American Association on Health & Disability

110 N. Washington Street Suite 328-J Rockville, MD 20850
T. 301-545-6140 **F.** 301-545-6144 www.aahd.us

AAHD - *Dedicated to better health for people with disabilities through health promotion and wellness*

LAKESHORE

September 7, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3347-P
P.O. Box 8010
Baltimore, Maryland 21244

Re: Medicare and Medicaid Programs; Requirements for Long-Term Care Facilities CMS-3347-P

Submitted electronically: http://www.regulations.gov

Dear Administrator Verma:

The American Association on Health and Disability and the Lakeshore Foundation appreciate the opportunity to provide comments.

The American Association on Health and Disability (AAHD) (www.aahd.us) is a national non-profit organization of public health professionals, both practitioners and academics, with a

primary concern for persons with disabilities. The AAHD mission is to advance health promotion and wellness initiatives for persons with disabilities.

The Lakeshore Foundation (www.lakeshore.org) mission is to enable people with physical disability and chronic health conditions to lead healthy, active, and independent lifestyles through physical activity, sport, recreation and research. Lakeshore is a U.S. Olympic and Paralympic Training Site; the UAB/Lakeshore Research Collaborative is a world-class research program in physical activity, health promotion and disability linking Lakeshore's programs with the University of Alabama, Birmingham's research expertise.

As explained in more detail below, we object to several of the proposed changes, and offer suggestions that we feel would improve quality of care and quality of life for America's nursing facility residents. Our comments are consistent with leading nursing facility resident organizations and their colleague advocate organizations. We have had family members who have resided in excellent not-for-profit nursing homes, better informing our experience.

We are concerned that an undue focus on "provider burden" could harm nursing facility residents. Nursing facility operators already have significant flexibility in how they provide care.

Furthermore, residents need the protections in the current regulations more than ever before. Over the years, residents have become frailer and more dependent, and the majority have dementia. Increased physical and cognitive impairments mean residents need more care and are more vulnerable to abuse and neglect. Any revisions to the regulations should only be made if they improve resident protections, not reduce them.

Our detailed recommendations are presented below.

PROVIDING RESIDENT WITH CONTACT INFORMATION FOR PHYSICIANS (Section 483.10(d))

We recommend retaining most current requirements.

We believe residents should always have up-to-date contact information regarding their attending physician and that the regulations should retain a resident's right to have the same access to contact information for "other" professionals (e.g. psychiatrists, therapists, etc.). This allows residents to contact their providers when they wish, without having to request and then possibly wait to obtain this information.

Because the term "remains informed" has some ambiguity, we agree with the greater specificity provided by a requirement that information must be provided at admission, at a change, and upon a resident's request. The conjunction "and" should be used rather than "or" to make sure that the facility has an obligation in each of these situations.

GRIEVANCES (Section 483.10(j))

We recommend that:

Complaints be treated as grievances when they are unresolved,

Residents be protected from retaliation whether or not a complaint is treated as a grievance,

Residents be notified of which facility employees to contact regarding grievances,

The regulations retain the specified duties for grievance processing and the specified components of a written grievance decision, and

The regulations maintain the requirement that facilities retain grievance decisions for three years.

Treating Complaints as Grievances When They Are Unresolved

We are concerned about how CMS proposes to distinguish between a grievance and "general feedback." We understand that not every complaint expressed by a resident should be subject to a full grievance process, but disagree with CMS's proposal to give a facility great discretion to decide not to treat a complaint as a grievance. Under CMS's proposal, many significant resident concerns inevitably would be improperly classified as "general feedback."

For distinguishing between feedback and a grievance, we propose using the comparable standards in CMS's hospital guidance. Under that guidance, a "complaint" is classified as a "grievance" if it "cannot be resolved at the time of the complaint by staff present, is postponed for later resolution, requires investigation, and/or requires further actions for resolution."[1] Notably, this standard is consistent with CMS's preamble statement accompanying the proposed regulations, "that general feedback or complaints stem from general issues that can typically be resolved by staff present at the time a concern is voiced, while grievances are more serious and generally require investigation into allegations regarding the quality of care."[2]

Preventing Retaliation

CMS's proposed language would prohibit a facility from retaliating against a resident who voices a grievance, but would not prohibit retaliation against a resident expressing "general feedback." The regulation should be written to prohibit retaliation whether or not a complaint is treated as a grievance.

Contact Information for Accessing Grievance Process

CMS proposes to eliminate the "Grievance Official" requirement, so that grievance-related duties can be shared by facility staff, with one individual responsible for overseeing the grievance process. If that change is made, we recommend revising the regulations to require a facility to notify residents of how to contact the facility employees responsible for the grievance

[1] CMS State Operations Manual, Appendix A (Survey Protocol, Regulations and Interpretive Guidelines for Hospitals (Interpretive Guidance for 42 C.F.R. § 482.13(a)(2)).

[2] 84 Federal Register at page 34,741.

process. The current regulations have a comparable requirement, but that requirement is lost in the proposed regulatory language and its deletion of the "Grievance Official" position.

Specifying Duties of Grievance Process

We oppose CMS's proposal to eliminate the specified duties of the staff members handling grievances. Even if a facility does not have one specified Grievance Official, the duties remain necessary. The duties specified in the current regulation are basic, reasonable, and necessary components of complaint investigation and resolution. They are also broad – leaving adequate flexibility to facilities.

Specifying Contents of Written Grievance Decision

We support maintaining the requirement to provide residents with a written decision regarding their grievance. We object, however, to CMS's proposal to remove most of the language detailing what must be included in the written decision. CMS states in its discussion of the proposed regulations that it "expects" that facilities will choose to include certain important information in the decisions, but our experience has long been that, in general, if it is not required, it is not done. Unless the specific contents of the notice are mandated, many facilities will provide only the bare minimum called for in the proposed regulations. The grievance regulations should continue to specify the information as required by the current regulations.

Retaining Evidence of Grievance Results for Three Years

We disagree with CMS's position that maintaining evidence related to grievances for three years is burdensome. Any documents concerning grievances will almost certainly be electronic. If not, handwritten documents can be scanned and become electronic. CMS proposes an 18-month requirement; retaining records for an additional 18 months (for a total of three years) would require little to no effort or cost.

Grievance results can indicate the types of problems the facility has had in the past, what was done to address those problems, and if those efforts were successful. This information can be used by both facilities and surveyors to identify problems or potential problems.

NOTICE OF TRANSFER/DISCHARGE WHEN RESIDENT IS HOSPITALIZED (Section 483.15(c))

We support focusing on notices to Ombudsman programs in situations where a resident is not being allowed to return from a hospitalization, but object to use of the terms "involuntary" or "facility-initiated" in the regulations.

We agree with CMS that notice to Ombudsman programs of transfer/discharge related to hospitalization (or other temporary absence) should be focused on situations where the facility is not allowing a resident to return, rather than on all instances when a resident is hospitalized. The scenario where a resident is sent to the hospital, treated, and then not permitted to return to their nursing facility continues to be a widespread problem. In a recent Consumer Voice transfer-

discharge questionnaire, approximately 61% of State Ombudsmen indicated that they have observed a trend of nursing facilities refusing to allow residents to return from hospitalizations. Any revision of the regulations, however, should not use the terms "involuntary" or "facility-initiated." Those terms currently are used in the guidance but not in the regulations. Inserting any of those terms into one line of the regulations would raise questions about how to interpret "transfer" or "discharge" in other areas of the regulations where those words are not modified by "involuntary" or "facility-initiated."

NURSE STAFFING DATA (Section 483.35)

We support retaining the current requirement that facilities maintain daily nurse staffing data for at least 18 months.

Currently, nursing facilities must retain daily nurse staffing data for at least 18 months, but CMS proposes to reduce this minimum time to 15 months.

We recommend that CMS retain the current 18-month minimum. Since surveys by law may be separated by as much as 15 months, 18 months provides leeway if a survey is late. Also, nursing facilities face no significant difficulty in retaining information for an additional three months, particularly because the information likely is kept electronically.

FOOD AND NUTRITION (Section 483.60(a)(2))

We recommend that current standards be retained, but with the grandfathering of current directors of food and nutrition services.

We support the current standards for directors of food and nutrition services and believe that CMS's proposed standards are much too weak. We point particularly to CMS's proposal to require no more than a vaguely described "course of study."

According to CMS, facilities have complained about their current directors of food and nutrition services not qualifying under the regulations. This perceived problem could be dealt with by grandfathering in the current employees. However, any concerns about current employees should not affect the application of the current standards to new hires.

FACILITY ASSESSMENTS (Section 483.70(e))

We recommend that CMS continue to require annual facility assessments.

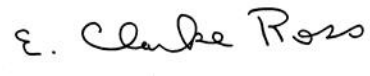
The facility assessment is critically important because it can help address the number one problem voiced by residents – lack of adequate numbers of well-trained and competent staff, particularly nursing staff. In an assessment, the facility follows a formal process to determine its staffing needs.

CMS proposes to reduce assessment frequency from annually to every-other-year. But because a facility's resident population is not static and staff turnover is high, reviewing and updating the

facility assessment at least annually is essential. Otherwise, too much time will elapse between reviews and the staffing levels may not reflect a change in the acuity level, types of diseases, conditions, and physical and cognitive disabilities of a facility's residents.

Thank you for the opportunity to comment. If you have any questions please contact Clarke Ross at clarkeross10@comcast.net.

Sincerely,



E. Clarke Ross, D.P.A.

Public Policy Director
American Association on Health and Disability
clarkeross10@comcast.net
Cell: 301-821-5410

Member, National Quality Forum (NQF) workgroup on Medicaid adult measures (December 2017-present), Medicaid-CHIP Scorecard Committee (October 2018-present) and Measure Sets and Measurement Systems TEP (June 2019-present). Member, National Quality Forum (NQF) workgroup on persons dually eligible for Medicare and Medicaid (July 2012-July 2017) and NQF population health task force (2013-2014) http://www.qualityforum.org/) and NQF representative of the Consortium for Citizens with Disabilities (CCD) Task Force on Long Term Services and Supports (http://www.c-c-d.org/). 2017 member, NQF MAP workgroup on Medicaid adult measures. 2016-2017 NQF duals workgroup liaison to the NQF clinician workgroup. 2015-2016 and 2014-2015 NQF duals workgroup liaison to the NQF PAC/LTC workgroup. Member, NQF Medicare Star Ratings Technical Expert Panel (June-September 2019). Member, ONC (Office of the National Coordinator for Health Information Technology) Health IT Policy Committee, Consumer Workgroup, March 2013-November 2015; Consumer Task Force, November 2015-April 2016. (http://www.healthit.gov/policy-researchers-implementers/federal-advisory-committees-facas/consumer-empowerment-workgroup). Member, SAMHSA Wellness Campaign National Steering Committee – January 2011-September 2014. (http://promoteacceptance.samhsa.gov/10by10/).

Roberta S. Carlin, MS, JD
Executive Director
American Association on Health and Disability
110 N. Washington Street, Suite 328J
Rockville, MD 20850
301-545-6140 ext. 206
301 545-6144 (fax)
rcarlin@aahd.us

Amy Rauworth

Director of Policy & Public Affairs
Lakeshore Foundation (www.lakeshore.org)
4000 Ridgeway Drive
Birmingham, Alabama 35209
205.313.7487
amyr@lakeshore.org