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September 28, 2015

Acting Administrator Andy Slavitt
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–3260–P
P.O. Box 8010
Baltimore, MD 21244

Re: Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities; CMS-3260-P

Dear Acting Administrator Slavitt:

AARP appreciates the opportunity to comment on this important proposed rule that revises the requirements long-term care (LTC) facilities, also referred to as skilled nursing facilities (SNFs) and nursing facilities (NFs), must meet to participate in the Medicare and Medicaid programs. The provisions of this rule are vital to the individuals who receive care in these facilities and their families. These facilities are also serving a population with increasingly complex care needs, including the nearly 60 percent of nursing home residents who have Alzheimer's or another dementia. We urge CMS to work with advocates for nursing home residents and their families as you implement the final rule and subsequent guidance.

Overall, AARP supports making the LTC facility requirements more person-centered, involving resident representative(s) to support residents, improving care transitions and discharges, and improving resident quality of life and care. We also raise areas of concern, especially in regard to proposed provisions on arbitration. Finally, we suggest areas to strengthen and improve in the proposed rule, such as provisions to reduce the inappropriate use of psychotropic drugs. References to nursing facilities in these comments refer to LTC facilities.

Enforcement of All Provisions that Impact Health and Safety

Several requirements in the proposed regulations impact residents' health, safety, and well-being. AARP believes strong enforcement of these requirements is needed to protect residents and ensure their quality of life and care. We urge CMS to provide

defined consequences for noncompliance with the regulations, particularly those related to residents' rights, grievances, and abuse and neglect. Noncompliance with these regulations should result in a finding of Immediate Jeopardy (as appropriate) and, ultimately, sanctions, including large civil monetary penalties, temporary management, directed corrective actions, and exclusion from participation in Federal health care programs, as appropriate.

Specific Sections of the Proposed Rule

Definitions (§483.5)

CMS proposes a number of important changes and additions to definitions which AARP supports. In particular, AARP supports CMS' proposed change to the definition of a "composite distinct part" of a facility to ensure that such a designation can't be used to segregate residents by payment status or on any other basis besides care needs. There have long been concerns that segregation of residents by source of payment may result in quality differences for residents based on their payment source.

The proposed rule would include a number of new definitions. AARP supports the addition of definitions for "abuse," "neglect," "exploitation," and "misappropriation of resident property." Having universally understood and applied definitions will improve clarity and help facilities, staff, residents and their representatives understand the kinds of behaviors that rise to the level of these terms so that they can be more easily prevented, identified and addressed.

Resident Representative. In §483.5, CMS proposes a new term "resident representative" and defines the term to mean "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." While CMS intends for this new term to be a "clarification" to ensure that facilities do not afford more decision making authority to a resident representative than what was intended by the resident or permitted under applicable law, we are concerned that the use of this single term may, in practice, add confusion. While CMS acknowledges on page 42182 that "resident representative" actually refers to three categories of resident support (court-ordered or otherwise designated under applicable law (e.g., state law), supported by documentation (that is, an advance directive), and informal/oral), the roles, authorities, rights and responsibilities of each of these categories of representative, while distinct, may, and often do, overlap. As such, a single term may not provide the clarity desired. AARP is concerned that the use of this term may, in fact, provide greater decision making authority than what was intended by the resident in some instances, and lesser authority than what was intended by the resident in other instances.

In considering whether to utilize this, or another single term, and, if so, how it will be defined, AARP urges CMS to use as a guiding principle and overall goal that residents should have the broadest possible support from the greatest number of family members, other loved ones, friends, neighbors and all other individuals residents wish

to have “in their corner”. For example, residents may wish to have a spouse participate in intake at the time of admission, to provide critical information about food and bathing preferences. The same resident may wish to have another individual (perhaps a former business partner living at a distance) act on their behalf for financial matters only and may have given a power of attorney (POA) for that specific purpose. The same resident may also wish their son to participate in regular care plan meetings. And the resident may be fine with any or all of these individuals participating in family council meetings, but may not want his POA to attend care plan meetings. It is important to note that in some instances the resident will not have anticipated the need to confer any specific authorizations upon certain individuals, but nevertheless may support such participation. The guiding principle should be to assume that interested parties’ participation in the life of the resident is welcomed by the resident, unless otherwise expressly opposed by the resident, or unless there is other evidence to the contrary.

At the same time, it will be important to clarify that a facility must not obligate a resident to choose or designate anyone to serve as a “resident representative.” And, it should be incumbent on a facility to engage all of these persons appropriately, rather than any single resident representative who may not represent the full interests and decision-making authority of a resident.

AARP believes that the final rule should effectively and appropriately capture the many relationships that family members, friends, legal representatives and others may have with the resident and the rights these individuals have acting on behalf of or advocating for the resident, as well as the rights these individuals have on their own independently. The term or terms used to describe these individuals and their roles should be clear and easy to understand for residents, the individuals, and the facilities and not too complex or burdensome to effectively use on a daily basis. However, these terms should not be utilized to exclude individuals who wish to continue to play a role in the lives of the resident, unless that is the expressed wish of the resident. The resident should retain as much choice and control as possible and flexibility is important to allow for the unique situation of each resident. These comments on resident representatives are relevant to the proposed rule overall, as many sections of the rule refer to resident representative or have provisions relevant to such individuals.

<u>Resident’s Rights (§ 483.10)</u>

This section includes many important rights for residents, including those regarding self-determination, respect and dignity, access to information, and grievances. AARP appreciates the resident representative’s role in supporting the exercise of resident rights and enhancing resident-focused care. While resident representatives may support the residents’ rights listed in this subpart, the presence of resident representatives may also benefit residents in other areas covered by the regulations. For example, a resident may want/need to have their representative present during care planning and review of medications prior to giving informed consent. AARP urges CMS to encourage an appropriately expansive view of the representative’s role while ensuring respect for the resident’s right to self-determination. See also our comments in §483.5 on resident representative.

Exercise of Rights (§483.10(a)(3)). AARP recommends that nursing facilities be required to have clearly defined procedures regarding resident representatives. As part of admission, nursing facilities must inform each resident that s/he may select one or more resident representatives and may specify which rights/responsibilities the s/he wants to delegate or share. As noted above, residents must have broad discretion in designating the scope of the representative's role in their care. Nursing facilities must inform residents of their rights specified in §483.10, and that, if the resident wishes, their representatives can fully participate in any meeting, including care-planning, assist with decision-making, and have access to all resident records in the same way that the resident would. The nursing facility must also advise each resident of his/her right to revoke the delegation of rights, except as limited by state law. AARP recognizes that a resident may not be prepared to designate a representative at the time of admission due to other pressing issues. Nursing facilities should periodically remind residents that they have the option to select one or more representatives.

AARP is concerned that nursing facility staff may not become aware of the resident's selection of a representative. We recommend that CMS require nursing facilities to establish a mechanism for formally recording the designation of a representative and informing staff of the resident's selection and scope of delegation of responsibilities.

We also recommend that nursing facilities have a process for the residents to designate what they want to happen in the event that a resident is adjudged to be incompetent under the state law. While proposed §483.10(a)(4) provides that the court-appointed resident representative would exercise the residents' rights on their behalf, the residents may have previously designated a legal representative. Residents' previous designation of legal representatives should be honored to the extent it does not conflict with state laws.

Planning and Implementing Care (§483.10(b)). AARP appreciates CMS' proposed language recognizing the residents' right to be informed in advance of the risks and benefits of proposed care and treatment, especially in light of the use of antipsychotic drugs often without first obtaining informed consent. As discussed in more detail below, in the event that a psychotropic medication is suggested as treatment, AARP believes that nursing facilities should be required to document that the attending physician discussed the benefits, risks, and alternatives of the drug with the resident and/or the resident's representative and that the doctor obtain informed consent prior to administering the drug. The resident should be informed of his/her right to refuse the medication and of alternative behavioral interventions, and this should be documented, as well. With respect to a resident's right to refuse a particular treatment or medication, AARP is concerned that §483.10(b)(7), as currently worded, could be used by nursing facility physicians and staff to deny a resident's/representative's request for alternative behavioral interventions on the basis that a physician or nursing facility nurse believes that a drug regimen is a better or more appropriate treatment. In order to protect the resident's right to self-autonomy, CMS should clarify the definition of "medically unnecessary or inappropriate" in this context to make it clear that such decisions should be evidence-based.

Access to Information (§483.10(f)(3)). We are concerned that the proposed regulation limits the type of information that residents can access. The existing regulation provides residents access to all records pertaining to the resident including clinical records. AARP recommends retaining the current language.

Facility Responsibilities (§483.11)

CMS begins the newly-named Facility Responsibilities section by expanding on existing requirements that facilities must treat residents with respect and dignity, and provide care and services that maintain or enhance the resident's quality of life and protect the resident's rights. AARP supports the new "Exercise of Rights" §483.11(a), including §483.11(a)(2)'s requirement that facilities provide "equal access to quality care regardless of diagnosis, severity of condition, or payment source and establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services for all residents regardless of source of payment." Nevertheless, we encourage CMS to provide greater clarity on §483.11(a)(3) and (4) over the expectations of facilities deferring to resident representatives for decisions that exceed the scope of a court order, resident delegation, or other applicable law. Similarly, §483.11(a)(5)'s language of expectations for facilities complying with state requirements in the case of a resident representative making decisions not in the best interest of the resident seems rather vague and may provide potential for abuse.

AARP supports proposed changes to ensure that the resident is informed of, and participates in, his or her treatment, and that the resident participates in care planning (§483.11(b)). However, we urge CMS to include stronger language with regard to including the resident or those whom the resident has chosen to support her, rather than simply facilitating inclusion of such individuals. AARP strongly suggests that CMS include specific language that would *require* (emphasis added) nursing facilities to provide reasonable advance notice to resident representatives (writ broadly) of the care planning meeting, establish alternative means of participating (via telephone or video conferencing, for example), offer a reasonable choice of dates and times, and document the same. This would help facilitate the participation of resident representatives in care planning.

Resident's Right to Choose their Own Attending Physician. CMS proposes to establish the right of residents to choose their own attending physicians and to require facilities to protect and promote that right. The proposed rule would also give facilities the responsibility to ensure that the chosen physician meets the professional credentialing requirements of the facility. If the physician does not meet those requirements, the facility can seek alternate physician participation.

In general, AARP supports changes designed to ensure that residents are the driving force in their care and allow them to make choices that preserve their dignity, reflect their preferences, and support their independence. In this case, however, the lack of clarity around what is meant by the "professional credentialing requirements of the facility" raises potential issues. The proposed rule does not include a clear definition of what is meant by the professional credentialing requirements of the facility and that

phrase is not otherwise defined in existing regulations. AARP is concerned that leaving this level of flexibility to facilities could allow facilities inclined to not accept residents' choices with a potentially fairly easy way to undermine this right. AARP urges CMS to make clear that credentialing requirements cannot be used for the purpose of denying a resident's right to choose their own physician without good cause and/or right of appeal.

Further, AARP requests clarification about how this right would be maintained when residents are in facilities that have closed medical staff models or that employ their own physicians. Finally, we note that credentialing itself does nothing to ensure adequate performance or competent care so we urge CMS to ensure that quality programs incorporate physician performance indicators and measures.

Self-Determination and Visitation. In general, AARP strongly supports changes to expand the rights of residents related to self-determination. AARP supports CMS' proposed changes to enable immediate access to the resident by the resident representative (§483.11(d)), as well as the requirement that facilities must have written policies and procedures regarding visitation rights of residents. AARP supports providing residents with more flexibility around when they receive visitors and who may visit. The ability to have visitors creates a more home-like environment and promotes resident comfort and dignity. Since family and other close visitors often know a resident best, they sometimes act as an intermediary or advocate for residents to support their care or to provide important information to nursing staff.

Resident and Family Groups. CMS proposes to revise §483.10(e)(5) and (6), clarifying that it is the *resident*'s (emphasis added) right to participate in family groups and have his or her family members or resident representatives participate in family groups in the facility. We recommend that it be clarified that it is also the right of family members or resident representatives (defined broadly) *themselves* (emphasis added) as well as other persons interested in the welfare of the resident or residents to participate in family groups. See our comments above on "resident representative" suggesting that the broadest resident support system is in the best interest of all residents.

While AARP supports the intent of the proposed language that requires nursing facilities to provide a resident or family group, *if one exists* (emphasis added), with private space, we believe that this is insufficient and should be strengthened. We believe the facility should be prohibited from impeding and furthermore should be required to facilitate the formation or continued existence of such groups. At a minimum, nursing facilities should be required to, with the approval of the groups, take reasonable steps to notify residents and family members of the groups (in formation and in existence) and of upcoming meetings in a timely manner. Notice should be provided, at a minimum, through conspicuous postings in the facility (perhaps in the same manner in which information on the LTC Ombudsman is posted) and in other means the facility uses to contact or inform residents and family members, including newsletters and mailings.

We are supportive of the proposed clarification in §483.11(d)(3)(ii) that the designated staff person who participates in this group must be approved by the resident or family

group and the facility. However, it should be clear that this designated staff person does not necessarily have to be the same person for both the resident group and the family group. In addition, there are times when the members may not wish the designated staff person to attend the meeting, and resident and family groups must be allowed to convene without a facility staff member present. Furthermore, this language should not be read to require family group meetings to be held at the facility, as these groups may at times or regularly wish to meet off-site. We support the proposal that the grievances and recommendations of the groups must be addressed, and if not implemented, the rationale for this must be provided to the group. We recommend this should be required to be done in writing.

Protecting Resident's Funds. AARP supports CMS efforts to pull provisions related to the protection of residents' funds together into one place for clarity, to update those requirements and to add limitations on the kinds of things for which facilities may charge residents. Under these rules, facilities would not be able to charge for items or services needed for a resident's care plan or for special food and meals ordered by health professionals, or for hospice services elected by the resident and paid for under the Medicare hospice benefit or paid for by Medicaid under a state plan, whether provided directly by the LTC facility or by a hospice provider under agreement with the facility.

AARP supports existing provisions to protect residents' funds by keeping them in an interest bearing account and by segregating them from the facilities' own funds, but AARP recommends that facilities should be required to periodically review those accounts for suspicious withdrawals and to require training for administrators in protecting resident accounts. Further, there should be regular monthly accounting statements prepared and given to the resident and his or her resident representative (as appropriate) to ensure that any changes are noticed as quickly as possible. Too often, residents' own funds are being siphoned off by unscrupulous employees in charge of keeping those funds safe.[1]

Information and communication. AARP supports the expansion of accessibility to information by the resident (§483.11(e)), including the language stating "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."

AARP supports the requirement that facilities provide residents with access to medical records in the form and format requested by the individual if they are readily producible, and if not, then in written form or in another form as agreed to by the individual and the facility. This requirement builds on the existing requirements that such information be made available within 24 hours, and upon oral and written request. Reflecting the reality that many nursing facility residents cannot access records electronically, AARP appreciates that the proposed rule leaves the decision to the resident as to whether to

[1] Peter Eisler, USA TODAY 3:28 p.m. EDT October 21, 2013, Facilities often lack financial safeguards and proper oversight for residents' money, http://www.usatoday.com/story/news/nation/2013/10/16/nursing-home-trust-fund-thefts/2967925/.

access records electronically or in another "readily producible" format. While AARP supports increased ease with which individuals may access their medical records, we are very concerned by the standards proposed for the fees that facilities may charge for these records contained in §483.11(e)(2)(iii). We oppose the proposal to move from a community standard to a cost-based standard under which the fee may include the cost of labor for copying the requested health information, the supplies for creating the paper copy or electronic media, and postage, which could be abused and could inappropriately and unfairly impede a resident's access to his or her own health records. At a minimum, AARP would recommend establishing a limit on fees that can be charged, and to ensure that said fee includes any labor charges (research fees, clerical fees, handling fees or related costs). In any event, these fees should not exceed what is permitted to be charged to obtain medical records under state law. In addition, we would recommend the establishment of a "hardship exemption" for low-income residents, allowing them to receive copies of their records at no charge, perhaps upon providing an affidavit of inability to pay or otherwise demonstrating an inability to pay fees.

AARP believes that CMS should clarify that a resident is entitled to his or her complete set of medical records, and proposes that the definition of "medical records" include all records concerning the resident during the period of time the resident was in the nursing facility's care. Without clarification, AARP is concerned that nursing facilities may self-define what records it considers to be "medical records" for the purposes of responding to resident requests to the exclusion of records related to outside consultations, financial records, and other records that may be kept outside of the facility medical records. Allowing nursing facilities this degree of flexibility may undermine the resident's right to access his or her own records and allow a nursing facility to conceal any deficient care provided to the resident.

AARP is pleased that CMS is proposing to require facilities to make reports related to surveys, certifications, complaint investigations, and plans of correction available for individuals to review, and to post a notice of this information's availability. Other information that AARP recommends be made available to residents includes:

- Results from independent resident/family caregiver experience surveys (resident and family) – such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Nursing Home Surveys;
- Whether or not the facility provides special care services and if so, the kinds of services provided;
- Policies of the facility. For example, whether it has family groups, allows pets, etc.; and
- Information available in other languages, as appropriate.

CMS may wish to consider, where appropriate, whether the existing standards that apply to medical records – that they be made available within 24 hours and upon oral and written request – should be extended to the other types of information that are required to be made available under §483.11(e).

Notification of changes. AARP also supports many of the provisions in §483.11(e)(7) requiring that facilities immediately notify the resident, consult with the resident's physician and notify the resident's representative when there is a change in the resident's condition, when treatment needs to be altered in a significant way, or when the resident is to be transferred or discharged.

Grievances. AARP strongly supports CMS' proposed additions to the standards relating to providing information about the right to file a grievance and how grievances are handled. The ability to make a grievance and to have it taken seriously by the facility is an important right and protection for residents. AARP requests clarification, however, on the proposal to require a facility to establish a policy that ensures the prompt resolution of all grievances "regarding the residents' rights contained in §483.10." The right to a prompt resolution of grievances should extend to all grievances and not only those relating to the rights enumerated in §483.10.

Freedom from Abuse, Neglect, and Exploitation (§483.12)

AARP appreciates that the proposed regulations include a prohibition on facilities employing individuals because of past findings of guilt, or actions or incidents of abuse, neglect, mistreatment or misappropriation of property. Existing rules in §483.13(b) prohibit facilities from employing such individuals. CMS proposes to add that facilities be prohibited from employing or otherwise engaging such individuals. In describing the individuals that cannot be employed or engaged in this section, CMS proposes to add those who have had a disciplinary action taken against their professional license by a state licensure body as a result of a finding of abuse, neglect, mistreatment of residents or misappropriation of resident property. CMS also proposes to add a requirement that facilities develop and implement written policies and procedures that prohibit and prevent such activities. AARP urges CMS to carefully describe the consequences for violations of these provisions in a manner that is consistent with the HHS Office of Inspector General's statutory provision related to hiring or retaining people who have been excluded from participating in federally funded health care programs, including but not limited to civil monetary penalties. By heightening the consequences for hiring staff that may potentially harm residents, CMS will properly incentivize these requirements. We also appreciate the inclusion of provisions regarding the reporting of crimes occurring in federally-funded LTC facilities.

Transitions of Care (§483.15)

Under the proposed regulations in §483.15(a), facilities may not request or require that residents or potential residents "waive their rights as set forth in this subpart and in applicable State, Federal or local licensing or certification laws." AARP has long opposed discriminatory admissions policies that are based on source of payment, ability to pay, or socioeconomic status. CMS' proposed regulations are an important step in ensuring that nursing facilities do not use their immense disparity in bargaining power to obtain broad waivers of residents' rights, including rights attendant to transitions of care.

The proposed regulations regarding transitions of care, however, do not address a resident's right to receive care in the most integrated setting appropriate to his/her needs. Under the Supreme Court's decision in *Olmstead v. LC*, it is settled law that unnecessary institutionalization of a person with a disability is discrimination under the Americans with Disabilities Act (ADA). Advance and ongoing planning for the resident's eventual transition to a home and community-based setting is critical to protecting a resident's rights under the ADA.

After months or years in a nursing facility, it becomes more difficult to transition back to living and receiving long-term services and supports in his/her home or in smaller, more integrated settings in the community. Over time, unnecessary stays in nursing facilities can cause nursing facility residents to lose available housing options or the support of family caregivers; some residents lose important identification documents that would enable them to secure services outside the nursing facility. As a result, residents are in need of specialized transition services to enable them to move into community-based settings. Therefore, AARP proposes that this rule reflect a requirement in §483.21 that nursing facilities begin the assessment and planning process for a resident's discharge upon the resident's admission to the facility. Additionally, this regulation should require nursing facilities to periodically revisit that plan and to assist the resident in securing the services and supports needed to transition to living in the community, including support for family caregivers who will be assisting the resident after discharge, especially those providing assistance under the discharge plans.

In the proposed rule, CMS expands the reasons for which a facility may discharge or transfer a resident from the facility to include the safety of other individuals in the facility. Moreover, "safety" has been further defined as safety "due to the clinical or behavioral status of the resident." While we understand that this proposed change represents an acknowledgement that the mental health of some residents may pose a danger to others, and that this new language represents a well-intentioned effort to protect other residents from harm, we believe this language is far too broad, subject to multiple interpretations, and could be misused to discharge residents whose behavior is challenging, but could be appropriately addressed through better staffing, staff training, behavioral and other evidence-based interventions, including improving access to mental health services and professionals.

We urge CMS to require the facility to bear the burden of demonstrating that the resident poses a legitimate safety concern, what steps it has taken before discharging or transferring to address the resident's clinical or behavioral status which is the reason for the discharge or transfer, including interventions, treatment, and therapies, and to confirm how it provided appropriate access to mental health services for the resident. Without these assurances, a facility may have an easy way to remove residents that it finds troubling, without good cause. Also critically important to this section is the need for CMS to require that the discharging facility facilitate a transition to another facility or to another setting where the individual can secure the appropriate support.

AARP supports CMS' proposed changes to the documentation and notice subsections. Having a clear and concise record will allow all individuals involved in

providing care, both in the present and the future, to the resident to do so with the best information available. A more defined structure for notification will ensure that the proper individuals, including resident representatives and the State Long Term Care Ombudsman, have the information early, when they need it the most, to set up the residents' care. We recommend adding the name and contact information of the resident's family member(s), if applicable, to the list of information that the facility must include in the transfer documentation. Similarly, we recommend adding these family members to the list of persons in §418.15(b)(3)(i) who should receive notice of transfer or discharge.

CMS proposes to add language in §483.15(c) regarding bed hold and reserve bed payment policies and has asked for comments. AARP is concerned that simply improving a facility's notice of its policies to residents does not address the underlying fairness or appropriateness of the policies in question. When a resident whose care is covered by Medicaid is transferred to a hospital and either his bed hold has expired or the state does not permit bed hold payments, nursing facilities may often seek payment from family members. Family members are asked if they would like to pay to "keep the bed" because the facility says it cannot guarantee there will be a bed when the resident returns to the facility. Understandably, family members are fearful of what will happen if the resident cannot return to the facility. Moreover, we are aware of instances where facilities ask the family member(s) to pay the private pay per diem rate, not the Medicaid adjusted direct rate, which the facility would otherwise be receiving. This could mean a spouse who is living on her spousal impoverishment protected amount being asked to pay three or even four times the Medicaid rate. In the same way nursing facilities currently are prohibited under law from requiring a family member to agree to be the financially responsible party for a nursing home resident as per §483.12(d)(2), we believe that they should be prohibited from asking a family member to hold a bed. This is true especially in the case where occupancy rates fall below a certain specified level.

In the alternative, we believe CMS should, at a minimum, restrict the fees that a nursing facility could charge someone acting on behalf of a Medicaid-eligible nursing home resident to no more than the Medicaid per diem direct rate, and in the case where a state pays for bed holds, to no more than the amount which the state would pay to hold the bed (often discounted depending on occupancy).

In addition, as part of the notice of bed hold policies, we believe CMS should require nursing facilities to provide information on the current occupancy rate (how many beds are currently available) so that residents and their families may make informed decisions about whether to pay to hold the bed.

Resident Assessments (§483.20)

AARP applauds CMS' proposed changes to clarify that the purpose of the comprehensive assessment of each resident's functional capacity is broader than only assessing their needs, but also extends to assessing residents' strengths, goals, life history and preferences. We believe these changes are instrumental to providing more

person-centered care because they incorporate into current assessments what is important to residents and will better engage residents as partners in their care.

Comprehensive Person-Centered Care Planning (§483.21)

AARP appreciates CMS' recognition of the need to plan for person-centered care. AARP supports proposed rule §483.21(b)(1)(iv) to require that discharge planning be included as a part of the comprehensive care plan. The discharge planning process should begin upon admission to the facility, involve the resident and resident representatives, and reflect the choices of the resident and include the desired outcomes of all parties, up to and including transition back to home or a community-based setting. We agree that discharge planning must include potential referrals to community transition agencies so that residents may be connected to resources for community living options and available services and supports, but we recommend that such planning be initiated as early in the admission as possible to prevent any unnecessary period of institutionalization.

AARP recommends that §483.21(b)(2) be changed to reflect an expectation that a comprehensive person-centered care plan must include the participation of the resident and resident representative(s). The rule, as proposed, includes their participation "to the extent practicable", which could be interpreted as an optional practice by a facility. The Department of Health and Human Services' Office of Inspector General (OIG) documented in the report "Nursing Facility Assessments and Care Plans for Residents Receiving Atypical Antipsychotic Drugs'' that 91 percent of the records did not contain evidence that the resident, resident's family, or resident's legal representative participated in the care planning process. We believe that facilities should be required to facilitate the participation of the resident and the resident representative(s) in the development of the care plan and document how this was done in the record, rather than simply documenting the reason why participation was "not practical". We also observe this OIG report references the resident's family or legal representative, capturing different types of resident representatives.

AARP also supports the inclusion of a nurse aide with responsibilities for the resident, a social worker, and a member of the food and nutrition services staff as members of the interdisciplinary team.

Discharge Planning. In addition to our discussion above related to the importance of discharge planning early in the admission process in §483.21(b), AARP suggests some changes to the related provisions in §483.21(c). Various places in this section acknowledge the roles of resident representative(s), caregivers, support person(s), and family of the resident. Such individuals, often family caregivers, are involved in a resident's care post-discharge from the facility. The discharge planning process is required in §438.21(c)(2)(iv) to "Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs." This is an important provision and we appreciate its inclusion. AARP urges CMS to strengthen the proposed rule that

in addition to the existing provisions, the discharge summary and plan must include whether the individual has a family caregiver and their contact information (with the consent of the resident and family caregiver), whether the family caregiver has voluntarily agreed to provide assistance to the resident under the discharge plan or post-discharge, and how prior to discharge the family caregiver was provided with or referred to supports they need to carry out their responsibilities post-discharge. This improvement would not only support the resident and family caregiver, but could also help prevent a return to the facility or an unnecessary hospitalization. We note services provided by family caregivers should only be included in the discharge plan if family caregivers have agreed to provide these services and have indicated their ability to carry out the actual tasks.

AARP also supports §483.21(c)(2)(iii) to add a requirement for facilities to reconcile all pre-discharge medications, both prescribed and non-prescription, with residents' post discharge medications and to include this information as part of the discharge summary. The addition of this requirement would ensure that residents avoid unnecessary medications, prevent adverse drug interactions, and assist individuals and their family caregivers post-discharge.

Quality of Care and Quality of Life (§483.25)

AARP strongly supports proposed changes to strengthen quality of care and quality of life for residents of facilities in §438.25 including:

- Requiring facilities to take into account a resident's comprehensive assessment, their preferences and choices in activities program and to provide activities that are designed to encourage independence and interaction in the community; and
- Including oral care as component of a basic hygiene activity of daily living (ADL). Oral health has been linked to many costly and debilitating chronic conditions and incorporating it has the potential to better improve the health of residents while also reducing costs.

CMS proposes, in several paragraphs in this section, that a resident receive care that is consistent with professional standards of practice. This standard is proposed to be added in several places in paragraph (4) Skin integrity and again in paragraph (15) Trauma-informed care. AARP recommends that CMS clarify that a standard of care that is "consistent with professional standards of practice" not be interpreted as a maximum standard or to limit care options for residents with complex conditions or unique needs. We urge CMS to clarify that when providing care that is consistent with professional standards of practice, the care also take into account individual residents' needs and complexity of individual residents' conditions. Finally, we note the overall importance of quality of life, in addition to quality of care, to nursing home residents.

Nursing Services (§483.35)

CMS acknowledges in the proposed regulations that there is abundant research that associates increased staffing with improved quality of care. Several sources are cited, including CMS' own study reporting that facilities with staffing levels below 4.1 hours per resident day for long stay residents may yield care that results in harm and jeopardy to residents (Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Phase II Final Report, 2001, Abt Associates).

CMS proposes a competency-based staffing approach in the proposed rule and does not propose minimum staffing levels. We note that minimum staffing levels and a competency-based approach are not necessarily mutually exclusive. For example, a facility may meet minimum staffing levels and further increase its staffing based on the results of the facility assessment referenced below. We urge CMS to give further serious consideration to these issues. With the upcoming implementation of the provision in current law requiring facilities to collect staffing data based on payroll data, facilities, CMS, states, consumers, and families will have more accurate information about current facility staffing levels, which could further assist in considering these issues.

Research shows that registered nurse (RN) staff hours in particular are correlated with better quality outcomes, including reduced incidence of pressure sores, lower use of physical restraints, and fewer hospital admissions. While licensed practical nurse (LPN) and certified nursing assistant (CNA) staffing is essential, it is not a substitute for RN staffing. Increasing staffing can improve the quality of care and quality of life of residents.

AARP is pleased that the proposed regulations require that facilities "have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident …" However, we have real concerns about the proposed mechanism for determining what constitutes "sufficient staff," with the "appropriate competencies and skills." The proposed regulations require the facility to conduct an assessment, at least annually, to determine the appropriate level and type of staffing needed. This proposal is of concern because it relies on the facility's own assessment of staffing needs without any enforcement mechanisms or safeguards to ensure that the facility is indeed objectively assessing resident needs, acuity, and other important factors and not unduly relying on other factors such as cost and convenience. AARP submits that this proposal requiring a "facility assessment" is not materially different from what nursing facilities currently do to determine staffing levels – a method which has produced serious staffing and quality deficiencies.

We agree with CMS that the regulations must not encourage facilities to set staffing levels based solely on regulatory minimum requirements and in lieu of actual resident needs and acuity levels of the residents they serve. We agree that the facility assessments should take into consideration all the factors set out in the proposed

regulation in §483.70(e) and we believe that each facility should conduct this assessment itself. However, we propose CMS require that the facility assessment be audited by a facility surveyor and that the surveyor be empowered to require, under threat of graduated monetary penalties, the facility to provide additional nursing resources if he/she disagrees with the facility's assessment. Lastly, we believe that the facility should be required to seek and use input from the Long-Term Care Ombudsman, the resident and family groups, and family caregivers when conducting its assessment.

Behavioral Health Services (§483.40)

AARP applauds and supports CMS' focus on ensuring that nursing facilities have sufficient direct care staff with the appropriate skills and competencies to provide the necessary care to residents with mental illness and cognitive impairment. We agree that those competencies and skills need to include knowledge of and training in how to implement non-pharmacological interventions. AARP supports the proposed requirement that facilities provide social services to residents. We agree that all behavioral health services that are indicated in the resident's comprehensive plan of care must be provided by the facility. See also our above comments regarding nursing services in relation to this section.

Pharmacy Services (§483.45)

AARP is deeply concerned about the prevalent and inappropriate use of psychotropic medications in nursing facilities. We support expanding the definition of drugs of concern, and also support the continued collection of data specific to antipsychotic drugs. Psychotropic drugs are powerful drugs often given to sedate or control elderly people with behavioral challenges caused by dementia and not by a major mental disorder as defined in 42 C.F.R. § 483.102; as such they are not prescribed/administered in accordance with the safeguards set out in current regulations. While AARP appreciates the additional safeguards that the pharmacist's periodic review of medical charts are intended to provide, the regulations fail to require an *immediate* response to any irregularities that are found and reported by the pharmacist. Additionally, the proposed regulations do not set out circumstances that could trigger an emergency review of the medical records of a resident who is administered psychotropic drugs.

AARP proposes that CMS revise its regulations to require the supervising nurse or nurse attending to a resident to request an emergency medical records review from the pharmacist for residents taking psychotropic drugs upon observation of adverse side effects, significant changes in the resident's condition, the absence of a diagnosis of a major mental disorder in the medical records, or the presence of a primary diagnosis of Alzheimer's or another form of dementia.

Additionally, AARP proposes that CMS revises its regulations to set a timeframe during which the attending physician, medical director, and/or director of nursing must take action on any reports of irregularities. Such reviews should include ensuring that appropriate informed consent has been secured from the resident or legally appropriate decision-maker. The regulations should require documentation of the action taken and

the underlying reasoning for this course of action in the resident's medical record. If the irregularity reported is the inappropriate use of psychotropic drugs, the regulations should require that the facility take immediate steps, per §483.45(e), to gradually reduce the drug and implement behavioral interventions with the goal of discontinuing the use of the drug as soon as is safe and practicable. Lastly, AARP proposes that CMS revise its regulations to require that pharmacists report instances of inappropriate use of psychotropic medication to the LTC ombudsman and CMS.

Dental Services (§483.55)

CMS proposes significant changes to the existing regulatory text for which AARP has comment. In the first instance, CMS would add language to prohibit the facility from charging a resident for the loss of or damage to dentures "determined in accordance with facility policy to be the responsibility of the facility." CMS notes that it considered, but is not specifying, the circumstances under which a facility is responsible and welcomes comment on this issue.

AARP supports the proposed policy that the resident not be charged for their lost or damaged dentures resulting from something that the facility or its staff has done. We believe that the proposed policy, however, leaves too much discretion to the facility to determine whether or not the resident should have to pay and could, therefore, be ineffective in achieving meaningful compliance in some or many instances. We urge CMS to give this policy greater clarity by specifying the minimum responsibilities for a facility, its staff, and contractor personnel in this regard.

Similarly, AARP supports CMS' proposed change to require that facilities refer residents for dental services within 3 business days or less from the time the loss or damage to dentures is "identified unless the facility can provide documentation of extenuating circumstances that resulted in the delay." We share CMS' concern that an expedited timetable for restoration of dentures is critical to avoid potential adverse health effects for facility residents. We believe, however, that this resident protection would be strengthened if CMS provided guidance on the meaning of "extenuating circumstances."

AARP also supports CMS' proposed changes related to the provision of assistance in scheduling of dental appointments and expanding the scope of dental services to include those provided at a dental clinic or dental school. Under the proposed modification to the existing regulation, if a resident requests assistance in scheduling a dental appointment, the facility would have to provide that assistance. This change in policy would improve upon timely access to needed dental care. Enabling dental services to be provided by clinics and dental schools and not just "dental offices" reflects what we hope to be an effort to improve high-quality and timely access to dental care. This change should not result in a replacement of dental visits. The goal should be to assure that residents receive assistance in accessing appropriate off-site locales on a timely basis.

Food and Nutrition Services (§483.35)

CMS proposes a number of important changes to facility requirements related to dietary and hydration needs of nursing home residents. As CMS notes, nursing home residents have become sicker with more complex conditions, requiring a higher level of staffing and training as well as a recognition of residents' more varying and potentially unique dietary and hydration needs.

AARP commends CMS' proposed requirement that facilities incorporate resident preferences in decisions about food and beverages as an effort to improve the responsiveness of facilities to the unique needs and preferences of their residents while also ensuring residents a greater sense of participation in decisions affecting care. We also strongly support CMS' changes to require facilities to recognize residents' religious, ethnic and cultural diversity with respect to the planning and provision of food and nutrition services. In addition, the existing rule requires that the facility provide at least three meals daily at regular times. AARP supports the proposed change to add language clarifying that meals be provided at times "in accordance with resident needs, preferences, requests and the plan of care." Finally, we support the requirement that a member of the food and nutrition services staff be on the interdisciplinary team.

Administration (§483.70)

Arbitration (§483.70(n)). AARP appreciates the recognition in the proposed regulation that arbitration agreements that require residents to waive their right to access the judicial system are increasingly prevalent and can be detrimental to residents' health and safety. However, we have serious concerns that the way in which CMS proposes to address these identified risks could, in fact, make protecting nursing facility residents from harm even more difficult. We recommend that CMS revise its proposal so that the use of arbitration agreements in the LTC facility setting is permitted only when the agreement to arbitrate is made after a dispute arises. In this way, both parties—who, as CMS acknowledges, do not have equal bargaining power—are fully aware of what dispute they are agreeing to remove from the jurisdiction of the courts and the commensurate rights they are waiving. This approach is necessary to ensure residents are knowingly and voluntarily entering such agreements. We also note CMS could borrow language from the President's "Fair Pay and Safe Workplaces" Executive Order last year, which also banned pre-dispute arbitration under certain laws.

Mandatory binding arbitration generally weakens the rights of individual consumers. The volatility of the LTC facility admission process makes it a particularly dangerous time for residents and their families to make decisions about waiving constitutional rights to access the judicial system to resolve future unknown disputes. Decisions regarding admission into a LTC facility are "emotionally-charged, stress-laden event[s]," typically made in the midst of a crisis brought on by an abrupt increase in disability level, precipitous deterioration in health, or the deterioration in health (or death) of a spouse or caregiver. See Podolsky v. First Healthcare Corp., 58 Cal. Rptr. 2d 89, 101(1996) (citing Donna Ambrogi, Legal Issues in Nursing Home Admissions, 18 Law Med. & Health Care 254, 255, 258 (1990)); Marshall B. Kapp, The "Voluntary" Status of Nursing

Facility Admissions: Legal, Practical, and Public Policy Implications, 24 New Eng. J. Crim. & Civ. Confinement 1, 3 (1998) (explaining that an older person's move to a nursing facility often follows a period of acute hospitalization when she or her family cannot manage home care demands). The emotional circumstances of admission to a LTC facility combined with the facility's superior bargaining power and knowledge increase the risks that arbitration agreements between the facility and a resident will not be fully understood by the resident and/or the resident's representative or will be coerced, unfair, or unconscionable.

While AARP appreciates CMS' recognition of these risks and efforts to address them, we do not believe that these risks can be effectively mitigated by the proposed regulations. First, CMS proposes to require that a LTC facility "explain the agreement to the resident in a form, manner and language that he or she understands and have the resident acknowledge that he or she understands the agreement." We do not believe that there is any manner in which the facility can effectively accomplish the goal of ensuring that the resident fully understands a pre-dispute arbitration agreement, in part, because the facility is not the appropriate party to provide such an explanation. Indeed, LTC facilities claim that they currently provide these explanations and obtain these acknowledgements, yet, when a dispute arises, residents and their representatives routinely express their complete lack of understanding of the rights they waived. LTC facilities have the greatest incentive and desire to resolve disputes outside of the public judicial system and, as such, have an inherent conflict of interest in explaining an arbitration agreement to the potential future adverse party. Despite this inherent conflict of interest and despite the inability to objectively verify that a nursing facility did indeed provide an adequate explanation of the agreement, having the "explain and acknowledge" requirement in the federal regulations will give arbitrators the impression that the arbitration agreements are presumptively fair—making it even more difficult to prove the unfairness of a particular arbitration agreement.

Furthermore, the resolution of disputes involving abuse and neglect through the process of arbitration shields facilities from having their poor quality or dangerous conditions exposed to the public and prevents judges from making findings of fact and conclusions of law that will influence future nursing facility conduct. The regulations acknowledge that arbitration agreements "may create barriers for surveyors and other responsible parties to obtain information related to serious quality of care issues. This results not only from the residents' waiver of judicial review, but also from the possible inclusion of confidentiality clauses that prohibit the resident and others from discussing any incidents with individuals outside the facility, such as surveyors and representatives of the Office of the State Long-Term Care Ombudsman." Though the proposed regulations attempt to address this by requiring that arbitration agreements "must not contain any language that prohibits or discourages the resident or any other person from communicating with federal, state, or local officials,…including representatives of the Office of the State Long Term Care Ombudsman", this requirement simply restates what is already a resident right to report regulatory violations, abuse, and neglect to the appropriate authorities. This proposed regulation does not address the more fundamental problems associated with the secrecy of arbitration and alternative dispute resolution: judicial inability to give guidance on legal issues of abuse and neglect and

resident inability to make his claims/allegations known to the general public and/or the media. The lack of transparency in alternative dispute resolution and arbitration thus deprives future residents, their families, and advocates of information that may be helpful to select safe and appropriate LTC facilities and to encourage facilities' legal compliance before disputes arise. In short, mandatory binding arbitration agreements are wholly inappropriate where health and life are at risk. For these reasons, we believe that this fundamental problem with arbitration can only be addressed if CMS permits only post-dispute arbitration agreements. By restricting the regulations to disputes in which the parties know precisely what they are waiving, CMS would increase the likelihood that it will enhance the needed transparency in serious and potential systemic disputes.

We support CMS' proposals never to allow arbitration agreements to be a condition of admission and to require that such agreements be a stand-alone agreement, separate from all other paperwork, as this reduces the risk of confusion and coercion. Arbitration agreements should also not be a condition of continued stay in the facility. However, AARP submits that these requirements can be effectively enforced only with post-dispute arbitration agreements and the prohibition of pre-dispute arbitration agreements. Similarly, we agree with CMS' proposal that "guardians or representatives cannot consent to an agreement for binding arbitration on the resident's behalf unless that individual is allowed to do so under state law, all of the other requirements in this section is met, and the individual has no interest in the facility." AARP suggests that this proposed regulation should be strengthened by including a mechanism by which the LTC facility representative would attest, under penalty of perjury, that s/he has verified the existence of all three of these conditions.

Quality Assurance and Performance Improvement (§483.75)

CMS proposes new §483.75 to implement the provisions of the ACA requiring the Secretary to establish and implement a Quality Assurance and Performance Improvement (QAPI) program for SNFs and NFs. Under the existing rule at §483.75(o)(3), a state or the Secretary is prohibited from requiring disclosure of the records of the facility's Quality Assessment and Assurance Committee "except in so far as such disclosure is related to the compliance of such committee with the requirements of this section." CMS proposes to move and modify this requirement so that it is included under the QAPI standards, consistent with its goal of assuring that the QAPI and the committee are working in cooperation. Specifically, the reporting and disclosure standard would be modified by the addition of the following language: "Demonstration of compliance with the requirements of this section may require State or Federal surveyor access to: (i) Systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; (ii) Documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; and (iii) Other documentation considered necessary by a State or Federal surveyor in assessing compliance." AARP supports this proposed modification. We believe it will improve facility compliance with the standards and assist in federal and state oversight.

Physical Environment (§483.70)

AARP appreciates CMS' proposal to update standards for the physical environment of nursing homes with respect to space and equipment, resident rooms and other aspects of the spaces that have a major effect on the well-being and quality of life of their residents. We firmly believe that physical environment is a critical factor, affecting everything from the basic safety of residents and facility staff to the physical, mental and social well-being of residents. Residents also benefit from being outdoors, not just in the facility. To this end, CMS should establish goals that help pave the way to more universal standards for facilities that are person-centered in all aspects, including physical environment that recognizes the needs of residents for privacy, dignity and personal choice. Culture change and models, such as the Green House® model, are important ways and examples to improve the well-being and quality of life of residents. We appreciate that not every nursing facility can follow the Green House® model in such respects as its small scale, provision of private rooms and baths and close integration with the neighboring community. However, where possible and appropriate, we encourage CMS to borrow more upon that model and other models and the evidence basis upon which they evolved in finalizing the revised physical environment standards.

Reducing room capacity from the existing four residents to two residents maximum should clearly be a priority for the reasons that CMS aptly describes. A room with four residents does not provide an environment that promotes maintenance or enhancement of each resident's quality of life. Under CMS' proposal, this new two person limit per room would not apply, however, if the facility is currently certified to participate in Medicare and/or Medicaid or has already received approval of construction or reconstruction plans prior to the effective date of this proposal. We encourage CMS to explore and think creatively about opportunities to encourage and facilitate exempt facilities under the proposed rule having a maximum of two residents per room. We suggest CMS consider a similar regulatory approach regarding each resident room having its own bathroom with at least a toilet, sink, and shower.

AARP also recommends that facilities be required to install safety features or special monitoring in bathrooms for residents whose ambulation is unstable. We believe that the addition of these would help to prevent falls and other accidents that can lead to rapid declines in a resident's physical and mental condition.

Training Requirements (§483.95)

AARP supports CMS' proposal to require facilities to establish a training program for all new and existing staff, individuals providing services under contractual arrangements, and volunteers, consistent with their expected roles.

With respect to the additional requirements for nurse aide training, AARP commends CMS for its proposed application of the ACA training requirements related to dementia management and patient abuse prevention for nurse aides. As CMS notes in its preamble discussion, nurse aide training has not kept pace with the care demands imposed by current resident diagnoses. Ongoing training in dementia management and

abuse prevention would clearly be valuable in improving the ability of nurse aides to work with residents who have Alzheimer's disease and other forms of dementia. Additional training should help to reduce instances of abuse and neglect. Moreover, it would help to improve the quality of life for nursing home residents.

CNAs working in LTC facilities are currently required to complete a 75-hour training course and pass a competency test within four months of beginning work with residents. Many states require more than the 75 hours of training, believing that this federal standard is inadequate. As of 2014, 31 states and the District of Columbia extended the minimum number of training hours for CNAs beyond the federally mandated 75 hours. AARP urges CMS to require at least 100 hours of training for CNAs. This would help improve quality of care for residents and enable improved training for CNAs to help them better meet the complex care needs of LTC facility residents.

AARP appreciates the opportunity to provide comments on this important proposed rule impacting LTC facility residents and their families. If you have questions, please contact me or Rhonda Richards (rrichards@aarp.org) on our Government Affairs staff at 202-434-3770.

Sincerely,

David Certner
Legislative Council & Legislative Policy Director
Government Affairs