June XX, 2017

Seema Verma

Administrator

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Room 445-G, Hubert H. Humphrey Building

200 Independence Ave., S.W.

Washington, D.C. 20201

Re:Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2018, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, Survey Team Composition, and Proposal to Correct the Performance Period for the NHSN HCP Influenza Vaccination Immunization Reporting Measure in the ESRD QIP for PY 2020.

**CMS–1679–P**

**RIN 0938–AS96**

**Submitted electronically:** [**http://www.regulations.gov**](http://www.regulations.gov)

Dear Administrator Verma:

[Brief introduction of organization submitting comments, with explanation of why your organization is interested in the federal nursing home regulations and skilled nursing facility care.]

[Name of organization] opposes any modification or removal of the regulations related to the grievance process, the Quality Assurance and Performance Improvement (QAPI) process, and discharge notices to long-term care ombudsmen. We also oppose any changes in other areas of the Requirements of Participation that are designed to reduce burden and cost to long-term care facilities.

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

In addition, we urge CMS to revise 1) how it is proposing to change payment for therapy in its new reimbursement system for skilled nursing facilities and 2) to modify its policy of not counting all the time a patient spends in the hospital toward the SNF 3-day rule as a way to eliminate unnecessary burdens for both residents and providers. CMS’s position on both these issues is harmful to the many individuals who need skilled nursing facility care and services.

Our detailed feedback on these points is presented below.

**GRIEVANCE PROCESS**

**Proposed revision #1: Retention of grievance records for less than three years**

We disagree that maintaining evidence related to grievances for 3 years is burdensome, unnecessary, and costly. Any documents concerning grievances will almost certainly be electronic. If not, handwritten documents can be scanned and become electronic. CMS itself notes in the preamble that “such evidence may be maintained electronically, rather than utilizing physical storage space.” 68724 Federal Register / Vol. 81, No. 192 / Tuesday, October 4, 2016 / Rules and Regulations). Preserving records online requires little to no effort or cost.

Maintaining records can help facilities, not burden them. As CMS pointed out in the preamble, the evidence provides a record of grievance investigations and can serve as a valuable information resource for facilities. The documentation can indicate the types of problems they have had in the past, what was done to address them and if those efforts were successful. This can help LTC facilities avoid similar grievances in the future or consider different problem resolution strategies if previous ones were not successful.

Grievance records can also assist facilities in proving that they did indeed respond to a resident concern in cases where that is called into question.

**Burden and cost to residents: How removing this provision harms residents**

Impacts surveyors’ ability to identify chronic, repeat deficiencies that are harming residents. When problems are not identified, they are not addressed.

***The major result of eliminating or modifying this provision would be to lessen providers’ accountability – not their cost or burden.***

**Proposed revision #2: Removing requirements regarding specific duties of the grievance official**

Consumer Voice objects to giving facilities greater flexibility in how they ensure grievances are fully addressed.

* The duties specified in the regulation are basic and reasonable components of complaint investigation and resolution processes that anyone wanting to properly address a complaint would be following anyway,
* Facilities that do a good job of handling grievances are already carrying out these responsibilities; specifying these duties would help other facilities know what to do,
* Duties that aren’t specified are usually not done,
* The duties are very broad, leaving a great deal of flexibility to facilities,
* Better requirements ensure that there is consistency in how complaints are handled.

**Burden and cost to residents: How removing this provision harms residents**

Without specific duties, facilities will be very inconsistent in how they handle complaints. Residents in nursing homes where complaints are not properly addressed may suffer because unresolved complaints can impact quality of care and quality of life.

**Proposed revision #3: Eliminating a grievance official to oversee the process**

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

**Burden and cost to residents: How removing this provision harms residents**

If there isn’t one person handling complaints:

* It’s confusing and unclear whom residents and family members should go to with grievances. This means that grievances may not be given to the right person which results in complaints that are unaddressed.
* No one develops the skill, experience and expertise required for proper, effective complaint handling, meaning that complaints will not be adequately addressed.
* Residents and families won’t have one person they trust and feel comfortable with, and who they know will protect their confidentiality, to go to. That will inhibit their willingness to raise grievances.

When complaints are not addressed, inadequately addressed or not raised, residents suffer. They may experience ongoing substandard care and poor quality of life.

**Proposed revision #4: Deferring to state law only if federal abuse and neglect reporting provisions are duplicative**

* It is pointless to remove these reporting requirements since the facility must comply with them anyway under the section on Freedom from abuse, neglect and exploitation – 483.12(c)(1).
* It’s important to have these requirements as part of the facility’s formal grievance process so residents, families, and staff are informed.
* These reporting provisions under the grievance process create absolutely no extra burden or cost to facilities since compliance is already required.
* Abuse and neglect reporting requirements that are duplicative of state law serve to reinforce the duty to report and underscore the importance of such reporting. Given how extremely vulnerable and dependent many residents are, reporting is so critical to resident safety that it cannot be overemphasized. The recent [CNN investigative report](http://www.cnn.com/interactive/2017/02/health/nursing-home-sex-abuse-investigation/) about sexual abuse illustrates this point.
* Deferring to state law is problematic since states vary enormously in how they define abuse, neglect and exploitation. Residents could be left vulnerable to abuse/neglect/exploitation in a federally certified NF if a state has a lower bar for these definitions.
* Since abuse is so egregious, maintaining duplicative language makes it possible to impose both state and federal sanctions – which serves as a greater deterrent.

**Burden and cost to residents: How removing this provision harms residents**

Lessening of any requirements related to abuse reporting leaves residents at greater risk of abuse. Reporting is already a problem. According to a [report from the US Department of Health and Human Services Office of Inspector General](https://oig.hhs.gov/oei/reports/oei-07-13-00010.pdf), in 2012, only 53% of allegations of abuse or neglect and the subsequent investigation results (1,338 allegations) were reported, as Federally required – meaning that 47% were NOT reported.[[1]](#footnote-1)

**QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT (QAPI)**

**Proposed revisions #1 and #2: Eliminating specific requirements regarding 1) how the program must be designed and 2) how a facility will determine underlying problems impacting systems in the facility, develop corrective actions, and monitor the effectiveness of its performance.**

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

**Burden and cost to residents: How removing these provisions harms residents**

As noted above, failure to include the provisions could negatively impact resident quality of life.

Given the shocking findings of the [OIG report about adverse events](https://oig.hhs.gov/oei/reports/oei-06-11-00370.pdf)[[2]](#footnote-2), facilities need to have the best possible systems in place for adverse event monitoring. The detail in the current regulation indicates what adverse event monitoring must entail. Without this detail, facilities would not be required to include each of the components listed, which could lessen the effectiveness of their adverse event monitoring. The result: serious harm or death of residents as documented in the OIG report.

**DISCHARGE NOTICES**

**In this request for feedback, CMS asks specific questions. Below are the questions and talking points.**

**Question #1: Is sending the discharge notice to the long-term care ombudsman achieving intended objectives to reduce inappropriate involuntary discharges?**

* Inappropriate involuntary discharges are an ongoing and serious problem that long-term care ombudsmen have been investigating and working to resolve for many years. In fact, involuntary discharges are the number one complaint that ombudsmen handle in nursing homes. Long-term care ombudsmen advocated for this mandatory notice in order to assure that residents have the fastest and easiest possible access to their services when facing possible eviction.
* Requiring facilities to notify the Ombudsman Program of involuntary discharges affirms CMS’s stated commitment to person-centered care by improving residents’ access to the services of the Ombudsman Program to assist during the discharge process. It also achieves CMS’s stated goal of protecting residents and ensuring the Office of the State LTC Ombudsman is aware of facility practices and activities related to transfers and discharges (Survey and Certification memo; May 12, 2017; S&C: 17-27-NH).
* Past experience in states where notice was already required to go to ombudsmen shows that receiving notices reduces inappropriate discharges. Ombudsmen are able to contact the resident and/or representative and provide assistance if requested. The majority of the time ombudsmen are successful in resolving a problem or concern that has triggered the proposed discharge, thereby allowing the resident to remain in his or her home.
* Reducing inappropriate discharges benefits residents.
  + Residents are able to stay in their homes, avoiding the trauma of being relocated which can result in: falls, weight loss, self-care deficits, anxiety, increased confusion, apprehension, depression, loneliness, vigilance, weight change, insecurity, withdrawal, sadness, restlessness, sleep disturbance, crying, feelings of hopelessness and helplessness.
  + Residents receive consistent care, which improves health outcomes.
* Reducing inappropriate discharges benefits facilities.
* Facilities gain a stable resident census since ombudsman participation often resolves the underlying root cause of the issue so discharge is not necessary. That, in turn, allows facilities to concentrate on residents they know and makes it possible for facilities to provide consistent care.
* Facilities experience decreased burden since frequent discharges result in substantial turnover in residents which means staff must handle the paperwork required by more admissions, more assessments, more care plans, and more consults among the departments as facilities are required to provide person-centered care to each new resident along with the current residents.
* Reducing inappropriate discharges reduces costs.
  + When ombudsmen address the underlying cause of the problem, the state does not incur the cost of an appeal hearing or an investigation.
  + Avoiding the effects of transfer trauma which can lead to a need for increased care and treatment can save money for both Medicare and Medicaid.
  + Preventing a discharge when a resident has been sent to the hospital can save Medicare thousands of dollars in cases where the hospital cannot place the resident and the resident remains in the hospital awaiting admission.
* Since the regulations have only been in effect for less than 7 months, it is likely that inappropriate discharges will be further reduced as ombudsman programs nationwide fine-tune and fully implement their systems for receiving and responding to these notices.
* To fully achieve the intended objective, nursing homes must comply with this requirement. State survey agencies must cite facilities for failing to send the discharge notice to residents and then take effective enforcement action.

**Question #2: Does the LTC Ombudsman have the capacity to receive and review/handle these notices?**

* Yes, ombudsman programs **can** handle receiving these notices:
  + Each state program is determining how it can best receive and respond to these notices.
  + Even without guidance and with the rule only being in effect since November 2016, most programs are already receiving and responding to notices.
* CMS survey and certification memo issued on May 12, 2017 has enhanced the ombudsman program’s ability to handle notices.

**Question#3:  To what extent will ombudsmen use the information in notices they receive?**

* Programs will use the information to help individual residents, track trends, and advocate for systems changes to reduce inappropriate discharges.

**Burden and cost to residents: How removing this provision harms residents**

Many residents are not connected to the ombudsman for help if discharge notices are not sent to the ombudsman.

* As a result:
  + Many residents never realize they can challenge the facility’s proposed discharge and remain in the facility. Instead, they are evicted against their will which can lead to the following:
    - The negative physical and psycho-social consequences described above: falls, weight loss, self-care deficits, anxiety, increased confusion, apprehension, depression, loneliness, vigilance, weight change, insecurity, withdrawal, sadness, restlessness, sleep disturbance, crying, feelings of hopelessness and helplessness.
    - Decline in quality of care since they will no longer by cared for by staff that know them and their needs.
    - Decline in quality of care if they are moved to a facility that provides substandard care.
    - Decline in quality of life if they are moved to a facility far from loved ones who are no longer be able to visit. Family members suffer too when they can’t visit a loved one as frequently as they would like - or even at all - given physical conditions, cost and transportation problems.
  + Many residents do not understand their rights during the discharge process, which can lead to residents being forced to:
    - Move to nursing homes where they don’t want to live
    - Go to homeless shelters, motels or other settings that are not appropriate and/or unsafe
    - Relocate without adequate preparation and orientation

**REVISIONS TO REIMBURSEMENT SYSTEM FOR SKILLED NURSING FACILITIES**

[Name of organization] strongly opposes the changes to the nursing facility reimbursement system being considered by CMS that would revise the payment system for therapy.

The proposed payment system would provide higher reimbursement for fewer types of therapy over a shorter period to time and even incentivize facilities to provide no therapy at all. Many SNF residents already have difficulty getting the full amount of therapy they require, including maintenance therapy. The revisions being suggested would not only exacerbate this problem, but create a perverse and illogical incentive to provide residents with even less or no therapy. This is totally contrary to CMS’s stated goal of reducing incentives to deliver therapy based on financial considerations rather than resident needs.

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

**REQUEST FOR INFORMATION ON CMS FLEXIBILITIES AND EFFICIENCIES (SECTION VIII OF PROPOSED RULE): OBSERVATION STATUS**

In response to CMS’s request for ideas for changes to eliminate unnecessary burdens for providers and patients, we urge CMS to use sub-regulatory guidance to clarify that **any** time a patient spends in the hospital counts toward satisfying the SNF 3-day rule required to qualify for Medicare coverage of a subsequent SNF-stay. Currently, each year thousands of beneficiaries are unable to access their skilled nursing benefit because their hospital stay is not administratively classified as “inpatient” even if their stay lasts longer than three days. For many of these beneficiaries, this means they cannot receive the skilled nursing and/or therapy care they need. CMS could create this sub-regulatory guidance by issuing a Medicare Benefit Policy Manual (using its authority to define “inpatient” care authority recognized by the Second Circuit and CMS itself).

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

Sincerely,

Your Name Your Title

1. U.S. Department of Health and Human Services Office of the Inspector General, *OEI-07-13-00010: Nursing Facilities’ Compliance with Federal Regulations for Reporting Allegations of Abuse or Neglect*, available at <https://oig.hhs.gov/oei/reports/oei-07-13-00010.pdf> (August 2014). [↑](#footnote-ref-1)
2. U.S. Department of Health and Human Services Office of the Inspector General, *OEI-06-11-00370: Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries,* available at <https://oig.hhs.gov/oei/reports/oei-06-11-00370.pdf> (February 2014). [↑](#footnote-ref-2)