June 9, 2020

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Quality, Safety & Oversight Group
Centers for Medicare & Medicaid Services
7500 Security Boulevard
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VIA E-MAIL: Evan.Shulman@cms.hhs.gov

Re: Ongoing Problems in CMS's Response to COVID-19 Emergency in Nursing Facilities

Dear Evan:

We appreciate the periodic telephone calls that you and CMS's Division of Nursing Homes conduct with us, as advocates for nursing facility residents. But we are troubled by the lack of action on items that we have mentioned multiple times, and that seem to require immediate action, given the death, infections, and isolation that have besieged nursing facility residents over the past few months. So that there is no miscommunication, we list below five items that we feel require immediate and decisive action. (This is not an exclusive list of important issues, of course; other issues are developing, and we will continue to raise issues with you and your colleagues in the weeks and months to come.)

1. **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.**

Through Blanket Waivers, CMS has waived aspects of transfer/discharge regulations in order to facilitate "cohorting" – placing COVID-positive residents with other COVID-positive residents, and COVID-negative residents with other COVID-negative residents. Under this waiver, CMS does not require a facility to give advance notice (or offer appeal rights) for an eviction based on cohorting. 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."[1] 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, we believe that a facility that is dedicated to the care of COVID-positive residents should meet higher standards. We see too frequently the opposite – the care of COVID-positive residents being left in the

[1] CMS, 2019 Novel Coronavirus (COVID-19) Long-Term Care Facility Transfer Scenarios, QSO-20-25-NH (April 13, 2020), at 1-2.

hands of facilities with checkered, or worse, quality-of-care histories.[2] We have raised this issue with you at least twice, but without any commitment from CMS to rectify the situation.

Also, we ask for CMS to set reasonable standards for advance notice of a cohorting-related transfer. We understand why the typical 30-day notice is not feasible, but contend that residents should be entitled to at least a) 72-hour advance notice and b) an opportunity to make decisions jointly with the facility and other health care providers.

2. CMS Should Require Facilities to Submit Staffing Data, in Compliance with Federal Law.

In order to provide transparency regarding staffing levels, nursing facilities must submit payroll-based staffing data to CMS.[3] This information is made available to the general public on the Nursing Home Compare website, which allows consumers and others to weigh direct care staffing levels and type of nurse licensing or certification in assessing nursing facilities' safety and quality.

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." We recognize a potential rationale for temporarily waiving the obligation to submit data, in order to allow facility staff to focus on an emergency situation. But you have told us that the waiver will be more extensive – specifically, that facilities *never* will submit the staffing information related to facility operations during the COVID emergency.

We see no justification for a permanent waiver. 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.

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[2] *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).

[3] 42 U.S.C. § 1320a-7j(g); 42 C.F.R. § 483.70(q).

3. CMS Should Emphasize that "Compassionate Care Situations" Are Not Limited to End-of-Life Circumstances.

As you know, 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."[4]

Based on the reports that we hear, 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.

We ask CMS to remedy this situation by clarifying that end of life is only an example of a compassionate care situation, so that nursing facilities feel more leeway to allow visitors. 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.

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

As you know, 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.[5] CMS has waived these requirements as part of the Blanket Waivers, leaving only requirements that a nurse aide be competent.

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. Now that initial response to COVID-19 is behind us, 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. We recommend at a minimum that CMS 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.

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[4] CMS, Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes, QSO-20-14-NH (March 13, 2020).
[5] 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).

5. 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. As the system is reopened, we ask that survey agencies 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 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.

We would appreciate your response to each of these items at your earliest convenience, and not later than our next conference call with you (not yet scheduled). Please let us know of any questions or suggestions.

Sincerely,

California Advocates for Nursing Home Reform (Tony Chicotel, Mike Connors and Janet Wells)
Center for Medicare Advocacy (Toby Edelman)
Justice in Aging (Eric Carlson)
Long Term Care Community Coalition (Richard Mollot)
National Consumer Voice for Quality Long-Term Care (Lori Smetanka and Robyn Grant)

cc: Gregg Brandush
Jean Moody-Williams
Karen Tritz
David Wright