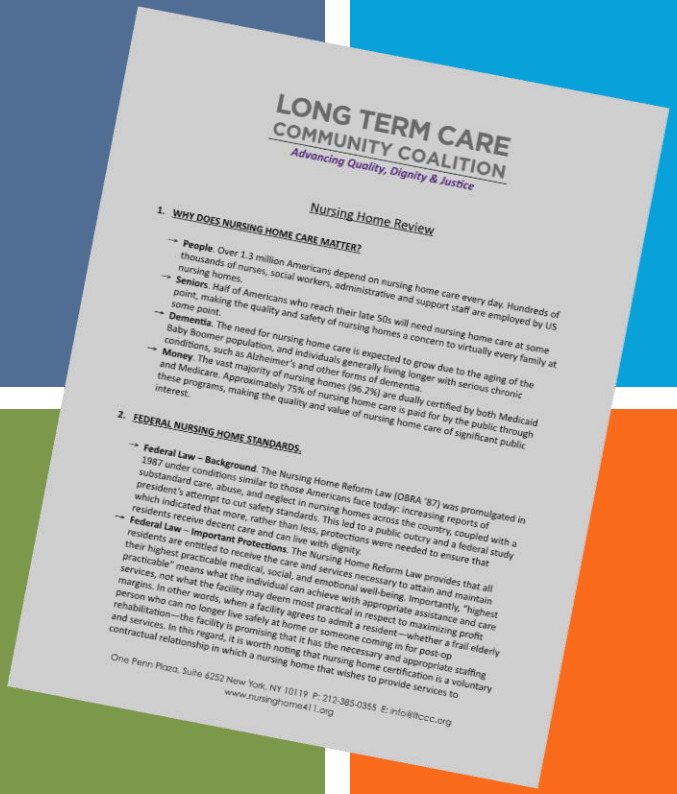


Protecting Residents in Nursing Homes & Assisted Living: Regulatory & Advocacy Essentials

National Aging & Law Conference - October 2018

The Long Term Care Community Coalition
www.nursinghome411.org

Justice in Aging
www.justiceinaging.org

The Center for Medicare Advocacy
www.medicareadvocacy.org

Today's Speakers

- **Eric Carlson** – Directing attorney, Justice in Aging (www.justiceinaging.org).
- **Toby Edelman** – Senior policy attorney, The Center for Medicare Advocacy (www.medicareadvocacy.org).
- **Richard Mollot** – Executive director, Long Term Care Community Coalition (www.nursinghome411.org).
- **Dara Valanejad** – Policy attorney at CMA and LTCCC.

Nursing Home Standards & Oversight

- Background to the Reform Law

BACKGROUND TO NURSING HOME REFORM LAW

- Reagan Administration's deregulatory efforts (1981 forward)
  - Repeal Carter Administration's residents' rights regulations (Jan. 21, 1981)
- Two Congressional legislative moratoria to stop deregulation
- Institute of Medicine (IoM), National Academy of Sciences, *Improving the Quality of Care in Homes* (1986)
- Congressional hearings (1986-1987)
- Campaign for Quality Care (organized by national residents' advocacy organization, National Citizens Coalition for Nursing Home Reform) met for a year to achieve consensus on IoM recommendations (particularly on standards of care); issued report with recommendations for federal legislation
- Reform Law enacted Dec. 1987, as part of Omnibus Budget Reconciliation Act (OBRA).

REQUIREMENTS OF PARTICIPATION

- Standards of care that facilities must meet in order to be eligible for public reimbursement (Medicare or Medicaid or, most often, both programs)
- Key principle: Each resident is to receive care and services, based on individualized assessment, to attain and maintain “the highest practicable physical, mental, and psychosocial wellbeing”
- Regulations made clear: resident should not decline unless the decline was medically unavoidable for that resident

INNOVATIONS OF NURSING HOME REFORM LAW

- Quality of life
- Nurse aide training (75 hours; requiring demonstration of competency before providing care)
- Resident assessment
- Multi-disciplinary state survey teams (requiring demonstration of competency before conducting surveys)
- Range of enforcement actions for noncompliance
  - Prior to Reform Law, only remedy was termination (loss of authority to received public reimbursement)
  - Consequence of limited remedy was tolerance of poor care

POSITIVE ASPECTS OF NURSING HOME REFORM LAW

- Resident assessment (Minimum Data Set, or MDS) includes "customary routines" (i.e., who is this person? How does this person like/want to live, pursue daily life activities?)
  - Resident assessment instrument translated into multiple languages; used in many countries
- *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes* (2001) *(*Federal study of staffing, required by Reform Law)
  - Found vast majority of nursing facilities did not have sufficient nursing staff to prevent avoidable harm or to meet the standards of federal law.
  - 4-volume report cited in many countries as most comprehensive analysis of nurse staffing needs in nursing facilities
    - Or course, now, more nursing staff needed

POSITIVE CHANGES IN RESIDENT CARE

- Comprehensive federal standards of care that residents, families, and advocates can point to as the actual requirements for care
- Resident assessment focuses on individual residents (strengths as well as weaknesses)
- Specific improvements include
  - Reduction in physical restraints
  - Residents' rights
    - E.g., better legal protections from involuntary transfer and discharge (although transfers and discharges remain a key problem)

Nursing Home Standards & Oversight

- Current challenges:
  - Poor oversight & accountability
  - Changes to federal requirements
  - Quality assurance under the Trump Administration

The Persistence of Abuse & Neglect

R

Though the Reform Law and regulatory Requirements set forth strong protections, substandard care continues to be a widespread and persistent problem:

- **2011** – HHS Inspector General found that 25% of nursing home residents administered dangerous antipsychotics, despite black-box warning not to give to elderly with dementia.
- **2014** – IG found that 33% of Medicare rehab patients harmed w/in one month of entering a facility; 59% of the harm preventable.
- **2015** – LTCCC study of state oversight finds that states rarely identify low staffing levels, inappropriate antipsychotic drugging, or avoidable pressure ulcers as causing ***any*** resident harm.

Significant Changes Underway

- **New Federal Regulations (2016 – 19)** – For the first time since 1991, the Requirements for nursing homes have been revised. While the underlying standards have not changed, the standards have been refined to better implement the promise of the Reform Law.
- **New Federal Guidance (2017)** – Sub-regulatory guidance provides detailed expectations about care for surveyors (inspectors), nursing homes, and consumers. What
- **New Survey Protocols (2017)** – CMS launched a new survey protocols that increases focus on observing and speaking to residents and their representatives.
- **Updates to Nursing Home Compare** – The federal nursing home information website is undergoing improvements to provide more accurate information, including more accurate reporting of every nursing home's staffing levels.

Trump Administration's Rollback of Resident Rights and Protections

D

- The Trump Administration has been advancing efforts to deregulate the nursing home industry. These efforts have resulted or will result in the rollback of resident rights and protections meant to ensure health, safety, and well-being.
- CMS's "Patients over Paperwork" newsletters highlight that the Administration is responding directly to the requests of the nursing home industry.

Example (January 2018):

- **"You Said:** Some Long Term Care (LTC) Facilities were not prepared for the start of Phase 2 of the Long Term Care Requirements of Participation beginning in November of 2017."
- **"We Heard You:** CMS directed LTC Facility surveyors to focus on education rather than discretionary penalties related to the implementation of specific new Requirements of Participation for 18 months. This gives facilities more time and support to comply while still supporting resident safety."

Trump Administration

D

- The Trump Administration has been in power for less than two years. In that time, CMS has undertaken the following actions:
  - Proposed to reverse the prohibition on pre-dispute arbitration;
  - Proposed to reverse requirements on grievance officers;
  - Issued new guidance on the immediate imposition of federal remedies;
  - Shifted the default civil money penalty (CMPs) from per day to per instance CMPs;
  - Imposed an 18-month moratorium on the full enforcement of eight standards of care (no fines or other meaningful penalties); and
  - Indicated that CMS plans to revise the Requirements of Participation, which it recently updated in 2016.
  - For the full list, please see our chart in the Don't Abandon Nursing Home Residents series: https://nursinghome411.org/dont-abandon-nursing-home-residents-series/.

Nursing Home Standards & Oversight

- Policy Analysis & Client Advocacy :
  - Antipsychotic Drugging
  - Staffing
  - Transfer & Discharge

AP Drugging

- As noted earlier, in 2011, HHS Inspector General found that 25% of nursing home residents administered dangerous antipsychotics, despite black-box warning not to give to elderly with dementia.
- We met with the CMS Acting Administrator Berwick, who agreed with our concerns and agreed to take action.
- Unfortunately, CMS action has been slow and weak, resulting in only moderate AP drugging reduction and diversion to other drugs.

<u>To address this we…</u>

- Continually advocate with CMS, OIG, Congress for more concrete action.
- Educate families and those who work with them about the standards and how to self-advocate.
- Publish quarterly data on AP drugging rates for all nursing homes and all state citations for inappropriate drugging.

E

Psychotropic Drugs: Falsehood & Truth

"Your mother needs medication to make her more manageable." – Not True

Medication can only be used to address a diagnosed illness.

E

No Unnecessary Drugs

- What is “unnecessary”?
  - Excessive dose.
  - Excessive duration.
  - Without adequate monitoring.
  - Without adequate indications for its use.
  - In the presence of adverse consequences that call for discontinuance or reduction.
    - 42 C.F.R. §483.45(d).

E

Psychotropics and Anti-Psychotics

- Psychotropics affect brain activities associated with mental processes and behavior, including
  - Anti-psychotics;
  - Anti-depressants;
  - Anti-anxiety drugs; and
  - Hypnotic drugs.
    - 42 C.F.R. § 485.45(c).

E

Psychotropics Used Only as Necessary

- Medication must be necessary to treat specific, diagnosed condition.
- Must be gradual dose reductions in effort to halt use of psychotropics.

E

Consent Required

- All medications require informed consent of resident or representative.

E

One Good Rule of Thumb

- Ask "What is this medication supposed to accomplish?"
  - OK if medication will address a resident's medical condition.
  - Not OK if medication is designed to make resident more manageable.

R

Staffing

- Staffing is **the most important indicator** of a facility's quality and safety.
- A landmark federal study in 2001 found that **91% of nursing homes lack sufficient staff** to provide decent care.
- Why? **No minimum staffing ratios**. Facilities can legally take in as many residents as they like without having to increase staffing.
- Nursing homes are required to have "sufficient" staff with appropriate competencies to ensure that **every resident is able to attain, and maintain, his or her highest practicable physical and psycho-social well being**.
- **Problem**: In the absence of a specific numerical ratio, states are disinclined to hold facilities accountable. Only about 850 citations/year for low staffing.

Example: Ms. Azar needs to go to the bathroom. She rings her call bell for a nurse to come. Thirty minutes go by and nobody comes, so Ms. Azar, now desperate, gets out of bed to go to the bathroom herself. She falls, breaking her hip.
Facility is cited for insufficient staffing, but at a no harm level. No penalty to nursing home.

E

Enforcing Staffing Standards

- As discussed, no firm numerical requirement:
  - "Sufficient nursing staff"
  - "Appropriate competencies and skill"
  - "[T]o [ensure] resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident."
    - 42 C.F.R. § 483.35.

Facility Assessments

E

- Staffing levels must consider “the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at § 483.70(e).”
- Assessment must be updated annually and upon significant change in facility.
- Broad listing of items to be considered.
- But no mention of assessment being available to public.

E

Resident-Specific Staffing Advocacy

- Advocacy will look to the resident, rather than to numerical staffing levels.
  - Is resident getting care that she needs to attain highest practicable well-being?
- Advocacy or litigation can focus more on numerical standards if state has minimum staffing levels.

E

Poor Care Often Linked to Medicaid Reimbursement

"Medicaid Does Not Pay for Individual Attention During Meals." – Not True

Medicaid-eligible residents must receive equivalent care.

E

No Discrimination Based on Payment Source

- Facility must have "identical policies and practices regarding transfer, discharge, and the provision or services … regardless of payment source."
  - 42 C.F.R. §483.10(a)(2).

Remember, Medicaid Certification Is Voluntary

- In order to receive Medicaid funding, facility promises to follow federal law.
- Unfair for facility to accept money, and then shortchange individual residents.

D

Transfer/Discharge

- Transfers and discharges may become a source of anxiety for residents. These actions, especially when involuntary, may affect the resident's physical health and safety, as well as their psychological well-being.
- CMS has noted that inappropriate discharges can cause residents to be "uprooted from familiar settings." Adding that relationships with staff, other residents, and family members might be affected.
- In 2017, CMS acknowledged that "facility-initiated discharges continue to be one of the most frequent complaints made to State Long Term Care Ombudsman Programs."

D

Transfer/Discharge

- The federal Nursing Home Reform Law provides residents with significant protections.
  - Nursing homes can only discharge residents under limited circumstances:
    - When it is necessary for the resident's welfare;
    - When the resident no longer needs services;
    - When the resident endangers the safety of others;
    - When the resident endangers the health of others;
    - When the resident failed to pay, or have Medicare or Medicaid pay, for services; and
    - When the nursing home closes.
- Nursing homes must also adhere to notice, appeal, and preparation and orientation requirements.

D

Transfer/Discharge

- CMS has stated that 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."
- Sadly, the standards of care are all too often ignored, as more reports come to light of residents being involuntarily discharged to inappropriate settings, such as homeless shelters and hotels (which might not even be compliant with the Americans with Disabilities Act).
- A 2013 OIG report found that 31 percent of nursing home stays resulted in the facility failing to meet at least one of the discharge planning requirements. The report called on CMS to make nursing homes more accountable and to increase enforcement of the related requirements.

E

Transfer/Discharge: Falsehood & Truth

"You must leave the nursing facility because you are a difficult resident." – Not True

Eviction is allowed only for six limited reasons.

Six Justifications for Involuntary Transfer/Discharge

1. Resident needs higher level of care.
2. Resident doesn't need nursing facility care.
3. Resident endangers others' safety.
4. Resident endangers others' health.
5. Nonpayment.
6. Facility is going out of business.
   - 42 C.F.R. § 483.15(c).

"Difficulty" Is Not Endangerment

- Facility should be well prepared to deal with dementia and other conditions.
- Any "difficulty" should lead to renewed care planning, rather than to transfer/discharge.

"Difficulty" Doesn't Mean Facility Can't Meet Resident's Needs

E

- Facility must list
  - Need that allegedly cannot be met.
  - Facility's attempts to meet that need.
  - Ability of new facility to meet that need.
    - 42 C.F.R. § 483.15(c)(2)(i)(B).

E

Best Defense Is Good Offense

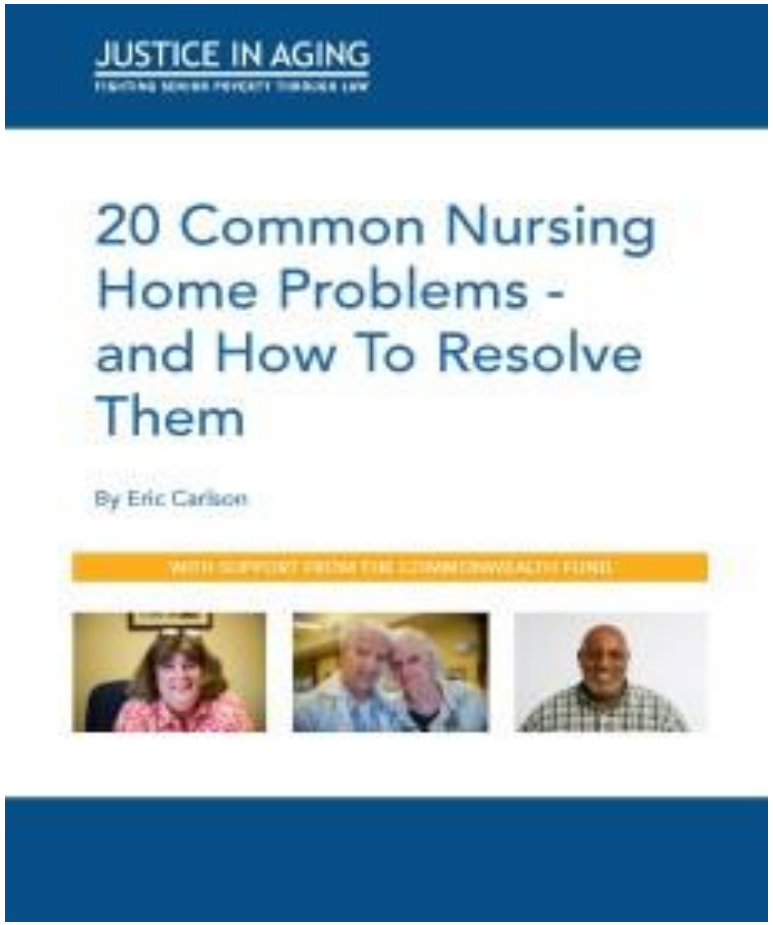
- Resident has right to administrative hearing.
- Don’t let facility blame resident for resident’s care needs or behavior.
- Care planning must be first step; eviction should be last resort.

Helping Consumers & Clients

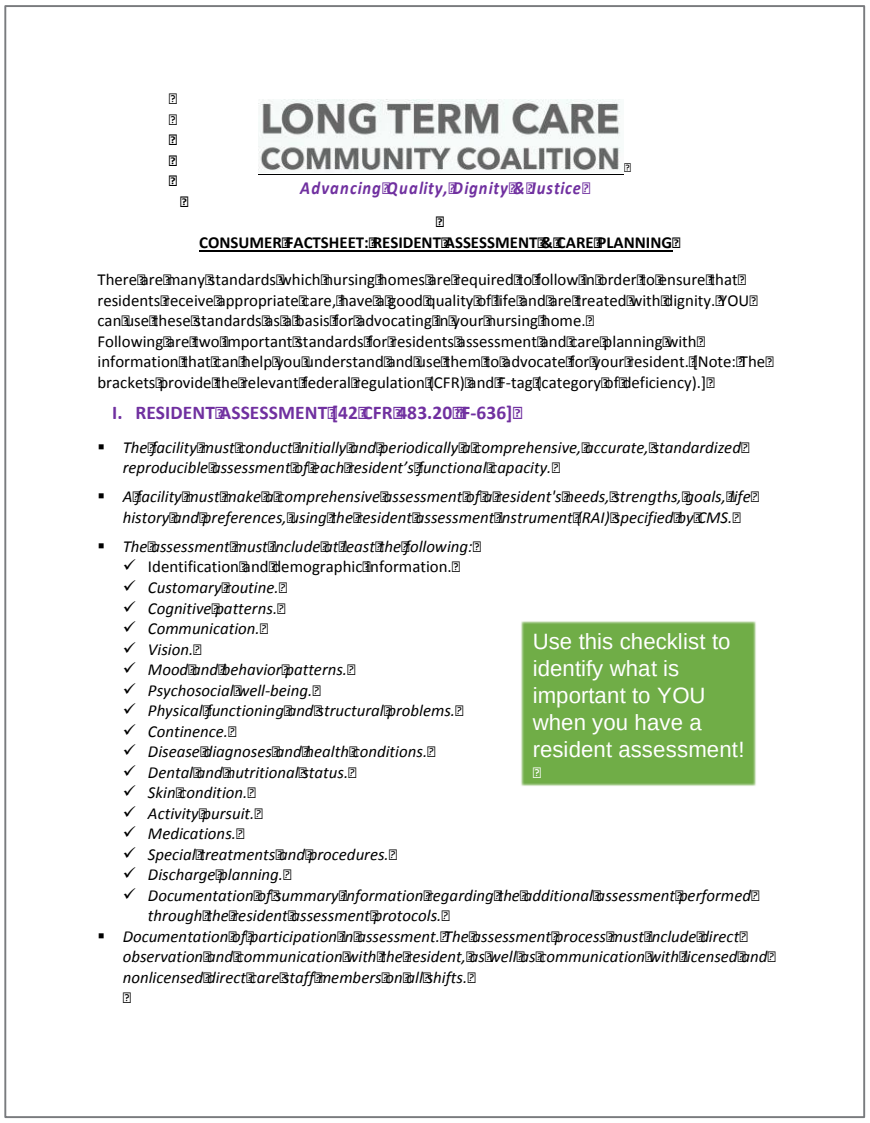
- Selected resources from:
  - LTCCC
  - Center for Medicare Advocacy
  - Justice in Aging

+ Resources: Justice in Aging

R



Resources: LTCCC



LONG TERM CARE COMMUNITY COALITION

Advancing Quality, Dignity & Justice

CONSUMER FACTSHEET: RESIDENT ASSESSMENT & CARE PLANNING

There are many standards which nursing homes are required to follow in order to ensure that residents receive appropriate care, have a good quality of life and are treated with dignity. YOU can use these standards as a basis for advocating in your nursing home. Following are two important standards for residents assessment and care planning with information that can help you understand and use them to advocate for your resident. [Note: The brackets provide the relevant federal regulation (CFR) and F-tag (category of deficiency).]

I. RESIDENT ASSESSMENT [42 CFR 483.20 F-636]

- *The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.*
- *A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS.*
- *The assessment must include at least the following:*
  - ✓ Identification and demographic information.
  - ✓ *Customary routine.*
  - ✓ *Cognitive patterns.*
  - ✓ *Communication.*
  - ✓ *Vision.*
  - ✓ *Mood and behavior patterns.*
  - ✓ *Psychosocial well-being.*
  - ✓ *Physical functioning and structural problems.*
  - ✓ *Continence.*
  - ✓ *Disease diagnoses and health conditions.*
  - ✓ *Dental and nutritional status.*
  - ✓ *Skin condition.*
  - ✓ *Activity pursuit.*
  - ✓ *Medications.*
  - ✓ *Special treatments and procedures.*
  - ✓ *Discharge planning.*
  - ✓ *Documentation of summary information regarding the additional assessment performed through the resident assessment protocols.*
- *Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.*

Use this checklist to identify what is important to YOU when you have a resident assessment!

- Fact Sheets on relevant nursing home care standards
- Free monthly lunch-and-learn webinars on resident-centered advocacy
- Facility, county, and state-level nursing home data
- Dementia Care Advocacy Toolkit
- Family & Ombudsman Resource Center

Email **INFO@LTCCC.ORG** or call **212-385-0355** to receive notifications.

Resources LTCCC: Nursing Home Staffing Data

R

City	County	Provider Name	MDS Census	RN Hours	LPN Hours	CNA Hours	Total Care Staff Hours	Avg Total Staffing Hours Per Resident Day	Avg RN Hours Per Resident Day
CAMDEN	Camden	MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE	100	0.0	106.5	191.1	297.6	3.0	0.0
BRIDGETON	Cumberland	SOUTH JERSEY EXTENDED CARE	112	1.0	86.3	204.0	291.3	2.6	0.0
NEWARK	Essex	SINAI POST ACUTE NURSING AND REHAB CENTER	355	10.1	317.1	715.6	1042.8	2.9	0.0
MAPLE SHADE	Burlington	STERLING MANOR	100	3.4	69.3	159.7	232.4	2.3	0.0
UNION CITY	Hudson	MANHATTANVIEW NURSING HOME	126	4.4	59.2	229.1	292.7	2.3	0.0
ATCO	Camden	FOUNTAINS AT CEDAR PARKE, THE	46	2.6	55.0	97.1	154.7	3.4	0.1
BERKELEY HEIGHTS	Union	RUNNELLS CENTER FOR REHABILITATION & HEALTHC	213	13.8	236.8	438.5	689.1	3.2	0.1
TOMS RIVER	Ocean	HOLIDAY CARE CENTER	162	11.0	117.9	302.2	431.1	2.7	0.1
TOMS RIVER	Ocean	ARBORS CARE CENTER	94	6.8	67.2	201.6	275.6	2.9	0.1
TRENTON	Mercer	PROVIDENCE NURSING AND REHABILITATION CENTEI	97	7.7	72.7	148.9	229.3	2.4	0.1
BLACKWOOD	Camden	ELMWOOD HILLS HEALTHCARE CENTER LLC	286	23.7	228.1	472.4	724.2	2.5	0.1
TRENTON	Mercer	RIVERSIDE NURSING AND REHABILITATION CENTER	119	11.7	117.4	208.2	337.3	2.8	0.1
PITTSGROVE	Salem	EAGLEVIEW HEALTH AND REHABILITATION	72	7.1	66.5	113.8	187.4	2.6	0.1
BARNEGAT	Ocean	BARNEGAT REHABILITATION AND NURSING CENTER	96	9.7	80.4	179.2	269.2	2.8	0.1
PERTH AMBOY	Middlesex	AMBOY CARE CENTER	154	16.2	123.3	277.7	417.3	2.7	0.1
PRINCETON	Mercer	PRINCETON CARE CENTER	94	10.4	114.6	175.4	300.4	3.2	0.1
TOMS RIVER	Ocean	COMPLETE CARE AT GREEN ACRES	131	14.4	135.8	228.5	378.7	2.9	0.1
CAPE MAY COURT HOU	Cape May	OCEANA REHABILITATION AND NC	103	11.8	71.0	151.1	233.8	2.3	0.1
CRANFORD	Union	CRANFORD PARK REHABILITATION & HEALTHCARE CI	82	9.5	76.3	216.2	302.0	3.7	0.1
ELIZABETH	Union	PLAZA HEALTHCARE & REHABILITATION CENTER	120	14.0	81.2	200.0	295.3	2.5	0.1
BRIDGETON	Cumberland	CUMBERLAND MANOR NURSING AND REHABILITATIC	154	18.8	143.3	262.7	424.8	2.8	0.1
RED BANK	Monmouth	MAJESTIC REHAB AND NURSING CENTER AT RED BAN	109	13.9	97.6	222.9	334.4	3.1	0.1
SOMERSET	Somerset	SOMERSET WOODS REHABILITATION & NURSING CEN	113	14.7	117.0	210.5	342.3	3.0	0.1
BRICK	Ocean	SHORROCK GARDENS CARE CENTER	148	20.1	123.0	328.7	471.8	3.2	0.1
CALIFON	Hunterdon	LITTLE BROOK NURSING AND CONVALESCENT HOME	27	3.8	20.4	54.9	79.1	2.9	0.1
PERTH AMBOY	Middlesex	ALAMEDA CENTER FOR REHABILITATION AND HEALTH	239	35.7	191.3	434.7	661.7	2.8	0.1
NORTHFIELD	Atlantic	MEADOWVIEW NURSING AND REHABILITATION CENT	164	25.3	113.8	375.8	514.9	3.1	0.2
NEPTUNE	Monmouth	KING MANOR CARE AND REHABILITATION CENTER	104	16.2	78.6	193.7	288.4	2.8	0.2
CHERRY HILL	Camden	ARISTACARE AT CHERRY HILL	111	17.6	138.8	276.3	432.7	3.9	0.2
LAKEWOOD	Ocean	LEISURE PARK HEALTH CENTER	49	8.0	64.7	71.6	144.3	2.9	0.2
LAKEWOOD	Ocean	FOUNTAIN VIEW CARE CENTER	111	18.2	95.2	191.9	305.3	2.8	0.2
LAKEWOOD	Ocean	ATLANTIC COAST REHAB & HEALTH	141	23.5	109.6	313.3	446.4	3.2	0.2

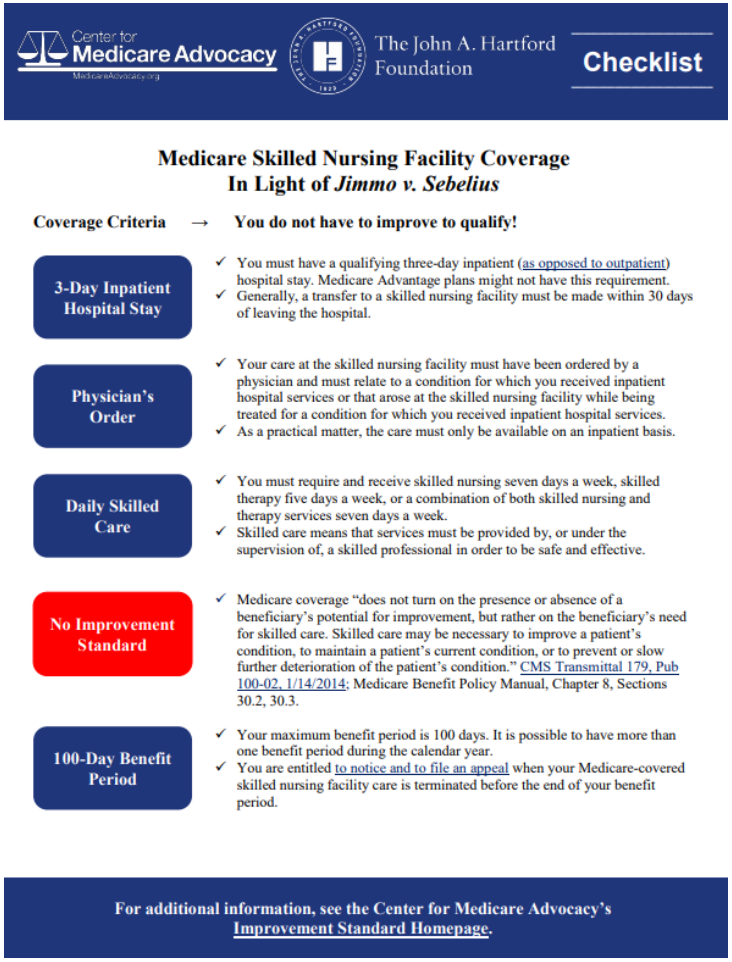
Resources LTCCC: Nursing Home AP Drugging Data

R

Facility Name	County	ZIP Code	Percent Receiving Antipsychotic Drugs	Percent Not Receiving Antipsychotic Drugs
A.G. RHODES HOME WESLEY WOODS	DeKalb	30329	6.61%	93.39%
MAGNOLIA MANOR METHODIST NSG C	Sumter	31709	27.71%	72.29%
PARK PLACE NURSING FACILITY	Walton	30655	11.73%	88.27%
NORTH DECATUR HEALTH AND REHABILITATION CENTER	DeKalb	30033	10.00%	90.00%
BELL MINOR HOME, THE	Hall	30507	18.28%	81.72%
WILLIAM BREMAN JEWISH HOME, THE	Fulton	30327	20.00%	80.00%
GLENWOOD HEALTH AND REHABILITATION CENTER	DeKalb	30032	35.58%	64.42%
MILLER NURSING HOME	Miller	39837	14.71%	85.29%
CENTER FOR ADVANCED REHAB AT PARKSIDE, THE	Catoosa	30741	25.00%	75.00%
AZALEA HEALTH AND REHABILITATION CENTER	Richmond	30907	22.89%	77.11%
MAGNOLIA MANOR OF COLUMBUS NURSING CENTER - WEST	Muscogee	31904	21.37%	78.63%
BROWN HEALTH AND REHABILITATION	Franklin	30662	21.59%	78.41%
HABERSHAM HOME	Habersham	30535	16.90%	83.10%
NHC HEALTHCARE ROSSVILLE	Walker	30741	8.60%	91.40%
EFFINGHAM CARE CENTER	Effingham	31329	22.68%	77.32%
SIGNATURE HEALTHCARE OF BUCKHEAD	Fulton	30309	11.21%	88.79%
SIGNATURE HEALTHCARE AT TOWER ROAD	Cobb	30060	12.50%	87.50%
SIGNATURE HEALTHCARE OF SAVANNAH	Chatham	31405	10.28%	89.72%
MAGNOLIA MANOR OF COLUMBUS NURSING CENTER - EAST	Muscogee	31904	10.61%	89.39%
NURSE CARE OF BUCKHEAD	Fulton	30305	15.20%	84.80%
ABERCORN REHABILITATION CENTER	Chatham	31419	26.67%	73.33%
NEWNAN HEALTH AND REHABILITATION	Coweta	30263	17.33%	82.67%
RIVERDALE CENTER	Clayton	30274	17.27%	82.73%
ANDERSON MILL HEALTH AND REHABILITATION CENTER	Cobb	30106	10.16%	89.84%
ORCHARD VIEW REHABILITATION & SKILLED NURSING CTR	Muscogee	31907	17.96%	82.04%

Resources: Center for Medicare Advocacy

- **Fact Sheets, Checklists, and Toolkits**
- *Jimmo* Settlement (2013) means that Medicare coverage "does not turn 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."



Center for Medicare Advocacy — The John A. Hartford Foundation — Checklist

Medicare Skilled Nursing Facility Coverage
In Light of *Jimmo v. Sebelius*

Coverage Criteria → You do not have to improve to qualify!

3-Day Inpatient Hospital Stay	✓ You must have a qualifying three-day inpatient (as opposed to outpatient) hospital stay. Medicare Advantage plans might not have this requirement. ✓ Generally, a transfer to a skilled nursing facility must be made within 30 days of leaving the hospital.
Physician's Order	✓ Your care at the skilled nursing facility must have been ordered by a physician and must relate to a condition for which you received inpatient hospital services or that arose at the skilled nursing facility while being treated for a condition for which you received inpatient hospital services. ✓ As a practical matter, the care must only be available on an inpatient basis.
Daily Skilled Care	✓ You must require and receive skilled nursing seven days a week, skilled therapy five days a week, or a combination of both skilled nursing and therapy services seven days a week. ✓ Skilled care means that services must be provided by, or under the supervision of, a skilled professional in order to be safe and effective.
No Improvement Standard	✓ Medicare coverage "does not turn 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." CMS Transmittal 179, Pub 100-02, 1/14/2014; Medicare Benefit Policy Manual, Chapter 8, Sections 30.2, 30.3.
100-Day Benefit Period	✓ Your maximum benefit period is 100 days. It is possible to have more than one benefit period during the calendar year. ✓ You are entitled to notice and to file an appeal when your Medicare-covered skilled nursing facility care is terminated before the end of your benefit period.

For additional information, see the Center for Medicare Advocacy's Improvement Standard Homepage.

D

Resources: Center & LTCCC

Center for Medicare Advocacy
MedicareAdvocacy.org

LONG TERM CARE COMMUNITY COALITION
Advancing Quality, Dignity & Justice

Elder Justice
What "No Harm" Really Means for Residents

Volume 1, Issue 9

In This Issue:

Introduction: What is a "No Harm" Deficiency?

Effective monitoring and oversight of nursing home care are critical to ensuring the safety and dignity of residents, as well as the integrity of the public programs which pay for a majority of nursing home care. Nevertheless, numerous studies over the years have indicated that, too often, the state agencies responsible for ensuring that nursing homes meet minimum standards of care fail to identify when residents experience substandard care, abuse, or neglect. Furthermore, CMS data indicate that, even when state surveyors *do* identify a health violation, they only identify the deficiency as having caused any harm to a resident about four percent (4%) of the time.

The failure to identify resident harm when it has occurred has pernicious implications on many levels.

The failure to identify resident harm when it has occurred has pernicious implications on many levels. Fundamentally, it signifies a lack of recognition of resident suffering, degradation and even, occasionally, death. Importantly, from a policy perspective, it means that there is likely no accountability because nursing homes rarely face financial or other penalties for "no harm" deficiencies. The absence of any penalty sends a message to nursing homes that such substandard care, abuse, and neglect will be tolerated.

The purpose of this newsletter is to provide the public with examples of these "no harm" deficiencies, taken from Statements of Deficiencies (SoDs) on Nursing Home Compare. Surveyors classified all of the deficiencies discussed here as "no harm," meaning that they determined that residents were neither harmed nor put into immediate jeopardy for their health or well-being. **We encourage our readers to read these residents' stories and determine for themselves whether or not they agree with the "no harm" determinations.**

LONG TERM CARE COMMUNITY COALITION
Advancing Quality, Dignity & Justice

Center for Medicare Advocacy
MedicareAdvocacy.org

Medical Loss Ratios for Nursing Homes: Protecting Residents and Public Funds

Background. Substandard care and insufficient staffing are longstanding problems in too many nursing homes across the United States. The nursing home industry often blames lack of funds for the failure to ensure appropriate staffing. However, the nonpartisan Medicare Payment Advisory Commission (MedPAC) reports that nursing homes have experienced double-digit Medicare profits for the last 17 years. Additionally, in July 2018, the Centers for Medicare & Medicaid Services (CMS) finalized a new payment system that provides for $820 million in increased payments to nursing homes and two billion dollars in savings over the next ten years. As one industry-oriented news outlet has noted, "historians may look back at 2018 as a kind of Golden Age for skilled care."

Meanwhile, CMS has begun to deregulate nursing homes through a process of rolling back resident rights and protections. As a result of the lack of accountability, some states are even being forced to take over nursing homes due to the poor management of private operators, leaving residents in danger of not receiving essential care. How can these two realities be reconciled? How can the industry experience a "golden age" while residents are forced back into the Dark Age?

Part of the problem is that some nursing home operators are not properly utilizing payments from Medicare and Medicaid for the benefit of residents. Instead, they all too often disproportionately use public reimbursement to pay for salaries, administrative costs, and other non-direct care services. For instance, the NY State Attorney General recently filed a complaint against an operator, alleging that the operator diverted Medicaid funds away from residents and "paid such monies for their own benefit through companies they owned or controlled." An article in *The New York Times* reports that related-party transactions have become a "common business arrangement, [as] owners of nursing homes outsource a wide variety of goods and services to companies in which they have a financial interest or that they control." *The New York Times* confirms that nursing homes with related-party transactions have "fewer nurses and aides 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."

Solution. A medical loss ratio (MLR)—requiring providers to use designated percentages of reimbursement on resident care—serves as a check to the poor use of public and private money. Federal law already places an MLR on health insurance companies under the Affordable Care Act, requiring them to spend at least 80 to 85% of premium dollars on medical care. The nursing home industry itself has come out in support of MLRs, with one industry group stating that "[t]he ACA recognizes the value of minimum MLR standards as a health reform measure . . . in order to maximize that portion of premiums spent on health care rather than administration and profit." A medical loss ratio for nursing homes would similarly work by placing an appropriate cap on the amount of money that a nursing home may use to pay for non-health care expenses, freeing money for hiring additional staff and improving resident care.

A medical loss ratio implements the mandate of the Nursing Home Reform Law—that every nursing home resident is entitled to services that attain or maintain his or her "highest practicable physical, mental, and psychosocial well-being." Our organizations believe it is time for Congress to enact a medical loss ratio for nursing homes.

For additional information and resources, please visit www.nursinghome411.org and www.medicareadvocacy.org.

Elder Justice Newsletter

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- The rollback of resident rights and protections has serious implications for the quality of care and quality of life of nursing home residents.
- Sadly, the rollback only exacerbates an enforcement system that has historically under-identified cases of resident abuse, neglect, and exploitation.
- An analysis of CMS's database shows that more than 95 percent of deficiencies are cited as not causing any harm to residents.
- "No harm" deficiencies rarely result in financial penalties. This under-enforcement means that, too often, facilities face no meaningful repercussions for poor care and resident harm.
- The Center and LTCCC have been publishing monthly newsletters highlighting "no harm" deficiencies from nursing homes across the country as a way of educating readers on what "no harm" means for residents.

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Elder Justice Newsletter

- Here are just a few examples from our newsletter, Elder Justice: What "No Harm" Really Means for Residents
  - Four-star facility in NY leaves resident sitting in feces and fails to follow infection control procedures.
  - Five-star facility in WA turns off heaters over the weekend, causing pain and displacement.
  - Five-star CA facility's staff member spits on resident's face during an argument.
  - One-star facility in IL fails to identify bed rails as a physical restraint and to reassess use after a resident was found "wedged between the wall and her bed."
  - One-star IL facility's inadequate housekeeping and maintenance results in a maggot infestation on resident's scrotum.

Assisted Living:
Recent Developments in Law, Policy & Quality Assurance

Assisted Living Law and Advocacy

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- Assisted living laws vary from state to state.
- Central issues in assisted living licensure:
  - One-level v. multi-level.
  - Different standards or licensure categories for small facilities.
  - Defined standards v. reliance on disclosure.
  - Incorporating health care expertise v. clinging to limited "social model."

Level of Care May Be Murky

- Legislatures often raise the ceiling on what type of care facilities *may* provide, without addressing the type of care that a facility *must* provide.
- Consumer problem:
  - Not getting needed care.
  - Threatened with eviction.

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Care Sometimes Is Abysmal

- Good facilities staff up to meet resident needs. …
- But the worst facilities admit residents with significant care needs, without capacity to meet those needs.

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Limited Federal Standards

- HCBS Settings Standards will become effective in March 2022.
  - Access to the greater community.
  - Resident has eviction protections at least equivalent to those provided under state's landlord/tenant law.
  - Lockable entrance doors to unit.
  - Control of schedules and activities.
  - Access to food at any time.
  - Accept visitors at any time.
    - 42 C.F.R. § 441.301(c)(4).

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GAO Finds Problems (Jan. 2018)

- 26 states could not report number of critical incidents in assisted living facilities.
- Failure to recognize certain incidents as “critical” for reporting purposes:
  - Unauthorized restraint use – 5 states don’t include.
  - Unauthorized seclusion – 6 states.
  - Attempted suicide – 7 states.
  - Medication error – 7 states.
  - Eviction – 24 states.
    - GAO-18-179.

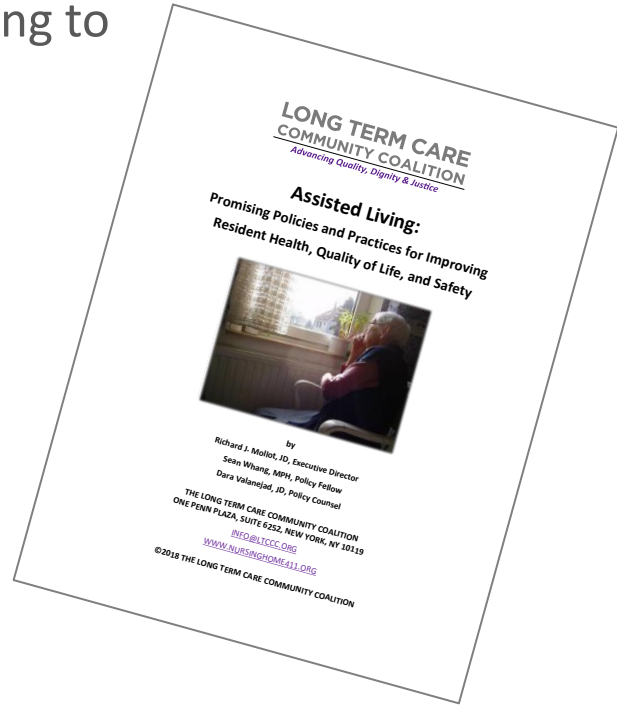
LTCCC Study: Assisted Living: Promising Policies & Practices

Questions:

- We know that there are good ALFs and bad ALFs – what are the good ones doing?
- We know that, though state regulations tend to be weak, there are some good standards out there – what are they?
- Following the GAO report, what should states be doing to protect residents?

Goal: To identify good policies and practices for…

- State and federal policymakers
- The assisted living industry
- Consumers



What did we focus on?

- Staffing Requirements: Registered Nurses
- Staffing Requirements: Administrators
- Staffing Requirements: Staff Ratios
- Staffing Requirements: Recreational Activities Directors
- Staff Training Requirements
- Dementia Care
- Oversight & Quality Assurance
- Resident & Family Councils
- Abuse & Neglect
- Transfer & Discharge
- Consumer Information (Disclosures)
- Public Information: Survey Reports & Complaint Investigations

For more information…

www.nursinghome411.org

www.medicareadvocacy.org

www.justiceinaging.org