# THE LTC JOURNAL

**Winter 2018** **The Long Term Care Community Coalition**

For the latest news and resources, connect with LTCCC on **Facebook** (facebook.com/ltccc) & **Twitter** (twitter.com/LTCconsumer) or visit us on the Web @ **www.nursinghome411.org**.

## In This Issue

## Government Standards & Quality Assurance

### GAO Report Reveals Thousands of "Critical Incidents" in Assisted Living Facilities

*The following is LTCCC and the Center for Medicare Advocacy's joint statement on the GAO report. It was published on February 5, 2018, and is reprinted here.*

Across America, assisted living is viewed by seniors and their families as a desirable option for residential care when an individual wishes to avoid the institutional environment characteristic of a typical nursing home. While the assisted living industry has grown rapidly to meet this demand, little is known about the quality and safety provided to residents in these facilities.

Today, the U.S. Government Accountability Office (GAO) reports, for the first time, on the extent to which states are monitoring care and ensuring safety in assisted living. The report, *Medicaid Assisted Living Services: Improved Federal Oversight of Beneficiary Health and Welfare Is Needed*, provides the results of a nationwide survey of state agencies. Forty eight states participated in the survey, which covered the year 2014 and focuses specifically on assisted living services provided to Medicaid beneficiaries.

***Federal and state governments spend $10 billion per year on Medicaid-funded assisted living facilities for 333,000 people. However, as a result of minimal oversight, the GAO found that 23,000 "Critical Incidents" occurred in 22 states in 2014 alone.***

Key findings include:

- Americans spend more than $10 billion per year in federal and state Medicaid funding to provide access to assisted living for 330,000 people.
- Nationally, the average spending per beneficiary on assisted living services in the 48 states in 2014 was about $30,000.
- Though state Medicaid agencies retain "ultimate administrative authority and responsibility" over the quality, safety, and integrity of Medicaid assisted living services, GAO found that:
  - Fewer than half the states surveyed (22 of the 48) were able to provide any information on abuse, neglect, exploitation, and death of residents (so-called "Critical Incidents").
  - Those 22 states alone reported nearly 23,000 Critical Incidents in 2014.
  - Delegation of important responsibilities from the state agencies to other agencies is widespread. Despite fundamental responsibility to oversee quality and safety, GAO identified significant failures among state agencies to even review Critical Incident reports, exclusion lists, reports of abuse, and LTC Ombudsman findings, provided by those agencies.
  - The 48 state Medicaid agencies varied in: their ability to report the number of Critical Incidents in their states; how they defined what a Critical Incident is, and the extent to which they made information on Critical Incidents readily available to the public.

Under federal law, Medicaid beneficiaries must need a nursing home level of care in order to qualify for coverage for assisted living care under a state's waiver program or other Medicaid plan. By definition, these individuals have significant needs. Despite this, and significant public investment in Medicaid assisted living services, there are no federal rules governing standards of care in assisted living (as there are for nursing homes) and the care that the industry provides is totally regulated at the state level.

"State oversight has failed assisted living residents and the taxpayers who help pay for their care," said Toby S. Edelman, Senior Policy Attorney, Center for Medicare Advocacy, "This national scandal cannot be swept under the rug any longer."

"This report verifies reports from families over the years indicating that, too often, the "promise" of assisted living is unfulfilled for seniors," said Richard Mollot, executive director of the Long Term Care Community Coalition (LTCCC), "Medicare beneficiaries deserve good care and dignity no matter where they access care and services."

More than a decade ago, when Medicaid paid for the care of 120,000 beneficiaries in assisted living and a four-part series in the Philadelphia Inquirer documented at least 55 deaths in assisted living facilities in Pennsylvania since 2000 because of lax state oversight, the Center for Medicare Advocacy concluded, "The dramatic increase in public funding of assisted living facilities over the last decade and the inadequate regulatory system at the state level indicate a need for federal oversight of the assisted living industry."

The GAO report makes clear that the problems identified in Pennsylvania 11 years ago were not an aberration. The oversight of the assisted living industry at the state level has failed to protect residents.

The Center and LTCCC call on the federal government to act now, without further delay. Our near term recommendations include:

- Take immediate steps to protect assisted living residents by enacting sensible standards to ensure safety and dignity;
- Develop federal and state websites, similar to Nursing Home Compare, with validated information on staffing, inspection results, complaints, and "Critical Incidents."

## Congress Repeals Medicare Outpatient Therapy Caps

Pursuant to the Balanced Budget Act of 1997, Medicare beneficiaries who were receiving outpatient therapy services were under the threat of having their care terminated based on Medicare payment limits, or therapy caps. In order to receive care once a beneficiary's therapy caps had been reached, an outpatient therapy provider was required to file for an "exception." Over the last twenty years, Congress has been tasked with renewing the expiring exceptions process but would occasionally fail to do so for some of period time, as was this case this year.

The Bipartisan Budget Act of 2018, which was signed into law this February, now ensures that Medicare beneficiaries and outpatient therapy providers no longer have to worry about therapy caps or expiring exceptions. Providers still have to use a modifier when claims are above $2,010 per year and may be subject to targeted medical review; however, as the

American Occupational Therapy Association (AOTA) notes, "the therapy cap will never again put beneficiaries at risk for being denied essential occupational therapy services." The repeal of outpatient therapy caps also improves access to care for Medicare beneficiaries in need of ongoing skilled therapy who are affected by the settlement agreement in *Jimmo v. Sebelius*, No. 5:11-cv-17 (D. Vt).

As a result of the *Jimmo* Settlement in 2013, Medicare beneficiaries with an ongoing need for skilled therapy no longer have to worry about receiving necessary care. The *Jimmo Settlement* required CMS to confirm that "[s]killed care may be necessary to improve a patient's condition, to maintain a patient's current condition, or to prevent or slow further deterioration of the patient's condition." With the *Jimmo* Settlement and the repeal of outpatient therapy caps, Medicare beneficiaries in outpatient therapy can now receive ongoing care to maintain their current condition, or to prevent or slow further deterioration of their conditions without the threat of therapy caps impeding their care.

- To read more about the *Jimmo* Settlement Agreement, please visit: http://www.medicareadvocacy.org/medicare-info/improvement-standard/.

## CMS Launches New Initiative to Address Inappropriate Nursing Home Discharges

### Federal Safeguards

The federal minimum standards for nursing homes provide specific requirements and safeguards in respect to discharging a resident from a facility. Overall, these requirements (excerpted below) protect a resident from being transferred or discharged, unless certain limited conditions are met:

- The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
- The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
- The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
- "The health of individuals in the facility would otherwise be endangered;
- The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
- The facility ceases to operate.

Additionally, the federal standards require that facilities document "the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s)." Facilities must also "provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility . . . in a form and manner that the resident can

understand." According to CMS's interpretative guidance, the overall goal of the transfer and discharge requirements is to limit the circumstances under which a facility can initiate a transfer or discharge, thus protecting nursing home residents from involuntary discharge."

### Current CMS Action

Unfortunately, despite these protections, inappropriate, facility-initiated discharges are a widespread and serious problem for residents and families. In fact, they represent one of the most frequent complaints made to State Long Term Care Ombudsman Programs. To address this burgeoning problem, CMS recently (December 2017) issued a memorandum laying out the steps it is taking to "examine and mitigate facility-initiated discharges that violate federal regulations." CMS is now requiring State Survey Agencies (SAs) to transfer cases involving inappropriate facility-initiated discharges to the CMS Regional Office (RO) for review. The CMS memo notes that ROs may take enforcement action against deficient nursing homes after the review.

The memorandum also encourages states to use civil money penalties (CMPs) to address inappropriate transfer and discharges, such as by funding projects that educate residents and families about their rights or educating "facility staff on best practices for engaging residents and families in collaborative strategies such as person-centered environments and care plans to reduce resident distress . . .."

**Note on Civil Money Penalties**: The use of CMPs to improve quality of care and quality of life for nursing home residents is an issue of longstanding interest and concern to LTCCC. CMPs are generally only imposed on a nursing home when there has been egregious abuse, neglect or substandard care *and* when one or more residents have been harmed (or killed) as a result.

We strongly support the use of these funds to make the lives of residents better. However, we also strongly support the federal requirement that these funds cannot be given to facilities to provide care or services which they are already being paid to provide. For example, nursing homes are already paid – and required – to provide a "person-centered environment." Therefore, allocation of these precious funds to facilities for this purpose is, in our view, not only inappropriate, it is a slap in the face to the residents whose harm or death resulted in the imposition of the penalty in the first place.

### LTCCC's Position

Although LTCCC appreciates CMS's attention to this problem, we believe that further steps are necessary to ensure that residents are protected from inappropriate and illegal discharges. We recommend that CMS provide the State Agencies and Regional Offices with clear, concise instructions and expectations for dealing with potentially inappropriate discharges. For instance, in cases in which a facility discharges a resident to a homeless shelter, we believe that SAs should be instructed to treat this as a *prima facie* case of inappropriate discharging and investigate both the appropriateness of the particular discharge as well as the extent to which the facility – or facilities owned by the same company – are discharging residents to homeless shelters or other inappropriate settings.

In addition, we are concerned by CMS's suggestions for the use of CMP funds to address this problem. Under federal regulation, CMP funds cannot be used to support activities that nursing homes are already paid to provide. While CMS notes this federal regulation in the memo, we believe that nursing homes, for instance, are already being paid to have "health professional{s} who could provide support . . . [on] resident assessments, and/or creating a more person-centered plan of care." As noted in the box on the previous page, CMPs are generally only imposed when there is very egregious harm or suffering. CMS should not exploit that suffering to "educate facility staff on best practices" when that is already a fundamental requirement of participating in Medicare and Medicaid.

- For LTCCC's discharge fact sheets, please visit: http://nursinghome411.org/?s=discharge.
- To read *The New York Times'* "Complaints About Nursing Home Evictions Rise, and Regulators Take Note," please visit https://nyti.ms/2BHxhKU.
- To read *The New York Times'* "How to Challenge a Nursing Home Eviction, and Other Tips," please visit: https://www.nytimes.com/2018/02/22/business/nursing-home-eviction-rights.html?rref=collection%2Fbyline%2Frobert-pear&mtrref=www.nytimes.com&gwh=A6CA8FD10E6518BC08BC39F27171404D&gwt=pay.

## New Data on Nursing Home Care Staffing Levels

Staffing is perhaps the most important factor in a nursing home resident's quality of care. Unfortunately, inadequate staffing is a widespread and persistent problem. It is often the underlining issue in other nursing home deficiencies, including pressure ulcers and antipsychotic drug use, because less staffing means less time adequately meeting the needs of residents. Unsurprisingly, insufficient staffing is a chief complaint among residents and families. With over half of Americans who reach age 60 expected to need nursing home care at some point, safe staffing is important to every family.

In November 2017, the federal Centers for Medicare & Medicaid Services (CMS) released, for the first time, information on nursing home staffing that is based on payroll or other auditable data sources (rather than unaudited data self-reported by facilities). This signifies a critical improvement in the accuracy of information provided to residents, families, and the public at large. Importantly, facilities are now required to report verifiable staffing data that distinguishes between staff who were assigned to resident care and those with administrative duties.

On March 7, 2018 LTCCC released data on the staff assigned to provide resident care in a user-friendly format for the most recent time period now available: 2017 Q3 (July – September 2017). Visitors to our website**,** www.nursinghome411.org, can download easy-to-use tables for each state that include (for each facility in the state in compliance with the reporting requirement):

1. The facility's resident census (population);
2. Its direct care RN, LPN and CNA staffing levels; and
3. The amount of care staff hours per resident per day for both all care staff and for RNs specifically.

To facilitate ease of use, the individual state files are easily sortable. For example, a state file can be sorted to identify which facilities have the highest reported levels of RN care and which have the lowest.

A few facts about the reported data:

- **70% of nursing homes report RN care staffing at 0.5 hours per resident day or less**. A 2001 landmark federal study indicated that 0.55 -0.75 is typically needed to meet a resident's clinical needs (the study did not significantly address services necessary to support resident dignity or fulfill important quality of life standards).
- **82% of nursing homes report total direct care staffing at 4.0 hours per resident day or less**. The 2001 federal study indicated that 4.1 hours of direct care staff time is typically needed to meet a resident's clinical needs.
- **30% of nursing homes report total direct care staffing of 3.0 hours per resident day or less**.

The direct link to the data for all licensed nursing homes is: http://nursinghome411.org/nursing-home-staffing-2017-q3/.

## LTC News & Briefs

### Human Rights Watch Publishes Devastating Report on Inappropriate Antipsychotic Drug Use in U.S. Nursing Homes

The inappropriate use of antipsychotic drugs on nursing home residents is a widespread and serious problem. Since 2012, LTCCC has been working on the local, state and federal levels to reduce the use of antipsychotics as chemical restraints and improve dementia care. We were glad to see the Human Rights Watch take on this issue since it is, without a doubt, one of the most significant human rights issues facing individuals with dementia in U.S. nursing homes.

***Over 179,000 nursing home residents are given off-label antipsychotic drugs every week. Human Rights Watch finds that such inappropriate use could constitute "abuse under domestic law and cruel, inhuman, and degrading treatment under international law."***

Below is an excerpt from the Human Rights Watch report, *'They Want Docile': How Nursing Homes in the United States Overmedicate People with Dementia*, followed by selected resources available on LTCCC's website.

> In an average week, nursing facilities in the United States administer antipsychotic drugs to over 179,000 people who do not have diagnoses for which the drugs are approved. The drugs are often given without free and informed consent, which requires a decision based on a discussion of the purpose, risks, benefits, and alternatives to the medical intervention as well as the absence of pressure or coercion in making the decision. Most of these individuals—like most people in nursing homes—have Alzheimer's disease or another form of dementia. According

to US Government Accountability Office (GAO) analysis, facilities often use the drugs to control common symptoms of the disease.

While these symptoms can be distressing for the people who experience them, their families, and nursing facility staff, evidence from clinical trials of the benefits of treating these symptoms with antipsychotic drugs is weak. The US Food and Drug Administration (FDA) never approved them for this use and has warned against its use for these symptoms. Studies find that on average, antipsychotic drugs almost double the risk of death in older people with dementia. When the drugs are administered without informed consent, people are not making the choice to take such a risk.

The drugs' sedative effect, rather than any anticipated medical benefit, too often drives the high prevalence of use in people with dementia. Antipsychotic drugs alter consciousness and can adversely affect an individual's ability to interact with others. They can also make it easier for understaffed facilities, with direct care workers inadequately trained in dementia care, to manage the people who live there. In many facilities, inadequate staff numbers and training make it nearly impossible to take an individualized, comprehensive approach to care. Many nursing facilities have staffing levels well below what experts consider the minimum needed to provide appropriate care.

- To read LTCCC's Issue Alert on antipsychotic drugs, please visit: http://nursinghome411.org/issue-alert-antipsychotic-drugs/
- To see LTCCC's database on antipsychotic medication rates, please see http://nursinghome411.org/us-nursing-home-antipsychotic-drugging-rates-2017q3/.
- To see LTCCC' database on citations for unnecessary drug use, please see http://nursinghome411.org/us-nursing-home-inappropriate-drugging-citations-november-2017/.
- To access LTCCC's dementia care toolkit, please see http://nursinghome411.org/learning-center/dementia-care-advocacy-toolkit/.

## Study: Medicare Advantage Enrollees have fewer Skilled Nursing Facility (SNF) Options than Traditional Medicare Beneficiaries

Medicare beneficiaries have the ability to choose between traditional Medicare and Medicare Advantage during their enrollment periods. Traditional Medicare has no network and is generally accepted by health care providers across the country. On the other hand, Medicare Advantage (MA) is offered to beneficiaries by private insurance companies. These private insurers advertise MA as offering beneficiaries greater flexibility at lower costs; however, unlike traditional Medicare, MA plans provide health coverage through a limited network of providers.

A January 2018 report by Health Affairs, *Medicare Advantage Enrollees More Likely to Enter Lower-Quality Nursing Homes Compared To Fee-For-Service Enrollees,* finds that MA plans have a detrimental effect on a nursing home resident's ability to choose the best nursing home provider. According to the authors of the report, traditional Medicare beneficiaries "tended to use higher-quality SNFs" than MA enrollees in the same zip code. Moreover, the report

discovers that MA enrollees in lower quality plans "entered SNFs with significantly higher re-hospitalization rates . . . ." The report posits that one reason for this discrepancy is that traditional Medicare beneficiaries are more influenced by publically available data on nursing home quality (such as Nursing Home Compare) than MA enrollees who are limited to specific networks based on their plans. Not surprisingly, the report also finds that MA enrollees were more likely to move to traditional Medicare after SNF stays.

***Traditional Medicare beneficiaries "tended to use higher-quality SNFs" than MA enrollees in the same zip code. Moreover, the report discovers that MA enrollees in lower quality plans "entered SNFs with significantly higher re-hospitalization rates . . . ."***

The report concludes that the Centers for Medicare & Medicaid Services (CMS) should require MA plans to "be more transparent about the quality of SNFs in their networks when beneficiaries make their Medicare enrollment decisions." Given that research indicates "using a SNF with historically lower re-hospitalization rates reduces a [resident's] likelihood of future re-hospitalization," LTCCC believes that CMS should address the findings of the report and take measures to ensure that Medicare beneficiaries have all the information they need to make informed decisions when choosing between traditional Medicare and Medicare Advantage.

## Nursing Homes Inflating Their Success in Reducing Inappropriate Use of Antipsychotic Drugs

CMS established the National Partnership to Improve Dementia Care in Nursing Homes in 2012 after a report by the HHS Office of the Inspector General found widespread and inappropriate antipsychotic drugging of nursing home residents. The stated goal of the Partnership is to reduce the use of antipsychotic drugs in nursing homes and to educate providers on the non-pharmacological approaches to treating residents with dementia. CMS's initial goal was a 15 percent reduction in antipsychotic drugging by the end of 2012. Unfortunately, CMS (and the nursing home industry) failed to meet this initial goal in the promised time period. In fact, the goal was not reached for another full year.

***Researchers conclude that the reduction in antipsychotic drug use in nursing homes is correlated to an increase in diagnoses of three excluded medical conditions. The study finds that "nationally reported rates of theses diagnoses increased by 12 percent in nursing homes."***

In 2014, CMS announced a new goal of reducing use by a total of 30 percent (including the previous year's reductions) by the end of 2016. CMS announced that the Partnership met this goal in October 2017. Despite the persistent failure of nursing homes to meet these goals in the announced time frame – thus consigning thousands of residents to inappropriate drugging – CMS, state agencies, and the nursing home industry continually tout the Partnership as a "success."

In measuring reductions in the use of antipsychotic drugs, CMS excludes antipsychotic drug use associated with clinical diagnoses of Huntington's disease, Tourette's syndrome, and schizophrenia. This has raised concerns over the years that nursing homes may have an

incentive to diagnose a resident with one of these conditions in order to give him or her antipsychotic drugs with impunity.

*Increased Reporting of Exclusionary Diagnoses Inflate Apparent Reduction in Long-Stay Antipsychotic Prescribing,* a report published in December 2017, concludes that the reduction in antipsychotic drug use is correlated to an increase in diagnoses of Huntington's disease, Tourette's syndrome, and schizophrenia—the three conditions excluded by CMS when it publishes each nursing home's antipsychotic drugging rate. Specifically, the study finds that, since the launch of the Partnership, "nationally reported rates of theses diagnoses increased by 12 percent in nursing homes." The study adds that it might even be the case that "as much as 20 percent of the reduction . . . could be explained by increased reporting of exclusionary diagnoses rather than a true reduction in medication use." Ultimately, the study determines that the "[a]pparent reductions in inappropriate long-stay antipsychotic use since the National Partnership may be exaggerated."

**Note**: See the bulleted list on page eight for LTCCC's resources on antipsychotic drugging.

## California Study Finds that Nursing Homes Inflate Self-Reported Data

Nursing home residents, families, and advocates use Nursing Home Compare in order to assess the quality of nursing homes throughout the country. This review is supposed to be assisted by CMS's five-star quality rating system, which provides individual star-ratings for a nursing home's health inspections, quality measures, and staffing, as well as a comprehensive star-rating based on all three factors. Unfortunately, much of the data used to determine a facility's star-rating is self-reported by nursing homes. LTCCC and other consumer advocates have long been concerned that some facilities may be adjusting their self-reported data to gain better ratings.

***Study finds "systemic evidence that some nursing homes are inflating the self-reported measures in Medicare's star-rating system."***

*Winning at All Costs: An Analysis of Inflation in Nursing Homes' Rating System*, a study published in November 2017, examines whether increases in a nursing home's star-ratings reflected actual improvements or were "unjustified ratings inflation." Based on data from 1,200 nursing homes in California, the study finds that there is "systemic evidence that some nursing homes are inflating the self-reported measures in Medicare's star-rating system." According to the National Institute for Health Care Management (NIHCM), the study found that:

- "Nursing homes with more to gain financially from higher ratings are more likely to improve their overall rating through self-reporting";
- "There is little direct correlation between self-reported measures and on-site inspection results, either contemporaneously or over time";
- "The number of residents' complaints is similar for nursing homes with the same objectively derived inspection rating but varies appreciably between facilities with the same overall rating, further suggesting inflation in self-reported measures";
- "Models indicate that at least 6 percent of the nursing homes inflate their self-reported measures"; and

- "Larger and for-profit nursing homes and those with the most to gain financially are more likely to inflate self-reported ratings."

## *The New York Times* Reports on the Trump Administration's Rollback of Nursing Home Fines

In December 2017, *The New York Times*' published an article, *Trump Administration Eases Nursing Home Fines in Victory for Industry*, which examined CMS's latest efforts to rollback nursing home regulations. The article notes that CMS issued guidance in July 2017 discouraging the use of per day civil money penalties (CMPs) in favor of per instance CMPs for nursing home violations that occurred before a nursing home inspection. As the article highlights, this shift in policy will allow nursing homes to be fined less than $21,000 for the death of a resident. The article also highlights federal guidance from October 2017 discouraging CMS regional offices from issuing fines resulting from a "one-time mistake," and a November memo placing an 18-month moratorium on enforcement of eight nursing home requirements.

Taken individually and together, LTCCC believes these regulatory and sub-regulatory changes will have a detrimental effect on the lives of nursing home residents across the country. Nursing home residents depend on the Nursing Home Reform Law and its implementing regulations to ensure that they receive decent care and quality of life services. By rolling back resident protections, the Trump Administration is placing residents at risk of harm, injury, and death. Unfortunately, it appears that CMS is listening to the requests of some in the nursing home industry who want to reduce industry "burdens," despite the added burdens placed on to residents. As the *Times'* report highlights, "[t]he shift in the Medicare program's penalty protocols was requested by the nursing home industry."

## *The New York Times* Reports on Related-Party Transactions in Nursing Homes

In January 2018, the *New York Times* published another article, *Care Suffers as More Nursing Homes Feed Money Into Corporate Webs,* which assessed related-party transactions in nursing homes. Related-party transactions allow "owners of nursing homes [to] outsource a wide variety of goods and services to companies in which they have a financial interest or that they control." As the article notes, nearly three-quarters of all U.S. nursing homes employ such transactions. For instance, the article notes that some nursing homes contract out management or real estate rentals with related companies. A California audit of one nursing home chain showed that "rental prices to real estate companies related to the chain of homes were a third higher than rates paid by other for-profit nursing homes in the same counties . . . ."

Given that these detrimental transactions have the power to siphon money away from nursing homes in favor of nursing home owners, nursing homes that utilize related-party transactions "have fewer nurses and aids per patient, they have higher rates of patient injuries and unsafe practices, and they are the subject of complaints almost twice as often as independent homes." According to the article, some in the industry say that these transactions are "an efficient way of running their businesses and can help minimize taxes." However, according to the article, nursing homes with related-party transactions employed eight percent fewer nurses and aides and were nine percent "more likely to have hurt residents or put them in immediate jeopardy of harm . . . ."

## The *Los Angeles Times* Reports on Nursing Home Infection Lapses

In December 2017, the *Los Angeles Times* and Kaiser Health News, published an article, *Infection Lapses Are Rampant In Nursing Homes But Punishment Is Rare*. The article reports on an analysis conducted by author Jordan Rau which found that "basic steps to prevent infections . . . are routinely ignored" in nursing homes around the country. Citing a 2014 report by the HHS Office of the Inspector General (OIG), the article shows that infections were the root cause of 26 percent of the adverse events nursing home residents experienced within the first month of being admitted to a nursing home. According to the report, "inspection records show nurses and aides are often not familiar with basic protocols . . . others are not trained properly . . . [and] others, in a rush and understaffed, take shortcuts that compromise sanitary precautions." Despite the impact that health care-associate infections have on nursing home residents, CMS placed an 18-month moratorium on enforcement of the recently implemented Antibiotic Stewardship Program requirements in November 2017.

- To read LTCCC's Issue Alert on the infection prevention and control program requirements, please see http://nursinghome411.org/ltccc-issue-alert-infection-control-prevention/.

## Skilled Nursing Facility Occupancy Rates Fall to 5-Year Low

A National Investment Center for Seniors Housing & Care (NIC) report found that the quarterly nursing home occupancy rate hit a record low of 81.6 percent in the third quarter of 2017. According to NIC, the decline is likely not a "seasonal phenomenon" and it represents the biggest decline of the past five years.

Additionally, the report found that Medicaid beneficiaries (66.8 percent) made up a growing share of nursing home occupancy. On the other hand, Medicare beneficiaries (12.2 percent) and private pay residents (9.1 percent) declined over the five year period.

## Former Employee of Florida's Survey Agency Sentenced to Prison for Accepting Bribes

The Department of Justice (DOJ) issued a press release in December 2017, reporting that a former employee of Florida's Agency of Health Care Administration (AHCA) was sentenced to 57 months in prison. The former employee was found guilty of "accepting bribes in exchange for providing confidential information about health care facilities that received Medicare and Medicaid funds." The former employee admitted that, between 2007 and 2015, she accepted bribes in exchange for sensitive information regarding skilled nursing facilities, assisted-living facilities, and home health agencies. This information included "schedules of future unannounced inspections by AHCA surveyors and previously undisclosed patient complaints filed with AHCA."

## The Center for Medicare Advocacy Publishes *Jimmo* Toolkits to help Medicare Beneficiaries Appeal Denials of Coverage Based on an Erroneous "Improvement Standard"

The Center for Medicare Advocacy (Center) and Vermont Legal Aid initiated a nationwide class-action lawsuit against CMS on behalf of Medicare beneficiaries who were denied continued

skilled nursing and skilled therapy services in skilled nursing facilities (SNFs), home health, and outpatient therapy based on the beneficiary's potential for improvement. The settlement agreement in *Jimmo v. Sebelius*, No. 5:11-cv-17 (D. Vt), now makes it clear that Medicare coverage of these skilled services must not be determined based "on the presence or absence of a beneficiary's potential for improvement, but rather on the beneficiary's need for skilled care. Skilled care may be necessary to improve a patient's condition, to maintain a patient's current condition, or to prevent or slow further deterioration of the patient's condition."

Unfortunately, Medicare beneficiaries are continuing to be denied coverage of these skilled services based an erroneous "Improvement Standard." To assist beneficiaries, the Center has published two Toolkits with self-help materials for knowing your rights under the *Jimmo* Settlement and navigating the appeals process.

- To access the Center's Medicare Skilled Nursing Facility Coverage and *Jimmo v. Sebelius* Toolkit, please visit: http://www.medicareadvocacy.org/wp-content/uploads/2018/01/Medicare%20SNF%20Coverage%20and%20Jimmo%20v.%20Sebelius%20Toolkit.pdf.
- To access the Center's Medicare Home Health Coverage and *Jimmo v. Sebelius* Toolkit, please visit: http://www.medicareadvocacy.org/wp-content/uploads/2018/01/Medicare%20Home%20Health%20Coverage%20and%20Jimmo%20v%20%20Sebelius%20Toolkit.PDF.

## Please Support LTCCC's Mission: Donate Today

Our donors enable us to be a strong voice for vulnerable people in nursing homes and assisted living, and their families. Your support, in any amount, would be helpful and appreciated. To make a tax-deductible donation, please visit our website, www.nursinghome411.org, and click on the purple "Make a Donation" button on the right-hand side of the page. It will take you to our secure, Network for Good donation page.

You can also support LTCCC at no cost by shopping online via our secure iGive page. iGive provides access to over 1,800 sites, from JC Penney to Neiman-Marcus for shopping to Expedia and Orbitz for travel.

## Free LTCCC Resources

### Elder Justice "No Harm" Newsletter

Reports indicate that state surveyors cite nursing home health deficiencies at a "no harm" scope and severity level 95% of the time. Unfortunately, this has a profound impact on a nursing home resident's quality of care and quality of life. CMS data provide clear evidence that residents are actually being harmed by too many such deficiencies, despite the misleading "no harm" label.

*Elder Justice: What "No Harm" Really Means for Residents*, is published jointly by the Center for Medicare Advocacy and the Long Term Care Community Coalition. The purpose of the newsletter is to provide residents, families, friends, and advocates information on what exactly

a "no harm" deficiency is, how prevalent "no harm" deficiencies are, and what "no harm" actually means to residents.

### LTCCC Issue Alerts

LTCCC publishes monthly issue alerts on the rights of nursing home residents. These issue alerts focus on specific standards of care that nursing homes must follow as a requirement of participating in Medicare and Medicaid. The goal of this project is to provide residents, families, and advocates with information on why a standard of care is important to residents, what the nursing home requirements for that standard are, how prevalent deficiencies in meeting that standard are, what resident harm looks like when nursing homes fail to meet that minimum standard of care, and where readers can go for additional information.

To date, LTCCC has published issue alerts on standards of care relating to pressure ulcers, antipsychotic drugs, staffing, and infection control.

### LTCCC Webinars

LTCCC regular conducts webinars on a variety of timely nursing home topics, ranging from the survey process to resident rights. These webinars are available on LTCCC's YouTube page. To receive notices of future webinars and LTCCC alerts, email info@ltccc.org.

### Learning Center: Free Resources on Resident Rights & Advocacy

The Learning Center on LTCCC's homepage, www.nursinghome411.org, has a variety of materials on nursing home care, resident rights, and dementia care standards. All materials are free to use and share. We thank the Fan Fox & Leslie R. Samuels Foundation and The New York State Health Foundation for supporting development of these resources.


## *The LTC Journal*

**Winter 2018 Volume 4, Number 1.** 

The LTC Journal is published quarterly by the Long Term Care Community Coalition, One Penn Plaza, Suite 6252, New York, NY 10119. Visit us on the Web at **www.nursinghome411.org**.

**Staff**: Richard J. Mollot, Executive Director; Sara Rosenberg, Office Manager; Dara Valanejad, Public Policy Counsel; Charles Gourgey, Public Policy and Program Specialist; Gloria Murray, Ombudsman Program Director; Theresa Norbom, Ombudsman Program Specialist.

**Board of Directors**: Deborah Truhowsky, Esq., President; Joan Burke; Geoffrey Lieberman; Martin Petroff, Esq.; and Jeanette Sandor.

**Benefactors**: This newsletter is made possible through the generous donations of our supporters, including The NY State Health Foundation & FJC – Foundation of Philanthropic Funds.