JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

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House Select Subcommittee on the Coronavirus Crisis

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I extend my thanks to Chair James Clyburn, Ranking Member Steve Scalise, and Subcommittee members for the opportunity to submit this statement on behalf of nursing facility residents, and their family members and friends.

Approximately 1.3 million Americans currently live in nursing facilities. Probably more than any other group of Americans, nursing facility residents have been subject to the worst horrors of COVID-19. The data is sobering. Over 43,000 Americans have died from COVID-19 in long-term care facilities. These facility-linked deaths constitute 45% of total United States deaths related to COVID-19 and, in 26 states, long-term care facility deaths constitute at least half of total deaths.[1] Furthermore, infections and deaths occur in a racially-disparate fashion: facilities with a significant number of African American and Latinx residents are twice as likely to have COVID-19 outbreaks than those where the population is overwhelmingly white.[2]

And, of course, data represent persons – mothers and fathers, grandparents, aunts and uncles, lifelong friends, co-workers, and others. They all moved to nursing facilities because they needed help, relying on the facility's promise to assist with daily tasks and provide necessary health care. It is simply a tragedy — 40,000 times over — for a resident to become infected and die from COVID-19, and often to do so in an empty room, alone, due to the months-long limitation on visitors.

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[1] Kaiser Family Foundation, State Data and Policy Actions to Address Coronavirus, June 9, 2020. *See also* NBC News, The Government Counts 26,000 COVID-19 Deaths in Nursing Homes. That's at Least 14,000 Deaths Too Low (June 2, 2020) (40,000 COVID deaths related to long-term care facilities; 40% of total deaths in United States).

[2] Robert Gebeloff et al., The Striking Racial Divide in How Covid-19 Has Hit Nursing Homes, N.Y. Times (May 21, 2020).

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These deaths were not inevitable, and there are steps that Congress and the Centers for Medicare & Medicaid Services (CMS) could take to better care for nursing facility residents. Nursing homes can be improved, as can the federal government's response to COVID-19.

1. Many Nursing Facilities Operate with Longstanding Problems that Have Had Lethal Consequences During the COVID-19 Pandemic.

Nursing facility management matters, and the better-run facilities provide care that focuses on a resident's individual needs. Many of these facilities are nonprofits or, regardless of corporate structure, have a sense of mission regarding the care of their residents.[3] But the bulk of facilities fall into a mediocre middle or worse-than-mediocre bottom tier, characterized by inadequate staffing levels that leave minimum-wage nurse aides with inadequate time to address resident needs.[4] CMS does not require any minimum staffing levels, instead requiring only that a facility each year conduct an internal evaluation of its staffing levels.[5] This tepid requirement results in the status quo — thousands of nursing facilities that continue to operate on a quality-of-care knife's edge, with disastrous consequences for too many residents.

The HHS Inspector General studied adverse events suffered by nursing facility residents reimbursed through Medicare. Because Medicare offers only short-term coverage for nursing facility care, the sampled beneficiaries resided in their nursing facilities for no more than 35 days. Even though the nursing facility stays were short, the Inspector General found that one-third of these residents suffered harm in the facility. Furthermore, reviewing physicians determined that 59 percent of these negative events were clearly or likely preventable, as they were the result of "substandard treatment, inadequate resident monitoring, and failure or delay of necessary care."[6]

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[3] *See* Charlene Harrington et al., Nursing Staffing and Deficiencies in the Largest For-Profit Chains and Chains Owned by Private Equity Companies, 47 Health Services Research, vol. 47, at 106 (Feb. 2012).
[4] Charlene Harrington et al., The Need for Minimum Staffing Standards in Nursing Homes, Health Services Insights, vol. 9, at 13 (Apr. 2016).
[5] 42 C.F.R. § 483.70(e).
[6] HHS Office of Inspector General, Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries, No. OEI-06-11-00370 (Feb. 2014).

The Government Accountability Office (GAO) recently reached a similar conclusion — persistent poor care — in examining nursing facilities' infection prevention practices. Infection prevention and control deficiencies have been the most common type of deficiency cited in surveyed nursing homes, with 82 percent of nursing facilities being cited at least once for such a deficiency from 2013 through 2017. These deficiencies included failure to properly complete such simple but vital tasks as washing hands, isolating sick residents, using masks, or sterilizing equipment.[7] Needless to say, the importance of these types of tasks — and these types of violations — has become painfully clear during the current pandemic.

Notably, the GAO found not only that infection prevention and control problems were widespread, but also that many facilities were consistently found to have been out of compliance. Almost half — 48 percent — of facilities with an infection prevention and control deficiency cited in one or more years had such a deficiency cited in multiple consecutive years from 2013 through 2017. These types of repetitive violations, the GAO noted, are "indicator[s] of persistent problems." Indeed, of the facilities with a deficiency cited in multiple consecutive years, 35 percent committed violations in 3 or 4 consecutive years, and 6 percent committed violations in each of the five studied years.[8]

Unfortunately, some of these deficient practices continued even after the danger of COVID-19 became clear. During the week of March 30, CMS began surveying facilities specifically and exclusively on their compliance with infection prevention and control requirements. During the initial round of surveys, 36 percent of facilities failed to follow proper hand washing guidelines, and 25 percent failed to properly use personal protective equipment. As CMS noted, "[b]oth of these [requirements] are longstanding infection control measures that all nursing homes are expected to follow per Federal regulation."[9]

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[7] GAO, Infection Control Deficiencies Were Widespread and Persistent in Nursing Homes Prior to COVID-19 Pandemic, at 4 (May 20, 2020).
[8] GAO, Infection Control Deficiencies Were Widespread and Persistent in Nursing Homes Prior to COVID-19 Pandemic, at 4-5 (May 20, 2020).
[9] CMS, Trump Administration Issues Key Recommendations to Nursing Homes, State and Local Governments (April 2, 2020).

All of these poor practices — short-staffing, negligent care, poor infection prevention and control practices — increase the risk presented by COVID-19 to nursing facility residents.[10] If, for example, a facility's staff is not taking appropriate infection prevention measures, it becomes more likely that the virus will take hold in a facility. CMS has confirmed the relationship between quality of care and COVID-19 outbreaks, stating that "[e]arly analysis shows that there is a statistically significant relationship between nursing home's inspection star rating, and nursing homes that have had large numbers of COVID-19 cases."[11]

Addressing overall quality of care is essential, but such efforts will necessarily involve many considerations. Unlike some issues discussed subsequently in this statement, the quality-of-care discussion cannot be resolved through one or two targeted recommendations. Some relevant considerations include direct-care staffing levels, the importance of putting Medicare and Medicaid reimbursements towards direct-care staffing, the efficacy of the enforcement system, and the accountability of nursing facility operators.

2. The Federal Government Should Prioritize Personal Protective Equipment and COVID-19 Testing for Nursing Facilities.

Like many other health care providers, nursing facilities have had difficulty in accessing personal protective equipment (PPE) and COVID-19 tests. The Federal Emergency Management Agency (FEMA) has committed to sending a two-week supply of PPE to each nursing facility, one week at a time,[12] but these shipments have been delayed and sometimes inadequate.[13] Due to an inability to access PPE, state survey agencies have been forced in some cases to curtail their activities.[14]

The lack of testing, of course, is particularly problematic, given the danger presented by asymptomatic persons who may nonetheless be infected with COVID-19. CMS's recommendations for "reopening" nursing facilities call for

[10] *See, e.g.*, Chris Kirkham & Benjamin Lesser, Special Report: Pandemic Exposes Systemic Staffing Problems at U.S. Nursing Homes, Reuters.com (June 20, 2020).
[11] CMS, Nursing Home COVID-19 Data Release External FAQs, FAQ #25 (June 4 2020).
[12] FEMA, Personal Protective Equipment for Medicare and Medicare Nursing Homes (April 30, 2020).
[13] CNN, Nursing Homes Receive Defective Equipment as Part of Trump Administration Supply Initiative (June 10, 2020).
[14] CMS, Prioritization of Survey Activities, QSO-20-20-All (March 23, 2020).

extensive testing of both staff and residents, but those thresholds for reopening cannot be met if the facility and residents do not have access to the required tests, or if the financial burden falls on residents or individual staff members.[15]

3. Congress and/or CMS Should Set Standards for Nursing Facilities that Are Dedicated to the Care of COVID-Positive Residents, and for the Transfers of Residents To and From Such Facilities.

The federal government and others increasingly recognize the benefits of "cohorting" residents — placing COVID-positive residents with other COVID-positive residents, and COVID-negative residents with other COVID-negative residents. Under its Blanket Waivers, CMS has waived aspects of the nursing facility transfer/discharge regulations in order to facilitate such cohorting. Under this waiver, CMS does not require a facility to give advance notice (or offer appeal rights) for an eviction based on cohorting.[16] CMS says, "In general, if two or more certified LTC facilities want to transfer or discharge residents between themselves for the purposes of cohorting, they do not need any additional approval to do so."[17] Accordingly, under CMS guidance, facilities have discretion to choose which facilities will be dedicated to the care of COVID-positive residents.

Given the great danger faced by nursing facility residents who have tested positive for COVID-19, a facility that is dedicated to the care of COVID-positive residents should meet higher standards. Too frequently, the laissez-faire attitude by CMS has led to the opposite – the care of COVID-positive residents being left in the hands of facilities with checkered, or worse, quality-of-care histories.[18]

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[15] CMS, Nursing Home Reopening Recommendations for State and Local Officials, QSO-20-30-NH (May 18, 2020).
[16] CMS, COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers, at 16-18 (June 5, 2020).
[17] CMS, 2019 Novel Coronavirus (COVID-19) Long-Term Care Facility Transfer Scenarios, QSO-20-25-NH (April 13, 2020), at 1-2.
[18] *See, e.g.*, Maggie Severns & Rachel Roubein, States Prod Nursing Homes to Take More COVID-19 Patients, Politico (June 4, 2020); Ed Williams & Rachel Mabe, Nursing Home for COVID-19 Patients to be Run by Firm with History of Safety Violations and Lawsuits, Searchlight New Mexico (April 21, 2020); County of Los Angeles Public Health Department, Listing of SNFs with Specific Units, Floors or Buildings Dedicated to COVID-19 Patients (listing of 21 facilities, many of which have long history of poor care); California Advocates for Nursing Home Reform, Patients Beware! L.A. County Is Discharging COVID-19 Patients to Dangerous Nursing Homes with Deadly Outbreaks; Mass. Advocates for Nursing Home Reform, Letter to Senator Patricia Jehlen and Representative Ruth Balser, Mass. Joint Committee on Elder Affairs, at 2 (May 26, 2020) (poor quality of care in facilities designated for COVID-positive residents).

A related problem is the lack of any advance notice of a cohorting-related transfer. Understandably, under current conditions, a full 30-day notice is unworkable, but there certainly are reasonable alternatives that fall between 30 days and no notice whatsoever.

Several positive models have been set forth by states and federal legislation. In Connecticut, the Healthcare Quality and Safety Branch has worked cooperatively with the Long-Term Care Ombudsman so that cohorting-motivated transfers are done in consultation with residents and their families.[19] In this same vein, the Quality Care for Nursing Home Residents and Workers During COVID-19 Act of 2020 requires 72-hour notice of a cohorting transfer, with a proviso that a resident or resident representative give written consent if a transfer is to go forward.[20] Similarly, the Health and Economic Recovery Omnibus Emergency Solution (HEROES) Act also requires for 72-hour notice that would include contact information for the state's long-term care ombudsman program.[21]

To ensure a better quality of care in COVID-dedicated facilities, the Quality Care legislation requires that a registered nurse be on duty 24 hours a day, and instructs CMS to develop additional standards.[22] The HEROES Act similarly would require that CMS develop standards, and also would limit participation to those facilities with 1) a 4- or 5-star rating on staffing on CMS's Nursing Home Compare website for the preceding two years, 2) a 4- or 5-star rating for health inspections, and 3) no infection control violation that placed residents in immediate jeopardy.[23]

[19] Conn. Healthcare Quality and Safety Branch and Conn. Office of the State Long-Term Care Ombudsman, Letter to Residents, Family Members or Responsible Parties (March 30, 2020).
[20] H.R. 6698, § 2.
[21] H.R. 6800, § 30208.
[22] H.R. 6698, § 2. Ordinarily, federal nursing facility law only requires registered nurses 8 hours per day. *See* 42 U.S.C. §§ 1395i-3(b)(4)(C)(i), 1396r(b)(4)(C)(i)(II).
[23] H.R. 6800, § 30208.

4. Congress or CMS Should Require Facilities to Employ a Full-Time Infection Preventionist with Broad Expertise.

Even prior to COVID-19, nursing facility residents have been at considerable risk from infections. Common infections have included — and continue to include — methicillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile* (C. diff).[24] In fact, infection has been the leading cause of morbidity and mortality among nursing facility residents. Each year, between 1.6 and 3.8 million infections occur, resulting in almost 388,000 deaths.[25]

Current federal regulations require a nursing facility to employ an infection preventionist on at least a part-time basis. The infection preventionist must have "primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field." As a practical matter, currently most infection preventionists are facility nurses, who are required by the regulation to complete an unspecified "specialized training in infection prevention and control."[26] Since March 2019, the Centers for Disease Control and Prevention (CDC), in collaboration with CMS, has offered a curriculum for infection preventionists, but it is unclear how widely that curriculum has been used.[27]

Recognizing the weakness of a "part-time" regulatory standard, CMS in 2019 proposed that the regulation be revised so that the infection preventionist "[h]ave sufficient time at the facility to achieve the objectives set forth in the facility's [infection prevention and control program]."[28] But neither "part-time" nor "sufficient" is an adequate regulatory standard. Particularly given that COVID-19 likely will be a threat for some time, the infection preventionist position should be elevated to full-time with commensurate training and responsibilities. California, for example, is requiring all nursing facilities to employ a "full-time, dedicated"

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[24] *See, e.g.*, Ana Montoya & Lona Mody, Common Infections in Nursing Homes: A Review of Current Issues and Challenges, Aging Health, vol. 7, no. 6 at 889 (Dec. 2011).
[25] 84 Fed. Reg. 34,737, 34,746 (July 18, 2019).
[26] 42 C.F.R. § 483.80(b).
[27] CDC, Infection Prevention Training, https://www.cdc.gov/longtermcare/training.html; CMS, Specialized Infection Prevention and Control Training for Nursing Home Staff in the Long-Term Care Setting Is Now Available, QSO-19-10-NH (March 11, 2019).
[28] 84 Fed. Reg. 34,737, 34,746-47, 34,766 (July 18, 2019).

infection preventionist.[29] The Quality Care for Nursing Home Residents and Workers During COVID-19 Act of 2020 likewise requires that facilities employ infection preventionists on a full-time basis.[30]

5. Given the Disparate Impact of COVID-19 on People of Color, CMS and CDC Should Require Facilities to Include Ethnicity in COVID-19 Reporting.

African Americans and other persons of color face a barrage of disparities in today's nursing facilities. Historically, facilities with larger percentages of residents who are persons of color have experienced lower staffing levels and more deficiencies.[31] During the COVID-19 emergency, persons of color disproportionately have suffered infections and deaths in the community.[32] And nursing facilities with a high number of African American residents have been found to be more likely to have COVID-19 infections.[33]

Under a recently promulgated regulation, nursing facilities across the country must report COVID-19 data to the CDC, which shares the information with CMS, which then publishes the information. The required information includes cases and deaths, along with information related to the facility's readiness, such as its supply of PPE and any staffing shortages.[34]

Congress or CMS should revise reporting requirements to include race. Given that reporting already is being done, there is no reason not to require data related to resident and staff race and ethnicity, so as to better identify and address disparities.

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[29] Cal. Dep't of Public Health, Coronavirus Disease 2019 (COVID-19) Mitigation Plan Implementation and Submission Requirements for Skilled Nursing Facilities (SNF) and Infection Control Guidance for Health Care Personnel (HCP), AFL 20-52 (May 11, 2020).
[30] H.R. 6698, § 2.
[31] Yue Li et al., Deficiencies in Care at Nursing Homes and Racial/Ethnic Disparities Across Homes, 2006-11, Health Affairs, vol. 34, no. 7, at 1139 (July 2015); Yue Li et al., Nurse Staffing Hours at Nursing Homes with High Concentrations of Minority Residents, 2001-11, Health Affairs, vol. 34, No. 12, at 2129 (Dec. 2015).
[32] Coronavirus in African Americans and Other People of Color, Johns Hopkins Medicine (Apr. 20, 2020).
[33] David Grabowski et al., Characteristics of U.S. Nursing Homes with COVID-19 Cases (June 2020).
[34] 42 C.F.R. § 483.80(g).

6. CMS Should Require Facilities to Submit Staffing Data, in Compliance with Federal Law, So that Congress, CMS, and Others Can Understand How Facilities Have Been Staffed During the Emergency Period.

In order to provide transparency regarding staffing levels, nursing facilities must submit payroll-based staffing data to CMS.[35] This information is made available to the general public on the Nursing Home Compare website, which allows consumers and others to evaluate and compare the adequacy of each facility's staffing levels.

CMS has waived this requirement as part of its emergency Blanket Waivers, in order "to provide relief to long-term care facilities on the requirements for submitting staffing data."[36] It is understood that, particularly during the first weeks of this emergency, a temporary waiver of reporting requirements could be useful to allow some stretched facilities to focus all their energies on providing care. Now, however, CMS states that the waiver will have a greater scope — specifically, that facilities *never* will submit the staffing information related to facility operations during the COVID emergency.

Such a permanent waiver is unsound public policy. Because the staffing data is based on a facility's payroll, the facility will possess the relevant information, even if reporting to CMS is delayed. And if ever there were a time when CMS, Congress and others would want to have access to facility staffing data, now is that time. In making plans to address future emergencies, CMS and others will want to have as complete an understanding as possible as to what has taken place in nursing facilities in 2020. Staffing levels are a critical component in quality of care, and the payroll-based staffing information will be invaluable in determining how the nation's long-term care system reacted to COVID-19.

[35] 42 U.S.C. § 1320a-7j(g); 42 C.F.R. § 483.70(q).
[36] CMS, Long Term Care Facilities (Skilled Nursing Facilities and/or Nursing Facilities): CMS Flexibilities to Fight COVID-19, at 2 (May 15, 2020).

7. CMS Should Emphasize that "Compassionate Care Situations" Are Not Limited to End-of-Life Circumstances, So that Nursing Facility Residents Are Not Indefinitely Isolated from Family Members and Friends.

Current CMS guidance allows visitors in nursing facilities only in "compassionate care situations." The guidance gives one example of a compassionate care situation – "an end-of-life situation."[37]

Based on reports from across the country, most nursing homes across the country are acting as if end of life is the *only* allowable compassionate care situation. Worse, facilities are limiting "end of life" to the absolutely last days or hours of a resident's life.

CMS should remedy this situation by clarifying that end of life is only an example of a compassionate care situation, and requiring that nursing facilities allow visits more freely. At this point in time, nursing home residents have been deprived of in-person visitors for approximately three months. Given that level of isolation, it is easy to understand why a visit might be authorized under compassionate care – simply to stave off depression. Any person living through the social distancing of Spring 2020, in virtually any community of the United States, should empathize with residents' deep physical and emotional need to connect with family and friends.

8. CMS Should Re-Establish Meaningful Standards for Nurse Aide Training.

Federal law requires that a nurse aide complete 75 hours of training within the first four months of employment, and complete 16 hours before working with residents.[38] CMS has waived these requirements as part of the Blanket Waivers, leaving only requirements that a nurse aide be competent.[39]

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[37] CMS, Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes, QSO-20-14-NH (March 13, 2020).
[38] 42 U.S.C. §§ 1395i-3(f)(2)(A)(i)(II), 1396r(f)(2)(A)(i)(II); 42 C.F.R. § 483.152(a)(1), (b)(1).
[39] CMS, COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers, at 16 (June 5, 2020).

Particularly as states move to reopen nursing facilities to visitors and surveyors, it is vital that CMS establish some meaningful standards for nurse aide training. The waiver was issued when CMS, states and others were focused on the possibility of the health care system being buried by COVID-19 infections. But some providers currently are requesting that the emergency nurse aides be grandfathered into the workforce, without compliance with federal training requirements.[40]

Now that initial response to COVID-19 has concluded, CMS should reinstate the statutory and regulatory standards as soon as possible. Likewise, CMS should take immediate action to start a four-month clock for completion of the nurse aide training requirements by any nurse aides who may have been hired under the Blanket Waivers. In the interim, CMS should require facilities to report all those nurse aides working under the training waiver, and prioritize those facilities for inspections.

If, for whatever reason, the nurse aide training standards are not reinstated in the near future, CMS should establish some standards beyond an unspecified "competency" for uncertified nurse aides. At a minimum, CMS should require specified hours of training (both classroom instruction and clinical practice) and also require that new hires demonstrate competency according to a standardized competency checklist.

9. CMS Should Require State Survey Agencies to Address Complaints Filed During the Emergency Period and Resume Comprehensive Onsite Surveys.

In order to focus surveyor resources, CMS has directed state survey agencies to not address complaints during the emergency, except for complaints alleging immediate jeopardy to a resident.[41] As the system is reopened, surveyors should be directed to now address any complaints that may have been filed during the emergency period. These past few months have been extraordinarily difficult and dangerous for residents – in part because there have been no visitors along with extremely limited oversight of facilities. To properly ensure quality care, state survey agencies should address any previously-filed complaints from the

[40] Letter from Leading Age Pennsylvania et al., to Pedro Rivera, Pa. Secretary of Education (June 8, 2020).
[41] CMS, Prioritization of Survey Activities, QSO-20-20-All (March 23, 2020).

emergency period now. CMS should closely monitor and audit state agency activities to ensure that states are conducting unannounced and on-site surveys of these complaints.

As quickly as possible, CMS should resume comprehensive, timely, unannounced, and on-site surveys at all facilities and impose appropriate and meaningful sanctions for noncompliance.

10. Congress Should Consider Bold Changes to Our Nation's System for Providing Long-Term Assistance to Older Americans and Persons with Disabilities.

The COVID-19 pandemic asks hard questions of our nation's systems for providing long-term services and supports. Bluntly put: should federal law and Medicaid policy be based on housing persons in large congregate settings with shared bedrooms? Under COVID-19, sharing a room is not just unwelcome for a consumer, but potentially deadly.

More progressive nursing homes today focus on single occupancy, a more home-like environment, and a staff that is empowered to make decisions and advance professionally.[42] But, ideally, broad reform would refashion the system so that older Americans and others would better be able to live at home rather than in a nursing facility. Under Medicaid law, a state must provide nursing facility services to each person who meets eligibility standards, but may impose enrollment caps on equivalent home and community-based services.[43] The result is waiting lists that in some states force eligible persons to wait years in order to access HCBS, and push them into nursing facilities in the interim.[44] If HCBS instead were promoted to equal status with nursing facility care, more persons would be able to live at home, with a better quality of life and less likelihood of becoming infected with COVID-19.

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[42] *See, e.g.*, The Green House Project, https://www.thegreenhouseproject.org/.
[43] 42 U.S.C. §§ 1396d(a)(4), 1396n(c).
[44] Kaiser Family Foundation, Waiting List Enrollment for Medicaid Section 1915(c) Home and Community-Based Services Waivers, https://www.kff.org/health-reform/state-indicator/waiting-lists-for-hcbs-waivers/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.