LTCCC LONG TERM CARE COMMUNITY COALITION
Working to improve long term care through research, education & advocacy

October 14, 2015

Andy Slavitt
Acting 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. Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities
MCS-3260-P

Submitted electronically via http://www.regulations.gov

Dear Acting Administrator Slavitt:

On behalf of the Long Term Care Community Coalition (LTCCC), I am hereby submitting comments on the proposed Requirements of Participation for long term care facilities.

LTCCC is a non-profit organization wholly dedicated to improving quality of life and quality of care for elderly and disabled individuals who rely on long term care services, particularly those who reside in nursing homes or other residential care settings. Our focus is on systemic advocacy; in furtherance of our mission we research relevant state and national laws and policies that effect the lives of long term care consumers; assess the effectiveness of oversight and accountability mechanisms; and educate state and federal policymakers and the general public on the critical issues that affect care and quality of life for people who live in assisted living and nursing homes.

General Comments & Recommendations

Systemic Change is Urgently Needed

We thank CMS for its work in these extensive revisions of the Requirements of Participation (RoPs). The 1987 Nursing Home Reform Law provides strong protections for nursing home residents in terms of both quality of care and quality of life. While we strongly believe that the existing regulations are robust and *should* be sufficient to ensure

that every resident receives the quality of care and quality of life that he or she deserves – and which, for the majority of residents, taxpayers pay for – it has become clear that changes are needed (in the implementation of these standards, if not the regulatory language itself) to realize the mandates of the Reform Law to a meaningful extent. In short, the persistence of widespread problems, many of which are serious, calls for a new, more vigorous approach to preventing abuse, neglect, inhumane conditions and the waste of public funds.

The need to move expeditiously to improve care and accountability in any and every way possible is clear. The pervasiveness and persistence of nursing home neglect and abuse – not to mention failures to provide the quality of services which the public pays for and has a right to expect - since the current regulations were promulgated are incontrovertible. Numerous US Government Accountability Office (GAO) studies have highlighted the unfortunate persistence of nursing home care problems and their under-identification by state and federal regulators.[1] The US Inspector General for DHHS, Daniel R. Levinson, has stated publicly that "[t]oo many… [nursing homes] fail to comply with federal regulations designed to prevent overmedication, giving nursing home patients antipsychotic drugs in ways that violate federal standards for unnecessary drug use…. Government, taxpayers, nursing home residents, as well as their families and caregivers should be outraged - and seek solutions."[2]

In another study, the Office of the Inspector General found that an astounding one in three Medicare beneficiaries experienced harm during their stay in a nursing home. According to the report, "[p]hysician reviewers determined that 59 percent of these adverse events and temporary harm events were clearly or likely preventable. They attributed much of the preventable harm to substandard treatment, inadequate resident monitoring, and failure or delay of necessary care."[3] Our own recent study found that states only find harm to residents 3.41% of the time that they cite a deficiency. Even in the case of pressure ulcers, a serious and costly problem, states cite nursing homes the equivalent of less than 3% of the time that a resident has a pressure ulcer. When states *do* cite a facility for inadequate

[1] Examples of relevant GAO reports over the years include: *Nursing Homes: Federal Monitoring Surveys Demonstrate Continued Understatement of Serious Care Problems and CMS Oversight Weaknesses*, GAO-08-517: (May 9, 2008); *Nursing Homes: Stronger Complaint and Enforcement Practices Needed to Better Ensure Adequate Care*, T-HEHS-99-89 {Mar 22, 1999). Publicly Released: Mar 22, 1999; *Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents*, HEHS-99-80 (Mar 22, 1999); *Increased Compliance Needed With Nursing Home Health and Sanitary Standards,* MWD-76-8: Published: Aug 18, 1975; *Nursing Homes: Many Shortcomings Exist in Efforts to Protect Residents from Abuse,* GAO-02-448T: Published: Mar 4, 2002; and *Nursing Home Oversight: Industry Examples Do Not Demonstrate That Regulatory Actions Were Unreasonable*, HEHS-99-154R (Aug 13, 1999).

[2] *Overmedication of Nursing Home Patients Troubling*, statement by Daniel R. Levinson, Inspector General, US Department of Health and Human Services (May 9, 2011).

[3] *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries*, OEI-06-11-00370 (Feb. 2014).

pressure ulcer care or prevention, they only identify this as harmful to residents about 25% of the time.[4]

In general, we appreciate and support the overall focus on person-centered care that is found throughout the proposed regulations. With meaningful enforcement, we believe this focus will enhance residents' quality of care and quality of life. There are other aspects of the proposed requirements that we support as well, including its greater focus on resident choice and preferences; more robust protections against abuse and neglect; and enhancements to the care planning process, such as a greater emphasis on resident participation. We are also pleased that residents' rights have been strengthened in certain provisions.

LTCCC has signed on in support of the comments submitted by both the National Consumer Voice for Quality Long-Term Care and the American Association For Justice. In addition, we strongly support the comments submitted by the Center for Medicare Advocacy, California Advocates for Nursing Home Reform (both CANHR's general comments and, perhaps most importantly, their separate comments on dementia care and antipsychotic drugging standards) and Justice in Aging.

Specific Comments & Recommendations

In the interest of brevity, we are limiting our comments on specific areas of the proposed requirement to those which we believe merit particular emphasis.

Arbitration

Nursing facilities should not be permitted to obtain, in any manner, arbitration agreements from residents (or their representatives) prior to a dispute arising. As a number of our colleagues (mentioned above) have written, the use of pre-dispute arbitration agreements in the nursing home context is patently unfair to consumers and, for this and other reasons, extremely poor public policy. 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 signing (in a rote manner and under difficult and stressful circumstances) everything put in front of them in order to gain admission to the facility.

In addition, 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. Also, nursing facility arbitration agreements often involve claims involving (for example) pressure sores, infections, malnutrition,

[4] Safeguarding NH Residents & Program Integrity: A National Review of State Survey Agency Performance (April 2015).

dehydration, asphyxiation, sexual assault, and death. It is unreasonable to expect residents and their representatives to make decisions regarding such catastrophic events during admission, long before the events have occurred.

We appreciate that CMS has recognized the significant negative impact of pre-dispute arbitration agreements. However, we are extremely concerned by the proposed language that attempts to establish procedural protections. As others have noted, CMS's proposed language, however well-intentioned, would make matters worse. No amount of procedural protections can change the basic power imbalance between an incoming resident (and his or her family) and the facility. Worse, if CMS's proposed language were to become law, facilities would be able to cite the regulatory language to courts as evidence that CMS approves nursing facility arbitration, and could argue that compliance with the regulation was proof that the arbitration agreement and the circumstances surrounding its signing were fair.

Care Staff

Along with many of our colleagues who are submitting comments (and many others, including residents, family members and ombudsmen with whom we work, who are unable to comment directly) we are very concerned that CMS has failed to address the greatest problem in nursing homes today —insufficient staffing. Good staffing practices are necessary for facilities to deliver quality person-centered care. They start with adequate numbers of nurses and nurse aides. Building on that foundation, good practices include competent staff, as well as systems that promote individualized care and consistent assignment.

The absence of a minimum staffing standard and a registered nurse in the facility around-the-clock can and does harm nursing home residents every day. In addition to the harm caused to residents, it results in the public not receiving the level and quality of care which it pays for through Medicare and Medicaid. 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. The proposed regulations must explicitly establish a level below which staffing cannot be cut. Without detailed, explicit staffing standards, many nursing homes have not – and will not – meet the needs of the frail elders and individuals with disabilities who reside there, nor will they comply with critical regulatory standards (either current or proposed).

As currently written, the proposed requirement calls for "sufficient nursing staff with the appropriate competencies and skills sets." This fails to address the long-standing problem that "sufficient" has not been sufficient to ensure that residents receive the care and services that they need and for which the public pays. Too often we see Statements of Deficiencies (SoDs) in which inadequate staffing is clearly a problem, yet insufficient staffing is not cited. And, even when staffing is cited, it is rarely identified as resulting in

harm to residents, even when the conditions described in the SoD are clearly harmful. Our recent study of Nursing Home Compare data indicated that the annual rate of staffing deficiencies per resident is infinitesimal – 0.042% – and that less than five percent (5%) of those deficiencies are identified as resulting in harm. Furthermore, for the three year period covered on Nursing Home Compare which we examined, 21 State Agencies never cited insufficient staffing as having resulted in harm to any nursing home resident in their states.[5]

The persistence of serious staffing problems in our nation's nursing homes, despite the longstanding requirement that they have sufficient staff to ensure that residents attain and maintain their highest practicable physical, emotional and psycho-social well-being, makes clear the need for concrete standards. We call on CMS to require that nursing homes maintain a minimum staffing level of 4.1 hours per resident day of RNs, LPNs and CNAs and require that nursing homes have an RN in the facility 24 hours per day.

Quality of Life

We urge CMS to maintain the Quality of Life provisions in their current structure, as an independent Requirement of Participation (RoP). Dispersing the Quality of Life provisions in the RoPs, as currently proposed, sends the message that they are not important and essential in and of themselves. Moreover, the significant structural changes proposed will undoubtedly result in confusion and, under the best of circumstances, a lengthy "learning curve" for surveyors and stakeholders (including providers). Our nation's nursing home residents simply cannot afford to have their ability to access a decent and dignified quality of life – already tenuous – put further at risk.

History, as well as our day-to-day experience, speak to the need to ensure that Quality of Life standards are clearly and distinctly articulated. One of the most important and valuable aspects of the Reform Law is its recognition of the importance of quality of life. In the years since its passage in 1987, both science and our society have further recognized that quality of life and quality of care go hand-in-hand, and that quality of life for all people is a critical component of one's overall well-being.

In 2009, CMS itself recognized the significant need to address quality of life practices when it issued revisions to Appendix PP, "Guidance to Surveyors" addressing, *inter alia*, resident dignity, self-determination and home-like environment.[6] Unfortunately, despite an initial public outreach effort by CMS, the need for meaningful implementation of the Reform Law's quality of life promise continues. We urge CMS to work within the existing RoP structure to ensure that this promise is better fulfilled when the new RoPs are promulgated.

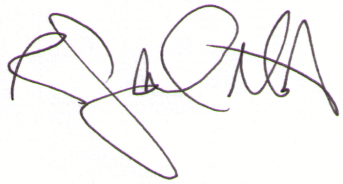
[5] *Id*. at pp. 23-24.
[6] CMS, Pub. 100-07 State Operations Provider Certification, Transmittal 48 (June 12, 2009).

Dementia Care

The proposed regulations are virtually silent on dementia care. Nothing is more central to the purpose of nursing homes than providing good care to people with dementia, who comprise half (if not more) of the nursing home resident population. The quality of care for persons who have dementia is often poor. Too often, residents who have dementia are chemically restrained, deprived of needed care and treated without dignity. Setting standards for dementia care in nursing homes is a common-sense necessity. We again refer to the specific comments on dementia care and chemical restraints submitted by CANHR, which articulates many of the concerns and recommendations which we and other stakeholders have been working with CMS to address since DHHS Inspector General Levinson issued his statement on antipsychotic drugging in nursing homes over four years ago.

Thank you for the opportunity to comment and for your consideration of our comments.

Sincerely,



Richard J. Mollot
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