OHCA Response to CMS Deregulatory RFI
June 10, 2025

Skilled nursing facilities

1. Proposal: Rescind Biden Administration rule expanding civil monetary penalties (CMPs) on SNFs that exceed the statutory framework.

   Regulatory reference: FY 2025 SNF payment rule, August 6, 2024 (CMS)

   Rationale: CMS implemented the statutory instruction to implement CMPs for survey citations many years ago. Late in the Biden Administration, CMS used the annual Medicare payment rule for SNFs to expand CMPs in several ways, increasing these regulatory penalties beyond the previous, statutorily-based levels.

2. Proposal: Rescind Biden Administration rule and related subregulatory guidance on ownership/additional disclosable party disclosure by SNFs.

   Regulatory reference: Final reporting rule, November 23, 2023, and subregulatory guidance (CMS)

   Rationale: This Biden Administration rule and subregulatory guidance that elaborates on the rule's requirements place enormous new reporting burdens on SNFs and additional processing responsibilities on the Medicare administrative contractors that review Medicare revalidation applications. The rule implemented provisions from the Affordable Care Act that were unused throughout the remainder of the Obama Administration and the first Trump Administration. Both the rule and subregulatory guidance should be rescinded while the statute is reviewed for potential repeal or amendment.

3. Proposal: Put in place specific reforms to the public-facing 5-Star Quality Rating System (5-Star) to make it more accurately reflect SNFs' quality performance. These reforms should include eliminating the red hand icon, basing overall star rating primarily on quality measures (QMs) instead of surveys, utilizing only the last 2 survey cycles, and eliminating forced distribution of ratings.

   Regulatory reference: 5-Star technical users' guide (CMS)

   Rationale: 5-Star's original purpose was to give consumers actionable information about SNFs to assist them in the selection process. It is the key feature of CMS's Care Compare website. Over the years, 5-Star has accrued other uses such as constructing managed care networks and establishing metrics for reimbursement. For 5-Star to achieve these goals, it must be as accurate as possible within the limitations of its data sources. Some

of the policy choices CMS made when they constructed 5-Star were based more on philosophy than giving the most accurate representation of each facility's performance. Those choices should be reversed through revisions to subregulatory guidance.

The red hand icon denoting an abuse citation is excessively frightening to 5-Star users and includes citations that did not involve actual abuse and situations where the SNF did everything it was required to do and abuse occurred anyway. CMS's QMs (which measure the most important outcomes of SNF care) should be used as the first building block of 5-Star instead of survey results – data instead of opinions. Survey results are inconsistent across and even within states. The QMs are based on data from the minimum data set (MDS) assessment, which is the same everywhere. The choice to use three survey cycles was a mistake that should be reversed. Three survey cycles could encompass 6-8 years, with the oldest survey not being an accurate depiction of the SNF's performance at present. Worst of all is the forced distribution CMS chose, which arbitrarily rates twice as many facilities as one-star vs. five-star, no matter how they actually performed. The forced distribution is an artifact of using survey as the driving factor. QMs are graded against fixed standards, not comparison with other facilities. The goal should be for all buildings to improve over time. Fixe goalposts provide a better incentive.

4. Proposal: Revise the requirements for the SNF Payroll-Based Journal (PBJ) to allow a correction period for PBJ data and count all time worked.

   Regulatory reference: PBJ policy manual (CMS)

   Rationale: CMS developed the PBJ system to obtain data measuring staffing levels in SNFs. All SNFs in the country must report PBJ data quarterly to CMS. The data are used for a variety of purposes, most notably to determine the staffing star in 5-Star and to inform surveyors inspecting SNFs about staffing levels. PBJ has two major flaws that distort the data and can result in significant negative consequences for SNFs. First, there is no period for correcting errors or omissions in reported data. Other data submission requirements typically allow a correction period. Second, CMS mandates that SNFs underreport actual hours worked by limiting salaried employees to 40 hours and requiring deduction of a 30-minute meal period whether taken or not. These two flaws should be corrected through revisions to the subregulatory guidance.

5. Proposal: Implement risk-based surveys nationwide and expand participation criteria to include 25% of the SNFs in each state.

   Regulatory reference: CMS website reference to risk-based surveys (April 2024, update) (CMS)

   Rationale: CMS tested risk-based surveys in 2024. This concept seeks to align the length and intensity of annual surveys with a SNF's performance on a variety of (unpublished)

metrics. Risk-based surveys offer great promise for conserving federal and states resources while still meeting statutory requirements for survey frequency and content. By all accounts, the pilot was a success, as the risk-based surveys identified deficiencies when they existed but took much less time and personnel. While an argument could be made that extending risk-based surveys to all facilities would improve government efficiency, implementing the program across the country and expanding the qualifying buildings to 25% instead of 10% in the pilot program would be a big help. This burden-relieving approach should be added to the subregulatory guidance on surveys.

6. Proposal: Rescind Biden Administration changes to State Operations Manual Appendix PP.

   Regulatory reference: QSO-25-14-NH (CMS)

   Rationale: This late Biden Administration publication exceeds long-standing guidance on many aspects of the Medicare/Medicaid requirements of participation (ROPs) for SNFs, adding more requirements even though the text of the rules hasn't changed. The revision should be rescinded in its entirety.

7. Proposal: Clarify that the requirement for written notice of discharge from a SNF to ensure does not apply if the discharge is voluntary on the part of the resident.

   Regulatory reference: 42 CFR 483.15(c)(3) (CMS)

   Rationale: Recent changes to State Operations Manual Appendix PP removed language distinguishing between resident-initiated and facility-initiated discharges and specifying that the requirements for notifying residents and the state ombudsman did not apply to resident-initiated discharges. This change to the subregulatory guidance increases useless paperwork and opens facilities up to citations. However, the revised guidance conforms to the current regulatory text, which does not distinguish between voluntary and involuntary discharges. The rule should be revised to limit the notice requirements to involuntary discharges.

8. Proposal: Replace the strict liability concept for certain deficiency citations where it appears in the ROPs and replace it with a non-compliance standard.

   Regulatory reference: 42 CFR chapter 483, most importantly 42 CFR 483.12 (CMS)

   Rationale: No other provider type regulated by CMS has a strict liability standard for citations (because a bad thing happened). Instead, they are governed by a non-compliance standard (the provider did not do something specific required by the regulations). Strict liability results in SNFs being cited and subjected to penalties when they did everything the regulations require, but something bad happened anyway. Revise 42 CFR 483.12 and analogous regulatory provisions to specify that a SNF should

not be cited because abuse, neglect, misappropriation, or another negative outcome occurs if the facility has complied with the numerous specific requirements for preventing and responding to the negative outcome.

9. Proposal: Remove provisions categorizing citations for paperwork violations such as failure to report or not having required policies as abuse, neglect, or misappropriation if the violation did not lead to an actual negative outcome.

   Regulatory reference: State Operations Manual Appendix PP, particularly F600 et seq. (CMS)

   Rationale: CMS lists buildings as having abuse citations when no abuse has occurred, which is damaging to the provider and misleading to the public. The other tags should be characterized as what they are: reporting, policies, etc.

10. Proposal: Revise guidance to stop classifying SNF self-reported incidents (SRIs) as complaints.

    Regulatory reference: State Operations Manual Chapter 7 (CMS)

    Rationale: The ROPs require SNFs to report allegations or suspicions of abuse, neglect, or misappropriation to the state survey agency (SA), as well as the results of the facility's investigation. These SRIs are denominated and handled as complaints even though they are not complaints. This incorrect designation vastly inflates reported data on complaints against SNFs and costs SAs and providers the time and expense of surveys on SRIs that SNFs are required to investigate themselves.

11. Proposal: Remove requirement to investigate complaints against SNFs that are frivolous or repetitive.

    Regulatory reference: State Operations Manual Chapter 7 (CMS)

    Rationale: CMS guidance calls for SAs to investigate all complaints against SNFs and to triage them in terms of severity of the allegations. The triage process determines when the investigation will take place, not whether the complaint requires investigation. As a result, SAs and providers waste resources on investigations of frivolous complaints, complaints alleging inconsequential issues, and repeated complaints where the complainant slightly changes the allegation. In the case of SAs, this time would be better spent doing annual surveys or revisits to verify correction of deficiencies. In the case of providers, this time would be better spent providing care. The subregulatory guidance should be clarified to allow SAs not to investigate these complaints.

12. Proposal: Prohibit states from having more stringent standards for special focus facilities (SFFs) than CMS does and include QMs in determining SFF status.

Regulatory reference: SFF subregulatory guidance, October 21, 2022 (CMS)

Rationale: CMS created the SFF program in 1998 to identify the poorest-performing SNFs in each state (according to survey results) and require greater scrutiny of those facilities, ultimately leading to termination from Medicare/Medicaid if they do not improve. The SFF subregulatory guidance sets timeframes for improvement or termination. Given that SFF is a federal program, CMS should revise its guidance to prevent states from interfering with the federal regulatory scheme, which happened in Ohio. In addition, the criteria for designating SNFs as SFFs should include performance on QMs as well as on surveys.

13. Proposal: Eliminate schizophrenia audits conducted by Myers and Stauffer under contract with CMS and remove the "six-month rule" from subregulatory guidance defining an appropriate schizophrenia diagnosis.

Regulatory reference: QSO-23-05-NH and Resident Assessment Manual errata sheet (CMS)

Rationale: These audits implemented by the Biden Administration, layered on top of the already-onerous survey process, are overkill. They can result in facilities receiving significant penalties for good-faith and clinically-appropriate prescriber behavior and cause certain individuals to be denied access to long-term care. The survey process is sufficient to address residents who are being harmed by inappropriate medications. The subregulatory guidance should be rescinded and the audit program stopped. In addition, the subregulatory guidance should be revised to remove the requirement for 6 months of documentation of persistent behavior issues. It is often impossible to obtain documentation that far back for individuals newly admitted to a SNF.

14. Proposal: Rescind requirement for SNFs to utilize enhanced barrier precautions.

Regulatory reference: Subregulatory guidance requiring SNFs to comply with EBP guidelines (CMS/CDC)

Rationale: Another Biden Administration initiative, the requirement for SNF personnel to wear gowns and gloves to provide care to residents with wounds or invasive medical devices, regardless of whether they have multi-drug-resistant infections, is excessive. The requirement is costly, administratively burdensome, and most importantly, negatively affects resident dignity and peace of mind.

15. Proposal: Rescind vaccination reporting requirements applicable to SNFs.

Regulatory reference: 42 CFR 483.80(g); FY 2024 SNF payment rule (August 7, 2023) (CMS/CDC)

Rationale: Originally a COVID-era requirement for SNFs to report cases and vaccination rates to the National Healthcare Safety Network (NHSN), an offshoot of CDC, the Biden Administration made it permanent and expanded it to include other respiratory infections. The ROPs never before required reporting to NHSN. The Biden Administration also made vaccination reporting part of the Quality Reporting Program (QRP), which penalizes non-compliant SNFs with a 2% Medicare rate cut. Both the ROP section and the QRP reporting requirement should be rescinded.

16. Proposal: Rescind educate-and-offer requirements for COVID-19 vaccine.

    Regulatory reference: 42 CFR 483.80(d)(3) (CMS)

    Rationale: Another holdover from COVID, the requirement for SNFs to provide periodic education to residents and employees about the COVID vaccine and offer the vaccine to them is obsolete and should be rescinded. Documenting education, offering, and responses is administratively burdensome.

17. Proposal: Rescind COVID-19 health care personnel (HCP) guidelines.

    Regulatory reference: HCP guidelines, May 8, 2023 (CDC)

    Rationale: The ROPs incorporate CDC guidelines as mandatory, and SNFs are cited for not following them. CDC has not updated the HCP guidelines to reflect current practice for two years, unlike what they did with guidance for the general public. The HCP guidelines should be repealed, making the general guidance the applicable standard for SNFs.

18. Proposal: Rescind the rule requirement for SNFs to designate an infection preventionist.

    Regulatory reference: 42 CFR 483.80(b) (CMS)

    Rationale: The ROPs require every SNF to have an effective infection control program that meets prescribed standards. SNFs are cited for deficiencies and potentially subjected to penalties if they do not follow the standards, especially if infections result from the failures. It is not necessary for the federal government to create a new role in a SNF – the infection preventionist – and dictate their qualifications, responsibilities, and work hours. It is sufficient to mandate that the SNF designate someone to be responsible for the infection control program and to judge the outcomes: whether infection control procedures are followed and infections prevented.

19. Proposal: Rescind SNF facility assessment requirement.

    Regulatory reference: Minimum staffing rule, May 10, 2024 (CMS)

Rationale: As with item 3 above, this requirement was included in the minimum staffing rule but not addressed by the court decision vacating the staffing standards. Also like item 3, this requirement should be rescinded. Facility assessments are an unnecessary administrative burden. Each SNF is required to follow a detailed administrative process to develop a plan for staffing the building. SNFs already are required to provide sufficient staffing to meet the care needs of their residents. Mandating the process that every facility must follow to determine staffing needs, complete with who must be involved and specific factors that must be considered, results in more paperwork and takes facility personnel away from providing care.

20. Proposal: Remove the requirement for a certified dietary manager (CDM).

Regulatory reference: 42 CFR 483.60(a)(2)(E) (CMS)

Rationale: This requirement is burdensome for SNFs, particularly in rural areas, as CDMs are hard to come by. CMS provided temporary relief during COVID, but that relief has expired. It should be updated and made permanent. The rule should be revised to read, "Has 2 or more years of experience working in food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving;"

21. Proposal: Remove the long-term care experience requirement to lead a nurse aide training and competency evaluation program (NATCEP).

Regulatory reference: 42 CFR 483.152(a)(5)(i) (CMS)

Rationale: The regulation requires a NATCEP course to be under the general supervision of a RN who has two years of experience, one of which must have been in long-term care. This overly prescriptive requirement makes it difficult to find primary instructors for NATCEPs, especially in career centers and community colleges, at a time when all efforts need to be directed to expanding the caregiving workforce to respond to the rapidly growing senior population. NATCEP involves training nurse aides, not nurses, and has a specific, mandated curriculum. The long-term care experience requirement should be removed from the regulation to expand the pool of potential NATCEP instructors.

"The training of nurse aides must be performed by or under the general supervision of a registered nurse who possesses a minimum of 2 years of nursing experience~~, at least 1 year of which must be in the provision of long term care facility services~~;"

22. Proposal: Delay the nursing staff turnover measure for SNF Value-Based Purchasing (VBP) until at the earliest FY 2028, utilizing date from FY 2023 and 2024.

Regulatory reference: Final SNF payment rule for FY 2024, August 7, 2023 (CMS)

Rationale: CMS adopted this measure for FY 2026 in the FY 2024 SNF payment rule. The measure looks at baseline FY 2021 and reports to FY 2022, when COVID was still having a heavy impact on SNF staffing.

23. Proposal: Amend sub-regulatory guidance on the physician certification statement for SNF care to ensure the Medicare General Information, Eligibility and Entitlement Manual is consistent with the Medicare Program Integrity Manual.

Regulatory reference: Medicare General Information, Eligibility and Entitlement Manual; Medicare Program Integrity Manual (CMS)

Rationale: Medicare denies SNF claims when the provider doesn't explicitly state that the patient needs continuation services in a SNF setting. However, there is no prescribed form or statement that CMS requires physicians to use. SNFs are supposed to be able to supplement the certification with medical records. But initial reviewers deny, we have to appeal, and then 5 years later they overturn in ALJ. It is administratively burdensome, on both sides. The Medicare Program Integrity Manual chapter 6, section 6.3 states that no specific procedures or forms are required for certification and recertification statements and the provider may adopt any method that permits verification. However, in the Medicare General Information, Eligibility and Entitlement Manual Chapter 4 CMS prescribes more specific guidance on certification statements for SNF services. This has led to confusion and erroneous denials by the MACs. CMS should update the General Information Manual to be consistent with the Program Integrity Manual.

Home health

- **Documentation Requirements for the Home Health Face-to-Face Encounter** 42 CFR 424.22(c)
  Medicare regulations are highly prescriptive regarding what constitutes a valid face-to-face encounter with a physician or non-physician practitioner. These requirements are intended to ensure that a physician has evaluated the patient for the condition requiring home health services. For example, the physician must sign and date the encounter documentation, and the encounter must occur within a specific time frame. However, sub-regulatory guidance issued by Medicare Administrative Contractors (MACs) has added excessive and inconsistent layers of

  scrutiny to this process. Claims are often denied for technical issues—such as the date not appearing on the exact "date" line or the physician's signature being deemed

illegible—even though such specifications are not included in the actual regulation. These arbitrary denials result in providers losing payment for valid, medically necessary care due to minor formatting or stylistic preferences. We recommend that sub-regulatory guidance be revised to ensure that compliance with the face-to-face requirement is based solely on the criteria explicitly stated in the regulation.

Additionally, Home health agencies frequently identify new or evolving care needs upon a patient's discharge from an inpatient facility, needs that may become the primary reason for initiating home health services. Current requirements that hospital documentation must precisely match the reason for home health services can prevent timely and appropriate care from being provided. We recommend allowing a waiver of the face-to-face documentation requirement in cases where patients are discharged directly from an inpatient stay to home health care, and where the primary reason for home health services emerges post-discharge. This flexibility would better reflect the real-world care trajectory of patients and support continuity of care.

- **All payer OASIS reporting requirement** 42 CFR 484.285
  The requirement to collect data on all patients, regardless of payer source, is set to take effect on July 1, 2025. However, CMS has not provided additional funding to support the increased administrative burden on home health agencies, particularly the added staff hours needed to complete these assessments. Additionally, the clinical profiles of patients covered by commercial payers often differ significantly from those of the Medicare population. Including this data without appropriate contextualization risks producing skewed or misleading results.

- **Social Determinants of Health for the Home Health Quality Reporting Program (HHQRP)** 42 CFR 484.245
  This newly introduced measure under the Home Health Quality Reporting Program (HHQRP) presents additional challenges for agency providers. Issues include the lack of consistent standards, mismatched coding requirements, and the need to screen patients for health-related social needs rather than clinical indicators. Furthermore, the measure is duplicative of the comprehensive assessment already mandated by the Home Health Conditions of Participation. We recommend that this requirement is removed.

- **COVID-19 vaccination reporting for the HHQRP** 42 CFR 484.245
  The COVID-19 vaccination reporting requirements under the Quality Reporting Program (QRP), while well-intentioned in promoting transparency, impose significant burdens on already short-staffed healthcare providers. These mandates divert critical staff time and resources away from direct patient care at a time when the workforce is already under

extreme strain. We urge reconsideration of this requirement or the implementation of streamlined reporting mechanisms to reduce administrative burden and allow providers to focus on delivering high-
quality care.

- **Admission to service policy:** 42 CFR 484.105 (i)

  The 2025 Medicare admission-to-service policy seeks to standardize how home health providers accept patients and communicate their services, with the goal of reducing access barriers. However, this policy largely codifies practices that are already in place and does little to address the underlying issue: limited provider capacity driven by persistent staffing shortages. Without meaningful strategies to support workforce recruitment and retention, standardizing admission processes will have minimal impact on improving access to care. We recommend that CMS pair any procedural changes with targeted efforts to strengthen the home health workforce.

Hospice

- **Hospice certifying physician enrollment requirement** 42 CFR § 424.507(b)
  - Requiring hospice physicians to be enrolled or opted-out imposes administrative burdens, risks delays in patient care, and may reduce the already limited pool of available physicians, particularly in rural areas, ultimately threatening timely and effective hospice services. In the initial roll-out period, providers experienced delays in payment and non-payment due to the confusion and ineffectiveness of the Medicare Administrative Contractors in implementing this policy.

- **Hospice Outcome and Patient Evaluation (HOPE) Tool Implementation**
  - The Hospice Quality Reporting Program is set to expand on October 1, 2025, to include data submission from the new Hospice Outcome & Patient Evaluation (HOPE) instrument, which will replace the current Hospice Item Set (HIS). At the same time, CMS will require hospices to adopt the new iQIES system for assessment submissions. The simultaneous implementation of these two new processes poses a significant risk of technical issues and errors for providers. We recommend that CMS waive timeliness submission requirements for at least the first quarter following implementation, allowing providers sufficient time to adapt to the new system and requirements.