National Association of State Long-Term Care Ombudsman Programs

June 22, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, D.C. 20201

RE: COMMENTS FROM THE NATIONAL ASSOCIATION OF STATE LONG-TERM CARE OMBUDSMAN PROGRAMS ON POSSIBLE BURDEN REDUCTION IN THE LONG-TERM CARE REQUIREMENTS AND PROPOSED CHANGES TO PAYMENTS FOR THERAPY - 0938-AS96

Dear Ms. Verma:

The National Association of State Long-Term Care Ombudsman Programs (NASOP) thanks the Centers for Medicare and Medicaid Services (CMS) for the opportunity to comment on the possible burden reduction in the long-term care requirements.

NASOP opposes any modification or removal of the regulations related to the grievance process, the Quality Assurance and Performance Improvement (QAPI) process, and discharge notices to Long-Term Care Ombudsman representatives. We also oppose any changes in other areas of the Requirements of Participation that are designed to reduce burden and cost to nursing facilities.

The proposed revisions and any future potential changes with the intent of reducing burden and saving money for nursing facilities are clearly designed to benefit only one group of stakeholders – providers. This is contrary to the basic purpose of regulation – which is to protect consumers, not to make life easier for the regulated.

To eliminate unnecessary burden for both residents and providers, we urge CMS to revise 1) how it is proposing to change payment for therapy in its new reimbursement system for skilled nursing facilities and 2) to modify its policy of not counting all the time a patient spends in the hospital toward the skilled nursing facility three-day rule. CMS's position on both these issues is harmful to the many individuals who need skilled nursing facility care and services.

The proposed payment system would provide higher reimbursement for fewer types of therapy over a shorter period to time and even incentivize facilities to provide no therapy at all. Many nursing facility

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residents already have difficulty getting the full amount of therapy they require, including maintenance therapy. The revisions being suggested would not only exacerbate this problem, but create a perverse and illogical incentive to provide residents with even less or no therapy. This is totally contrary to CMS's stated goal of reducing incentives to deliver therapy based on financial considerations rather than resident needs.

We urge CMS to rethink this "pay more for less" approach which would have a devastating effect on people needing therapy and completely ignore the Jimmo v. Sebelius mandate to provide maintenance therapy.

In response to CMS's request for ideas for changes to eliminate unnecessary burdens for providers and residents, we urge CMS to use sub-regulatory guidance to clarify that any time a patient spends in the hospital counts toward satisfying the skilled nursing facility three-day rule required to qualify for Medicare coverage in a subsequent nursing facility. Currently, each year thousands of beneficiaries are unable to access their skilled nursing benefit because their hospital stay is not administratively classified as "inpatient" even if their stay lasts longer than three days. For many of these beneficiaries, this means they cannot receive the skilled nursing and therapy care they need. CMS could create this sub-regulatory guidance by issuing a Medicare Benefit Policy Manual (using its authority to define "inpatient" care authority recognized by the Second Circuit and CMS itself).

With regard to the grievance process, NASOP disagrees that maintaining evidence related to grievances for three years is burdensome, unnecessary, and costly. Any documents concerning grievances will almost certainly be electronic. If not, handwritten documents can be scanned and become electronic. CMS itself notes in the preamble that "such evidence may be maintained electronically, rather than utilizing physical storage space." 68724 Federal Register/Vol. 81, No. 192/Tuesday, October 4, 2016/Rules and Regulations). Preserving records online requires little to no effort or cost. Maintaining records can help facilities, not burden them. As CMS pointed out in the preamble, the evidence provides a record of grievance investigations and can serve as a valuable information resource for facilities. The documentation can indicate the types of problems they have had in the past, what was done to address them and if those efforts were successful. This can help nursing facilities avoid similar grievances in the future or consider different resolution strategies if previous ones were not successful. Grievance records can also assist facilities in proving that they did indeed respond to a resident concern in cases where that is called into question.

NASOP objects to giving facilities greater flexibility in how they ensure grievances are fully addressed. The duties specified in the regulation are basic and reasonable components of complaint investigation and resolution processes that anyone wanting to properly address a complaint would follow. LTC

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Ombudsmen observe facilities that do a good job of handling grievances already carrying out these responsibilities. Specifying these duties would help other facilities know what to do. Without specific duties, facilities will be very inconsistent in how they handle complaints. Residents in nursing facilities where complaints are not properly addressed may suffer because unresolved complaints can impact quality of care and quality of life.

As CMS states in the preamble, a grievance official is necessary to ensure that there is an individual who has both the responsibility and authority for ensuring, through direct action or coordination with others, that grievances are appropriately managed and resolved. Facilities have been required for years to respond to complaints, so most (if not all) likely already has a person who serves this function, if not with the specific title. The regulations do not require that this be a new, full-time hire. CMS writes, "It is not our expectation that every facility hire a new, full-time individual to perform this function, but, instead, that every facility have a designated individual to serve this function, consistent with the needs of that facility." NASOP views this function of grievance official similar to a facility's designation of an abuse coordinator. Similarly, that designation is important, but not a full-time position. If no one person serves as grievance official the responsibilities of handling concerns may fall through the cracks and complaints may be mishandled or not handled at all.

NASOP disagrees with proposed language which would allow providers to defer to state law if federal abuse and neglect reporting provisions are duplicative. It is pointless to remove federal reporting requirements since the facility must comply with them under the section on Freedom from abuse, neglect and exploitation – 483.12(c)(1). It is important to have these requirements as part of the facility's formal grievance process so residents, families, and staff are informed. These reporting provisions under the grievance process create absolutely no extra burden or cost to facilities since compliance is already required. Abuse and neglect reporting requirements that are duplicative of state law serve to reinforce the duty to report and underscore the importance of such reporting. Given how extremely vulnerable and dependent many residents are, reporting is so critical to resident safety that it cannot be overemphasized. Deferring to state law is problematic since states vary in how they define abuse, neglect and exploitation. Residents could be left vulnerable to abuse, neglect or exploitation in a federally certified nursing facility if a state has a lower bar for these definitions. Abuse must never be tolerated and maintaining duplicative language makes it possible to impose both state and federal sanctions, which serves as a greater deterrent.

With regard to Quality Assurance and Performance Improvement (QAPI) activities, NASOP has concerns about proposed revisions #1 and #2: Eliminating specific requirements regarding 1) how the program must be designed and 2) how a facility will determine underlying problems impacting systems in the facility, develop corrective actions, and monitor the effectiveness of its performance.

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QAPI is new in the nursing facility setting and most facilities do not have a great deal of experience in creating and implementing a QAPI system. Requiring specific elements helps facilities know how to proceed and better ensures that all nursing facilities develop and operate a QAPI process that is effective and useful. Requiring these elements promotes consistency between facilities so that all residents can benefit from an adequate QAPI process regardless of which facility they reside. Not specifically requiring these elements means that important components are likely not to be included in the design or feedback, monitoring or analysis processes. Examples: 1) quality of life and resident choice could be left out of program design; 2) adverse event monitoring could fail to include the specific methods by which the facility will identify, report, track, investigate, analyze and use data related to adverse events. This could impact resident quality of life and care.

In September 2015, NASOP sent CMS numerous comments on the proposed conditions of participation for skilled nursing facilities. One item that we highlighted in particular was the proposed requirement for facilities to send a copy of discharge or transfer notices to representatives of the Office of the State Long-Term Care Ombudsman. Specifically, we stated:

> NASOP sees the value of new language at 483.15(b)(3) which would require the facility to send a copy of the discharge or transfer notice to a representative of the Office of the State Long-Term Care Ombudsman (with resident consent)…We also suggest that CMS require facilities to send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman when the resident cannot provide informed consent and there is no resident representative. This is consistent with LTCOP federal rule. NASOP suggests that the new language added at 483.15(b)(5)(iv) that includes information about what needs to be in the notice, including the right to appeal the transfer or discharge to the State, how to file an appeal, be revised to state and the name, address and telephone number of the representative of the Office of the State Long-Term Care Ombudsman.
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> NASOP is supportive of new language at 483.15(c)(3)(ii) requiring a facility to notify in writing, a resident who is hospitalized or on therapeutic leave with an expectation of returning to the facility, when the facility determines that the resident cannot be readmitted to the facility, and the information provided in paragraphs (b)(5)(iv) of this section. We believe this may also reduce inappropriate discharges or transfers. NASOP recommends creating a new subsection to 483.15(b)(5)to read as follows: *"Readmission after state fair hearing. Following a discharge State fair hearing decision in favor of the resident to remain in or be readmitted to the facility, the facility must*

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> *readmit the resident in their previous room if available or immediately upon the first availability."*

In May 2017, CMS issued Survey & Certification Letter 17-27-NH, which stated:

> The regulation at 42 CFR 483.15(c)(3)(i) requires, in part, that before a facility transfers or discharges a resident, the facility must "notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand…." The facility must also "…send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman." Sending a copy of the notice to a representative of the Office of the State Long-Term Care (LTC) Ombudsman provides added protection to residents and ensures the Office of the State LTC Ombudsman is aware of facility practices and activities related to transfers and discharges.

NASOP wholeheartedly agrees with CMS's statement that sending a copy of the notice to a representative of the Office of the State LTC Ombudsman provides added protection to residents and ensures the Office of the State LTC Ombudsman is aware of facility practices and activities related to transfers and discharges. For this reason, we believe that facilities should continue to send these notices to representatives of the Office of the State LTC Ombudsman.

In your request for feedback, CMS stated that it is re-evaluating this requirement to determine if the process is achieving intended objectives to reduce inappropriate involuntary discharges. In addition, CMS is concerned as to whether State LTC Ombudsman programs have the capacity to receive and review these notices and to what extent they will use this information.

Inappropriate involuntary discharges are an ongoing and serious problem that LTC Ombudsman representatives have been investigating and working to resolve for many years. In fact, nationally, problems with discharge and eviction have been the number one complaint that State LTC Ombudsman programs handle in nursing facilities. NASOP advocated for this mandatory notice in order to assure that residents have the fastest and easiest possible access to their services when facing possible eviction.

Requiring facilities to notify the State LTC Ombudsman Program of involuntary discharges affirms CMS's stated commitment to person-centered care by improving residents' access to the services of the State LTC Ombudsman Program to assist during the discharge process. It also achieves CMS's stated goal of

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protecting residents and ensuring the Office of the State LTC Ombudsman is aware of facility practices and activities related to transfers and discharges (Survey and Certification Letter 17-27-NH).

Reducing inappropriate discharges benefits residents. Residents are able to stay in their homes, avoiding the trauma of being relocated which can result in falls, weight loss, self-care deficits, anxiety, increased confusion, apprehension, depression, loneliness, vigilance, weight change, insecurity, withdrawal, sadness, restlessness, sleep disturbance, crying, and feelings of hopelessness and helplessness. Residents receive consistent care, which improves health outcomes.

Reducing inappropriate discharges benefits facilities. Facilities gain a stable resident census since LTC Ombudsman participation often resolves the underlying root cause of the issue so discharge is not necessary. That, in turn, allows facilities to concentrate on residents they know and makes it possible for facilities to provide consistent care. Facilities experience decreased burden since frequent discharges result in substantial turnover in residents which means staff must handle the paperwork required by more admissions, more assessments, more care plans, and more consults among the departments as facilities are required to assess and implement new person-centered care plans for new resident along with the current residents.

Reducing inappropriate discharges reduces costs. When LTC Ombudsman representatives address the underlying cause of the problem, the state does not incur the cost of an appeal hearing or a State regulatory investigation. Avoiding the effects of transfer trauma, which can lead to a need for increased care and treatment, can save money for both Medicare and Medicaid. Preventing a discharge when a resident has been sent to the hospital can save Medicare thousands of dollars in cases where the hospital cannot place the resident and the resident remains in the hospital awaiting nursing facility admission.

Since the regulations have only been in effect for less than seven months, it is likely that inappropriate discharges will be further reduced as State LTC Ombudsman programs nationwide fine tune and fully implement their systems for receiving and responding to these notices. To fully achieve the intended objective, nursing facilities must comply with this requirement. State survey agencies must cite facilities for failing to send the discharge notice to residents and then take effective enforcement action.
Past experience in states where notice was already required to go to representatives of the Office of the State LTC Ombudsman shows that receiving notices reduces inappropriate discharges. Ombudsman representatives are able to contact the resident and/or resident representative and provide assistance if requested. The majority of the time, Ombudsman representatives are successful in resolving a problem or concern that has triggered the proposed discharge, thereby allowing the resident to remain in his or her home.

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State LTC Ombudsman programs can handle receiving these notices. Each state program is determining how it can best receive and respond to these notices. Even without guidance and with the rule only being in effect since November 2016, programs are receiving and responding to notices. Clarification from CMS in its Survey and Certification Letter issued on May 12, 2017 has enhanced State LTC Ombudsman programs' ability to handle notices.

LTC Ombudsman programs will use the information they receive in these notices to help individual residents, track trends, and work with providers and other stakeholders on systems changes to reduce inappropriate discharges. NASOP strongly encourages CMS to continue to require facilities to send representatives of the Office of State LTC Ombudsman these notices which help prevent inappropriate involuntary discharges, minimizes the risk of transfer trauma, and reduces costs for states and the federal government.

Sincerely,

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NASOP Advocacy Committee

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