CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

September 16, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 314-G
Washington, D.C. 20201

SUBJECT: CMS-3347-P, Medicare and Medicaid Programs; Requirements for Long-Term Care Facilities: Regulatory Provisions to Promote Efficiency and Transparency, Federal Register (Vol. 84, No.138), July 18, 2019

Dear Administrator Verma:

On behalf of our more than 400 member hospitals and health systems, including approximately 100 hospital-based skilled-nursing facilities (SNFs), the California Hospital Association (CHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule for reforming the Requirements for Long-Term Care Facilities.

CHA recognizes that the comprehensive 2016 reform of the long-term care requirements reflects CMS' ongoing commitment to ensuring the requirements support quality care and resident health and safety. Moreover, we appreciate CMS' current review and modifications to reduce administrative burden and eliminate items that are unnecessary or obsolete.

Overall, CHA supports CMS' current proposals, including proposals to:

- Make changes to the grievance process to distinguish between resident feedback and a grievance, including identifying specific duties of the individual responsible for overseeing the grievance process and other changes.
- Expand provisions to allow the attending physician or prescriber to document in the medical record a rationale for a longer duration for pro re nata, or as needed, orders for anti-psychotic drugs, in addition to psychotropics.
- Make changes to certain aspects of the informal dispute resolution (IDR) process, including instructing states not to upload survey results into the Certification and Survey Provider Enhanced Reporting system until the IDR process is completed.
- Delay implementation of certain "Phase 3" requirements by one year to avoid unnecessary work and confusion associated with revisions to the quality assurance and performance improvement program, and the compliance and ethics program.

CHA strongly supports CMS' proposal to modify requirements for notification of a resident discharge/transfer to be sent to the Office of the State LTC Ombudsman. However, CHA urges CMS to:

- **Provide additional clarification of "facility-initiated discharge," particularly in the context of short-term post-acute care stays.**

499 So. Capitol Street SW, Suite 410, Washington, DC 20003 • *Telephone:* 202.488.3740 • *Facsimile:* 202.488.4418
1215 K Street, Suite 800, Sacramento, CA 95814 • *Telephone:* 916.443.7401 • *Facsimile:* 916.552.7596 • www.calhospital.org
Corporate Members: Hospital Council of Northern and Central California, Hospital Association of Southern California, and Hospital Association of San Diego and Imperial Counties

- **Take additional steps to ensure that a resident's right to return to their SNF of residence is protected, by requiring notification to both the LTC Ombudsman and the resident when the SNF declines to readmit a resident following an acute care hospitalization.**

CMS proposes to modify requirements for Admission, Transfer, and Discharge Rights so that, before a facility transfers or discharges a resident, it must send a copy of the notice to a representative of the LTC Ombudsman. Under the proposal, this requirement would apply only to involuntary transfers or discharges initiated by the facility.

CMS references language included in State Operations Manual (SOM) Appendix PP – Guidance to Surveyors for Long Term Care Facilities Surveyors that defines a "facility-initiated transfer or discharge" as a transfer or discharge that the resident objects to, did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences. While this expanded definition is helpful, CHA believes additional clarification is needed.

For example, in our discussions with representatives of the California LTC Ombudsman, we learned that they interpreted this language to mean that all transfers and discharges not expressly requested by the resident would require notification to the LTC Ombudsman, even in instances when the planned discharge aligns with their goals for care and preferences, and when the resident does not object.

Many patients are admitted to a SNF for short-term transitional care and do not anticipate remaining in the SNF as a resident on an ongoing basis. In these cases, the patient/resident and physician have agreed upon a course of care that includes a limited SNF stay prior to a planned return to home and community. CHA believes that such short-term, post-hospital stays should not be view as "facility-initiated," except when the resident/patient objects to the planned discharge.

CHA requests that CMS clarify the regulatory language to clearly indicate that a discharge after a short-term SNF stay that is based on a documented plan of care established between the clinical team and the patient/resident, and to which the resident/patient does not object, **does not constitute a "facility-initiated" discharge, and notification to the LTC Ombudsman is not required.** CHA believes this interpretation is consistent with CMS' stated goals to focus the notification process on involuntary transfers or discharges, and to improve resident access to the Ombudsman program by allowing them to focus directly on inappropriate and involuntary discharges.

CHA also urges CMS to require the long-term care facility to notify the LTC Ombudsman of involuntary facility-initiated discharges resulting from the inability of a SNF to readmit a resident following their transfer to an acute care hospital.

The guidance in Appendix PP of the SOM notes, "In situations where the facility has decided to discharge the resident while the resident is still hospitalized, the facility must send a notice of discharge to the resident and resident representative, and must also send a copy of the discharge notice to a representative of the Office of the State LTC Ombudsman."
CHA appreciates this guidance and agrees that discharges that result from a facility's decision not to readmit a resident who has been hospitalized should be included in the notification requirements. However, based on reports from our member hospitals, we believe that such notifications are rare.

CHA agrees that, in instances where the resident is transferred to the acute care hospital and subsequently returns to the originating SNF, notification to the LTC Ombudsman is not necessary. However, it is all too common that a SNF resident is sent to the hospital on an emergent basis and then, once treatment is complete, refused readmission to their SNF of residence. Based on CMS guidance, these "refusals to readmit" clearly constitute facility-initiated discharges, but rarely is direct communication provided to the LTC Ombudsman or the resident. As a result, the resident does not receive the benefit of support from the LTC Ombudsman, and the hospital must continue to provide care for that patient until an alternative discharge plan can be identified. Hospitals and patients/residents may pursue a lengthy and cumbersome administrative appeals process to (try to) reverse the SNF non-admission decision, and the patient/resident may remain in the acute hospital for an extended time — far beyond what is required to address their original medical need.

CHA urges CMS to clarify that the notification requirements include facility-initiated discharges when residents are discharged from their SNF of residence through an emergency hospital transfer and subsequent refusal to readmit.

In the current proposal, CMS seeks comments on whether the notification requirement should apply to transfers made on an emergency basis to an acute care facility, regardless of return status. CHA believes that all emergent discharges should be reported, with appropriate modifications to support efficient work processes.

At the time of an emergent transfer to the emergency department or acute care hospital, the return status of the resident may not be known. If, for example, the facility records that the patient will return but subsequently decides not to readmit them, this facility-initiated discharge may fall through the cracks and not be communicated to the Ombudsman, who may be able to provide valuable assistance in facilitating return.

The notification process for emergent transfers would necessarily be somewhat different than it is for planned discharges from the facility, where advance notification and communication are possible. We believe that the process discussed in the SOM is appropriate, which requires the notices to be sent "as soon as practicable," such as providing a monthly list of emergent transfers. This list could also be used to indicate anticipated return status, and include additional tracking and notification when re-admission does not occur.

CHA appreciates the opportunity to comment on the FFY 2020 SNF PPS proposed rule. If you have any questions, please do not hesitate to contact me at akeefe@calhospital.org or (202) 488-4688; or my colleague Pat Blaisdell, vice president continuum of care, at pblaisdell@calhospital.org or (916) 552-7553.

Sincerely,
/s/
Alyssa Keefe
Vice President Federal Regulatory Affairs