April 29, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

Dear Administrator Oz:

The undersigned organizations write to urge the Centers for Medicare & Medicaid Services (CMS) to maintain and strengthen its nursing home antipsychotic drug quality measure. This measure has been a critical tool in driving reductions in inappropriate antipsychotic drug use, improving transparency for consumers, and safeguarding nursing home residents from unnecessary and dangerous chemical restraints. Recent oversight findings reaffirm both the continued prevalence of misuse and the measure's effectiveness in addressing it—making now precisely the wrong time to weaken or eliminate this essential protection.

The inappropriate use of antipsychotic drugs in nursing homes has been recognized for decades as a serious and widespread problem. As early as 2007, national reporting found that nearly one-third of nursing home residents were receiving these powerful medications, often not for clinically indicated conditions but to quiet or control behaviors associated with dementia.[i] These practices raised significant concerns about the use of antipsychotics as chemical restraints rather than for legitimate medical treatment.

In 2011, HHS Inspector General Daniel Levinson confirmed the scope of the problem, finding that antipsychotic drugs were frequently prescribed in ways that violated federal standards for unnecessary drug use. Most notably, his office found that 88 percent of these drugs were prescribed to elderly residents with dementia, despite FDA "black-box" warnings that such use increases the risk serious and life-threatening side-effects.[ii] Inspector General Levinson concluded that "government, taxpayers, nursing home residents, as well as their families and caregivers should be outraged — and seek solutions."[iii] Subsequent research, data, and news media reports have consistently found that these concerns persist. In 2021, a *New York Times* investigation found that "government and the industry are obscuring the true rate of antipsychotic drug use on vulnerable residents."[iv]

Over the last 15 years, CMS has taken numerous steps to address this widespread, harmful, and expensive practice, starting with the Partnership to Improve Dementia Care. While the Partnership had some success, the problem has persisted and, in fact, grown worse during the COVID pandemic and in the years since the end of the public health emergency.

In 2011, CMS introduced quality measures designed to gauge the number of nursing home residents receiving—or having received—antipsychotic drugs. These measures were intended

to give consumers access to critical information related to the use of chemical restraints, enabling them to make more informed decisions about their care.

Over the years, the National Partnership to Improve Dementia Care has reported progress, with antipsychotic drug use among long-stay residents reportedly declining by approximately 35–40 percent. However, last month, the HHS Office of Inspector General issued two reports on this persistent problem, finding that "[n]ursing homes gave antipsychotic drugs to residents with dementia to manage their behavior for the benefit of staff, despite FDA's warning that these drugs may increase the risk of death."[v] Facilities were also found to fail to follow required safeguards, including attempting non-pharmacological interventions, ensuring appropriate clinical indications, and monitoring for adverse effects. These practices are inconsistent with longstanding federal requirements that residents be free from unnecessary drugs and chemical restraints.

In another report, the OIG found that some nursing homes have "inappropriately diagnosed residents with schizophrenia" in order to mask ongoing use and improve reported performance.[vi] Because the measure excludes residents with certain diagnoses—most notably schizophrenia—facilities had a clear incentive to increase the use of exclusionary diagnoses. As antipsychotic use for long-stay residents appeared to decline, diagnoses of schizophrenia rose sharply, calling into question whether reported reductions truly reflected changes in prescribing practices or merely shifts in documentation.

To its credit, CMS had already identified many of these vulnerabilities and started to take meaningful action by auditing antipsychotic use in certain nursing homes and strengthening the measure by incorporating Medicare Part D claims data to validate self-reported MDS information. These actions acknowledge both the importance of the measure and the need to improve its accuracy.

Importantly, despite identifying serious and ongoing misuse of antipsychotic drugs, the OIG found that the antipsychotic quality measure has been **successful in reducing overall antipsychotic use** in nursing homes. We strongly agree with this conclusion and urge CMS to continue refining and strengthening the measure to ensure its accuracy and credibility.

We were very disheartened to learn that the quality measure will now exclude hospice patients from the denominator. At a time when hospice fraud is a notable public concern, a hospice exclusion will only increase incentives to have nursing home residents who are not terminally ill enrolled in hospice. Most troubling though, is that the factors contributing to the shameful misuse of antipsychotics for people with dementia are very similar to those for hospice patients. Hospice patients often experience significant pain, discomfort, and confusion and are unable to express them in words. They use behavior as communication but the behavior is incongruent with the notion of a "peaceful" patient - so antipsychotics are used to sedate them. We urge you to re-consider adding another antipsychotic exclusion that will increase costly fraud and the use of chemical restraints.

We are aware that CMS is facing increasing pressure from segments of the pharmaceutical industry to eliminate the measure altogether. CMS must reject these efforts. Rather than

abandoning a measure that has demonstrably improved care, the appropriate response is to reinforce it—by closing loopholes, improving data validation, and ensuring that reductions in antipsychotic use reflect meaningful changes in clinical practice, not documentation gamesmanship.

Nursing home residents are entitled to care that upholds longstanding federal protections, including the right to be free from unnecessary drugs and chemical restraints. At the same time, taxpayers have a right to expect that public funds are used responsibly—not spent on inappropriate, harmful, and avoidable medications. We urge CMS to stand firm in maintaining and strengthening this critical quality measure. Doing so will protect vulnerable residents and help prevent fraud, waste, and abuse by ensuring that taxpayer dollars are not used to support improper prescribing practices.

Sincerely,

California Advocates for Nursing Home Reform
Center for Medicare Advocacy
Justice in Aging
Long Term Care Community Coalition
Michigan Elder Justice Initiative
National Consumer Voice for Quality Long-Term Care

cc: Dora Hughes, M.D., M.P.H. Chief Medical Officer and Director, CCSQ
Karen Tritz, Director, Survey Operations Group, CCSQ
Evan Shulman, Director, Division of Nursing Homes

[i] Lagnado, Lucette, "Prescription Abuse Seen In U.S. Nursing Homes: Powerful Antipsychotics Used to Subdue Elderly; Huge Medicaid Expense," *The Wall Street Journal* (December 4, 2007).
[ii] US HHS Office of Inspector General, "Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents," Report number: OEI-07-08-00150 (May 4, 2011).
[iii] Levinson, Daniel R., "Overmedication of Nursing Home Patients Troubling" (May 9, 2011).
[iv] Thomas, Katie, Gebeloff, Robert, and Silver-Greenberg, Jessica, "Phony Diagnoses Hide High Rates of Drugging at Nursing Homes," *The New York Times* (September 11, 2021).
[v] US HHS Office of Inspector General, "Nursing Homes' Inappropriate Use of Antipsychotic Drugs Poses a Risk to Residents," Report number: OEI-02-23-00200 (March 16, 2026).
[vi] US HHS Office of Inspector General, "Nursing Homes Inappropriately Diagnosed Residents with Schizophrenia to Mask the Misuse of Antipsychotic Drugs," Report number: OEI-02-23-00201 (March 16, 2026).