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200 Independence Ave., S.W.
Washington, D.C. 20201

**Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities
MCS-3260-P**

Submitted electronically: <http://www.regulations.gov>

Dear Acting Administrator Slavitt:

Community Catalyst respectfully submits the following comments to the Centers for Medicare & Medicaid Services (CMS) in response to the proposed regulations updating requirements for long-term care facilities.

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1997, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers, and foundations, providing leadership and support to change the health care system so it serves everyone – especially vulnerable members of society.

Our comments are informed by our work over nearly two decades to ensure consumers get quality affordable care has focused on vulnerable populations, including those residing in nursing facilities. We have also worked with advocates in states across the country to promote improvements in nursing facility policies as part of our initiative to protect consumer interests in the financial alignment demonstrations for dually eligible consumers and in Medicaid managed care overall.

Given the significant changes in nursing facilities since the last comprehensive update in these regulations, we applaud CMS for making great strides to bring these rules into sync with current practice and policy on person-centered care. We believe these regulations will enhance residents' quality of care and quality of life. We support the increased focus on resident choice and preferences; enhancements to the care planning process, including the greater emphasis on resident participation; cultural competency; strengthening of residents' rights; and new requirements for increased staff training.

We believe there are a number of areas where the regulations should be strengthened further to ensure nursing facilities provide the quality of care that we all want for our loved ones.

Below are our specific comments and recommendations:

Resident rights -- §483.10, 483.11, 483.15

Family and resident groups §493.10(e) (4) and §483.11(c) (3)

Recommendation: Require facilities to create and support these groups, while ensuring they operate independently.

A critical component of exercising one's right to self-determination is the opportunity to meaningfully engage with others to support each other and work together to improve the care community in which they reside or their family member resides. That opportunity can be further enhanced by requiring each facility to form and support a family group and a resident group. These groups provide social support as well as valuable input to the facility to improve quality of care and resident/family satisfaction. Integrated health care delivery systems, such as the managed care plans serving Medicare-Medicaid beneficiaries under the CMS Financial Alignment Initiative, are required to meaningfully engage beneficiaries through the formation of consumer advisory committees, which often include family members. Similar requirements should apply to nursing facilities.

While it may be necessary for a designated staff person to assist the family or resident group with logistics and to facilitate communications between the group and facility administrator, the staff person should not interfere with or in any way influence the actions of the family or resident group. For the family or resident group to work as it should, as a vehicle for mutual support and the exchange of ideas on how to improve life in the facility, the group must be allowed to function independently from the facility, and its members must feel safe to be open and honest without fear of repercussion.

Visitation §483.10(e)(3); §483.11(d)(1)

Recommendation: Visitation should not be restricted for clinical or safety reasons

We strongly support the visitation rights provision and agree with CMS that being able to receive visitors of the resident's choosing, at the time of the resident's choosing, is an essential element of self-determination. Since the facility is the resident's home, residents should have the same 24 hour access to visitors as those of us who live in the community. However, the proposed changes would allow the facility to create written policies restricting resident access to visitors for clinical or safety reasons. Such restrictions are not consistent with federal law. We recommend that these restrictions be eliminated.

Access to Records §483.10(f)(3)

Recommendation: Access should not be limited

The proposed regulations would weaken residents' rights to access their records. Current requirements give residents access to all their records. The new rule would change "all records" to "medical records," giving residents access to less information than before. This is a step in the wrong direction. Moreover, the proposed "cost-based fee" for the provision of copies that includes labor could easily become prohibitively expensive, further limiting a resident's right to their records. We recommend restoring the current rule language of "all records" and eliminating any fees for labor costs.

Protection during transfers/discharges § 483.15(b)(3)(i)

Recommendation: Automatically send the Ombudsman Program copies of notices of proposed transfer/discharge

We support the proposed provision requiring copies of transfer/discharge notices be sent to the Long-Term Care Ombudsman Program. However, we ask CMS to delete the language requiring resident consent since it seems an inherent conflict to have facility staff ask residents if they want a notice sent to the ombudsman in order to challenge the facility's decision.

Assessment and care planning -- §483.20, §483.21

Expanded assessment §483.20(b)(1)

We are pleased that a facility would be required to assess a resident's strengths, goals, life history and personal and cultural preferences since this would help staff know more about the resident as a person and devise a more person-centered care plan. As previously required, direct care staff must be consulted. These employees often know a great deal about the resident, his or her well-being, needs and preferences, and can supplement information provided by the resident.

Recommendation: We recommend that the regulations define direct care staff to provide more clarity, with special mention of nurse aides. An added benefit of inclusion of nurse aides would be to increase staff retention, which resource has shown is improved when aides are included in the care planning process. Residents benefit greatly from reduced staff turnover.¹

Baseline care plan §483.21(a)(1)(i)

We strongly support requiring the facility to develop a baseline care plan for each resident within 48 hours of admission. Staff members need to have relevant information about the resident and instructions for care immediately upon admission in order to support the resident in an individualized and person-centered manner and prevent decline and injury.

Recommendation: CMS should also require the facility to obtain information about the resident's customary routines and preferences, as well as medication orders.

Expanded Interdisciplinary Team §483.21(b)(2)(ii)

We commend CMS for proposing that the interdisciplinary team include a nurse aide with responsibility for the resident, a member of the food and nutrition services staff and a social worker. It is important that these staff members be full members of the team and not tokens.

Recommendation: We urge CMS to also mandate the participation of a pharmacist if a resident is prescribed psychotropic drugs.

Resident Involvement in Care Planning Process §483.21(b)((2)(ii))(F)

Including the resident and the resident's representative(s) in care planning is essential. We support the proposed requirement that the facility provide an explanation if staff decide such participation is not practicable.

Recommendation: We urge CMS to require that the facility facilitate and promote resident and resident representative involvement. Facilitation would entail advance written notice of the date and time of the care plan meeting and reasonable accommodation of the schedules of the resident, resident representative or others invited at the resident's request. The facility should also arrange for conference calls or electronic tools for video conferencing if necessary to permit participation.

Discharge Planning §483.21(c)

We applaud CMS for including comprehensive and meaningful requirements for discharge planning and for requiring that the comprehensive care plan describe residents' preferences and potential for future discharge. For too long, facilities have not sufficiently involved residents and their representatives in

discharge planning, and residents have left the facility with inadequate preparation and too little information for the receiving providers.

Recommendations:

- We urge CMS to require the facility to ensure the resident has received full and accurate information about community options, including the services and financial benefits available to individuals in those settings.
- As part of discharge planning, we recommend the facility assess the capacity, capability and willingness of a caregiver/support person to perform required care and offer referrals to community supports for caregivers.

Staffing, nursing services -- §483.35

We are very concerned with the “competency-based” approach that CMS is proposing to ensure adequate staffing in nursing facilities. Despite the extensive research tying quality of facility care with staffing, many facilities are still poorly staffed, leaving residents at risk of harm, or suffering harm. The proposed language of “sufficient nursing staff” with “competencies” based on a facility assessment does not adequately protect residents when nursing homes owned by corporations or private equity firms are incentivized in many ways to reduce staffing to dangerously low levels. CMS’s own report, “Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes,” and several other studies support minimum staffing requirements.

CMS asked for comment on whether to require a registered nurse in each facility 24 hours a day, up from the current 8 hours. Three Institute of Medicine studiesⁱⁱ have recommended that at least one RN be on duty at all times. Twenty-four hour RN coverage is essential because:

- The acuity level of nursing home residents has increased dramatically since the federal Nursing Home Reform law was passed.ⁱⁱⁱ Expert nursing skills are required to anticipate, identify and respond to changes in condition, ensure appropriate rehabilitation, and maximize the chances for a safe and timely discharge home.
- A resident’s condition can destabilize or deteriorate at any time. When that occurs, the individual must be immediately assessed and a determination made about whether the resident needs to go to the hospital for treatment or whether he or she can be properly cared for in the nursing home. Because physicians do not have to be on-site, registered nurses are often the only medical personnel in a nursing home with the education and licensure to conduct the assessment required for diagnosis and treatment.
- Higher RN levels result in lower antipsychotic use, fewer pressure ulcers, less restraint use and cognitive decline,^{iv} and fewer unnecessary hospitalizations.^v

Recommendations:

- We urge CMS to take another look at the staffing issue, particularly the link between staffing and quality and the failure of so many facilities to have adequate staffing. We recommend the regulations establish a floor for nurse and nurse aide staffing that is linked to the facility’s resident count and case mix. If CMS does decide to proceed with this “sufficiency” approach, we urge

CMS to carefully monitor outcomes following implementation of the new policy and make course corrections as needed to protect residents.

- We recommend CMS require 24-hour RN staffing.

Behavioral health -- §483.40, §483.45 and §483.95

We appreciate the inclusion of a specific section on behavioral health, since this is a growing issue for residents of nursing facilities. We believe this section should be expanded to address additional concerns.

Recommendations:

We urge CMS to:

- Add more specificity to these sections, spelling out that the facility must provide services for substance use disorders as well as mental illness and dementia.
- Require that all staff receive training in working with residents with these conditions, rather than leaving this to be determined by the facility's own assessment. Residents may develop these conditions at any point in their stay and staff must be prepared to address these immediately and effectively.
- Include standards for dementia care in the regulations. The quality of care for persons with dementia is often poor. Too often, residents who have dementia are chemically restrained, deprived of needed care and treated without dignity. To improve the quality of dementia care, we strongly recommend that CMS codify key provisions of CMS S&C Letter 13-35-NH on Dementia Care in Nursing Homes that it published on May 24, 2013.
- Include stronger provisions to address pervasive use of psychotropic drugs as chemical restraints. Specifically, we recommend CMS establish a presumption that chemical restraint is harmful to residents, require written informed consent before use of psychotropic drugs, require physicians to examine residents before prescribing antipsychotic drugs and justify that the potential benefits clearly outweigh the potential harmful effects, and require consultant pharmacists to be free of conflicts that compromise their independence.

Arbitration -- §483.70

CMS asked for comments on "whether agreements for binding arbitration should be prohibited." Our answer is "yes."

Recommendation: We recommend that agreements for arbitration not be allowed during admission or at any time prior to a dispute arising.

It is unfair for nursing facilities to bind residents to arbitration at the time of admission. As a practical matter, residents (or resident representatives) sign arbitration agreements at admission not because they think arbitration is a good choice, but because they are routinely signing everything put in front of them. Unlike other types of pre-dispute arbitration agreements, which may cover a single transaction or a specific type of dispute, arbitration agreements in nursing facilities cover every single aspect of a resident's life, and may apply through weeks, months or years that the resident lives in the facility.

Furthermore, the arbitration process tends to be slanted against consumers such as nursing facility residents. Arbitration companies have a financial incentive to side with the nursing facilities who are responsible for sending them cases on an ongoing basis.

Quality assurance and performance improvement -- §483.75

We strongly support the requirement that each facility develop, implement, and maintain an effective, comprehensive, data-driven Quality Assurance and Performance Improvement (QAPI) program as required under section 6102 of the Affordable Care Act. The QAPI program would require the facility to evaluate clinical care, quality of life, resident choice, resident autonomy, resident and family input, and other person-centered metrics. However, we are concerned that the regulations are not explicit about how the facility would collect that data. Without requiring the facility to have a family or resident group and without the requirement of other consumer engagement strategies, such as surveys and focus groups, some of these metrics may be difficult to obtain. In addition, we believe CMS is missing an opportunity to address racial and ethnic disparities in care by not explicitly requiring a focus on these problems through the QAPI.

Recommendations:

- The regulations should require multiple consumer engagement strategies to collect resident input be used in setting and achieving QAPI goals.
- Data collected should be stratified by race, ethnicity, primary language, gender identify and sexual orientation to enable identification of disparities. In addition, QAPI programs should prioritize strategies to reduce disparities.
- We strongly urge CMS to require that at least one resident and/or family member, such as the resident council president, participate on the Quality Assessment and Assurance committee that is charged with developing and implementing the QAPI program.

The regulations, while requiring QAPI, are silent as to the potential use of QAPI outcomes to drive how states pay facilities for quality and value rather than per resident day. It is assumed that a robust QAPI program will improve quality of care and resident outcomes and reduce costs associated with deteriorating conditions and adverse events. While this should be enough of an incentive, facilities may need more. We agree with the recommendations in [Evaluation of the Nursing Home Value-Based Purchasing Demonstration](#) and urge CMS to work with more states to pay for quality and value in facilities.

Recommendation: We urge CMS to require states to use rate incentives to promote paying for quality. In this context, we would like to see CMS and states focus on specific outcomes such as reduction in preventable hospital admissions, ER visits, adverse events, and use of psychotropic medications; and increase in transitions back into the community using home and community based services. We also urge utilization of patient reported outcomes measures (PROMs), which can support understanding of how residents do over time and assess care performance. Focusing on PROMs can help reduce costs while maintaining or even improving outcomes for residents.

Training -- §483.95

We are pleased to see that CMS proposes training requirements for all staff, contractual employees, and volunteers on a number of important topics, including communication, residents' rights, and abuse,

neglect and exploitation. Ensuring that everyone who works or volunteers in a nursing home is knowledgeable in these areas will improve both quality of care and quality of life. However, we are concerned that the minimum number of hour per year of in-service training has not been increased to reflect this expansion of training topics.

Recommendations:

- We encourage CMS to study this issue in order to determine a minimum hourly requirement. We urge CMS to consider the recommendations from the Institute of Medicine^{vi} that nurse aides receive at least 120 hours of pre-employment training.
- We urge CMS to expand these required topics to also cover the aging process, appropriate dementia care, end-of-life care, teamwork, and problem-solving.

Cultural and Linguistic Competency:

We applaud the explicit inclusion of requirements for cultural competency, including in assessment, care planning, meals, and facility assessment. This will help ensure that residents' preferences and needs are met. We also support the reiteration of requirements that facilities address residents and provide written notices and other information in a language and format they understand. We encourage CMS to consider requiring that the direct care worker for any resident be someone who speaks the same language and/or has a similar cultural background as the resident.

Thank you for this opportunity to provide comments on this proposed rule, and for keeping consumers a priority. If you have any questions regarding our comments, please contact Alice Dembner at adembner@communitycatalyst.org.

Respectfully submitted,



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ⁱ Banaszak-Holl, J., & Hines, M.A. (1996).

ⁱⁱ Institute of Medicine, 2001. Improving the quality of long term care. Washington, DC National Academy of Medicine; Institute of Medicine, 2004. Keeping patients safe: transforming the work environment of nurses. Washington, DC: National Academy of Medicine. Institute of Medicine, 1996. Nursing staff in hospitals and nursing homes: Is it adequate? Washington, DC National Academy of Medicine.

ⁱⁱⁱ Mor, V et al. Changes in the quality of nursing homes in the U.S.: A review and data update. 2009.

^{iv} Weech-Maldonado R, Meret-Hanke L, Neff MC, Mor V. 2004. Nurse staffing patterns and quality of care in nursing homes. *Health Care Manage Rev.* 2004 Apr-Jun;29(2):107-16. Konetzka, R.T., Stearns, S.C., Park, J. (2008). The Staffing-Outcomes Relationship in Nursing Homes. *Health Services Research*, 43(3):1025-104). Horn, S.D., P. Buerhaus, N. Bergstrom, and R.J. Smout. 2005. RN Staffing Time and Outcomes of Long-stay Nursing Home Residents: Pressure Ulcers and Other Adverse Outcomes Are Less Likely as RNs Spend More Time on Direct Patient Care. *American J. of Nursing*. 105 (11):58-70).

^v Decker, F.H. 2008. The Relationship of Nursing Staff to the Hospitalization of Nursing Home Residents. *Research, Nursing and Health*. 31 (3):238-51.

^{vi} IOM, 2008, "Retooling for an Aging America: Building the Health Care Workforce."

<http://iom.nationalacademies.org/en/Reports/2008/Retooling-for-an-Aging-America-Building-the-Health-Care-Workforce.aspx>