October 14, 2015

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

Re: 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:

On behalf of CARIE, the Center for Advocacy for the Rights and Interests of the Elderly, thank you for the opportunity to provide comments regarding the Centers for Medicare & Medicaid Services’ (CMS) proposed rules for nursing facilities. Founded in 1977, CARIE, is a non-profit advocacy organization working to improve the well-being, rights and autonomy of older adults. CARIE routinely helps older adults and their caregivers understand and resolve problems related to Medicare, Medicaid, and long term services and supports. In addition, CARIE currently serves as the local ombudsman for certain areas of Philadelphia and through this capacity serves residents in nursing facilities. Through our work, we are acutely aware of the needs, issues and problems that nursing facility residents and their families encounter.

We appreciate CMS’ efforts to update the regulations to better meet the needs of nursing facility residents. Overall, CARIE has numerous concerns about the proposal including the lack of adequate staffing levels and training requirements, eliminating “quality of life” as an independent Requirement of Particiation, scattering quality of care regulations throughout the regulations, and the authorization of binding arbitration agreements. However, we are supportive of many of the provisions such as the focus on person-centered care that is found throughout the proposed rules, the requirement facilities create a baseline care plan within 48 hours, the increased focus on resident choice and preferences, more robust protections against abuse and neglect, and that residents’ rights have been strengthened in certain provisions. CARIE also fully supports the recommendations made by the Consumer Voice and the Center for Medicare Advocacy. CARIE offers the following comments and recommendations to help strengthen the proposed regulations.
Staffing and Staff Training
Multiple studies throughout the years as well as our own experience has shown that inadequate staffing and training leads to poor care and negative outcomes for residents. Insufficient staffing also leads to exorbitant and avoidable health care costs. CMS should better address staffing in the proposed rule especially if it wants to realize the improvements it identified and hopes to achieve. In short, CMS must assure adequate staffing levels by establishing nurse staffing ratios and requiring a registered nurse 24 hours a day.

CARIE supports a minimum staffing standard of 4.1 hours per resident day. Chronic understaffing is at the root of poor care. CMS’s proposed requirement, “sufficient nursing staff” with “competencies” based on a facility assessment, is not very different from the how things work now. The regulations must establish a level below which staffing cannot be cut. A minimum standard of 4.1 hours of direct care nursing per resident day is supported by many studies, including CMS’s own report, “Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes.”

CARIE supports 24-hour coverage by a registered nurse. Registered nurses often are the only medical personnel in a facility who can assess residents. Most facilities already meet this standard and others should also be required to do so for the safety of their residents since problems can arise at any time, not just during the day shift.

CARIE supports the expansion of training requirements. While we are pleased to see that CMS proposes required training on a number of important topics for all staff, contractual employees, and volunteers, we urge CMS to expand these required topics to also include the aging process, appropriate dementia care, and resident abuse prevention. We also recommend that in-service training for certified nursing assistants include end-of-life care, teamwork, and problem-solving, and that the minimum annual hours of in-service training be increased.

Freedom from Abuse, Neglect, and Exploitation
CARIE strongly supports the creation of this new section, which brings more attention and focus to abuse, neglect and exploitation. We also support the new provisions that would provide greater protections for residents.

Physician Services
CARIE opposes the proposed regulation that would require facilities to establish credentialing requirements for physicians. This proposal conflicts with a resident’s statutory right to choose a physician and, since individual facilities have neither the time nor the expertise to create meaningful credentialing standards, would do more harm than good.

CARIE also opposes the proposal to require in-person examination by a physician prior to transfer to a hospital. This requirement is impractical, because physicians are rarely onsite at nursing facilities. The requirement would make it too difficult for residents to be transferred to hospitals, leading to unnecessary medical complications and deaths.

Transitions of Care: Admission, Readmissions, Transfer/Discharge
CARIE strongly believes that CMS should explicitly prohibit pre-dispute binding arbitration agreements between nursing facilities and its residents. The nursing home admission process is
typically a chaotic and stressful time for older adults and their families. They are given multiple papers to sign and believe that they have no choice but to sign them all to ensure the consumer gets admitted. This is true whether the person is being transferred from a hospital or from home when care can no longer be provided in that setting. Residents and families are not thinking about the possibility of poor care and the ramifications of agreeing to arbitration. How could they be expected to imagine these circumstances and understand all of the ramifications when their focus is to do whatever is needed to complete the admission process? In our experience, these agreements never work well for consumers. CMS’s proposed language suggests that pre-dispute arbitration agreements are approved by CMS and this could worsen the problem, even with the proposed conditions, that already exists with facilities having consumers or their responsible parties sign these agreements without fully understanding what they mean and the permanency of the agreement even if something egregious happens years later. Since arbitration may be beneficial in some situations over formal litigation, residents should be able to use this option to help resolve problems that occur but the decision to use arbitration should be made when a situation arises. This is when true informed consent could occur. CMS should prohibit arbitration agreements from being signed before a dispute arises to ensure the quality of care and quality of life provisions described in the rule.

CARIE supports the right to appeal a denial of readmission as suggested in CMS’ discussion in the preamble that indicates residents have a right to appeal when a facility refuses readmission from a hospital or denies a bed hold. The actual regulation should be revised to make this appeal right clear. We also strongly recommend that readmission be required whether the available room is private or semi-private. Any Medicaid-certified room should be appropriate for a resident’s readmission, and the semi-private-only requirement can drastically limit residents’ ability to return from the hospital.

As a local ombudsman, we understand the importance and support the proposed provision requiring copies of transfer/discharge notices be sent to the Long-Term Care Ombudsman Program. CMS should delete language requiring resident consent, since that would give facilities an easy alternative for not notifying ombudsman programs. Ombudsman programs are “health oversight agencies” under HIPAA, so the resident’s consent is not required prior to release of information. (See Information Memorandum AOA-IM-03-01 from Feb. 4, 2003).

We oppose the proposed reduced notice of transfers/discharges. Current law says that under certain circumstances a facility “may” give reduced notice of proposed transfer/discharge. The proposed regulations change “may” to “must” that would lead to facilities to always give the most limited notice period possible. In addition, we oppose changing transfer/discharge notices after given to residents. A transfer/discharge notice should not be able to be “updated” after being given to the resident. A resident must have fair notice of the facility’s allegations and intentions. If circumstances change, or the facility’s original notice was in error, the facility should issue a new notice with the notice period required by law.

Restraints, Antipsychotic Use, Behavioral Health Services, and Dementia Care
CARIE supports the proposed requirement that facilities try alternatives to bed rails, assess residents for entrapment risks, and regularly inspect bed rail systems. We urge CMS to specify a resident’s right to be free of bed rails used as restraints, to mandate that bed rails can only be used if the resident requests them for mobility or other assistance, and to require a safety assessment by an interdisciplinary team prior to any use of bed rails. Many facilities in Pennsylvania have been
successful in safely reducing the use of bed rails so other facilities should be able to implement these protocols.

The proposed regulations should **strengthen language to prevent psychotropic drugs from being used as chemical restraints**. We recommend a framework proposed by the federal government in 1992. The final regulations should establish a presumption that chemical restraints are harmful, require written informed consent before use of psychotropic drugs, focus on misuse of antipsychotic drugs, require physicians to examine residents before prescribing antipsychotic drugs, and require that consulting pharmacists be free of conflicts that compromise their independence.

**CARIE supports the addition of the new section of behavioral health services to the proposed rules.** The mental health needs of nursing home residents are often not addressed. **Clinical social workers should be able to bill Medicare Part B for psychotherapeutic services to help meet residents’ mental and behavioral health needs.** **CMS should also provide Medicare and Medicaid reimbursement for behavioral health consultation and staff training.** Providing reimbursement for staff training around behavioral health issues and dementia care would go a long way to improving the quality of care residents receive.

Given the prevalence of residents with dementia in nursing facilities, and facilities’ often low-quality dementia care, the regulations should **establish explicit standards for dementia care**. We recommend standards based on CMS S&C Letter 13-35-NH (May 24, 2013), which instructed surveyors on evaluating dementia care.

**Care Planning**
CARIE strongly supports the proposal to require facilities to develop a baseline care plan within 48 hours. Facilities need to have enough information about a new resident to be able to provide the appropriate care as soon as the resident is admitted. This will help avoid unnecessary bad outcomes because an appropriate care plan is lacking.

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. We urge CMS to also require participation of a pharmacist, if a resident is prescribed psychotropic drugs.

**Quality of Life**
We strongly oppose combining the Quality of Care and Quality of Life sections. Contrary to CMS’ stated intent to promote person-centered care, the deletion of the Quality of Life Requirement of Participation diminishes the importance of the quality of life needs of residents.

**Resident Rights**
All resident rights should be listed in the “Resident Rights” section. Many rights are proposed to be listed under “Facility Responsibilities,” and are not listed at all under “Resident Rights” in section 483.10. Since residents, their families and others may only look to the resident rights section to learn about resident rights, the statement of resident rights must be thorough, comprehensive, and accurate.
We oppose the proposed regulation that would place restrictions on visitation to authorize facility policies restricting resident access to visitors for clinical or safety reasons. Such restrictions are not consistent with residents’ rights under federal statute. This proposal would make it too easy for a facility to create reasons as to why a visit could be harmful to a resident.

CARIE also opposes the proposal to change “all records” to “medical records,” that would limit residents from being able to access all of their information. We also oppose requiring residents inspect their records prior to purchasing copies as this would delay access. Current law appropriately allows facilities to charge no more than the community standard for copies. However, CMS’ proposed regulation instead authorizes a fee that includes labor costs among other things. This fee could be excessively expensive and create a barrier to residents receiving needed records.

Concluding Remarks
We are pleased to see that CMS incorporated “person-centered care” into many provisions of the new rule. This will provide greater opportunities for facilities to know more about the residents and allow residents to have more control and choice in their daily lives. Person-centered care should improve both quality of care and quality of life for residents.

Thank you again for the opportunity to share our comments and recommendations. CARIE hopes CMS will strengthen the final nursing home rule and that the updated regulations will bring a new era of stringent federal enforcement of the revised rules. If you have any questions, please feel free to contact me directly at menio@carie.org or 267-546-3434.

Sincerely,

Diane A. Menio
Executive Director