JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

October 14, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-3260-P
P.O. Box 8010
Baltimore, Maryland 21244-8016

Re: Comments on Proposed Nursing Facility Regulations;
File Code CMS-3260-P

Dear Mr. Slavitt:

Justice in Aging is a national organization founded in 1972; we were known as the National Senior Citizens Law Center until our name change earlier this year. We advocate on behalf of older adults with limited resources; one of our principal goals is access to affordable health care. We have decades of experience with nursing facilities, and were active advocates in the enactment of the Nursing Home Reform Law and the development of the implementing regulations. We have decades of experience in assisting nursing facility residents and their families.

We thank you and your staff for the many positive features of the proposed regulations. The emphasis on person-centered care is welcome, as is the focus on effective discharge planning. We also see, however, many areas in which the regulations could and should be improved. Our comments below address many important issues, and provide suggested deletions for consideration by you and your staff. For particular sections or subsections, we discuss relevant considerations and then set forth our recommended regulatory language.

42 C.F.R. § 483.5 Definitions

<u>Several Definitions Should Be Clarified or Otherwise Improved (§ 483.5)</u>

We offer recommended language to clarify the definition of "abuse."

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

Our recommended definition for "common area" uses "present" rather than "located" because the word "located" makes residents seem like things rather than persons.

We recommend a revision to the definition of "neglect" to clarify that neglect can occur when a resident has been deprived of goods or services; the resident does not have to be deprived of both.

We recommend revision of the definition of "nurse aide" to clarify the definition, and to address the fact that some states (e.g., New Hampshire and Vermont) license nursing assistants.

We recommend revision of the definition of "person-centered care" to improve the sentence structure.

We see several problems with the proposed definition of "resident representative." It is circular to base status as a resident representative on whether a person "has access to information and participates in healthcare discussions" — a person would have access to information and be able to participate in healthcare discussions only if he or she already were the resident representative. Also, the focus on "legal standing" is too narrow, given that state laws often recognize representative status even without a particular legal document or surrogacy designation. Our recommended language is adapted from the long-term care ombudsman regulations at 45 C.F.R. § 1327.1.

We recommend that "transfer or discharge" be revised to transfer or discharge. This is consistent with the statute. *See, e.g.*, 42 U.S.C. §§ 1395i-3(c)(2)(A), (B) and (C), 1396r(c)(2)(A), (B) and (C). "Transfer" and "discharge" are considered two distinct actions.

Recommended Revisions for 42 C.F.R. § 483.5

…

Abuse. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This definition presumes that any instance~~s~~ of abuse of any~~all~~ resident~~s~~, irrespective of the resident's~~any~~ mental or physical condition, cause~~s~~ physical harm, pain or mental anguish. ~~It~~ Abuse includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. *Willful,* as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

…

Common area. Common areas are areas in the facility where residents may gather together with other residents, visitors, and staff or engage in individual pursuits, apart from their residential rooms. This includes but is not limited to living rooms, dining rooms, activity rooms, outdoor areas, and meeting rooms where residents are present~~located~~ on a regular basis.

…

Neglect is the failure of the facility, its employees or service providers to provide a good~~s~~ or~~and~~ service~~s~~ to a resident that is~~are~~ necessary to avoid physical harm, pain, mental anguish or mental illness.

Nurse aide. A nurse aide is any individual providing nursing or nursing-related services to residents in a facility~~. This term may also include an individual who provides these services through an agency or under a contract with the facility, but~~ who is not a licensed health professional, a registered dietitian, or someone who volunteers to provide such services without pay. The term "n~~N~~urse aide~~s~~" includes persons licensed as a nurse aide, a nursing assistant, or a similar licensure category, but does not include those individuals who furnish services to residents only as paid feeding assistants as defined in § 488.301 of this chapter.

Person-centered care. For purposes of this subpart, person-centered care means care that~~to~~ focuses on the resident as the locus of control and supports ~~the~~ residents in making their own choices and ~~having~~ controlling ~~over~~ their daily lives.

Resident representative. For purposes of this subpart, the term resident representative means ~~an individual of the resident's choice who has access to information and participates in healthcare discussions or a personal representative with legal standing, such as a power of attorney, legal guardian, or health care surrogate appointed or designated in accordance with state law. If selected as the resident representative, the same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated.~~ any of the following:

(1) An individual chosen by the resident to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications;

(2) A person authorized by State or Federal law (including but not limited to agents under power of attorney, representative payees, and other fiduciaries) to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications; or

(3) The court-appointed guardian or conservator of a resident.

(4) Nothing in this section is intended to expand the scope of authority of any resident representative beyond that authority specifically authorized by the resident, State or Federal law, or a court of competent jurisdiction.

…

Transfer or~~and~~ discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer or~~and~~ discharge does not refer to movement of a resident to a bed within the same certified facility.

42 C.F.R. § 483.10 Resident Rights

Same-Sex Spouses Should Have Rights Equivalent to Those of Opposite-Sex Spouses (§ 483.10(a)(5))

The proposed regulations state that a same-sex spouse should receive the treatment as an opposite-sex spouse "if the marriage was valid in the jurisdiction in which it was celebrated." That qualifier should be eliminated, given the Supreme Court's recent ruling in *Obergefell v. Hodges*, 135 Sup. Ct. 2584 (2015).

If Care Planning Truly Is to Be Person-Centered, the Resident Must Have the Right to Object to, and Appeal the Care Plan (§ 483.10(b)(5))

The proposed regulations refer to the right to see the care plan, including the right to sign the care plan after it has been changed. These rights, along with the other proposed care plan provisions, suggest that the resident and resident representative have a subservient role in the care planning process.

Such a meager role is inappropriate, given CMS's discussion of the importance of person-centered care,[1] and the proposed definition of person-centered care as meaning "to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives." Proposed 42 C.F.R. § 483.5. For "person-centered care" to become a reality, and not just an attractive concept, a resident must have significant control over the care plan. A right to see and sign the care plan falls far short. To address this inadequacy, we recommend that subsection 483.10(b)(5) be revised to provide the resident or resident representative with authority to object to, and appeal the care plan.

[1] In introducing the proposed regulations, CMS references its "desire to promote person-centered care and improve the quality of care and services, while further protecting resident's safety, choice and well-being." 80 Fed. Reg. 42,168, 42,174 (2015).

A Resident's Right to Choose a Physician Should Not Be Limited By Facility Credentialing (§ 483.10(c)(2))

The Nursing Home Reform Law provides residents with the "right to choose a personal attending physician."[2] The proposed regulations, however, would limit this right by allowing access to the facility only to those physicians who meet "professional credentialing requirements" established by the facility.

We oppose the proposed credentialing requirement. The proposed regulation sets no standards as to what credentialing requirements might include, and would seem to open the door to facilities setting arbitrary requirements. We are familiar with situations in which a facility has resisted, for improper and selfish reasons, a resident's choice of physician. Furthermore, even assuming that a nursing facility might be operating in good faith, the vast majority of nursing facilities do not have the expertise and time to establish, maintain and enforce a facility-specific credentialing system.

CMS does not identify the legal or policy justification for authorizing a credentialing requirement. Even assuming that a credentialing requirement in some situations might enable a facility to exclude a licensed but incompetent physician, we believe that occasional benefit is outweighed by the danger that a facility will use its credentialing authority improperly, in violation of a resident's statutory right to choose a physician. If the right to choose a physician is to be meaningful, the facility cannot dictate the physicians allowed to see residents.

Residents' Access to Records Should Not Be Limited to Medical Records and Should Be Made Easier (§ 483.10(f)(3))

The proposed regulations would weaken residents' rights to access their records. Current requirements give residents access to all their records. By contrast, the new regulations would change "all records" to "medical records," giving residents access to less information. This is a step in the wrong direction. Moreover, the "cost-based fee" for the provision of copies that includes labor could easily become prohibitively expensive, further limiting a resident's right to their records. We understand that the cost language is adapted from the HIPAA requirements at 45 C.F.R. § 164.524(c)(4), but there is no reason why the HIPAA procedures should be automatically extended to nursing facility residents. The majority of nursing facility residents are Medicaid-eligible, and retain only $40-50 monthly from their incomes — a charge for copies, under CMS's proposed language, could easily consumer much or all of their available monthly income. Accordingly, we recommend restoring the current language of "all records" and eliminating any fees for labor costs. We recommend setting charges at a cost not to exceed the community standard, which is the standard used in current law.[3]

[2] 42 U.S.C. §§ 1395i-3(c)(1)(A)(i), 1396r(c)(1)(A)(i).
[3] *See* 42 C.F.R. § 483.10(b)(2)(ii).

We also urge changes to language proposed to be retained from the existing regulations. Four long-standing concerns with resident access to records have been that 1) facilities often refuse to share records with persons of the resident's choosing, 2) the 24-hour time frame for accessing current records excludes weekends and holidays, 3) the resident must inspect records before purchasing them, and 4) the 24-hour and 2-day time frames can be unnecessarily long.

We recommend that the regulations be revised to specify that a resident can share access to records with persons of the resident's choosing. In our experience, facilities often (and improperly) cite HIPAA's Privacy Rule as justification for refusing to provide access to family members and friends, even though the resident has consented to provide access to the person in question.

Because the facility is the resident's home, access to records should be 24/7 and not contingent upon weekday staffing. Furthermore, a resident may wish to review records with family members, whose visits may occur more frequently on weekends and holidays.

Additionally, we can see no valid reason for making residents inspect records prior to purchasing copies, except to delay resident access. There is no such requirement for persons who wish to obtain copies of their records in settings outside of nursing facilities.

Finally, there often is no reason why a resident (or resident representative) should have to wait 24 hours to view records, or wait 2 days to receive copies. The standard should be based on reasonable effort, with the 24-hour and 2-day time periods being outside limits that cannot be exceeded.

Recommended Revisions for 42 C.F.R. § 483.10

The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

(a) *Exercise of rights.* (1) The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

…

(5) In the case of a resident who has not been adjudged incompetent by the state court, any legal surrogate designated in accordance with state law may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse~~ if the marriage was valid in the jurisdiction in which it was celebrated~~.

(b) *Planning and implementing care.* The resident has the right to be informed of, and participate in, his or her treatment, including:

(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.

(2) The right to be informed, in advance, of the care to be furnished and the disciplines that will furnish care.

(3) The right to be informed in advance of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.

(4) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive as specified in § 483.11(e)(6).

(5) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:

(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

(iii) The right to be informed, in advance, of changes to the plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after changes to the plan of care.

<u>(vi) The right to object to, and appeal the care plan.</u>

…

(c) *Choice of attending physician.* The resident has the right to choose his or her attending physician.

(1) The physician must be licensed to practice <u>in the state in which the facility is located</u>~~,~~ ~~and~~

~~(2) The physician must meet the professional credentialing requirements of the facility~~.

~~(3) If the physician chosen by the resident refuses to or does not meet requirements specified in this part, the facility may seek alternate physician participation as specified in § 483.11(c) to assure provision of appropriate and adequate care and treatment.~~

…

(f) *Access to information.* (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.

…

(3) The resident has the right to access ~~medical~~ all records pertaining to him or herself, and to share those records with a person or persons of the resident's choosing--

(i) Upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such medical records are maintained electronically); or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, including current medical records, as soon as can be accomplished with reasonable effort and within 24 hours ~~(excluding weekends and holidays)~~; and

(ii) ~~After receipt of his or her medical records for inspection, t~~To purchase~~,~~ a copy of the medical records or any portions thereof (including in an electronic form or format when such medical records are maintained electronically) upon request ~~and 2 working days advance notice to the facility~~. The copies must be provided as soon as can be accomplished with reasonable effort and within 48 hours, at a cost not to exceed the community standard, including ~~. The facility may impose a reasonable, cost-based fee on the provision of copies, provided that the fee includes only the cost of:~~

~~(A) Labor for copying the medical records requested by the individual, whether in paper or electronic form;~~

~~(B) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; and~~

~~(C) P~~postage, when the individual has requested the copy be mailed.

…

42 C.F.R. § 483.11 Facility Responsibilities

The Proposed Regulations Give Facilities Excessive Authority to Deny Visitation (§ 483.11(d)(2))

We strongly support the visitation rights provisions and agree with CMS that being able to receive visitors of the resident's choosing, at the time of the resident's choosing, is an essential element of self-determination. Since the facility is the resident's home, residents should have 24-hour access to visitors.

The regulations' visitation rights, however, are drastically limited by regulatory exceptions that are not authorized by the Nursing Home Reform Law itself. We recommend that this proposed regulatory language be deleted. Otherwise, there is a great danger that facilities will impose limitations for improper reasons, e.g., on the basis that a visitor will be upsetting to the resident. Such a limitation would be inconsistent with the Nursing Home Reform Law and with the precepts of resident self-determination.

Residents Should Not Be Required to "Designate" Visitors (§ 483.11(d)(2)(ii))

The proposed regulations refer to visitors whom the resident "designates." We recommend that this language be deleted, because the word "designates" suggests that a resident would have to make an advance designation of approved visitors. If, on the other hand, the word "designates" is meant by CMS to just indicate a resident's consent, the use of "designates" is redundant: the regulatory sentence in a separate clause already refers to resident consent.

Residents Should Not Be Charged Separately for Any Item or Service Covered Under the Medicare or Medicaid Programs (§ 483.11(d)(6))

We recommend a slight change to emphasize that the list of covered service at section 483.11(d)(6)(i) is not exclusive.

Facilities Should Be Required to Make Prompt Refunds, in Order to Better Enable Discharge to the Community (§ 483.11(e)(11)(iv)) The proposed regulations require refunds within 30 days of discharge, but a 30-day delay can limit access to community living. We recommend that refunds be required at the date of discharge, or ten days after the facility learned that the resident would be leaving, whichever is later. There is no logistical reason why facilities could not comply with such deadlines.

All Admission Contacts Should Comply with the Federal Regulations (§ 483.11(e)(11)(v))

We thank CMS for the provision that specifies that an admission contract must not conflict with the federal regulations. We request one small revision. The regulation's current language applies only when the facility "requires" execution of an admission contract. The language should be changed to refer to all admission contracts, whether or not "required." Nursing facilities often attempt to avoid contract-related laws by claiming that a resident or resident

representative was not required to agree to a contract or provision, but purportedly "volunteered" to do so.

Other Residents' Actions Should Not Be Subject to Grievances (§ 483.11(h)(2))

We recommend deletion of the proposed language that would extend grievances "to the behavior of other residents." Any conflicts between residents should be addressed through discussion and care planning, and not through grievance processes.

Recommended Revisions for 42 C.F.R. § 483.11

…

(d) *Self-determination.* The facility must promote and facilitate resident self-determination through support of resident choice as specified in § 483.10(e) and as follows:

…

(2) The facility must have written policies and procedures regarding the visitation rights of residents~~, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation~~. A facility must meet the following requirements:

(i) Inform each resident (or resident representative, where appropriate) of his or her visitation rights~~, including any clinical or safety restriction or limitation on such rights,~~ when he or she is informed of his or her other rights under this section.

(ii) Inform each resident of the right, subject to his or her consent, to receive ~~the~~ visitors ~~whom he or she designates,~~ including, but not limited to, a spouse (including a same-sex spouse), a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time.

(iii) Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.

(iv) Ensure that all visitors enjoy full and equal visitation privileges consistent with resident preferences.

…

(6) The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for

applicable deductible and coinsurance amounts). A non-exclusive list of such covered services is provided in subsection (6)(i) below. The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with § 489.32 of this chapter. (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See § 447.15 of this chapter, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual.)

(i) *Services included in Medicare or Medicaid payment.* During the course of a covered Medicare or Medicaid stay, facilities may not charge a resident for the following categories of items and services:

(A) Nursing services as required at § 483.35.

(B) Food and Nutrition services as required at § 483.60.

(C) An activities program as required at § 483.25(c).

(D) Room/bed maintenance services.

(E) Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing assistance, and basic personal laundry.

(F) Medically-related social services as required at § 483.40(d).

(G) Hospice services elected by the resident and paid for under the Medicare Hospice Benefit or paid for by Medicaid under a state plan.

…

(e) *Information and communication.* (1) With the exception of information described in paragraph (e)(2) of this section, the facility must ensure that information is provided to each resident in a form and manner the resident can access and understand, including in an alternative format or in a language that the resident can understand. Summaries that translate information described in paragraph (e)(2) of this section may be made available to the patient at their request and expense in accordance with applicable law.

…

(11) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/Medicaid or by the facility's per diem rate.

(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible;

(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.

(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.

(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within ten~~thirty~~ days from when the facility learned that the the resident would be leaving the facility, or on the resident's date of discharge from the facility, whichever is later.

(v) ~~Where the facility requires the execution of~~ For any admission contract by or on behalf of an individual seeking admission to the facility, the terms of the contract must not conflict with the requirements of these regulations.

…

(h) *Grievances.* (1) The facility must make information on how to file a grievance or complaint available to the resident, including the information required under paragraph (f)(2) of this section.

(2) The facility must make prompt efforts to resolve grievances the resident may have~~, including those with respect to the behavior of other residents~~.

…

42 C.F.R. § 483.15 Transitions of Care

Resident Rights Should Continue To Be Described as "Rights," Rather than Provisions Relating to "Transitions" (§ 483.15)

Proposed section 483.15 uses the title "Transitions of Care," although it contains many provisions that are denominated as "Admission, transfer and discharge rights" in current 42 C.F.R. § 483.12. The proposed loss of the term "rights" is troubling, for two reasons.

First, the term "rights" emphasizes the fact that a nursing facility is home to its residents, and they should not be deprived of that home except in rare circumstances. The term "transitions," by contrast, suggests that a resident's place of residence is of relatively little import as the resident "transitions" through levels of care. Second, state nursing facility laws often incorporate the federal resident rights. If the federal rights in section 483.15 are no longer denominated as rights, they may not be incorporated by these state law provisions, which would lessen the protection extended to nursing facility residents.

42 C.F.R. § 483.15(a) Admissions Policies

Facilities Should Not Be Allowed to "Request" Improper Contractual Provisions (§ 483.15(a)(2), (3))

We strongly support the addition of the word "request" in subsections (2)(i), (ii), (iii), and (3). Sometimes facilities attempt to evade current law by using contracts that "request" but purportedly do not "require" residents to take on certain unfair obligations. From a consumer's perspective, these provisions are objectionable whether the provision is phrased as a request or requirement. In either case, the facility is drafting the contract, and the resident (or resident representative) is signing the contract with little understanding of its contents, and little or no ability to negotiate terms.

Residents Should Not Waive Their Rights to Medicare or Medicaid (§ 483.15(a)(2)(i))

We strongly support this subsection. We suggest that it be modified to reflect the relatively-recent statutory provision that allows a continuing care retirement community to "require residents to spend on their care resources declared for the purposes of admission before applying for medical assistance."[4]

Waivers of Liability Should Not Be Allowed (§ 483.15(a)(2)(iii))

We support the provision that prohibits waivers of a facility's liability for loss of personal property, but do not understand why this provision should be limited to personal property. All waivers of liability should be prohibited, whether they relate to (for example) the loss of a

[4] *See* 42 U.S.C. § 1396r(c)(5)(B)(v).

resident's clothing, or negligent care by facility staff. Courts across the country have concluded that consumer waivers of liability are improper in health care settings.[5]

Admission Agreements Should Not Authorize the Nursing Facility to Sue a Resident's Family Member or Friend for a Resident's Unpaid Facility Bills (§ 483.15(a)(3))

Regarding the obligation of a resident representative to pay the facility from the resident's income or resources, we note that many facilities today are skirting the no-financial-guarantee rule by using contracts that commit a resident representative to pay facility charges from the resident's income or resources, and to take all necessary steps to submit a Medicaid application on the resident's behalf. If the resident's bill is unpaid, the facility then sues the representative on the contract, arguing that the representative has breached his or her contractual duties, and also arguing that this contractual obligation does not violate the current no-financial-guarantee provisions of 42 C.F.R. § 483.12(d)(2).[6] Our recommended language would prohibit this evasion of current law. A resident's family member should not face potentially enormous financial liability because a resident's bill is (allegedly) not paid in full, or a Medicaid application is denied due to insufficient information. Such contractual provision are just as unfair and coercive as the financial guarantees that explicitly are prohibited by current federal law.

We note that existing law has other tools for a nursing facility to use if a resident representative has misappropriated a resident's money, rather than paying a facility. For example, courts have found family members liable to nursing facilities for fraudulent conveyance when they have used the resident's money for themselves, rather than paying nursing facility bills. A fraudulent conveyance lawsuit is the proper route for a nursing facility when a family member misappropriates money that should be paid to the nursing facility. Nursing facilities should not be using contracts that facilitate collection suits against a resident's family member or friend simply because a resident's bill is unpaid and/or a Medicaid application is denied.

Facilities Should Not Disclose "Special Characteristics or Service Limitations"; Such Disclosure Would Authorize Improper Transfers and Discharges (§ 483.15(a)(6))

We urge complete deletion of proposed subsection (a)(6), which obligates a nursing facility at admission to give "notice of special characteristics or service limitations." The terms "special characteristic" and "service limitations" are extremely broad. More fundamentally, the proposed subsection implies that a facility could use this notice to lower the standard of care

[5] *See, e.g.*, Tunkl v. Regents of Univ. of California, 383 P.2d 441 (Cal. 1963) (no liability waiver for surgery); Cudnik v. William Beaumont Hosp., 525 N.W. 2d 891, 895-96 (Mich. Ct. App. 1994) (no liability waiver for radiation treatment).

[6] *See, e.g.*, Sunrise Healthcare Corp. v. Azarigian, 821 A.2d 835, 839-41 (Conn. App. Ct. 2003) (resident's daughter held liable under contract, which is found not to violate the no-financial guarantee rule of federal nursing facility law); Alzheimer's Res. Ctr. of Conn. v. Carlstrom, 2005 Conn. Super. LEXIS 1490 (Conn. Super. Ct. 2005) (pre-judgment remedy of over $42,000 assessed against resident's son for failure to comply with contractual obligation to arrange for resident's Medicaid eligibility; no violation of no-guarantee rule of federal nursing facility law).

otherwise established by federal and state law, and to justify involuntary transfers and discharges for a purported inability to meet a resident's needs.

The preamble discussion refers to a "more predictable" transfer if "the need for specific types of care or services later become necessary," and gives the example of notice that a facility could not care for residents needing "psychiatric care."[7] In fact, many persons, both inside and outside of nursing facilities, have psychiatric diagnoses, and the nursing facility regulations explicitly establish a nursing facility's duty to provide specialized services for residents with mental illness.[8] Under the proposed subsection, a facility might well attempt to engineer the involuntary transfer or discharge of a "heavy care" resident with mental health issues, rather than providing the care required under the federal nursing facility law.

The preamble discussion also suggests that a facility's "religious affiliation" might lead to a facility giving notice of "any special characteristics, requirements, or limitations."[9] This is a slippery slope, threatening a situation where a facility might cite its religious affiliation to justify various limitations on care. We understand that some providers may have conscience-based objections to withholding care from terminally-ill residents, and that the Patient Self-Determination Act sets standards for notification of conscience-based limitations.[10] Proposed subsection (a)(6), however, is written much more loosely than the Patient Self-Determination Act, in a way that would give religious-affiliated providers broad discretion to limit the level of care provided.

For all these reasons, we urge the deletion of subsection (a)(6). Alternatively, the subsection could be modified to emphasize that "special characteristics or service limitations" cannot reduce the standard of care set by federal or state law, and/or to employ language similar to that used in the Self-Determination Act for conscience-based exceptions. We emphasize, however, that the far better option would be to simply delete subsection (a)(6). If it were to go into effect, its primary effect would be encourage facility discrimination against residents with higher care needs.

Recommended Revisions for 42 C.F.R. § 483.15(a)

(a) *Admissions policy.* (1) The facility must establish and implement an admissions policy.

(2) The facility must--

[7] 80 Fed. Reg. at 42,189.
[8] *See, e.g.*, 42 C.F.R. §§ 483.45 (facility's obligation to provide or purchase mental health rehabilitative services for mental illness and intellectual disability), 483.120 (specialized services for nursing facility residents with mental illness).
[9] 80 Fed. Reg. at 42,189.
[10] *See* 42 U.S.C. § 1396a(w)(3) (recognition in Patient Self-Determination Act of conscience-based objections); 42 C.F.R. § 489.102(a)(1)(ii) (statement of conscience-based limitation on inability to implement advance directive).

(i) Not request or require residents or potential residents to waive their rights as set forth in this subpart and in applicable State, Federal or local licensing or certification laws, including but not limited to their rights to Medicare or Medicaid; ~~and~~

(ii) Not request or require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits, with the exception that contracts for admission to a State licensed, registered, certified, or equivalent continuing care retirement community or life care community, including services in a nursing facility that is part of such community, may require residents to spend on their care resources declared for the purposes of admission before applying for medical assistance;~~.~~ and

(iii) Not request or require residents or potential residents to waive potential facility liability ~~for losses of personal property~~.

(3) The facility must not request or require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may request or~~and~~ require a resident representative who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability and without taking on any contractual duty that could obligate the representative to pay for facility care, to provide facility payment from the resident's income or resources.

…

~~(6) A nursing facility must disclose and provide to a resident or potential resident, at or prior to time of admission, notice of special characteristics or service limitations of the facility.~~

42 C.F.R. § 483.15(b) Transfers and Discharges

Equal Access Policies Should Be Implemented (§ 483.15(b)(1)(i)(A))

We thank CMS for adding "and implement" to the equal access requirement. In our representation of nursing facility residents, we have encountered facilities that claim compliance with regulations by pointing to their establishment and maintenance of policies, without regard to whether those policies are followed. Requiring implementation of policies is essential to making these requirements effective.

Private Pay Rates Should Be Subject to State Law (§ 483.15(b)(1)(i)(B))

We support the addition of the phrase "unless otherwise limited by state law" to the subsection related to private-pay rates. Without this limitation, the regulatory language is too broad in

saying that the facility may charge "any amount" to residents not being reimbursed through Medicaid.

Alternatively, subsection 483.15(b)(1)(i)(B) could be deleted entirely. Since CMS does not regulate private-pay rates, a regulation saying that that a facility can charge "any amount" will likely do more harm than good.

A Facility's Inadequate Care Should Not Justify a Transfer or Discharge Based on the Facility's Inability to Meet the Resident's Needs (§ 483.15(b)(1)(ii)(A))

The proposed language is identical to current language. We suggest a slight revision to emphasize, consistent with previous guidance from the federal government, that a facility's inability to meet a resident's needs cannot be based on the facility's substandard quality of care.[11]

In Determining Whether a Resident Is Subject to Transfer or Discharge, the Need for Services Should Be Based on General Nursing Facility Services, and Not on Specialized Services that a Facility May Provide (§ 483.15(b)(1)(ii)(B))

We recommend a change from "the services provided by the facility" to "nursing facility services." We have represented clients who have received transfer/discharge notices based on claims that they no longer needed the facility's supposedly specialized services. Such supposed specializations should not be justification for transfer or discharge; our recommended change, by eliminating the reference to the particular facility, avoids this problem.

When Transfer of Discharge Is Based on Endangerment of Others, the Justification Should Be Related to the Resident's "Clinical or Behavioral Status" (§ 483.15(b)(1)(ii)(C))

We support the proposed addition of the phrase "due to the clinical or behavioral status of the resident." Such specificity is helpful in ensuring that involuntary transfer or discharge is only done when absolutely necessary.

Residents Should Not Be Transferred or Discharged When Nonpayment Is Due to Ongoing Processes for Third-Party Payment (§ 483.15(b)(1)(ii)(E))

We support the proposed addition of the sentence that forbids transfer or discharge for nonpayment when a third-party payor (such as Medicaid) is determining whether to pay. Residents should not be penalized for the administrative delays of others, and the proposed language is similar to language in the current surveyor's guidelines.[12]

[11] "[A] facility would be out of compliance if it refused to provide a statutorily defined service in in order to eliminate certain residents under one of the transfer reasons." 56 Fed. Reg. 48,826, 48,839 (1991).
[12] State Operations Manual, Appendix PP, Surveyor's Guideline to 42 C.F.R. § 483.12(a).

A Nursing Facility Should Not Transfer or Discharge a Resident While an Appeal is Pending (§ 483.15(b)(1)(iii))

We support this common-sense protection. To protect residents and the integrity of the appeal process, facilities must be barred from conducting involuntary transfers or discharges while an appeal is pending.

A Nursing Facility Should Document the Reasons Why a Resident's Needs Allegedly Cannot Be Met (§ 483.15(b)(2)(i)(B))

We support this new provision requiring documentation of why a resident's needs supposedly cannot be met, the facility's attempts to meet those needs, and the services available at the receiving facility to meet those needs. In our experience, facilities often try to transfer away residents with relatively higher care needs, even when those care needs are (or should be) well within the facility's competence. The proposed new language will help prevent such unfair transfers.

Transferring Facilities Should Provide Relevant Information to a Receiving Facility (§ 483.15(b)(2)(iii))

We support this new provision that specifies the information that must be provided to a receiving facility. In the very rare cases when involuntary transfer is justified, the receiving facility should have complete information on the resident's history and needs.

Ombudsman Program Should Receive Copies of the Notices of Proposed Transfer/Discharge (§ 483.15(b)(3)(i))

We agree on the importance of having copies of transfer/discharge notices sent to the Long-Term Care Ombudsman Program. We ask CMS to delete language requiring resident consent, since that would give facilities an opportunity to find justifications for not notifying ombudsman programs. Ombudsman programs are "health oversight agencies" under HIPAA, so the resident's consent is not required prior to release of information. *See* Information Memorandum AOA-IM-03-01 (Feb. 4, 2003). We also recommend that the notice be sent to the local ombudsman office (rather than to the state ombudsman office, for example).

Facilities Should Not Be Required to Give the Least Possible Notice of Proposed Transfer/Discharge (§ 483.15(b)(4)(ii))

We propose two important revisions to the provision that allows for reduced notice under certain circumstances. A reduced notice period should be an option ("may") rather than a requirement ("must") for facilities. Otherwise, a facility would feel an obligation to always give the most limited notice period possible, to avoid allegations that (for example) a longer notice period would have endangered the health or safety of individuals in the facility.

We also suggest a revision to ensure that "practicable" notice provides sufficient time for a resident to have his or her appeal heard. Our recommended language coordinates subsection (b)(4)(ii) with subsection (b)(1)(iii), which prohibits a facility from transferring or discharging a resident when an appeal is pending.

Residents Should Be Given Extensive Information About the Right to Appeal an Involuntary Transfer or Discharge (§ 483.15(b)(5)(iv))

We support the new language that requires that the resident be given additional information on how he or she can appeal an involuntary transfer or discharge.

Notices Should Provide Contact Information for the Local Office of the Ombudsman Program (§ 483.15(b)(5)(v))

We recommend that the contact information for the long-term care ombudsman program be the local program, rather than the state office.

Facilities Should Not Be Allowed to Modify Transfer/Discharge Notices After Delivery to Residents (§ 483.15(b)(6))

A transfer/discharge notice should not be able to be "updated" after being given to the resident. A resident must have fair notice of the facility's allegations and intentions. If circumstances change, or the facility's original notice was in error, the facility should issue a new notice with the notice period required by law. Otherwise, a resident could be blindsided by a facility changing its allegations late in the process. To address this situation, we recommend that CMS delete subsection (b)(6) in its entirety.

Orientation Information Should Be Provided in a Form and Matter that the Resident Can Understand (§ 483.15(b)(7))

We support the new language that specifies that the orientation for transfer and discharge "must be provided in a form and manner than the resident can understand."

Recommended Revisions for 42 C.F.R. § 483.15(b)

(b) *Transfer and discharge* --(1) *Facility requirements* --(i) *Equal access to quality care.* (A) A facility must establish, maintain and implement identical policies and practices regarding transfer, discharge, and the provision of services for all individuals regardless of source of payment;

(B) The facility may charge any amount for services furnished to non-Medicaid residents unless otherwise limited by state law and consistent with the notice requirement in § 483.11(e)(11)(i) and (e)(12) describing the charges; and

(C) The State is not required to offer additional services on behalf of a resident other than services provided in the State plan.

(ii) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless--

(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility, with the facility providing or offering to provide all services required by law;

(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs nursing facility~~the~~ services ~~provided by the facility~~;

(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;

(D) The health of individuals in the facility would otherwise be endangered;

(E) 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. Non-payment does not apply unless the resident does not submit the necessary paperwork for third party payment or until 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

(F) The facility ceases to operate.

(iii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter.

(2) *Documentation.* …

(3) *Notice before transfer.* Before a facility transfers or discharges a resident, the facility must--

(i) Notify the resident and the resident~~'s~~ representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. ~~Subject to the resident's agreement,~~ T~~t~~he facility must send a copy of the notice to the appropriate local office ~~a representative~~ of the Office of the State Long-Term Care Ombudsman.

(ii) Record the reasons for the transfer or discharge in the resident's clinical record in accordance with paragraph (b)(2) of this section; and

(iii) Include in the notice the items described in paragraph (b)(5) of this section.

(4) *Timing of the notice.* (i) Except as specified in paragraphs (b)(4)(ii) and (b)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.

(ii) Notice may~~must~~ be made as soon as practicable before transfer or discharge, but with adequate time for a resident to obtain an appeal decision prior to the proposed transfer or discharge, when--

(A) The safety of individuals in the facility would be endangered under paragraph (b)(1)(ii)(C) of this section;

(B) The health of individuals in the facility would be endangered, under paragraph (b)(1)(ii)(D) of this section;

(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (b)(1)(ii)(B) of this section;

(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (b)(1)(ii)(A) of this section; or

(E) A resident has not resided in the facility for 30 days.

(5) *Contents of the notice.* The written notice specified in paragraph (b)(3) of this section must include the following:

(i) The reason for transfer or discharge;

(ii) The effective date of transfer or discharge;

(iii) The location to which the resident is expected to be transferred or discharged;

(iv) A statement that the resident has the right to appeal the action to the State, the name, address (mailing and email), and telephone number of the State entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;

(v) The name, address (mailing and email) and telephone number of the appropriate local office of the Office of the State Long-Term Care Ombudsman;

…

~~(6) *Changes to the notice*. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.~~

…

42 C.F.R. § 483.15(c) Bed Holds and Readmissions

Residents Should Be Given Adequate Notice at the Time of Transfer to a Hospital (§ 483.15(c)(1), (2))

We support the requirement in the proposed regulations that a facility's notice to a resident must include (among other things) the state's bed-hold policy, and an explanation of the state Medicaid program's ability (if any) to pay to reserve a bed while a resident is temporarily absent (§ 483.15(c)(1)). Each of these pieces of information is an important consideration for a resident leaving the facility for a hospitalization.

We note, however, that the proposed requirements are less extensive for the notice provided at the time of transfer, compared to the notice that must be provided prior to transfer (and usually is provided, as a practical matter, during admission). *See* 42 C.F.R. § 483.15(c)(1), (2). Based on our extensive experience with readmissions from hospitals, we have found that the notice provided at the time of transfer is much more accessible and useful to consumers than the information provided earlier. As a result, we recommend that the proposed regulations be modified to require the same level of notice both prior to the transfer and upon the transfer. This information should include, among other things, a resident's right to return under a bed hold, and not just the resident's right to return to the next available bed.

A Resident Should Have a Right to Readmitted to the Previous Room, If that Room Is Available (§ 483.15(c)(3)(i))

We support the requirement that, in readmitting the resident to the next available bed, the resident should be readmitted to the previous room, if that room is available.

A Resident Should Have a Right to Readmitted to the Next Available Room, Whether Private or Semi-Private (§ 483.15(c)(3)(i))

We strongly recommend that readmission be required whether the available room is private or semi-private. Any Medicaid-certified room should be appropriate for a resident's readmission, and the semi-private-only requirement can drastically limit residents' ability to return from the hospital. In Louisiana, for example, Medicaid bed buy-back programs have limited the availability of semi-private rooms, and facilities have refused readmission from the hospital on the grounds that their only available rooms were private.

In Determining Whether a Resident Should Be Refused Readmission for Not Needing Facility Services, the Need for Services Should Be Based on General Nursing Facility Services, and Not on Specialized Services that a Facility May Provide (§ 483.15(c)(3)(i)(A))

We recommend a change from "Requires the services provided by the facility" to "Requires nursing facility services." In our experience, some nursing facilities try to evade their readmission obligations by claiming that they have some limited specialty that a particular resident no longer needs. Such supposed specializations should not be justification for abandoning a resident at a hospital. Our recommended change, by eliminating the reference to the particular facility, addresses this problem.

Residents Should Have a Clear Right to Appeal When Denied a Bed Hold or Readmission (§ 483.15(c)(3))

We are both encouraged and troubled by subsection (c)(3) which, in our reading, authorizes an administrative hearing for residents who have been denied readmission. The troubling aspects of the subsection are its limited scope and vague language. The subsection relates only to readmissions, but should also include instances when a facility refuses to honor a bed hold. Our biggest concern is the subsection's failure to clearly state that a resident has an appeal right when he or she is not allowed to return to a facility after a hospitalization or other therapeutic leave. For us and for many of our colleagues, the current language of subsection (c)(3)(ii) suggests upon first reading that a facility could refuse to readmit a resident simply by providing written notice of the reasons purportedly justifying such refusal. We concluded that an appeal right is intended only by considering the cross-reference to subsection (b)(5)(iv) and reading the relevant discussion in the Federal Register.[13]

Given the importance of appeal rights, and the many instances in which nursing facilities essentially dump residents in hospitals, the final regulations should be much more explicit in stating that a resident has a right to appeal when denied his or her rights under a bed hold or under the provision that provides readmission to the next available room. Our recommended language below provides the needed clarity, along with specification that the appeal hearing must be conducted within 72 hours, given that the resident is likely under pressure to be discharged from the hospital. Our recommended language is adapted from readmission provisions in California law.[14]

We strongly urge deletion of CMS's proposed language referencing a facility giving written notice of the reasons purportedly justifying a refusal to readmit a resident. The regulations

[13] "Residents often do not realize that there are requirements allowing them to return to a facility after a hospitalization or that they may have appeal rights. This provision is intended to ensure that residents have an opportunity to exercise an appeal right if they choose to do so." 80 Fed. Reg. at 42,191.
[14] *See* Cal. Health & Safety Code § 1599.1(h).

should not establish denial of readmission/bed hold as an alternative mechanism for transfer/discharge. It would be too easy for a facility to take advantage of such a notice mechanism to dump residents at hospitals.

Recommended Revisions for 42 C.F.R. § 483.15(c)

(c) Notice of bed-hold policy and readmission -- (1) Notice before and upon transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, and also at the time of any such transfer, the nursing facility must provide written information to the resident or resident representative that specifies--

(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;

(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;

(iii) The nursing facility's policies regarding bed-hold periods and readmission, which must be consistent with state bed-hold policy and paragraph (c)(2~~3~~) of this section, permitting a resident to return; and

(iv) A resident's right to appeal, under paragraph (c)(3) of this section, the facility's refusal to honor a bed hold or a resident's right to be readmitted under ~~The information specified in~~ paragraph (c)(2~~3~~) ~~of this section~~.

~~(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (c)(1) of this section.~~

(2~~3~~) Permitting resident to return to facility. A nursing facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following.

(i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, is readmitted to the facility to their previous room if available or immediately upon the first availability of a bed ~~in a semi-private room~~ if the resident--

(A) Requires nursing facility~~the~~ services ~~provided by the facility~~; and

(B) Is eligible for Medicaid nursing facility services.

(ii) ~~A resident who is hospitalized or placed on therapeutic leave with an expectation of returning to the facility must be notified in writing by the facility when the facility~~

~~determines that the resident cannot be readmitted to the facility, the reason the resident cannot be readmitted to the facility, and the information specified in paragraphs (b)(5)(iv) through (vii) of this section.~~ If a resident has been hospitalized or placed on therapeutic leave, and the facility refuses to honor the resident's bed hold or the resident's right to be readmitted under paragraph (c)(2), the resident may appeal the facility's refusal. Appeal decisions must be rendered within 72 hours of the resident's request for an appeal.

42 C.F.R. § 483.21 Comprehensive Person-Centered Care Planning

A Baseline Care Plan Should Be Developed Within 48 Hours of a Resident's Admission, As CMS Proposes (§ 483.21(a))

We strongly support CMS's proposal to require development of a care plan soon after a resident's admission. Residents are particularly vulnerable immediately after admission, and their early care in the facility should be coordinated to the greatest extent possible.

Facilities Should Not Have the Right to Reject PASARR determinations (§ 483.21(b)(1)(iii))

The proposed regulations suggest that a facility could "disagree" with —and presumably disregard —a PASARR determination by "indicat[ing the facility's] rationale in the resident's medical record." We urge CMS to delete this provision, and to characterize PASSARR results as "determinations" rather than "recommendations." The PASARR statute allows for appeal by a resident but not by a facility. The facility should be bound by a PASARR determination that a resident requires special services or specialized rehabilitative services, and should provide the services that a resident requires.

Facilities Should Be Required to Make the Care Planning Process Accessible to Residents and Their Representatives (§ 483.21(b)(2)(ii)(F))

We support CMS's proposal to require facilities to document a resident's medical record if it is deemed "not practicable" for the resident and resident representative to participate in the care planning process. To make such participation more likely, we urge that facilities be required to schedule care plan meetings when residents and representatives can attend, and to enable participation by phone, Skype, or comparable technology.

Recommended Revisions for 42 C.F.R. § 483.21

…

(b) *Comprehensive care plans.* (1) The facility must develop a comprehensive person-centered care plan for each resident, consistent with § 483.10(b)(1) and § 483.11(b)(1), that includes measurable objectives and timetables to meet a resident's medical,

nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following--

…

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR determinations~~recommendations~~. ~~If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.~~

…

(2) A comprehensive care plan must be--

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

(E) A social worker.

(F) To the extent practicable, the participation of the resident and the resident's representative(s). The facility must support and encourage participation by the resident and resident representative by scheduling care planning meetings at times when both are able to participate. If in-person participation is not feasible, the facility must support and enable participation by other means, such as telephone, Skype, or other format that enables participation in real time. An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.

(G) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

…

42 C.F.R. § 483.25 Quality of Care and Quality of Life

Staff Scheduling When Possible Should Follow Principles of Consistent Assignment (§ 483.25(a)(4))

Given the recognized importance of person-centered care, the nursing facility regulations should acknowledge the value of consistent assignments, i.e., assigning the same personnel to work with the same residents. Personal relationships matter, especially given the sensitive nature of much assistance with daily living. Accordingly, our recommended language calls for facilities to use consistent assignment to the extent possible.

"Resident Preferences" Is Too Casual of a Justification for Dehydration or Malnutrition (§ 483.25(d)(8)(i))

Under the proposed regulations, a facility is relieved of its duty to maintain a resident within desirable body weight and protein levels if the resident's clinical condition demonstrates that this is not possible, or "resident preferences indicate otherwise." The reference to "preferences" is objectionable. "Resident preference" (or "resident rights") should not absolve a facility from its obligation to provide adequate nutrition. A facility would need to demonstrate that it served nutritious and appetizing food; identified the resident's food preferences; offered alternative foods to the resident; had sufficient numbers of trained staff to assist the resident in eating; maintained a pleasant environment for meals; provided assistive devices, as needed; addressed the resident's mental health needs; had received a medical determination from the resident's physician that the resident's medical condition indicated that weight loss was unavoidable; and took other necessary steps before it could justify not meeting a resident's nutritional needs. We recommend regulatory language to address this problem.

Enteral Feeding Should Be a Last Resort (§ 483.25(d)(8)(iv))

Under current law, naso-gastric feeding should not be done unless "the resident's clinical condition demonstrates that use of a naso-gatric tube was unavoidable."[15] Under the proposed regulations, however, use of naso-gastric tubes and other enteral feeding procedures would seem to be expanded, as proposed section 483.25(d)(8)(iv) allows enteral feeding if it is "clinically indicated and consented to by the resident."

This change in policy is not supported by CMS's discussion in the Preamble, which cites an American Geriatric Society position statement that "notes that enteral feeding is not associated with better outcomes in older adults with advanced dementia, but is associated with agitation, increased use of restraints, and worsening pressure ulcers and is not recommended for older

[15] 42 C.F.R. § 483.25(g)(1).

adults with advanced dementia and recommends careful hand-feeding."[16] Indeed, medical research has found that benefits of enteral feeding are often outweighed by the negatives.[17]

In nursing facilities, the reality often is that hand-feeding would be best, but that enteral methods are easier and cheaper for the facility. Unfortunately, CMS's proposed language would make it easier for facilities to choosing enteral feeding over hand-feeding, by claiming that enteral feeding was "clinically indicated." We ask CMS to correct this problem by returning to regulatory language that allows enteral feeding only if it is unavoidable.

<u>The Regulations Should Set Standards for Dementia Care (§ 483.25 or in separate section, at CMS's discretion)</u>

We refer CMS to the careful discussion of this issue in a comment letter focusing on dementia care and chemical restraints, submitted by California Advocates for Nursing Home Reform (CANHR).

Given the prevalence and importance of dementia in nursing facility, the issue receives relatively little attention in the proposed regulations. This is a clear shortcoming in the regulations. A regulatory failure to address dementia will lead to facilities being ill-equipped to care for residents with dementia.

Our recommendations below relating to dementia care are adapted from CANHR's comment, letter, which in turn is adapted from CMS's Survey and Certification Letter No. 13-35-NH (May 24, 2013).

Recommended Revisions for 42 C.F.R. § 483.25

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless

[16] 80 Fed. Reg. at 42,198.
[17] *See, e.g.,* Thomas Finucane et al., *Tube Feeding in Dementia: How Incentives Undermine Health Care Quality and Patient Safety*, 8 J. Am. Medical Directors Ass'n, No. 4, at 205-208 (January 1, 2008); Susan Mitchell et al., *Clinical and Organizational Factors Associated With Feeding Tube Use Among Nursing Home Residents With Advanced Cognitive Impairment*, 290 J. Am. Med. Ass'n 73 (2003); Diane E. Meier et al., *High Short-Term Mortality in Hospitalized Patients With Advanced Dementia: Lack of Benefit of Tube Feeding,* 161 Archives of Internal Medicine 594 (2001); Muriel Gillick, *Rethinking the Role of Tube Feeding In Patients With Advanced Dementia*, 342 N. Eng. J. Med. 206 (2000); Thomas Finucane et al., *Tube Feeding In Patients With Advanced Dementia: A Review of the Evidence*, 282 J. Am. Med. Ass'n 1365 (1999).

circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:

(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section,

(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene, and

(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to the resident's advance directives.

(4) Staff scheduling to a reasonable and practical extent follows principles of consistent assignment, so residents generally to receive assistance from the same personnel.

(b) *Activities of daily living.*

…

(d) *Special care issues.* Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care, in accordance with professional standards of practice and the residents choices, related to the following special concerns--

…

(8) *Assisted nutrition and hydration.* (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident--

(i) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and protein levels, unless the resident's clinical condition demonstrates that this is not possible or the resident or resident representative, despite the facility's best efforts to comply with this subsection, makes choices that lead to the resident's condition being outside of acceptable parameters~~resident preferences indicate otherwise~~;

(ii) Is offered sufficient fluid intake to maintain proper hydration and health; and

(iii) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.

(iv) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was unavoidable~~clinically indicated~~ and consented to by the resident; and

(v) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.

[to be placed at appropriate place within regulations] *Dementia Care.* The facility shall:

(1) Provide a supportive and safe physical and psychosocial environment for residents with dementia that promotes comfort and enables them to achieve their highest practicable physical, mental and psychosocial wellbeing;

(2) Individualize care for each resident with dementia by tailoring it to all relevant considerations for that individual, including physical, functional, and psychosocial aspects;

(3) Engage residents and their representatives in all aspects of decision-making about their care;

(4) Apply knowledge of residents' lifelong patterns, preferences, and interests for daily activities to enhance quality of life and individualize routine care;

(5) Treat behavioral expressions of distress as a form of communication and identify, to the extent possible, factors that may underlie a resident's distress;

(6) Evaluate residents who have new or worsening expressions of distress through the resident's interdisciplinary team, including the physician, in order to identify and address treatable medical, physical, emotional, psychiatric, psychological, functional, social, environmental and other factors that may be causing the distress;

(7) Monitor any interventions to determine efficacy, risks, benefits and harm;

(8) Ensure that residents are free from unnecessary use of psychoactive drugs and chemical and physical restraints;

(9) Train all staff on dementia care and the facility's policies and procedures for meeting these requirements; and

(10) Ensure that residents with dementia who cannot verbalize their wishes are not denied their right to be visited by family members and others with immediate access.

42 C.F.R. § 483.30 Physician Services

An In-Person Evaluation Should Not Be Required Prior to a Resident Being Transferred to the Hospital (§ 483.30(e))

CMS proposes requiring an in-person evaluation by a physician (or other specified health professional) prior to a resident's transfer to a hospital. While we understand the interest in reducing unnecessary hospitalizations, we believe CMS's proposed language would be counterproductive and recommend its deletion. As the Center for Medicare Advocacy points out in its letter, many nursing facility residents are harmed by not being timely transferred to a hospital —we ourselves have encountered such situations in our work advocating for nursing facility residents. Given that physicians and the other specified health professionals are not routinely present in nursing facilities, CMS's prosed language is likely to make transfers unduly difficult. Accordingly, we recommend the complete deletion of proposed subsection (e).

Recommended Revisions for 42 C.F.R. § 483.30

…

~~(e) *Availability of a physician, physician assistant, nurse practitioner, or clinical nurse specialist to evaluate resident for non-emergent transfer to a hospital.* The facility must provide or arrange for an in-person evaluation of a resident by a physician, a physician assistant, nurse practitioner, or clinical nurse specialist prior to transferring the resident to a hospital.~~

~~(1) The evaluation must occur expeditiously once the potential need for a transfer is identified.~~

~~(2) This requirement does not apply in emergency situations where the health or safety of the individual would be endangered.~~

…

42 C.F.R. § 483.35 Nursing Services

A Registered Nurse Should Be Working in the Facility at All Times (§ 483.35(b)(1))

The Institute of Medicine recommended in 1996[18] and again in 2001[19] that nursing facilities be required to employ a registered nurse 24 hours per day, seven days a week. That recommendation is even more urgent in 2015, given the rising acuity of the nursing facility population.

Our recommended language would require around-the-clock staffing by registered nurses. We endorse the September 2, 2015 comments and recommendations on staffing requirements submitted by Charlene Harrington, Ph.D., and other current and former members of the CMS TEP 5-Star Nursing Home Compare Committee.

The Nursing Facility Should Be Responsible For Ensuring the Competence of All Nurse Aides Working In the Facility (§ 483.35(d)(2))

We strongly support the requirement that nurse aide competency standards apply to non-permanent employees. Too many facilities rely excessively on agency staff, and the negatives of this practice would be compounded if facilities did not have an obligation to ensure worker competence.

Recommended Revisions for 42 C.F.R. § 483.35

…

(b) *Registered nurse.* (1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse at all times~~for at least 8 consecutive hours a day, 7 days a week~~.

…

42 C.F.R. § 483.45 Pharmacy Services

Consulting Pharmacists Must Be Independent (§ 483.45(b), (c))

In October 2011, CMS recommended in proposed regulations that consulting pharmacists be independent.[20] Unfortunately, CMS declined to follow through.[21]

[18] Institute of Medicine, *Nursing Staff in Hospitals and Nursing Homes: Is It Adequate?* (1996).
[19] Institute of Medicine, *Improving the Quality of Long-Term Care*, page 193, Recommendation 6.1 (2001).
[20] 76 Fed. Reg. 63,017, 63,039 (Oct. 11, 2011).
[21] 77 Fed. Reg. 22071, 22100-22107 (Apr. 12, 2012).

In the final regulations, CMS acknowledged that "a significant number of commenters who identified themselves as current or former consultant pharmacists acknowledged they had experienced conflict of interest in the past or confirmed our understanding that conflicts of interest were an on-going problem."[22] CMS described the conflicts and problems at length. Nevertheless, CMS declined in the final regulations to require the independence of consultant pharmacists, saying such a rule, by itself, would not solve the problem of overprescribing of antipsychotic drugs for nursing home residents.[23] CMS contended that a broader approach, addressing facility staff and prescribers as well, would be needed.

The time for a broader approach is now. As part of a comprehensive review of all nursing facility regulations, CMS should mandate the independence of consultant pharmacists.

Since CMS proposed independent consultant pharmacists, the evidence of the need for consultant pharmacists to be independent has continued to mount.

In December 2014, when the U.S. Department of Justice intervened in the consolidated whistleblowers' cases against Omnicare under the False Claims Act, it described Omnicare's consultant pharmacists' practice of promoting Depakote "for controlling behavioral disturbances exhibited by dementia patients residing in nursing homes serviced by Omnicare."[24] The Government's complaint explains, in its opening paragraph, the role of consultant pharmacists in this scheme:

> For more than a decade, Defendants Omnicare, Inc. ("Omnicare") — the nation's largest provider of pharmacy services to nursing homes — solicited and received kickbacks from drug manufacturer Abbott Laboratories ("Abbott") to promote the use of the prescription drug Depakote to control the behavior of elderly nursing home residents with dementia. Through its consultant pharmacists, Omnicare wielded enormous influence over the drugs administered to the residents of Omnicare-serviced nursing homes. In exchange for millions of dollars in kickbacks disguised as rebates, educational grants, and other corporate financial support, Omnicare used its consultant pharmacists to tout Depakote as a tool to control agitation, aggression, and other behavioral disturbances and to avoid federal regulations designed to prevent the use of chemical restraints on the elderly. By knowingly and actively soliciting kickbacks to promote Depakote, Omnicare enhanced its profits at the expense of the elderly nursing home residents it purported to protect and caused the Medicaid and Medicare

[22] 77 Fed. Reg. at 22,101.
[23] 77 Fed. Reg. at 22101-22107.
[24] *United States of America v. Abbott Laboratories*, Civil Action No. 1:07-cv-00081 (W.D. Val, filed Dec. 22, 2014).

programs to pay hundreds of millions of dollars for claims that should not have been paid.[25]

McKnight's Long-Term Care News reported in July 2015 Omnicare's announcement that it will settle two False Claims Act lawsuits with the Department of Justice alleging that Omnicare accepted millions of dollars of bribes for promoting the use of Depakote in nursing homes.[26] In May 2012, the U.S. Department of Justice announced that Abbott Labs would pay $1.5 billion to resolve criminal civil investigations of its off-label promotion of Depakote for nursing home residents."[27]

These incidents demonstrate that pharmacist review in nursing facilities may be ineffective if the pharmacist is not independent. We accordingly recommend that CMS revise the regulations to require independent pharmacists.

A Pharmacist Should Review the Resident's Medical Chart When the Resident Is Taking a Psychotropic Drug or an Antibiotic (§ 483.45(c)(2))

We support CMS's proposal to review pharmacist review of the resident's medical chart when the resident is new, has returned from the hospital, or has been prescribed or is taking a psychotropic drug, an antibiotic, or any drug flagged by the facility's quality assessment and assurance committee.

Psychotropic Drugs Should Not Be Administered on a PRN basis (§ 483.45(e)(3))

CMS is well aware of the dangers presented by psychotropic drugs and particularly by anti-psychotics.[28] Given that danger, we urge CMS to prohibit PRN administration of psychotropic drugs.

Under the proposed regulations, PRN orders for psychotropic drugs would be limited to 48 hours, although they could be continued if the physician or primary care provider were to document "the rationale for this continuation in the resident's clinical record." CMS's proposed

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[25] U.S. Department of Justice, "United States Files Suit Against Omnicare Inc. for Accepting Kickbacks from Drug Manufacturer to Promote an Anti-Epileptic Drug in Nursing Homes" (News Release, Dec. 22, 2014), http://www.justice.gov/opa/pr/united-states-files-suit-against-omnicare-inc-accepting-kickbacks-drug-manufacturer-promote http://www.justice.gov/sites/default/files/opa/press-releases/attachments/2014/12/22/omnicare-abbott_laboratories_us_complaint.pdf.

[26] Emily Mongan, "Omnicare will settle with DOJ in Depakote kickback cases," *McKnight's Long-Term Care News* (July 8, 2015), http://www.mcknights.com/news/omnicare-will-settle-with-doj-in-depakote-kickback-cases/article/425386/.

[27] U.S. Department of Justice, "Abbott Labs to Pay $1.5 Billion to Resolve Criminal & Civil Investigations of Off-label Promotion of Depakote; Company Maintained Specialized Sales Force to Market Drug for Off Label Purposes; Targeted Elderly Dementia Patients in Nursing Homes," (News Release, May 7, 2012).

[28] *See, e.g.*, 80 Fed. Reg. at 42,204; CMS, 2014 Final Report and 2015 Expansion Project — Centers for Medicare and Medicaid Services (CMS) Focused Dementia Care Survey Pilot, S&C Letter 15-31-NH (March 27, 2015).

language is a timid requirement that we expect would have limit or no impact on the overuse of psychotropic drugs.

Given the danger posed by psychotropic drugs, it is reasonable to expect that their administration be based on a physician's explicit order, and not on a judgment call made by a nurse or other staff member. Our recommended language, as set forth below, would prohibit PRN administration of psychotropic drugs in nursing facilities. At the very least, CMS should prohibit the PRN administration of anti-psychotic drugs.

Use of Antipsychotic Drugs Should Be Strictly Limited

Sadly, antipsychotic drugs continue to be misused in nursing facilities to keep residents more manageable. We endorse the comprehensive comments and suggestions submitted by California Advocates for Nursing Home Reform (CANHR).

Recommended Revisions for 42 C.F.R. § 483.45

(b) *Service consultation*. The facility must employ or obtain the services of an independent licensed pharmacist who--

(1) Provides consultation on all aspects of the provision of pharmacy services in the facility;

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(c) Drug regimen review. (1) The drug regimen of each resident must be reviewed at least once a month by an independent licensed pharmacist.

(2) This review must include a review of the resident's medical chart at least every 6 months and:

(i) When the resident is new, that is the individual has not previously been a resident in that facility; or

(ii) When the resident returns or is transferred from a hospital or other facility; and

(iii) During each monthly drug regimen review when the resident has been prescribed or is taking a psychotropic drug, an antibiotic, or any drug the QAA Committee has requested be included in the pharmacist's monthly drug review.

(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:

(i) Anti-psychotic;

(ii) Anti-depressant;

(iii) Anti-anxiety;

(iv) Hypnotic;

(v) Opioid analgesic; and

(vi) Any other drug that results in effects similar to the drugs listed in paragraphs (c)(3)(i) through (v) of this section.

(4) The independent pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.

(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.

(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.

(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

(5) To be considered "independent," a licensed pharmacist must not have any individual incentive, financial or otherwise, to overprescribe or to prescribe inappropriately. Accordingly, an independent licensed pharmacist must not be employed, under contract, or otherwise affiliated with the facility's pharmacy, a pharmaceutical manufacturer or distributor, or any affiliate, subsidiary, or parent of such entities.

…

(e) *Psychotropic drugs.* Based on a comprehensive assessment of a resident, the facility must ensure that--

(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; and

(3) Residents do not receive psychotropic drugs pursuant to a PRN order ~~unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and~~

~~(4) PRN orders for psychotropic drugs are limited to 48 hours and cannot be continued beyond that time unless the resident's physician or primary care provider documents the rationale for this continuation in the resident's clinical record~~.

42 C.F.R. § 483.60 Food and Nutrition Services

CMS Should Retain the Current Requirement that the Evening Meal and Breakfast Generally Not Be Separated By More Than 14 Hours (§ 483.60(f))

CMS proposes to omit the current requirement, under frequency of meals, that there be no more than 14 hours between a substantial evening meal and breakfast the following morning, unless the facility offers a nourishing snack at bedtime, in which case there can be a 16-hour lapse between the evening meal and breakfast.[29]

CMS's explanation of the deletion — that it is focusing on resident preference for times to eat and on ensuring that food is provided at those times — is neither compelling nor satisfactory. The preamble language — "We do not intend to require a 24-hour-a-day full service food operation or an on-site chef" — does not reflect a resident-centered focus to the deletion.[30] It suggests instead that CMS is concerned with limiting the current regulatory requirement that facilities ensure that appropriate food is available and provided to residents at reasonable times. We see no reason not to retain the current requirement and therefore recommend that it be retained.

Recommended Revisions for 42 C.F.R. § 483.60

…

(f) *Frequency of meals.* (1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the

[29] 42 C.F.R. § 483.35(f)(2), (4).
[30] 80 Fed. Reg. at 42,208.

community or in accordance with resident needs, preferences, requests, and plan of care.

(2) Suitable, nourishing alternative meals and snacks must be available for residents who want to eat at non-traditional times or outside of scheduled meal service times and in accordance with the resident plan of care.

(3) There must be no more than 14 hours between a substantial evening meal and breakfast the following day. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.

…

42 C.F.R. § 483.70 Administration

Requiring Facility Self-Assessments Is Insufficient to Ensure Adequate Staffing Levels (§ 483.70(e))

As has been repeatedly emphasized in recent years by the National Consumer Voice for Quality Long-Term Care and others, inadequate staffing is the central impediment to an adequate quality of care. The continuing mediocrity of nursing facility care is attributable in large part to the lack of a meaningful minimum staffing standard.

The "competency-based approach" proposed by CMS does not get to the root of this problem. The Reform Law has always required nursing homes to use "qualified persons" to provide services to residents. Changing the term "qualified" to "competent" will have little impact on how nursing homes are operated.

Nor will the proposed annual facility resource assessment help improve staffing levels. If nursing homes are already doing these assessments, as CMS believes, how will the proposed assessments lead to a better quality of care? In many or most cases, facilities will produce assessments stating they need exactly the type and numbers of staff they already have, and state survey agencies and CMS will not be in a position to tell them otherwise.

We strongly urge CMS to set minimum nurse staffing levels for nursing facilities. We endorse the September 2, 2015 comments and recommendations on staffing requirements submitted by Charlene Harrington, Ph.D., and other current and former members of the CMS TEP 5-Star Nursing Home Compare Committee.

Nursing Facilities Should Not Be Allowed to Obtain Blanket Arbitration Agreements Prior to a Dispute Arising (§ 483.70(n))

CMS has asked for comments on "whether agreements for binding arbitration should be prohibited." Our answer is an emphatic "yes." More precisely, we recommend that agreements for arbitration not be allowed during admission or at any time prior to a dispute arising. It is unfair for nursing facilities to bind residents to arbitration at the time of admission. As a practical matter, residents (or resident representatives) sign arbitration agreements at admission not because they think arbitration is a good choice, but because they are routinely signing everything put in front of them.

Unlike other types of pre-dispute arbitration agreements, which may cover a single transaction or a specific type of dispute, arbitration agreements in nursing facilities cover every single aspect of a resident's life, and may apply through weeks, months or years that the resident lives in the facility. Also, nursing facility arbitration agreements often involve claims involving (for example) pressure sores, infections, malnutrition, dehydration, asphyxiation, sexual assault, and death. It is unreasonable to expect residents and their representatives to make decisions regarding such catastrophic events during admission, long before the events have occurred.

Furthermore, the arbitration process tends to be slanted against consumers such as nursing facility residents. Arbitration companies have a financial incentive to side with the nursing facilities who are responsible for sending them cases on an ongoing basis. Also, discovery is limited in arbitration, hindering plaintiffs from developing their cases. Arbitration proceedings are secretive, often protected by confidentiality rules. And, while court filing fees are relatively nominal, arbitrators charge by the hour, with the extensive costs generally split between the parties.

As part of the proposed regulations, CMS rightly recognizes the significant negative impact of pre-dispute arbitration agreements, proposing regulatory language that would set various procedural protections. CMS's proposed language, however well-intentioned, would make matters worse. No amount of procedural protections can change the basic power dynamic of the admissions process — incoming residents and their families are generally in a time of great stress, and the terms of the admission agreement are drafted exclusively by the facility. Worse, if CMS's proposed language were to become law, nursing facilities would cite the regulatory language to courts as evidence that CMS approves nursing facility arbitration, and would argue that compliance with the regulation was proof that the arbitration agreement and the circumstances surrounding its signing were fair.

We emphasize that our recommendation would not prohibit a resident or resident's representative from choosing arbitration after a dispute has arisen, if the resident or representative at that time concludes (likely through legal counsel) that arbitration is the best option. Any pre-dispute arbitration agreement, however — particularly if it is signed during the admission process — is unfair to residents and should not be allowed.

Each Nursing Facility Should Employ a Social Worker With a Degree in Social Work (§ 483.70(p))

The proposed regulations continue current law by requiring a full-time social worker only in facilities with more than 120 beds, and requiring that a social worker have a degree in social work or "in a human services field including, but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology." We believe that these standards are too lax, given the increased focus on person-centered care and discharge planning, and the enhanced psychosocial screening requirements in the MDS 3.0 assessment instrument. Nursing facility residents deserve real social work, and not just the administrative assistance provided in many nursing facilities by social service designees. Theses social service designees, although well-meaning, are not equipped to provide the assistance that residents need. Accordingly, we recommend that social workers be required to have a degree in social work, not just in a "human service field."

We also recommend that a full-time social worker be required in all facilities, regardless of size. At a minimum, CMS should reduce the trigger point to far less than 120 beds. Very few nursing facilities have over 120 beds, but a good many have a capacity from 75 to 100 beds. Given the size of these facilities, and the needs of their residents, a full-time social worker is vital for providing care that truly is person-centered.

Recommended Revisions for 42 C.F.R. § 483.70

…

(n) *Binding arbitration agreements.* ~~If the~~ A facility may not enter~~s~~ into a~~n~~ pre-dispute agreement for binding arbitration with its residents. ~~:~~A "pre-dispute arbitration agreement" is an arbitration agreement that purports to commit the parties to arbitration for disputes based at least in part on incidents or occurrences that took place after the time of the signing of the arbitration agreement.

~~(1) The facility must ensure that:~~

~~(i) The agreement is explained to the resident in a form and manner that he or she understands, including in a language the resident understands, and~~

~~(ii) The resident acknowledges that he or she understands the agreement.~~

~~(2) The agreement must:~~

~~(i) Be entered into by the resident voluntarily;~~

~~(ii) Provide for the selection of a neutral arbiter;~~

~~(iii) Provide for selection of a venue convenient to both parties.~~

~~(3) Admission to the facility must not be contingent upon the resident or the resident representative signing a binding arbitration agreement.~~

~~(4) The agreement must not contain any language that prohibits or discourages the resident or anyone else from communicating with Federal, State, or local officials, including but not limited to, Federal and State surveyors, other federal or state health department employees, and representatives of the Office of the State Long-Term Care Ombudsman, in accordance with § 483.11(i).~~

~~(5) The agreement may be signed by another individual if:~~

~~(i) Allowed by state law;~~

~~(ii) All of the requirements in this section are met; and~~

~~(iii) That individual has no interest in the facility.~~

…

(p) *Social worker.* ~~Any~~Each facility ~~with more than 120 beds~~ must employ a qualified social worker on a full-time basis. A qualified social worker is:

(1) An individual with a minimum of a bachelor's degree in social work~~ or a bachelor's degree in a human services field including, but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology~~; and

(2) One year of supervised social work experience in a health care setting working directly with individuals.

We thank CMS for its important work in elevating the quality of care and quality of life for nursing facility residents. Feel free to contact Eric Carlson of our staff with any questions or suggestions regarding this letter's recommendations.

Sincerely,

Kevin Prindiville
Executive Director