

# JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

June 26, 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>

Dear Administrator Verma:

Justice in Aging is a national non-profit legal advocacy organization that fights senior poverty through law. Since our founding in 1972, we've worked for access to affordable health care and economic security for older adults with limited resources, focusing especially on populations that have traditionally lacked legal protection. We were part of the coalition that developed the Nursing Home Reform Law in the mid-1980's, and have assisted nursing facility residents since that time with policy advocacy, technical assistance, and education.

We write to respond to CMS's discussion of "Possible Burden Reduction in the Long-Term Care Requirements."<sup>1</sup> In general, we oppose the proposed changes. In most of the situations raised by CMS, the burden of the particular regulation is relatively small, and is outweighed by the benefit to nursing facility residents. We understand that nursing facility representatives may have advocated for changes similar to those proposed in the Federal Register but, based on our decades of experience in this area, we believe that the facilities' concerns may be overstated. In any case, we know from experience that the regulatory provisions in question will be exceedingly useful in improving quality of care received by nursing facility residents.

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<sup>1</sup> 82 Fed. Reg. 21,014, 21,088- 89 (May 4, 2017).

**WASHINGTON**

1444 Eye Street, NW, Suite 1100  
Washington, DC 20005  
202-289-6976

**LOS ANGELES**

3660 Wilshire Boulevard, Suite 718  
Los Angeles, CA 90010  
213-639-0930

**OAKLAND**

1330 Broadway, Suite 525  
Oakland, CA 94612  
510-663-1055

## **GRIEVANCE PROCESS**

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

The federal nursing facility regulations currently require a nursing facility to retain “evidence demonstrating the results of all grievances” for at least three years.<sup>2</sup> We fail to see a significant burden in such a requirement. 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 to the regulations that “such evidence may be maintained electronically, rather than utilizing physical storage space.”<sup>3</sup>

Furthermore, even if documentation was maintained on paper, the required storage space likely would be no more than one drawer in a file cabinet. We note that the regulation calls for “evidence demonstrating the results of all grievances.” In response to the proposed regulation, a commenter had asked for a requirement “that facilities maintain all investigative documentation related to the grievance.” In response, CMS did “not agree it is necessary to explicitly require that all investigation documentation be retained.”<sup>4</sup>

Thus, the relatively minimal burden is far outweighed by the value of records retention. As CMS pointed out in the preamble, the records “can serve as a valuable information resource for facilities.”<sup>5</sup> It would be very helpful to know, for a three year period, what type of grievances were made, whether a particular grievance was supported by the evidence, and how the facility responded to substantiated grievances. This type of information could be critical for a facility’s quality improvement efforts, as the facility evaluates past problems and the effectiveness of interventions.

Overall, the document retention required by this provision reflects an infinitesimal fraction of the information that a nursing facility routinely handles, including but not limited to health care records and Medicare/Medicaid payment information. In this instance, facilities’ claims of burden cannot withstand scrutiny.

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

CMS states that it is considering “removing prescriptive language in the requirements regarding the specific duties of the grievance official and allow facilities greater flexibility in how they ensure that grievances are fully addressed.”<sup>6</sup> Here, word for word, are the grievance official’s duties under the current regulation:

- I. Overseeing the grievance process;

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<sup>2</sup> 42 C.F.R. § 483.10(j)(4)(vii).

<sup>3</sup> 81 Fed. Reg. 68,688, 68,724 (Oct. 4, 2016).

<sup>4</sup> 81 Fed. Reg. 68,688, 68,724 (Oct. 4, 2016).

<sup>5</sup> 81 Fed. Reg. 68,688, 68,724 (Oct. 4, 2016).

<sup>6</sup> 82 Fed. Reg. 21,014, 21,089 (May 4, 2017).

2. Receiving and tracking grievances through to their conclusion;
3. Leading any necessary investigations by the facility;
4. Maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously;
5. Issuing written grievance decisions to the resident; and
6. Coordinating with state and federal agencies as necessary in light of specific allegations.<sup>7</sup>

We respectfully suggest that these duties are far from controversial — in fact, these may be the bare minimum of duties for a reasonably competence grievance resolution system. Also, they are written in relatively broad language, giving an individual facility great flexibility in exactly how the facility chooses to implement federal law.

**Proposed revision #3: Not requiring that an identifiable person be appointed as a grievance official.**

Current law simply requires that the facility “identify” a grievance official with responsibility for the grievance program.<sup>8</sup> CMS confirms in the preamble that the regulation does not require a new full-time hire, but instead requires that a facility identify one staff member who will have responsibility for handling grievances.<sup>9</sup>

Again, we fail to see the burden in this requirement. It would hardly be more efficient for a facility to spread responsibility for a grievance program among multiple employees. Furthermore, failure to identify a person-in-charge would almost guarantee an ineffectual grievance program. And appointing one person as grievance official will not burden that one person unduly, since he or she can carry out his or her duties “through direct action or coordination with others.”<sup>10</sup>

The principal reason to retain this requirement is to provide residents with a good quality of care. Residents deserve good care, and care is greatly improved if a facility has the capacity to respond effectively to resident grievances. If responsibility for a grievance programs was to be shared by various facility employees, residents’ grievances almost certainly would be handled poorly – for one thing, residents and family members might not know whom to speak with to file a grievance. Also, if responsibility were divvied up among various employees, no one employee would develop the expertise that a single grievance official otherwise would accrue. Quality of care doubtlessly would suffer, and residents would be more likely to be subject to insufficient care and resident rights violations. There are no good reasons to change the requirement of a grievance official, and many reasons to maintain the current regulatory language.

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<sup>7</sup> 42 C.F.R. § 483.10(j)(4)(ii).

<sup>8</sup> 42 C.F.R. § 483.10(j)(4)(ii).

<sup>9</sup> 81 Fed. Reg. 68,688, 68,724 (Oct. 4, 2016).

<sup>10</sup> 81 Fed. Reg. 68,688, 68,724 (Oct. 4, 2016).

#### **Proposed revision #4: Deferring to state law on federal abuse and neglect.**

The grievance provision requires a facility's grievance policy to include the duty to report abuse, neglect or misappropriation "to the administrator of the provider; and as required by State law."<sup>11</sup> CMS reports now that it is considering eliminating this requirement to the extent that the requirement duplicates state law.<sup>12</sup> Presumably the alleged duplication relates only to the requirement that the grievance policy include reporting as required by state law. We respectfully disagree — a facility's policy should include all reporting obligations, whether those requirements are set by federal or state law.

We also disagree with the proposed change if the alleged "duplication" relates to the requirement that a grievance policy include reporting to the administrator. There is no reason to think that this exact requirement is already set by state law in all 50 states. And, even if we were to assume that all 50 states already have this requirement in state law, there still would be value in uniformity.

Finally, we note that the regulatory provision relates to the inclusion of reporting requirements in the grievance policy, and requires that the grievance policy be shared upon request with the resident.<sup>13</sup> Employees and residents should understand the proper process for reporting alleged abuse, which is an independent reason why these reporting requirements should be included in the grievance regulations. Rates of reporting are too low; the HHS Inspector General found in a recent report that only 53% of abuse or neglect allegations were properly reported.<sup>14</sup>

In summary, there appears to be little risk of duplication with state law. It is *extremely* unlikely the laws of all 50 states require that reporting requirements be included in a grievance policy, and that a residents be given a copy of the grievance policy. These provisions of the federal regulations play an important role in protecting residents and should be retained.

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

### **Proposed revisions #1 and #2: Eliminating specific requirements regarding 1) program design and 2) program feedback, monitoring and analysis.**

In setting out the justification for the proposed change, CMS says that "[s]everal stakeholders have indicated that our requirements are very detailed, too prescriptive, and significantly exceed the QAPI related requirements for other providers."<sup>15</sup> We do not think that this is

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<sup>11</sup> 42 C.F.R. § 483.10(j)(4)(iv).

<sup>12</sup> 82 Fed. Reg. 21,014, 21,089 (May 4, 2017).

<sup>13</sup> 42 C.F.R. § 483.10(j)(4).

<sup>14</sup> U.S. Dep't of Health and Human Services, Office of the Inspector General, Nursing Facilities' Compliance with Federal Regulations for Reporting Allegations of Abuse or Neglect, Report No. OEI-07-13-00010, at 12 (Aug. 2014).

<sup>15</sup> 82 Fed. Reg. 21,014, 21,089 (May 4, 2017).

true: in fact, the existing regulatory language is not particularly prescriptive. There is some detail, to be sure, but that type of detail is appropriate, considering that the QAPI process may be new to many nursing facilities. By requiring specific elements, CMS will better ensure that all nursing facilities develop and operate an effective QAPI process. The regulatory language promotes consistency, which is good for both residents and facilities.

If certain provisions were eliminated, the remaining QAPI provisions might be inadequate. For example, current regulatory language requires that a QAPI program “[i]nclude clinical care, quality of life, and resident choice.”<sup>16</sup> None of these elements should be overlooked, which means that this language should be retained in the regulations.

## **DISCHARGE NOTICES**

**CMS raises the following three questions in its request for comments.<sup>17</sup>**

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

The new regulatory requirement is a well-considered way of addressing inappropriate discharges. Year after year, ombudsman programs report that facility-initiated discharge is the most common issue that ombudsman programs address. When CMS solicited comments on the proposed nursing facility regulations, ombudsman programs advocated for the requirement that facilities share discharge notices with ombudsman programs.

Some states have had a pre-existing requirement that nursing facilities share discharge notices with ombudsman programs. Those ombudsman programs report that this requirement has been effective. They are able to make prompt contact with residents and counsel those residents appropriately. This limits inappropriate discharges, since residents will better understand the rules, and will be more likely to defend their rights when the facility is in the wrong regarding the involuntary discharge. If, on the other hand, the facility is in the right, the resident is better able to understand that fact and to explore his or her options.

Of course, the federal requirement has only been in effect since November 2016, and the CMS guidance on this requirement was issued less than two months ago.<sup>18</sup> We expect the new federal requirement to become more effective as both ombudsman programs and facilities incorporate the new CMS guidance into their practices. The new regulation has great promise. As the Nursing Home Reform Law counsels, there should be very limited instances in which a nursing facility forces a resident to leave. Nursing facilities must be able to provide a comprehensive package of nursing services, so residents in general shouldn’t have to move to a

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<sup>16</sup> 42 C.F.R. § 483.75(b).

<sup>17</sup> 82 Fed. Reg. 21,014, 21,089 (May 4, 2017).

<sup>18</sup> CMS, Implementation Issues, Long-Term Care Regulatory Changes: Substandard Quality of Care (SQC) and Clarification of Notice before Transfer or Discharge Requirements, S&C 17-27-NH (May 12, 2017).

different nursing facility in order to receive the necessary services. And nursing facility residents, like anyone else, can suffer physically or suffer other setbacks when being forced to move from one place to another. The potential negative consequences include self-care deficits, anxiety, increased confusion, apprehension, depression, loneliness, excessive weight gain or loss, sleep disturbance, crying, and feelings of hopelessness and helplessness.

Under the Nursing Home Reform Law, care should be person-centered to the extent possible, and the facility should be as home-like as possible. For all these reasons, residents should have enough support so that they do not leave the facility unless they choose to, or unless the facility can prove one of the six justifications for eviction under the Nursing Home Reform Law.

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

Yes, we are in contact with many ombudsman programs and they report that they do have the capacity. For example, we presented a training in St. Louis, Missouri, several weeks ago, and the program there reported that they are actively working to publicize the new law so that they can receive more notices and help more residents.

There was some initial confusion among nursing facilities and ombudsman programs about implementation of the new requirement, but most of that was resolved by the guidance issued on May 12, 2017. Regarding that guidance, we reiterate our support of a broad requirement that requires notice whenever discharge is initiated by a facility. Because residents almost always are unfamiliar with nursing facility procedures and rules, and often are intimidated by being reliant on facility staff 24 hours a day, it is important that notice is required whenever the facility takes the initiative on a discharge — for example, whenever a facility suggests that a resident should leave after his or her Medicare coverage has ended.

When a resident takes the initiative, and says that he or she wants to leave the facility in order to move home (for example), there is no need for the facility to issue notice. But in other instances, when the impetus to leave comes from the facility, the resident should receive notice that informs him or her of the relevant rules and the appeal rights, and a copy of that notice should be sent to the long-term care ombudsman program.

We have many years of experience with this issue, and have spoken to many consumers who were influenced by a nursing facility to leave the facility for improper reasons, and only weeks later (after speaking to us) realized that they were treated unfairly by the nursing facility. The new regulation, requiring that notice be shared with ombudsman programs, is an effective way to limit these situations in the future. Residents should know their rights at a time when those rights can be particularly useful to them.

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

We expect ombudsman programs to use this information extensively. Ombudsman programs will use the information to help individual residents, track trends, and advocate for system changes to reduce inappropriate discharges. As discussed above, we believe that the new requirement is a relatively simple requirement that could have a huge benefit, by identifying situations where residents and their families can benefit from the prompt assistance of a long-term care ombudsman program.

Overall, the limited burden of sending a notice is far outweighed by the benefit of ombudsman programs being able to assist residents in times of great need. As discussed above, the consequences of an unnecessary and unwanted transfer can be very severe for nursing home residents. How does any person feel when being forced to move? And in the case of nursing facility residents, moving also means a complete change in the persons providing care, and in all other persons the resident sees during a day.

**REQUEST FOR INFORMATION ON CMS FLEXIBILITIES AND EFFICIENCIES (SECTION VIII OF PROPOSED RULE): NECESSARY REFORM OF MEDICARE'S OBSERVATION STATUS RULES**

CMS has asked for “improvements that can be made to the health care delivery system that reduce unnecessary burdens for clinicians, other providers, and patients and their families.”<sup>19</sup> We urge CMS to issue guidance to establish that any time a patient spends in the hospital counts toward satisfying the 3-night stay requirement for subsequent Medicare coverage of nursing facility care.

Current policy unfairly limits Medicare coverage under an arbitrary practice that distinguishes “observation” stays in a hospital from “inpatient” care. Each year, thousands of beneficiaries are unable to access their Medicare skilled nursing benefit because their hospital stay is not administratively classified as “inpatient” even if their stay lasts longer than three days. The arbitrary distinction between inpatient care and observation status often deprives persons of coverage for nursing facility care and accompanying therapy services. This issue could be resolved by CMS through subregulatory guidance, consistent with a previous federal court ruling that deferred to CMS on this issue.

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<sup>19</sup> 82 Fed. Reg. 21,014, 21,090 (May 4, 2017).

Thank you for the opportunity to comment and for your consideration of our comments.  
Please feel free to call at any time with any questions or suggestions.

Sincerely,

A handwritten signature in black ink, appearing to read "K. Prindiville". The signature is written in a cursive style with a large initial "K" and a stylized "Prindiville".

Kevin Prindiville  
Executive Director