new program. Banning CNA training at a facility for two years is counterproductive and especially onerous for facilities trying to improve their staffing numbers in the midst of a CNA shortage. Having an NATP helps many facilities to attract and retain qualified CNAs and can help to improve the quality of care offered by the facility.

A 2017 CMS Survey and Certification Memo (Ref: SC18-02-NH) clarified that federal law and regulations allow states to waive this two-year ban under limited circumstances: if the State determines that there is no other such program offered within a reasonable distance of the facility; assures that an adequate environment exists for operating the program in the facility; and provides notice of such determination and assurances to the State long-term care ombudsman. CMS also has the authority to waive the two-year ban based on a CMP if the amount imposed meets the dollar threshold noted above, and the CMP was not related to the quality of care furnished to residents. These waivers are narrowly defined and seldom granted by States or CMS.

CMS should issue a directive to its regional offices and States to streamline and liberalize these waivers to ensure that these essential programs are continued whenever possible. CMS should broaden its interpretation of its waiver authority in order to allow for additional waivers. It should also support a statutory amendment to eliminate or circumscribe the two-year ban.

4. **Rescind or Streamline "Preadmission Screening and Resident Review for Mental Disorders and/or Intellectual Disabilities" (PASRR) for nursing homes.** 42 CFR § 483.20(k)

Rationale: This requirement, known as the PASRR, was implemented to prevent unnecessary placement of individuals with mental illness or intellectual disabilities in nursing homes. Under these requirements, nursing homes must complete preadmission screenings to determine that individuals with mental illness or intellectual disabilities require the level of services provided by the nursing home. In addition, the state mental health or intellectual disabilities authority must make a determination prior to admission, based on an independent evaluation by an external entity, that the individual requires a SNF level of care and if so, whether they require specialized services. Both the evaluation and the determination by the state authority often require agency coordination and layers of administrative processing that cause unnecessary delays in hospital discharges and delays in accessing medically-appropriate nursing home care. The delays in hospital discharges can also result in unnecessary costs to the Medicare program and contribute to shortages of hospital beds and associated back-ups in emergency rooms.

While we agree that inappropriate placement of individuals with mental illness and/or developmental disabilities in nursing homes must be prevented, the PASRR requirements, as operationalized through 42 § CFR 483.20(k), are unnecessary and overly burdensome. Regulations at 42 § CFR 483.30 require the personal approval, in writing, by a physician, of any recommendation that a person be admitted to the nursing home. Requirements implemented through the 2016 rule Federal Register: Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities require resident assessment and care planning for all residents to ensure that the needs of residents are identified and addressed, and that nursing homes do not admit residents whose needs they are unable to meet. Regulations at 42 CFR § 483.21(a)(1) require nursing homes to assess a resident's needs and develop a baseline care plan within 48 hours of admission. Under 42 CFR §§ 483.20(b) and 483.21(b), a comprehensive assessment must be completed within 14 days of admission and a comprehensive care plan developed within 7 days of the assessment, and both the assessment and care plan must be reevaluated upon a significant change in functioning or at least quarterly thereafter. The assessments and care plans must include consideration of, and measurable objectives to meet the resident's physical mental, and psychosocial needs. See CMS State Operations Manual, Appendix PP, F636, F655.

These requirements for physician approval, assessment, and care planning ensure that, individuals with mental illness or intellectual disabilities are not inappropriately admitted to a nursing home and that once they are appropriately admitted, their needs are promptly identified and addressed. Eliminating or streamlining the PASRR requirements at 42 CFR § 483.20(k) will lessen administrative burden on both nursing homes and state agencies, while also helping to ensure that individuals with disabilities do not experience unnecessary delays in accessing needed nursing home care.

1C. Are there specific Medicare administrative processes, quality, or data reporting requirements that could be automated or simplified to reduce the administrative burden on facilities and providers?

1. Limit the written discharge notice requirements to nursing facility-initiated transfers/discharges
State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities, Survey Tag F628, citing 42 CFR § 483.15(c)(3)

Rationale: The regulations at 42 CFR § 483.15(c)(3) require a nursing home, prior to transferring/discharging a resident, to notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. The overall intent of this regulation is to ensure that the resident or their representative are notified in advance of an impending transfer or discharge.

A facility-initiated transfer/discharge is one which either a resident objects to, did not originate via a resident's verbal or written request, and/or does not align with the resident's stated goals for care and preferences. A resident-initiated transfer/discharge is one that has been requested by the resident, or if appropriate, the resident's representative, either verbally or in writing.

Prior to more recent modifications to the CMS State Operations Manual, Appendix PP which took effect in April 2025, the requirement to send a copy of the notice to the State Ombudsman applied only to facility-initiated transfers/discharges and not to resident-initiated transfers/discharges (see CMS Memo SC17-27.SQC and Notice of Transfer-LTC). Producing these detailed notices, issuing them to all affected parties and documenting these actions for resident-initiated transfers/discharges is time-consuming and diverts precious staff resources that could be better spent on direct resident care/interaction. Moreover, notifying the resident and their representative of a discharge or transfer that they requested serves no meaningful purpose. Further, the Ombudsman's resources would be better spent on reviewing documents relevant to resident care and quality of life, rather than notices of transfers and discharges that the resident requested.

CMS should modify the regulation and guidance to streamline the content of the notice and documentation for resident-initiated transfers/discharges. At a minimum, the requirement to send copies of these notices to the State Ombudsman for resident-initiated transfers/ discharges should be discontinued.

2. Waive informed consent requirements for medications in urgent or emergent situations in nursing homes.
State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities, Survey Tags F552 and F757, citing 42 CFR § 483.10(c)

Rationale: Under regulations at 42 CFR § 483.10(c) and Appendix PP of the CMS State Operations Manual (F552, F757), prior to initiating or increasing the dose of a medication, the resident or the resident's representative must be informed of the risks, benefits, and alternatives for the medication. The resident's medical record must include documentation of the transmission of this information and the fact that the resident or their representative was given an opportunity to choose their preferred option. If there is no documentation demonstrating compliance with the resident's right to be informed and participate in treatment, the nursing home may be cited for noncompliance with 42 CFR § 483.10(c).

While we agree that informed consent is an key element of quality care, obtaining informed consent in every case involving medication order changes can be infeasible and lead to preventable suffering for the resident. A resident may have an urgent need for a new medication or an increased dosage of an existing medication and

lack capacity to make medical decisions. The resident's representative may be unreachable, leading to delays in the delivery of medication necessary to alleviate the resident's symptoms, combat infections, and/or prevent a decline in the resident's condition.

At the same time, the informed consent requirement may conflict with nursing home regulations and guidance that require medical providers to comply with professional standards. For example, a facility could be cited for deficient practice at Survey Tag F697 if it fails to provide pain management to a resident experiencing pain. Further, Appendix PP under Survey Tag F757 acknowledges that, "The regulations and guidance are not intended to supplant the judgment of a practitioner in consultation with facility staff, the resident, and his/her representatives and in accordance with professional standards of practice." For these reasons, informed consent requirements should be waived when professional standards of practice dictate initiating or increasing the dose of a medication in an urgent or emergent situation, when the resident lacks capacity to consent, and the resident's representative is not available.

Topic 2. Opportunities to Reduce Administrative Burden of Reporting and Documentation

2A. What changes can be made to simplify Medicare reporting and documentation requirements without affecting program integrity?

1. Exercise enforcement discretion with regard to the 2-hour deadline for nursing homes to report allegations of abuse and serious bodily injuries. State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities, Survey Tag F609; 42 CFR §483.12, 42 U.S.C. 1320b–25

Federal law and regulations require nursing homes to report to the State Survey Agency and one or more law enforcement authorities all allegations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.

We recognize the importance of reporting allegations such as these to appropriate authorities. However, the two-hour timeframe for reporting diverts the attention of facility leaders from responding to the needs of residents in the wake of an alleged incident and interferes with the facility's ability to conduct a prompt investigation. We recommend that CMS exercise enforcement discretion to allow reporting beyond the 2-hour time limit in appropriate cases when necessary to enable the facility to attend appropriately to the alleged incident. We further recommend that the administration seek amendments to the statute to extend the deadline.

2C. Are there documentation or reporting requirements within the Medicare program that are overly complex or redundant? If so, which ones? Please provide the specific Office of Management and Budget (OMB) Control Number or CMS form number. (The OMB Control Number consists of two groups of four digits joined by a hyphen and it generally appears on the top right of the first page of a Medicare form and the CMS form number generally appears on the bottom left of the page of a Medicare form.)

1. Simplify the CMS Form 855A Ownership Disclosure Requirements, Especially as They Pertain to Not-for-Profit and Public Nursing Homes. 42 CFR 424.502, 424.516; 42 CFR 455.101, 455.104, Social Security Act (SSA) § 1124(c)

Rationale: Recently adopted regulations (CMS Final Rule, 88 FR 80141), dated Nov. 17, 2023, require time-consuming collection and disclosure of detailed information about the ownership and management of nursing homes, as well as their "additional disclosable parties" (ADPs) including unrelated consultants, accounting firms, and others that provide goods and services to the facilities.

These enhanced requirements were prompted by concerns related to a lack of transparency and accountability of certain ownership structures in the nursing home sector, including, but not limited to, private equity companies and real estate investment trusts. The new CMS Form 855A emerged out of these concerns. However, the Form 855-a gathers far more information than it needs to, if the goal is to identify the individuals and entities controlling nursing homes behind the scenes. The scope of the additional disclosable parties that must be included is extraordinarily broad, and the amount of information that must be disclosed about the ownership and the specific employees of the ADPs is quite detailed.

While the collection of some of this information might be justified for complex investor-owned nursing home operators, it does not make any sense for not-for-profit (NFP) and government-operated nursing homes. NFP and government operators have transparent governance structures. NFP nursing homes must file IRS Form 990s disclosing their board members and the salaries of their top executives. NFP organizations are accountable to volunteer boards. Public nursing homes, which are sponsored by state and local governments, likewise have transparent governance through elected officials and executives who are subject to public appointment processes and government ethics rules.

The extensive disclosures required by the new Form 855a are administratively burdensome for any nursing home, but are especially unnecessary for NFP and public nursing homes. For purposes of these requirements, NFP nursing homes should only have to disclose the ownership information reported by such facilities to the Internal Revenue Service on Form 990 and should not be subject to ADP disclosure requirements. Public facilities should not be subject to these ownership and ADP disclosure requirements.

Topic 3. Identification of Duplicative Requirements

3A. Which specific Medicare requirements or processes do you consider duplicative, either within the program itself, or with other healthcare programs (including Medicaid, private insurance, and state or local requirements)?

Eliminate Schizophrenia Audits of Nursing Homes. CMS memo QSO-23-05-NH, State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities.

Rationale: CMS began conducting schizophrenia audits in 2023 in an effort to identify erroneous coding of schizophrenia on the Minimum Data Set (MDS) assessment. CMS has stated that the audits target facilities based on the number of residents over age 40, who were diagnosed with schizophrenia after admission to the nursing home. It is not surprising that a nursing home might lack documentation of a resident's earlier diagnosis with a mental illness. Because residents with mental illness are more likely to have experienced lapses in care and fragmented care, it is often difficult to assemble documentation of a history of a mental illness.

Once a nursing home is targeted for an audit, it is faced with extensive documentation requests to support schizophrenia diagnoses, sometimes relating to admissions years earlier, before such detailed documentation of mental health diagnoses was required. The standards by which the documentation is assessed are unclear. The consequences for failing to produce the requested documentation or producing documentation that does not

meet the auditors' standards are severe. Facilities that have coding inaccuracies identified through the schizophrenia MDS audit will have their 5-Star Quality Measure (QM) ratings downgraded. The penalties do not appear to be proportional to the infraction and do not seem to be calibrated based on the level of culpability or scope of inaccuracies or incompleteness.

We agree that inappropriate diagnoses should be identified and corrected, and nursing homes should be held accountable when they fail to exercise due care in assigning diagnoses. However, the schizophrenia audits and associated penalties are now duplicative of provisions enforced through the CMS survey process. Updates in the long-term care surveyor guidance (Appendix PP of the State Operations Manual) in November 2024, incorporated a process for evaluating accuracy of diagnoses and coding. As of the April 2025 implementation of this updated guidance, all nursing homes are now subject to these procedures during the standard recertification survey or any related complaint surveys. Diagnoses lacking appropriate documentation are cited under F641 Accuracy of Assessment and subject to enforcement remedies including civil money penalties. In addition, under Appendix PP, patterns of inaccurate coding can be referred to the Office of Inspector General and appropriate professional licensing boards.

3B. How can cross-agency collaboration be enhanced to reduce duplicative efforts in auditing, reporting, or compliance monitoring?

1. Eliminate the CDC NHSN Weekly Acute Respiratory Illness Reporting Requirements. 89 Federal Register 88354: Medicare Program; Calendar Year (CY) 2025 Home Health Prospective Payment System (HH PPS) Rate Update modifying 42 CFR § 483.80(g)(1)

Rationale: Effective Jan. 1, 2025, revisions to 42 CFR § 483.80(g)(1) require nursing homes to electronically report through the CDC's National Healthcare Safety Network (NHSN) information on acute respiratory illnesses (i.e., influenza, COVID-19, SARS-CoV-2 and respiratory syncytial virus (RSV)) in a standardized format and frequency specified by the Secretary. The Final Rule specifies weekly reporting of facility census, resident vaccination status, confirmed resident cases of these illnesses and hospitalized residents with confirmed cases of these illnesses, as well as enhanced reporting during future Public Health Emergencies. This broader standard replaced the COVID-19 reporting standards for nursing homes that had expired in Dec. 31, 2024.

The reporting requirements duplicate data collected through other platforms. Relevant COVID-19 reporting has been incorporated into other systems and programs, and other respiratory illnesses are collected through the Minimum Data Set (MDS) assessments. Infection data are already reported through other mandatory mechanisms such as reporting surveillance data to local authorities, public health agencies or state health departments as part of infection control requirements, including clusters of respiratory virus symptoms and information about confirmed cases.

Given these other data collection channels, requiring continued reporting through the NHSN is unnecessary and duplicative. CMS and CDC should coordinate with public health agencies to access the data. Furthermore, NHSN's guidelines for reporting data differ from the guidelines for MDS reporting, which further increases the administrative reporting burden on facilities. For these reasons, the ongoing acute respiratory illness reporting requirements in 42 CFR § 483.80(g)(1) should be eliminated. Minimally, the frequency of reporting should be reduced and/or reporting limited to peak respiratory illness seasons.

2. **Eliminate duplicative CMS/state survey inspections for veterans nursing homes.** 42 CFR § 488.305, SSA § 1819(g)(1)(A) and United States Code (U.S.C.) Title 38 § 1742

Rationale: State Veterans Homes that provide nursing home care are subject to survey inspections by multiple agencies, specifically the Department of Veterans Affairs (VA), CMS and state survey agencies in most states, including New York. Under federal law [U.S.C. Title 38 §1742], the VA is the only federal entity that oversees all state veterans homes and must ensure they meet applicable quality of care and other standards in order to provide them with payments. Most Veterans Homes participate in Medicare or Medicaid, and are thus also overseen by CMS to ensure they meet the federal quality standards required to receive those payments. CMS enters into agreements with state survey agencies to inspect these homes for compliance with federal standards. Finally, most states including New York inspect these facilities for compliance with state-specific regulations. VA survey inspections include annual, for-cause, and abbreviated surveys of State Veterans Homes that provide nursing home care.

Inspections by multiple agencies, using largely identical requirements of participation, are unnecessarily duplicative. They are exceedingly time-consuming for both facility staff and survey inspectors and divert nursing home resources away from resident care and agency resources from oversight of other Medicare/Medicaid facilities. We recommend "deemed status" be applied to substitute the VA survey process for the duplicative CMS/State survey process.

3C. How can Medicare better align its requirements with best practices and industry standards without imposing additional regulatory requirements, particularly in areas such as telemedicine, transparency, digital health, and integrated care systems?

1. Conduct surveys of high-performing nursing homes less often than other facilities. 42 CFR § 488.308 and SSA § 1819(g)(2)(A)(iii), 42 USC 1395i-3.

Rationale: Under CMS regulations and federal statute, the state survey agency must conduct a standard survey of each nursing home within 15 months of the last day of the previous standard survey. The statewide average interval between standard surveys is not supposed to exceed 12 months. For facilities that provide high quality care (e.g., CMS 4- and 5-Star facilities), surveys every 12-15 months are not necessary. These facilities should be subject to full standard surveys less frequently than those that do not provide high quality care. This would enable surveyor resources to be focused on facilities that may need help with quality improvements and reduce unnecessary oversight of top-performing facilities.

CMS should institute policies for federal/state surveyors to inspect providers with superior track records less frequently and providers with poor track records more often. Current requirements allow for limited variation among facilities in the frequency of survey. CMS should support a statutory increase in survey frequency to 24 months for high-performing facilities. In the interim, CMS should (and direct state survey agencies to) utilize the 15-month standard to its fullest extent for high-quality facilities and streamline the standard survey as much as possible for high-quality facilities consistent with SSA § 1819(g)(2)(A)(ii) and the enabling regulations.

2. Allow nursing homes surveyed by national accrediting agencies to secure "deemed status." 42 CFR § 488.305 and 42 USC §1395i-3.

Rationale: Pursuant to SSA § 1864 agreements, 42 USC §1395i-3 and federal regulations, state survey agencies are required to conduct surveys to determine whether nursing homes meet the Medicare and Medicaid requirements of participation (ROPs). Other provider types, such as hospitals, home health agencies, and hospice programs, are eligible for "deemed status"—their accreditation by an approved accrediting organization (like The Joint Commission) is deemed to meet or exceed the CMS requirements of participation. In these cases, CMS and states accept the accreditation organization's survey process in lieu of the state agency conducting a routine licensure inspection. This policy should be considered for nursing homes.

Some nursing homes already seek independent accreditation for various reasons including encouraging referrals, meeting payer requirements, and improving quality. State surveys of accredited facilities are duplicative, as well as time-consuming. Allowing deemed status for nursing homes that opt for accreditation by an approved accrediting organization would mitigate this duplication. Moreover, independent accreditation would not only ensure compliance with ROPs, it would also provide a greater focus on quality improvement and access to the accreditation organization's quality improvement protocols, expertise, and resources**.**

3. Expand the scope of physician visits that may be conducted by non-physician practitioners (e.g., nursing practitioners and physician assistants) employed by nursing homes. 42 CFR 483.30, State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities, Survey Tag F712

Federal regulations require nursing home residents to be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. Visits after the initial visit may alternate between personal visits by the physician and visits by an NPP. Generally, when the regulation specifies a task to be completed "personally" by physician, that task may not be delegated to an NPP. However, under 42 CFR 483.30(f), a state may permit NPPs to perform tasks which the regulations specify must be performed personally by the physician, provided that the NPP is not an employee of the facility, but is working in collaboration with a physician.

The employment-based limitation on the role of NPPs, especially in the context of physician shortages in many communities, does not make sense. NPPs in New York State, and in many other states, are authorized to diagnose and to prescribe medications and therapeutic interventions. Subject to certain experience requirements, nurse practitioners in New York State may even practice independently. Like physicians, NPPs are subject to professional standards and oversight by the applicable professional boards. Their employment by a facility does not affect their scope of practice nor the standards they must meet. There is no reason to exclude employed NPPs from conducting required visits with nursing home residents.

Topic 4: Additional Recommendations

We welcome any other suggestions or recommendations for deregulating or reducing the administrative burden on healthcare providers and suppliers that participate in the Medicare program.

1. Expand the definition of clinical contraindications to Gradual Dose Reductions (GDR) for psychotropic medications in nursing homes. CMS State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities, Survey Tag F605, citing 42 CFR § 483.45(e)(2)

Rationale: Under the regulations at 42 CFR § 483.45(e)(2), residents who use psychotropic drugs must receive GDR and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

Under Survey Tag F605, a GDR may be considered clinically contraindicated for reasons that include, but are not limited to: (1) a determination that continued use meets relevant current standards of practice and the physician documents the clinical rationale for why any attempted GDR would likely impair the resident's function or exacerbate an underlying disorder; or (2) the resident's symptoms returned or worsened after the most recent GDR attempt and the physician documents the clinical rationale for why any additional attempted GDR would likely impair the resident's function, exacerbate an underlying disorder or increase distressed behavior.

We agree that weaning a resident off of a medication that can cause serious side effects is an ideal treatment outcome. In practice, however, GDR decisions should be resident-centered and specific to the clinical presentation and history of the resident. Unwarranted reductions in the dose of medications can cause avoidable suffering for residents. When a medication at a particular dosage has had positive effects on a resident's wellbeing, nursing homes and their medical professionals should not be pressured by the threat of penalties to reduce the dose of the medication to the point that the resident experiences an exacerbation of symptoms. For example, a resident who is admitted with a mental illness and has been stabilized on a psychotropic medication in the community, should not be denied the appropriate dose of that medication until the nursing home can document that a reduction has caused a symptom relapse.

The allowable clinical contraindications to avoid a GDR should be expanded and clarified to allow medical professionals to make resident-centered decisions about the use of psychotropic medications without first requiring an impairment in the resident's function.

2. Enhance provider ability to contest deficiencies in-person through Informal Dispute Resolution (IDR) and Independent IDR and assure independence of reviewer.
Medicare State Operations Manual, Chapter 7 - Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities, citing 42 CFR § 488.331 and 42 CFR § 488.431

Rationale: The regulations at 42 CFR § 488.331 allow SNFs to contest citations issued during health inspections or complaint investigations. The IDR process allows facilities to present evidence and arguments against the findings before they become part of the public record, and any penalties are imposed. The IDR is typically heard by the survey agency that cited the deficiencies, but when an outside entity conducts the informal dispute resolution process, it makes a recommendation of noncompliance or compliance to the State, which is the final decision-maker. The process may be conducted by telephone, in writing, or in a face-to-face meeting. Under federal law and 42 CFR §§ 488.331 and 488.431, nursing homes can also request an Independent IDR (IIDR) if CMS imposes civil money penalties which are collected and escrowed pending a final administrative decision. This process is independent from the state survey agency or, in the case of Federal surveys, the CMS Location.

Facilities rely on the IDR and IIDR processes to challenge citations that seem to be unjustified or incorrect; when the citations unfairly affect the facility's reputation; when new evidence is available and for other reasons. Often, providers can make their cases more effectively if they are offered the opportunity for a presentation and dialogue in a face-to-face or virtual meeting. Unfortunately, these opportunities are unavailable in some states, and the IDR process relies on submission of paperwork by the facility to the state survey agency. For less serious citations, the state survey agency (and perhaps even the regional office that issued the citation) makes the determination. More serious findings may involve a panel which considers the written submission and makes a recommendation to the State.

CMS should modify its regulations and guidance to ensure that any facility: (1) has its IDR/IIDR considered by parties that are independent of the state survey agency team/regional office that made the original citation(s); (2) may select an in-person or virtual meeting or written presentation of its IDR/IIDR; and (3) may have legal counsel present at any in-person or virtual meeting.