May 12, 2025

The Honorable Russell T. Vought
Director
The Office of Management and Budget
725 17th St NW
Washington, DC 20503

Re: Request for Information: Deregulation [Docket No. OMB-2025-0003-0001]

Submitted via regulations.gov

Dear Director Vought,

Thank you for the opportunity to submit comments regarding proposals to rescind or replace regulations that "stifle American businesses and American ingenuity" as part of the Office of Management and Budget's (OMB) request for information (RFI). As the nation's largest association representing long term and post-acute care facilities, the American Health Care Association/National Center for Assisted Living (AHCA/NCAL) stands ready to work with the Trump Administration on productive policies that support those who live and work in these facilities. We applaud your efforts to streamline government regulations in order to promote job growth, support small businesses, expand consumer choice, and encourage innovation.

AHCA/NCAL's more than 15,000 members provide essential, life-affirming care to millions of individuals in America's nursing homes, assisted living communities, and centers for individuals with intellectual and developmental disabilities (ID/DD). In order to continue to enhance this care and prepare for our nation's rapidly growing aging population, we must work together to advance bold and innovative solutions.

For decades, federal bureaucrats have piled on regulations and penalties, especially on nursing homes, but these punitive policies have failed to produce real change. Instead, we have an inconsistent and ineffective oversight system that does not drive quality improvement among facilities or enhance the quality of life for residents. What it does drive is highly qualified and passionate caregivers out of or away from the long term care profession, contributing to our sector's ongoing workforce challenges. Stakeholders across the gamut are unsatisfied with the results, and policymakers and taxpayers aren't getting an optimal return on their investment.

AHCA/NCAL fully supports appropriate oversight, consumer transparency, and accountability of chronic poor performers to ensure the safety and wellbeing of our residents. However, we also believe there are many long term care regulations and guidance that are duplicative, antiquated, confusing, and inconsistent with other health care settings. AHCA's "Better Way" policy priorities for 2025 includes Rationalizing Regulations. We have practical solutions that would create a more effective and balanced regulatory environment.

This does not mean compromising the quality of care long term care facilities provide—it means enhancing it. When we streamline regulations and guidance to prioritize what's best for residents, we can elevate the care being provided, encourage innovation, help recruit dedicated caregivers, and empower seniors and their families with clear, useful information. It can also ensure accountability while creating government efficiencies. It's a win for everyone.

Therefore, per your RFI, we submit to you today several regulations and guidance that should be modified or repealed that would make a meaningful difference in advancing quality improvement in long term and post-acute care. Some of these recommended changes could be made immediately by the appropriate federal agency (typically the Centers for Medicare and Medicaid Services) through sub-regulatory guidance, and other changes would require formal rulemaking. They are outlined in the attached appendix. Ultimately, the regulatory changes we put forth today help put patients over paperwork, modernize care delivery, advance workforce development efforts, encourage innovation, streamline reporting requirements, and ensure government accountability and transparency.

AHCA/NCAL's mission is to improve lives by delivering solutions for quality care. Therefore, we greatly appreciate the opportunity to share our solutions. We welcome meeting with officials from OMB or the relevant federal agencies to discuss these proposals further. Together, we can develop a better regulatory system that is more efficient, consistent, and fair. For the sake of our nation's most vulnerable who deserve the utmost care and the staff who work in these facilities who should be recognized and empowered, we appreciate your thoughtful consideration.

Sincerely,

Clifton J. Porter, II
AHCA/NCAL President & CEO

cc:
HHS Secretary Robert F. Kennedy, Jr.
CMS Administrator Mehmet Oz

Encl.: Appendix: Long Term Care Regulations and Guidance for Modification or Repeal

Appendix: Long Term Care Regulations and Guidance for Modification or Repeal

Submitted by AHCA/NCAL

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Respiratory Illness Reporting Requirements

***References*:**

483.80 Infection Control, (g) Respiratory Illness Reporting
eCFR :: 42 CFR 483.80 -- Infection control.
Also see: CMS QSO-25-11-NH

***Background*:**

In November of 2024, as part of the Calendar Year 2025 Home Health Prospective Payment System Rate Update, the Centers for Medicare and Medicaid Services (CMS) released new acute respiratory illness reporting requirements for nursing homes, which replaced the requirements at 483.80 (g). These requirements added even further data elements required by providers to report to the National Health Safety Network (NHSN) to include the following: facility census; resident vaccination status for COVID-19, Influenza and RSV; confirmed Resident cases of COVID-19, Influenza, and RSV (overall and by vaccination status); and hospitalized residents with confirmed cases of COVID-19, Influenzas and RSV.

***Justification for Rescission*:**

The continued mandatory weekly reporting of acute respiratory illness on the NHSN platform by nursing home providers is unnecessary, duplicative, and burdensome. The COVID-19 Public Health Emergency (PHE) ended in May 2023, and weekly reporting is no longer necessary. Relevant COVID-19 reporting has been incorporated into other systems and programs. Resident-level vaccination status includes COVID-19 and influenza and is reported via Minimum Data Set (MDS), the standardized assessment tool for nursing homes. Respiratory illnesses are reported to many local public health departments, which results in duplication of data, causing additional unnecessary reporting burdens for facilities.

Additionally, the misalignment between NHSN reporting definitions and ICD-10 coding standards creates ongoing inconsistencies and inefficiencies in data reporting. The NHSN system is flawed with errors, which results in additional unnecessary time spent completing administrative tasks and taking time away from resident care. Delays in getting NHSN logins persist, and the email-only Help Desk causes further delays due to back-and-forth messages that could be resolved faster with a phone Help Desk or online chat system.

Elimination of this requirement will allow health care professionals more time to focus on delivering quality care to residents in long term care facilities. AHCA recommends discontinuing the mandatory NHSN reporting per final rule and allowing for voluntary reporting. This could be done via interim final rule for immediate effect.

***Recommended Action*:**

We recommend CMS issue an interim final rule (IFR) discontinuing the mandatory NHSN reporting requirement for LTC Facilities.

Payroll Based Journal Reporting

***References*:**

CMS Payroll-Based Journal - §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format.

Background:

Section 6106 of the Affordable Care Act (ACA) requires nursing homes to electronically submit direct care staffing information (including agency and contract staff) based on payroll and other auditable data. Payroll-Based Journal (PBJ) was created by CMS as a method to collect auditable and verifiable staffing data from nursing home providers. The first mandatory reporting period began July 1, 2016. CMS posts the data, combined with census information, to be used to report to the public on the level of staff in each nursing home, as well as employee turnover and tenure. PBJ data is also used to calculate five-star ratings intended to inform consumers.

Current CMS PBJ policies are overly complex, inconsistent and detract from providing a full picture of facility staffing information to those interested including consumers, insurers, and regulators. At present, PBJ policy does not allow providers to submit corrected or missing data for any reason, even when there are unexpected technical issues. Facilities that inadvertently miss the quarterly deadline for submitting staffing data receive the lowest possible score for the corresponding staff turnover measures. Facilities that fail a PBJ audit are faced with a similar reduction in score.

***Justification for Modification*:**

As previously stated above, PBJ policy does not allow providers to submit corrected or missing data for any reason, which is both misleading to consumers and families and unfairly punitive for facilities. According to CMS, a purpose of collecting and displaying this data in the Nursing Home Five Star Quality Rating system is "to help consumers understand the level and differences of staffing in nursing homes". Current policy outlines that facilities failing to submit staffing data or submitting erroneous data receive the lowest possible score for the corresponding staff turnover measures resulting in CMS suppressing the turnover data for six quarters. This is not an accurate representation to the public of staff in the facility. Furthermore, the lack of ability

to correct data for future use makes this policy unnecessarily punitive as the provider is already being penalized for the quarter at hand.

Additionally, with the scheduled adoption of PBJ-based measures into the Medicare Skilled Nursing Facility (SNF) Value based Purchasing Program in FY 2026, allowing for corrected PBJ data will help ensure more facilities have their Medicare reimbursement tied to accurate staffing levels and turnover. If a facility has missing or incomplete PBJ data for the VBP measurement windows, their VBP payment adjustment is determined only by other quality measures.

The SNF Quality Reporting Program (QRP) Reconsideration policy and process finalized in the FY 2016 SNF Prospective Payment System provides a fair and reasonable process for nursing facilities to follow and should be used as a model for PBJ reporting. The policy allows nursing homes to request reconsideration of an initial determination that the SNF did not comply with the reporting requirements under the SNF QRP. Here's how the SNF QRP Reconsideration policy works:

- Facilities have the ability to file a request for reconsideration generally within 30 days of the initial notification of noncompliance and are required to submit supporting documentation and evidence demonstrating their full compliance with the SNF QRP requirements.
- Facilities also have the ability to request an extension or exception and have the ability to communicate extraordinary circumstances that may have existed (as defined in the policy) to cause a failure in filing a timely request of exception (such as a natural or man-made disaster), in order to extend the 30-day deadline.
- CMS is required to notify the SNF in writing via email of its final decision for a request for extension to file a reconsideration of non-compliance.
- Finally, the policy states that if a SNF is dissatisfied with a reconsideration request decision, the SNF may file an appeal with the Provider Reimbursement Review Board.

Establishing review and reconsideration processes for PBJ reporting will provide more complete and accurate information to consumers about nursing home staffing. Improved consistency and clarity in staffing data reporting will result in more effective use of this information for regulators, consumers, and providers.

***Recommended Action*:**

We recommend CMS issue interpretive rule modifying sections of *CMS Electronic Staffing Data Submission Payroll-Based Journal Long-Term Care Facility Policy Manual* to establish review and reconsideration processes for nursing homes.

- Review process: We recommend CMS provide facilities with a preview report (like the 1750D PBJ Staffing Data Report) after the final submission is complete for the quarter. This report should flag areas of potential concern and facilities should be provided with at

least 14 business days to review and correct the data so that this information available to residents and families is accurate and complete.

- Reconsideration process: We recommend that CMS provide facilities with a reconsideration and appeal process similar to the SNF QRP Reconsideration policy outlined above.

SNF Quality Reporting Program

***References*:**

§ 413.360 - Requirements for the Skilled Nursing Facility (SNF) Quality Reporting Program (QRP); 42 CFR 413.360(b) - Data Submission Requirement

Background:

The IMPACT Act of 2014 established Quality Reporting Programs (QRP) for various post-acute care (PAC) settings, including skilled nursing facilities. AHCA/NCAL was supportive of the legislation, as it intended to improve patient coordination through standardized patient data and data on measures that were key quality drivers. However, since it's implementation, the vision of the IMPACT Act to focus on meaningful outcomes measures has been lost and instead, CMS has expanded the QRP to include process reporting measures that do not improve care.

***Justification for Modification*:**

We are not recommending the removal of the QRP or the regulatory requirement. However, we are requesting the removal of several measures promulgated through rulemaking that meet the regulatory requirements for CMS to 'remove a quality measure' as stipulated in 42 CFR 413.360(b). Overall, these measures should be removed because they do not result in better resident outcomes. Many of them are also inconsistent with the statute, which requires that measures be interoperable, risk-adjusted, and endorsed by an approved contractor. The failure of these measures to meet these standards as well as the fact that they are process measures makes comparing performance between providers—one of the primary purposes of the program—meaningless. Put together, the costs associated with a measure outweigh the benefit of its continued use in the program.

Measures recommended for removal and justification:

1. **COVID-19 Vaccination Coverage among Healthcare Personnel (HCP)** - Not a resident-specific measure; Healthcare personnel are not required to receive this vaccine; Process measure so performance on measure cannot be linked to a resident outcome or meaningful or valid comparisons made between providers; The costs of this measure that

cannot be linked to a resident's outcomes outweigh potential benefit of continued use in the SNF QRP.

2. **Influenza Vaccination Coverage among HCP** - Not a resident-specific measure; Healthcare personnel are not required to receive this vaccine; Process measure so performance on measure cannot be linked to a resident outcome or meaningful or valid comparisons made between providers; The costs of this measure that cannot be linked to a resident's outcomes outweigh potential benefit of continued use in the SNF QRP.
3. **Drug Regimen Review Conducted With Follow-Up for Identified Issues PAC SNF QRP** - Not endorsed; Process measure so performance on measure cannot be linked to a resident outcome or meaningful or valid comparisons made between providers; Checkbox process measure reporting a task was done that could contribute to other available risk adjusted outcomes measures (duplication) rather than serving as a stand-alone outcome measure; High risk for performance to be high and unvarying between SNFs to render the measure meaningless; The costs of this measure that cannot be linked to a resident's outcomes outweigh potential benefit of continued use in the SNF QRP.
4. **Transfer of Health (TOH) Information to the Provider (PAC)** - Not endorsed; Process measure so performance on measure cannot be linked to a resident outcome or meaningful or valid comparisons made between providers; Checkbox process measure reporting a task was done that could contribute to other available risk adjusted outcomes measures (duplication) rather than serving as a stand-alone outcome measure; High risk for performance to be high and unvarying between SNFs to render the measure meaningless; The costs of this measure that cannot be linked to a resident's outcomes outweigh potential benefit of continued use in the SNF QRP.
5. **Transfer of Health (TOH) Information to the Patient (PAC)** - Not endorsed; Process measure so performance on measure cannot be linked to a resident outcome or meaningful or valid comparisons made between providers; Checkbox process measure reporting a task was done that could contribute to other available risk adjusted outcomes measures (duplication) rather than serving as a stand-alone outcome measure; High risk for performance to be high and unvarying between SNFs to render the measure meaningless; The costs of this measure that cannot be linked to a resident's outcomes outweigh potential benefit of continued use in the SNF QRP.
6. **COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date** - Not endorsed; Not a resident-specific measure; Residents are not required to receive this vaccine; Process measure so performance on measure cannot be linked to a resident outcome or meaningful or valid comparisons made between providers; Duplicates information required to be submitted on the SNF MDS RAI increasing burden; The costs of this measure that cannot be linked to a resident's outcomes outweigh potential benefit of continued use in the SNF QRP.

Removing these specific measures from QRP would help put patients over paperwork and readjust the program to focus more on the metrics that matter for patients. Providers would be able to devote more resources to improving patient care and modernizing health information exchange capabilities rather than to these administrative duties.

***Recommended Action*:**

We recommend CMS issue an interim final rule (IFR) rescinding the following measures from the SNF QRP:

1. COVID-19 Vaccination Coverage among HCP
2. Influenza Vaccination Coverage among HCP
3. Drug Regimen Review Conducted With Follow-Up for Identified Issues PAC SNF QRP
4. Transfer of Health (TOH) Information to the Provider (PAC)
5. Transfer of Health (TOH) Information to the Patient (PAC)
6. COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date

NOTE: An alternative to the Interim Final Rule process to rescind the specific SNF QRP process measure items could be for CMS to apply an approach similar to the CMS announcement on May 6, 2025, "Suspension of Eight Improvement Activities for the Merit-based Incentive Payment System (MIPS)" which includes the removal of process measures related to COVID-19 vaccines and other non-outcomes-based measures. Such an approach would allow SNF providers and CMS to immediately put patients over paperwork while CMS addresses the formal regulatory removal of the specific ineffective and burdensome process measures in future rulemaking.

Facility Assessment

***References*:**

483.71 Facility Assessment

Background:

In 2016, CMS added a new regulation for nursing homes, the Facility Assessment to evaluate each facility's resident population. CMS further expanded this regulation on May 10, 2024, at 483.71. The expanded requirements ordered nursing homes to document in detail a variety of new topics. This is a paperwork centered requirement and can limit innovative staffing approaches in facility operations.

***Justification for Rescission*:**

The Facility Assessment requirement is both overly burdensome and duplicative, as much of the information collected in the facility assessment overlaps with other required documentation, such as staffing plans, resident care policies, and quality assurance activities. Requiring nursing home staff to direct more of their time and attention to additional layers of paperwork takes away from staff time that is better spent focusing on resident care and quality of life outcomes.

Additionally, there is insufficient evidence to show that facility assessments lead to better care for residents. The process does not directly impact operational improvements, making it an ineffective tool for enhancing quality. Eliminating the facility assessment requirement would streamline compliance efforts, allowing facilities to focus on what is most important, substantive activities that improve resident outcomes and quality.

***Recommended Action*:**

We recommend through a Notice of Proposed Rulemaking, CMS remove the entire language at 483.71 Facility Assessment.

Nurse Aide Training and Competency Evaluation Program (NATCEP) Instructor

***References*:**

42 CFR §483.152(5)(i) - Requirements for approval of a nurse aide training and competency evaluation program

Background:

There is currently a significant shortage of qualified nurse instructors available for the Nurse Aide Training and Competency Evaluation Program (NATCEP). The instructor shortage is reducing access to training programs that support a steady pipeline of trained Certified Nursing Assistants (CNAs) to strengthen the nursing home workforce across the country.

Current federal regulations require that the training of CNAs must be performed by or under the general supervision of a registered nurse who possesses a minimum of two years of nursing experience. Additionally, it further qualifies that the nurse must have at least one year of prior stated experience in the provision of long term care (LTC) facility services.

***Justification for Rescission*:**

The current NATCEP instructor requirement to have one year of experience in LTC excludes many qualified nurses who have relevant experience in other health care settings. Narrowing the pool of candidate instructors when there is already a demonstrable shortage exacerbates current caregiver shortages. Removing this requirement will expand the eligibility criteria and increase the instructor pool, enabling more training programs to help to grow the nursing home workforce with qualified caregivers.

The proposed change does not affect the state-approved training content or the required competency demonstrations for nurse aides; therefore, it would not compromise the quality of the training program.

***Recommended Action*:**

We recommend CMS issue an Interim Final Rule to rescind the following language under §483.152(5)(i):

> *"at least 1 year of which must be in the provision of long term care facility services".*

Food & Nutrition Director

***References*:**

483.60 (a)(2)(i)(E) – Food and Nutrition Services

Background:

Federal regulation 483.60 contains requirements related to the food and nutrition services provided in the nursing home setting. As part of these requirements under subsection (a) Staffing, the agency sets forth requirements for the facility to "employ sufficient staff with the appropriate competencies and skills sets to carry out the function of the food and nutrition service". The regulation further mandates that the food service director meets minimum qualifications outlined in the rule.

One of the options in order to meet these requirements includes having two or more years of experience in the position of director of food and nutrition services in a nursing facility setting and completing a course of study in food safety and management, however this option essentially expired on October 1, 2023.

***Justification for Modification*:**

AHCA/NCAL supports ensuring that nursing home staff who work in food, nutrition, and dietary services have the necessary experience and training. However, the current requirements limit the availability of recruiting directors of food and nutrition who have valuable experience working in the field. Reinstating the option for experience as well as course completion will help attract qualified individuals into this important position. It will also allow for expanding career pathways for nursing home staff as well as the pool of candidates.

***Recommended Action*:**

We recommend CMS issue an Interim Final Rule to modify 483.60 Food and Nutrition services as follows:

> "Has 2 or more years of experience working in ~~the position of director of~~ food and nutrition services in a nursing facility setting or other healthcare setting and has completed a course of study in food safety and management~~, by no later than October 1, 2023,~~ that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving".

Civil Monetary Penalty Policy Improvements

***References*:**

42 CFR Part 488

Background:

The Centers for Medicare & Medicaid Services (CMS) has authority to impose civil monetary penalties (CMPs) in healthcare settings that accept federal Medicare and Medicaid payment, including hospitals, home health, hospice, and nursing homes. However, CMS imposition of CMPs on healthcare settings widely varies and disproportionately imposes CMPs on nursing homes as compared to other healthcare settings, while there is no evidence that this excessive imposition of CMPs on nursing homes improves quality.

The shared goal of CMS and the nursing home profession is to gain and maintain substantial compliance and provide quality care to residents. Congress intended that nursing home enforcement actions, including CMPs, be remedial in nature, rather than punitive. However, CMS's approach has been solely punitive. For example, CMP notices are often issued significantly past the time that facilities have already corrected the deficient practice(s) weeks or months or even years before CMS imposes the CMP, which means the facility is being punished with a CMP long after they have already corrected the deficient practice(s). Most importantly, greater CMPs divert funds from care and services for residents. More than $200 million of CMPs were imposed by CMS on nursing homes annually each of the past two years (2022 and 2023).

There are several problems with the consistency and effectiveness of CMPs in nursing homes. State Survey Agency (SSA) delays in processing result in providers accumulating excessive per day CMP fines. Some states are reporting delays of more than 30 days in the receipt of the CMS form 2567 which outlines the deficient practices. Also, many facilities are not notified of fines until months or even years after the deficiency occurred, as SSA's are reporting significant delays

in sending CMP notices to providers. In fact, some SSAs have reported delays up to four years after noncompliance is identified. Six out of the ten CMS Regions have at least one CMP notice that was sent a full year after identification of noncompliance.

***Justification for Rescission/Modification*:**

We propose several policy improvements as it relates to the imposition of Civil Monetary Penalties (CMPs), to improve the consistency, efficiency, and impact of such remedies in nursing homes. We recommend:

- Providing an opportunity for imposed CMPs to be used by nursing homes to correct the CMP associated deficiency and improve care.. CMPs do not currently support quality improvement under the current CMS policies and do not serve the statutory intent as a remedy. Allowing a nursing home to use the CMP owed by the facility to correct the alleged deficient practice directly connects the imposed CMP to improvement in nursing homes. This approach better serves the statutory intent rather than a punishment that does not improve quality, and is consistent with CMS regulation which supports CMP funds being used for facility improvement initiatives. This could be done through a process that brings improved efficiency and cost-savings for the agency, by not requiring the procedural task of money to be placed into escrow and then released by CMS for this approved use. (§ 488.431), assisting in achieving the Trump Administration's directives of identifying areas of unnecessary spending.

- CMPs should only be applied when facilities fail to submit plans of correction and/or achieve substantial compliance by the first revisit, which would be consistent with the current application of CMPs in other healthcare settings. CMS is able to levy a CMP on a hospital for failure to meet the requirements of public disclosure/price transparency (as found in Title 45 Subtitle A Subchapter E Part 180 Subpart C § 180.90), but only after the hospital fails to respond to their corrective action plan or make the appropriate corrections, see language below: CMS may impose a civil monetary penalty on a hospital identified as noncompliant according to § 180.70, and that fails to respond to CMS' request to submit a corrective action plan or comply with the requirements of a corrective action plan as described in § 180.80(d). Additionally, the use of Category 1 remedies such as directed in-service, directed plans of correction, and state monitoring are also tools that are available to promote prompt and effective compliance, without imposition of unnecessary financial penalties which are inconsistent with statutory intent.

- CMS should not issue CMPs for facility self-reported incidents, to encourage self-reporting and quality improvement activities.

- Setting survey timelines and eliminating delayed CMP notifications, to improve consistency and compliance by enforcing timely notifications to providers.

- Establishing a system of accountability for the CMS locations, the regional offices that are charged with serving the federal government's purpose of assuring consistent implementation of CMS programs, policy and guidance. We believe that creating a CMS Location Performance Standards System, would assist in ensuring timely CMS Location actions and more consistent application of CMPs nationwide. This would further advance the Administration's aim to eliminate regulation that is causing unnecessary burden to health care providers.

***Recommended Action*:**

We recommend CMS issue a Notice of Proposed Rulemaking with the following:

- **Apply CMPs only in cases where the facility fails to submit a plan of correction and/or achieve substantial compliance**.
    - At 42 CFR 488.408 and/or 42 CFR 488.412, CMS could revise the regulatory language to indicate that, for deficiencies not cited at an Immediate Jeopardy level, a CMP may only be levied when the facility fails to submit a plan or correction and/or come into substantial compliance as determined by the revisit. Use Category 1 remedies as first option prior to CMP. At 42 CFR 488.408, the SSA is authorized to both recommend and impose one or more Category 1 remedies. Category 1 remedies include a directed plan of correction, state monitoring and directed in-service training and are specifically designed to align with the purpose of attaining and sustaining compliance based on the circumstances of each case. This contrasts with CMPs, which are merely a penalty for noncompliance. However, Category 1 remedies are infrequently used as the first choice of remedy by SSAs. CMS could achieve similar gains to the recommendation above by clarifying in Chapter 7 of the SOM these remedies are to be used as first choice to prompt compliance.
- **Allow CMP fines to be used to correct deficient practice(s)**: This could be operationalized in any of the following ways:
    - The facility could submit a summary of how the CMP fine amount was expended to correct the deficient practice and/or improve care related to the deficient practice which upon review by CMS would account for the CMP fine being met by the facility.
    - CMS could add a category to the CMP Reinvestment Program for this purpose and provide a simple, user friendly request form that is sent with each CMP imposition notice for the facility to opt (if desired) to demonstrate funds used to correct the deficient practice and/or improve care related to the deficient practice which upon review by CMS would account for the CMP fine being met by the facility. These submissions could help inform CMS on common improvement/correction approaches by facilities that may be useful to future CMS training or resources.

- **Establish standards related to survey timeline**: At 42 CFR 488.402, CMS can issue regulation that establishes the following timelines for issuing 2567 and conducting revisits:
    - The SSA must issue the CMS form 2567 within 10 days of the survey end date. Any time beyond that, facilities are not subject to accumulating fines.
    - The SSA must conduct revisits 5 days from the point of facilities compliance date. Any point beyond that, facilities are not subject to accumulating fines.
- **Eliminate delayed CMP Notifications**: At 42 CFR 488.402, CMS can set a required timeframe of when a CMP must be issued, including: type of CMP (per diem or per instance), amount of CMP. This information would be included in the initial notification of enforcement remedies letter issued to the facility under a timeframe dependent on whether an IJ was issued: the 10th working day after the last day of survey (non-IJ) or two calendar days, one of which must be a working day, following the last date of the survey (IJ). The SSA must notify in writing the facility of the IJ findings and that the survey entity is recommending to the CMS Location that the provider agreement be terminated and that a CMP or other remedies may be imposed.
    - If the deadline (required timeframe noted above) passes, the CMP cannot be issued/is null and void.
    - At no point should a CMP be issued past the facility being in substantial compliance if they have not received notification of the CMP.
- **Establish a State Performance Standards System (SPSS) measure**: CMS should establish and publicly report an SPSS measure to measure and publicly report performance by SSA in meeting the required time frames, such as timeliness of 2567's and CMP imposition letters. This will add accountability to the SSA, which may ultimately improve performance. In addition, it will allow CMS to measure consistency across the nation and correlate that consistency to survey outcomes, compliance, and quality improvement.
- **Eliminate the Use of CMPs for Self-Reported Incidents**: Except in cases of immediate jeopardy, at 42 CFR 488.404, CMS can include regulatory language indicating that facilities who self-report incidents and upon survey have deficiencies but have made good faith effort to address/correct, should not be issued a CMP. This would be consistent with statutory intent of CMPs/remedies which is to prompt compliance as the facility has already demonstrated self-response to compliance.

CMP Enforcement Expansion

***References*:**

Part 488—Survey, Certification, And Enforcement Procedures

42 CFR Part 488, Section VIII Nursing Home Enforcement of the Proposed Rule- Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities;

Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2025.

Background:

In the FY 2025 SNF PPS, CMS inflated their enforcement authority to expand the number of Civil Monetary Penalties (CMPs) that could be imposed on LTC facilities. This expansion allowed for more per-instance CMPs to be imposed for the same survey. It also expanded CMS authority to impose multiple per-instance CMPs when there is more than one type of noncompliance within a single citation, which constitutes duplicative enforcement. Furthermore, the regulation change enables CMS or the States to impose a CMP for the number of days of past noncompliance since the last three standard surveys versus since the last standard survey, which is a significant deviation in its enforcement approach. This change paired with the chronic survey backlog that exists in multiple states, would have drastic effects on a nursing facility and their ability to continue to operate.

By rescinding this regulation, the focus can be on creating an environment where nursing homes are encouraged to make improvements rather than face disproportionate financial penalties that do not improve care.

***Justification for Rescission*:**

When CMS issued the new regulations, the agency stated that it was “expanding its ability to impose financial penalties". This is a clear indication of agency overreach when it comes to enforcement and conflicts with congressional intent. Congress has directly spoken to this precise question; it intended that nursing home enforcement actions be remedial in nature, rather than punitive. The statute explicitly describes CMPs as a tool to "remedy a skilled nursing facility's deficiencies". Accordingly, CMS is directed to limit its enforcement mechanisms (including CMPs) to the level necessary to promote compliance with the participation requirements and effect remediation. This revised CMP regulation, which allows CMPs to exceed this threshold, is both punitive and contrary to agency authority as delegated by Congress. In light of Executive Order 14219 and the President's subsequent memo regarding unlawful regulations, this regulation should be rescinded.

Additionally, there are substantial differences in CMS's application of CMPs across healthcare settings, further driving inconsistent remedial practices by the agency. For example, CMS only allows per-day CMPs to be used for hospital settings and per-instance CMPs. A per-day and a per-instance CMP may not be imposed simultaneously for the same deficiency in home health and hospice. In hospice settings, a CMP may only be imposed for the number of days of immediate jeopardy. Home health and hospice per-day CMPs start at the beginning of the last day of the survey, versus assessing back as early as the noncompliance was identified by CMS or the state. Ultimately, the CMP regulation in this final rule causes further inconsistencies across Medicare settings and intensifies the punitive nature of CMPs in nursing homes in a much more

extreme manner than CMS's use of CMPs in many other settings including hospitals, home health and hospice.

The purpose behind government oversight is to ensure the safety and wellbeing of our residents, and nursing home providers share in that purpose. However, this regulation not only exceeds statutory authority, it does nothing to create meaningful change. There is no evidence that imposing CMPs directly improves quality of care in nursing homes. Instead, CMPs divert critical resources away from necessary improvements without providing constructive support for residents or addressing root causes.

This CMP regulation goes even farther with excessive fines that run the risk of pushing nursing homes already on the financial brink to closure, uprooting vulnerable residents and dedicated staff, and putting unnecessary stress on family members to search for new care options. Moreover, expanding CMPs would also further reduce the number of nursing homes eligible to offer nursing assistant training programs that are known to help hire and develop nursing staff, thus exacerbating the profession's current workforce challenges.

By rescinding this policy, the focus can be on creating an environment where nursing homes are encouraged to make improvements rather than face disproportionate financial penalties that do not improve quality for residents.

***Recommended Action*:**

We recommend CMS issue an Interim Final Rule to rescind the changes that were made in the aforementioned rule to Part 488—Survey, Certification, And Enforcement Procedures.

Informal Dispute Resolution Process

***References*:**

42 CFR 488.331, 488.431

Background:

The regulations that govern the enforcement remedies authorized by the statute were published in the Federal Register on November 10, 1994 (59 FR 56116). Facilities that are dissatisfied with a certification of noncompliance have an informal opportunity, if they request it, to dispute cited deficiencies upon receipt of the official statement of deficiencies. For surveys conducted pursuant to section 1864 of the Act, this informal dispute resolution (IDR) process is provided by the state. The requirement for IDR is specified at § 488.331. Policy guidance in section 7212 of CMS's State Operations Manual (Pub. 100-07) (SOM) specifies the mandatory elements that

must be included in each State's IDR process. There is no specification for how long the IDR process should take to be completed.

Nursing facilities (NFs) and dually participating SNF/NFs are provided the opportunity to request and participate in an Independent IDR if CMS imposes CMPs against the facility. The requirement for Independent IDR is specified at § 488.331. Policy guidance in section 7213 of CMS's SOM specifies the mandatory elements that must be included in each State's Independent IDR process.

Current guidance in the SOM at 7212.3 and 7213.9 specify that the results of a survey should not be uploaded to the Certification and Survey Provider Enhanced Reports (CASPER) system before the resolution of the IDR or the Independent IDR. However, these instructions are not always being followed and entering the survey results before the dispute processes have been completed can negatively affect a facility's Five Star quality rating on Nursing Home Compare.

***Justification for Modification*:**

We recommend revising § 488.331(b)(1) by adding new language to specify that the IDR process shall be completed within 60 days of the facility's request to dispute the survey findings if the request by the facility is timely – this timeframe is consistent with the current Independent IDR process. In order to reduce confusion and ensure consistency between the IDR and Independent IDR processes, the same time frame for completion should be required for both processes, providing clear expectations for all parties. In the case where a CMP is imposed, facilities disputing the survey results are still required to pay the CMP and it is held in an escrow account until a final administrative decision has been made, further demonstrating the importance of clear timelines.

At § 488.331(b)(2), we recommend adding specific instructions to states explaining when survey results should be uploaded into the CASPER system. These survey results are used to calculate a facility's Five-Star quality rating on the Nursing Home Compare website and are not to be uploaded into CASPER before the resolution of the IDR or Independent IDR processes. This specification will provide consistency to the upload process and prevent survey results from being uploaded prior to completion of the dispute process. Recognizing that the public as well as other organizations use Nursing Home Compare to assist in decision-making about residing or contracting with a specific facility, this will ensure that the CMS website contains accurate survey information that includes any post-survey review through the IDR or Independent IDR process. It would also reduce the burden on states by minimizing the amount of corrections and changes to data that would need to be made if information were uploaded prematurely.

At § 488.431(a)(2), we recommend adding new language to specify that the facility must receive written notification of the results of the IDR or Independent IDR, including the rationale for the final decision. The rationale must be provided by CMS or the states depending upon who made the final determination. If the region overturns the state findings (disagreement between state and CMS location), CMS Central must review and make the final determination, if the state

overturns the independent reviewer's findings, the CMS location must make the final determination. The rationale (including basis of disagreement and any supporting documentation) must be provided to the facility and to the SSA or CMS location for when the CMS locations or CMS Central override the decision of the state or independent reviewer. Although SOM guidance instructs states and CMS to send written notification of the Independent IDR recommendation to the facility, there may be times when the state or CMS disagrees with the Independent IDR entity's recommendation, and it is not accepted as the final decision. In this case, the rationale for the disagreement must be documented by CMS or the state as part of their normal process and provided to the facility to ensure clarity in why a final decision was made that differs from the Independent IDR's recommendation. This would enhance transparency and reduce the burden on facilities as they would be made aware of the availability of this information and would not have to spend time trying to figure out the process for requesting an explanation of the final decision.

At § 488.431(a)(4)(i), we recommend adding language to clarify that, in order to be approved to conduct an Independent IDR, a component of an umbrella state agency must have a specific understanding of Medicare and Medicaid program requirements. Although this information is provided in guidance, including it in regulation will strengthen this provision. In addition, it will streamline government resources and reduce burden by decreasing the possibility of providers having to dispute the qualifications of the entity chosen to conduct the Independent IDR process and/or its recommendations.

At § 488.431(d), we recommend adding new language to specify that CMS track and publish the number of IDRs/IIDRs changed at the state and CMS location and final determinations made by CMS locations or CMS Central. We recommend adding the specified timeframe for final determinations to be made by either the CMS Location or CMS Central (as applicable to the location that overturned the original decision) as soon as practicable, but no later than 10 calendar days. The CMS Location or CMS Central will then send written notification of the final decision to the facility within 10 calendar days of determination of the final decision.

***Recommended Action*:**

We recommend CMS issue a Notice of Proposed Rulemaking to add language to the CMS enforcement regulations at § 488.331 and § 488.431 to clarify and strengthen regulations and provide more specific requirements to states and CMS regarding both the IDR process and the Independent IDR processes, as follows:

(1) specify that an IDR process must be completed within the same timeframe that is specified for the Independent IDR process (60 days);
(2) provide states with more specific instructions that survey results are not to be uploaded into CASPER before the resolution of the IDR or Independent IDR processes. We additionally request that the portion of QSO-23-05 be rescinded, which addresses this topic, as this memo initiated posting of citations that are under informal dispute on the Nursing Home Care Compare website.

(3) clarify the knowledge required by an approved independent entity; and
(4) specify that the final result of an Independent IDR (including the rationale behind the decision) must be relayed to a facility by either the state or CMS in writing;
(5) specify that the final result of an IDR (including the rationale behind the decision) must be relayed to a facility by either the state writing;
(6) specify requirements for when the region overturns a state IDR decision or when the state overturns an IIDR decision to include timeframe requirements for review of overturned decisions;
(7) specify that the state cannot impose a CMP while the state IDR or Independent IDR is pending; and
(8) specify that CMS track and publish the number of IDRs/IIDRs changed at the state level and the decision overturned at the CMS location level. Include the specified timeframe for final determinations to be made by either the CMS location or CMS Central (as applicable to the location that overturned the original decision) as soon as practicable, but no later than 10 calendar days. The CMS Location or CMS Central will then send written notification of the final decision to the facility within 10 calendar days of determination of the final decision.

HIPAA/Cybersecurity

***References*:**

RIN 0945-AA22 - HIPAA Security Rule To Strengthen the Cybersecurity of Electronic Protected Health Information at 45 CFR Part 160 and 45 CFR Part 164

Background:

In January 2025, the Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS) issued a Notice of Proposed Rulemaking (NPRM) to modify the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Rule. The stated purpose of these proposed regulation updates is as follows in the proposed rule summary:

> "The proposed modifications would revise existing standards to better protect the confidentiality, integrity, and availability of electronic protected health information (ePHI). The proposals in this NPRM would increase the cybersecurity for ePHI by revising the Security Rule to address: changes in the environment in which health care is provided; significant increases in breaches and cyberattacks; common deficiencies the Office for Civil Rights has observed in investigations into Security Rule compliance by covered entities and their business associates (collectively, ‘‘regulated entities’’); other cybersecurity guidelines, best practices, methodologies, procedures, and processes; and court decisions that affect enforcement of the Security Rule."

***Justification for Rescission*:**

As per provisions in the President's recent Executive Order "Regulatory Freeze Pending Review," we believe that this proposal raises substantial questions of fact, law, and policy that warrant careful consideration to rescind. For example, this proposed rule would impose new mandates without acknowledging P.L. 116-321. This law explicitly requires HHS to consider a regulated entity's current state of adoption of recognized security practices, or digital maturity status, when enforcing the Security Rule. However, this proposed regulation fails to address or incorporate that legal requirement to scale the requirement to a provider's cybersecurity risk profile and digital maturity, directly contradicting existing statute.

In this quest to improve digital maturity of the healthcare sector, we believe that rational and realistic strategies are necessary to target defensive efforts that are scaled to the risk profile of the organizations subject to these regulations. Unfortunately, the proposed rule is extremely inefficient for both the government and the private sector. The complexity and scope of the requirements establish a burdensome compliance floor for all entities regardless of size or risk profile that would necessitate substantial investments in time, resources, and personnel to achieve compliance. The proposed compliance floor is based on existing standards established for hospitals and primary care provider networks that have received billions in financial support and interoperable standards development since the enactment of the Health Information Technology for Economic and Clinical Health (HITECH) Act over 15 years ago, while no such support has been provided to long term and post-acute care providers, including those that AHCA/NCAL represents.

Such extensive compliance activities designed for larger and higher risk hospital and healthcare systems divert attention and funds away from the highest cybersecurity risk and other critical areas, most importantly – providing high quality patient care. Imposing additional regulatory burdens on long term care organizations, particularly those with small resident populations that are located in rural and underserved locations, that already face historic workforce challenges and that are operating on razor thin margins would have an inadvertent and negative impact on these providers and the patients they serve.

The proposed rule places a substantial unfunded mandate on providers of at least $9 billion during the first year and at least $6 billion per year thereafter. For SNFs, assisted living communities, and ICFs, HHS estimates the costs are $1.04 billion in Year 1 and $694 million per year thereafter. For each establishment, this averages to $10,328 in Year 1 and $7,294 per year afterwards. We believe these HHS cost estimates are grossly underestimated. We have heard from some providers that project annual costs of this rule ranging from $250,000 to $400,000 per organization.

Despite the significant costs associated with the proposed rule, we do not believe it will result in meaningful improvements to reducing cybersecurity attacks. The proposed measures do not effectively address the evolving cybersecurity threats faced by the healthcare sector, leading to a significant expenditure of resources without commensurate benefits in terms of enhanced

security. This regulation would result in slower response times to cyber incidents and decreased overall efficiency, making healthcare providers more vulnerable to attacks, rather than more secure.

The administration should instead collaborate with impacted stakeholders to identify and propose a better approach that aligns and scales cybersecurity costs and burdens with the risk profile of the regulated entity, and that the approach includes a phased-in approach for implementation aligned with such risk profiles.

Full AHCA/NCAL comments regarding this proposed rule were submitted to regulations.gov on 3/7/2025 and can be downloaded at https://www.regulations.gov/comment/HHS-OCR-2024-0020-4575.

***Recommended Action*:**

We recommend OCR withdraw the proposed rule HIPAA Security Rule To Strengthen the Cybersecurity of Electronic Protected Health Information (RIN 0945-AA22).

Medicaid Access Rule

***References*:**

42 CFR Parts 431, 438, 441, and 447
[CMS-2442-F]
RIN 0938-AU68

Background:

On January 28, 2021, the President signed Executive Order (EO) 14009, "Strengthening Medicaid and Affordable Care Act". On April 5, 2022, EO 14070 "Continuing To Strengthen Americans' Access to Affordable, Quality Health Coverage" directed Agencies to review agency actions. As a result, effective July 9, 2024, CMS authorized this final rule, dubbed the “Medicaid Access Rule” to help States strengthen Medicaid and improve access to and quality of care provided.

The rule included a provision that states generally ensure a minimum of 80 percent of Medicaid payments for homemaker, home health aide, and personal care services be spent on compensation for direct care workers furnishing these services, as opposed to administrative overhead or profit.

***Justification for Rescission*:**

The objectives outlined within HCBS Access Rule including payment adequacy, quality measures and reporting, will only limit access to service and supports for HCBS waiver recipients in Assisted Living (AL) or ID/DD settings across the country for several reasons, including how HCBS waivers in these settings are categorized, what services are covered, and how services are paid for/reimbursed.

First, this rule is an unfunded mandate, as there are no federal funds to assist with implementation. Without funding, access to services may have an adverse effect because providers may not be able to afford to continue to provide services. Capacity may be a significant constraint, as states must allocate already limited resources (e.g., personnel and funding) to effectively carry out the requirements within tight timelines. The rule also requires an electronic management system to be put in place with no additional reimbursement to create those systems. NCAL supports quality improvement efforts, but adequate funding is needed for these efforts, and ultimately, none is offered or proposed.

Second, while we intimately understand the workforce shortage issues and agree that adequate, competitive wages can help with staff recruitment and retention, there is no one size fits all percentage across states that will successfully fulfill wage adequacy. It is especially concerning that CMS is mandating a pre-set percentage of Medicaid reimbursement to direct caregivers' compensation without an evaluation of the adequacy of HCBS waiver rates in all 50 States and the District of Columbia. Reimbursement methodologies are different in each state, but HCBS Waiver reimbursement rates in many states are well below the cost of care and services. Prior to this rule, NCAL has heard from many providers that they are already at risk of unenrolling from their state HCBS waiver program due to insufficient reimbursement. As the rule rolls out, we believe more providers will unenroll, leaving an even larger gap in access to affordable services.

Additionally, low reimbursement rates impair HCBS providers from having sufficient funds to cover the cost of all other covered services for the residents, additional employee benefits, administrative and non-administrative operational expenses. For example, with the remaining 20 percent, an employer would need to cover employee health insurance, paid time off, and general management, among their other operational expenses. Moreover, because the Medicaid Access Rule only covers three fee-for-service (FFS) areas (homemaker, home health aide services, and personal care services), it is unclear how payment adequacy can be achieved when some providers often provide more services than the ones outlined, and those services may be billed separately because they are included in a bundled rate.

Furthermore, elements of the Medicaid Access Rule are duplicative, including the grievance process and critical incident reporting requirements, which are often already requirements within state licensing regulations.

Lastly, when it comes to quality measures and reporting, there is no flexibility in finding quality measures that are most appropriate for each state and the HCBS populations they serve. It is important to ensure that there is no duplication if states are already collecting data or have something similar in place. NCAL recommends not setting national performance targets as this

deters from allowing states the flexibility to make informed determinations about the quality measures collected and reported.

***Recommended Action*:**

We recommend CMS issue a Notice of Proposed Rulemaking to rescind Medicaid Program; Ensuring Access to Medicaid Services Rule.

Medicaid HCBS Settings Rule

***References*:**

42 CFR Parts:
§441.301
§441.530
§ 441.710
RIN 0938-AO53; 0928-AP61

Background:

In 2014, CMS issued the "Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers" commonly referred to as the Home and Community-Based Settings (HCBS) Settings Rule. The rule requires that every state ensure that services delivered to seniors and people with disabilities living in the community, outside of institutions, meet minimum standards for integration, access to community life, choice, autonomy, and other consumer protections. It dictates that settings must be integrated into the broader community, allowing individuals full access to community resources and opportunities.

Within the HCBS Settings Rule, CMS has provided guidance that some settings, called "presumptively institutional settings," may have institutional characteristics. If these settings wish to receive Medicaid HCBS funding, they must prove that they can overcome that presumption and actually meet all of the requirements of the Rule. This process is called "heightened scrutiny." Heightened scrutiny is how the federal government makes sure Medicaid HCBS funds only go to settings that are truly community-based, and not to institutional settings (which are funded under a different Medicaid program). If a state reviews a setting that is presumptively institutional and believes it overcomes the presumption and actually meets each of the Rule's requirements for a HCBS setting, the state can submit evidence to CMS. CMS then must decide if it agrees with the state. CMS and the state both have to agree that the setting passes heightened scrutiny before the setting can receive HCBS funding.

CMS has said settings are presumptively institutional if any of the following apply to them:

- They are located in buildings that are also public or private institutions;
- They are on the same grounds as, or next to, public institutions; or
- They isolate people from the broader community.

All presumptively institutional settings must be individually reviewed by the state to determine if they have institutional characteristics or if they meet each of the requirements set out in the HCBS Settings Rule.

After a state receives and considers public comment, it must submit a heightened scrutiny package to CMS. The package must contain evidence explaining why the state believes the setting has overcome the institutional presumption. CMS will randomly review a sample of settings from the state that have undergone heightened scrutiny.

CMS will then:

- Determine if, during its review, the state was thorough enough in onsite visits, interviews with people receiving supports, and reviews of person-centered plans.
- Examine remediation plans, and
- Examine summaries of public comments. CMS may also review other information when necessary.

According to CMS, the evidence submitted for review should focus on the organization's policies and procedures that support community integration and support of individual person-centered service plans.

***Justification for Rescission*:**

Written reports in a heightened scrutiny evidence package cannot sufficiently convey residents' experiences receiving services in their assisted living home. It is the role of states to administer their Medicaid programs, and they are best positioned to conduct the necessary in-depth review, including site visits, to adequately assess a setting.

Additionally, many due process questions remain about the heightened scrutiny process, including the timeline, appeal rights, right to supplement the file, and right to request a site visit; there is no evidence that demonstrates that when a home and community-based setting is co-located on the same campus as an institutional setting that the HCBS community is institutional.

This language is too restrictive and can easily eliminate many important resident-centered options for seniors and people with disabilities. In essence, it says that certain settings are guilty of being institutional before being proven innocent. Thus, it prejudges settings including assisted living units in continuing care retirement communities, Alzheimer's care facilities, and multi-level campuses. Such a presumption increases the risk of disqualification from the Medicaid program and deters investment in residential care facilities willing to serve Medicaid beneficiaries, which already are in short supply in most states.

Furthermore, since the HCBS Settings Rule was finalized in March 2023, after many years of delay, CMS is behind in keeping up with the volume of heightened scrutiny reviews that must take place on a regular basis. AHCA/NCAL has heard of settings waiting up five years for their final approval.

***Recommended Action*:**

We recommend CMS issue a Final Rule to rescind the following parts of 42 CFR:

- Part 441 - Aged, Family planning, Grant programs-health, Infants and children, Medicaid, Penalties, Reporting and recordkeeping requirements.
    - §441.301 - Contents of request for a waiver (b)(4)(vi)(F)(5)(v)
    - §441.530 - Duration, extension, and amendment of a waiver (a)(1)(vi)(F)(2)(v)
    - §441.710 - § 441.710 State plan home and community-based services under section 1915(i)(1) of the Act (a)(1)(vi)(F)(2)(v)

Surveying Intermediate Care Facilities

***References*:**

42 CFR 442.109

Background:

There are over 5,300 intellectual or developmental disabilities (ID/DD) residences, or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) serving more than 56,000 residents. ICFs serve residents of all ages, with over 75 percent being between the ages of 22 and 65. Many of these individuals are non-ambulatory, have seizure disorders, behavior problems, mental illness, visual or hearing impairments, or a combination of the above.

ICFs provide active treatment and services for people with significant support needs. They offer 24-hour supervision, health care, therapies, activities, and training intended to maximize residents' autonomy and independence. Virtually all funding for ID/DD residents is under Medicaid benefits.

Current federal regulations require that the State Survey Agency (SSA) must conduct a survey of each ICF/IID not later than 15 months after the last day of the previous survey. Meanwhile, hospitals, home health, and hospice settings follow a three-year survey cycle.

***Justification for Modification*:**

ICFs consistently meeting compliance and quality standards should not be subjected to frequent surveys due to ongoing demonstrated compliance. Therefore, we are proposing a change to how often ICFs are surveyed based on performance. Those ICFs that do better on survey would be surveyed less often and others would be monitored more closely. The aim is to optimize resource allocation, reduce the administrative burden on good-performing facilities, and align with CMS's and SSA's capacity while maintaining the quality and safety of resident care.

This would bring ICFs more in line with the three-year survey cycle available for hospitals, home health, and hospice settings. Extending the interval rewards these facilities and encourages sustained, high performance. Additionally, it may help states who struggle to meet the timelines to do so for underperforming facilities that need extra attention.

***Recommended Action*:**

We recommend CMS issue a Notice of Proposed Rulemaking to adjust 42 CFR 442.109 to modify survey frequency to once every 36 months consistent with other healthcare settings.