

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

July 7, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5531-IFC
P.O. Box 8010
Baltimore, Maryland 21244

Re: Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program; CMS-5531-IFC

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

Dear Administrator Verma:

Justice in Aging is a national organization that uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. We have represented the interests of nursing facility residents since our founding in 1972, and have played a significant role in the enactment and implementation of the Nursing Home Reform Law.

We support the collection and publishing of nursing facility COVID-19 data, and appreciate the work of CMS in developing and implementing the interim rule. We write to discuss how the rule can be improved in its finalization.

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1. The Data Must Include Demographic Information.

As CMS certainly understands, COVID-19 has been observed to have a disparate impact upon persons of color. Early obtained data show that facilities with a significant number of Black and Latinx residents are twice as likely to have COVID-19 outbreaks than those facilities where the population is overwhelmingly white.¹ Regardless, the interim rule does not require submission of demographic information. This is a lost opportunity to obtain data that can inform policies and direct targeted resources to address disparities. Since data regarding infections and deaths are being submitted, facilities and the federal government should take the relatively small additional step to include, for residents and staff, the following demographic data:

- Race/Ethnicity.
- Age.
- Sex.
- Sexual orientation/Gender identity.
- Disability.

The first step in addressing disparities is to identify them. Given the nationwide reporting that is being done, it simply makes sense to include the additional demographic information. This information will help CMS and others to better respond to the COVID-19 pandemic.

2. The Final Rule Should Clarify “Suspected” Cases, Facility-Related Deaths, and Personal Protective Equipment.

Further clarity is needed in at least three areas. The current language speaks of “suspected” infections. This creates some significant ambiguity. We request that CMS define “suspected” infections using the definition provided in the National Health Safety Network (NHSN) system, Instructions for Completion of the COVID-

¹ Robert Gebeloff et al., *The Striking Racial Divide in How Covid-19 Has Hit Nursing Homes*, N.Y. Times (May 21, 2020). See also, Richard Oppel, Jr. et al., *The Fullest Look Yet at the Racial Inequity of Coronavirus*, N.Y. Times (July 5, 2020).

19 Long-term Care Facility Resident Impact and Facility Capacity Form (CDC 57.114.0).

Also, the language should ensure that deaths are reported whether the resident dies in the facility, or in a hospital or another location. Regardless of where the death occurs, it certainly is relevant to understanding how COVID-19 has impacted that facility. We understand that CMS addressed the inclusion of deaths occurring outside the facility in its May 6, 2020 FAQs (question 11) but, for greater clarity, we recommend that the same concept be included in the final rule.

In addition, the final rule should be more specific about personal protective equipment (PPE). This term should be defined to include but not be limited to N95 masks, surgical masks, eye protection, and gloves. These items correspond to what facilities must report in the NHSN.

3. The Final Rule Should Provide More Detail Regarding Testing.

We respectfully submit that the current language, “access to testing,” is not specific enough. This item should be quantitative to allow for meaningful data. Accordingly, we recommend the following specific categories for the evaluation of testing:

- (a) How many residents have been tested?
- (b) How many staff members have been tested?
- (c) Percentage of total residents tested.
- (d) Percentage of total staff tested.
- (e) Frequency of resident testing.
- (f) Frequency of staff testing.
- (g) Number of available tests.
- (h) Whether the facility pays for the testing.

4. The Final Rule Should Include More Detail About Staffing and Staffing Shortages.

The term “staffing shortages” is considerably vague. Although the NHSN instructions discuss what is meant by staffing shortages, the Interim Final Rule does not include a definition of staff. We recommend that the NHSN definition be spelled out in the rule.

Also, as you know, federal law does not set any minimum staffing ratio, so determining a “shortage” is problematic. Requiring facilities to provide daily staffing levels by shift would begin to address this issue. We note that facilities are already mandated to post this information inside the facility, pursuant to section 483.35(g). This quantitative information would be submitted in addition to any facility finding that it was undergoing a staff shortage.

5. Facilities Should Submit Information Regarding Cases and Deaths from the Beginning of the Emergency Period.

The interim rule does not require data prior to May 8, 2020. We understand that CMS has taken this position because the interim rule was not promulgated until that date. We contend, however, that nothing prevents reporting of cases and deaths starting from the beginning of the emergency period.

Evidently CMS believes that it cannot require an action that would be effective prior to the effective date of the regulation. But a revised rule would not be requiring that a facility take an action in, for example, March 2020. Instead, the regulation would be requiring a current action – for example, a facility on September 1, 2020, submitting data from dates prior to May 8, 2020. Disclosure standards could be limited slightly for the pre-May 8 data to recognize that facilities might have less access to relevant demographic information for those earlier time periods.

6. The Final Rule Should Include More Detail About How Residents and Residents' Families Are Notified.

The interim rule does not lay out requirements regarding the method of providing information to residents, their representatives and families, and staff. We support the language set forth in QSO-10-29-NH, F885: COVID-19 Reporting to Residents, their Representatives, and Families:

“We note that there are a variety of ways that facilities can meet this requirement, such as informing families and representatives through email listservs, website postings, paper notification, and/or recorded telephone messages. We do not expect facilities to make individual telephone calls to each resident’s family or responsible party to inform them that a resident in the facility has laboratory-confirmed COVID-19. However, we expect facilities to take reasonable efforts to make it easy for residents, their representatives, and families to obtain the information facilities are required to provide.”

We recommend that a modified version of this language be included in regulatory language. We suggest the following language, which has been drafted by the National Consumer Voice for Quality Long-Term Care:

(g)(4) The facility must make all reasonable efforts to ensure that it is easy for residents, their representatives and families, and staff to obtain this information. Information should be provided to residents orally and in writing. Methods to provide information to resident representatives, families, and staff may include email listserv, website postings, paper notifications, and/or recorded telephone messages. This information must also be posted inside the facility and at facility entrances.

7. CMS Should Extend These Requirements to Other Congregate Settings.

Justice in Aging strongly supports expanding the reporting requirements outlined in this rule to other institutional and congregate settings. People with disabilities

and older adults in these facilities are also at serious risk related to COVID-19. As noted in a letter from the Consortium of Citizens with Disabilities (CCD), there have been similar outbreaks and deaths in:

- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IIDs), including in Illinois (where the outbreak has been so significant that the National Guard has been called in), Massachusetts (where nearly half of the residents in a state-operated ICF are infected), Utah, Texas, and New Jersey;
- Institutions for Mental Disease (IMDs) and other psychiatric and substance use disorder treatment facilities, including in Washington state, District of Columbia, and New York; and
- Group homes across the country, including across New York, Maryland, and New Jersey.

We urge CMS to extend these requirements to all institutional settings — including ICF-IIDs, IMDs, substance use disorder treatment facilities, and psychiatric residential treatment facilities — and other Medicaid-funded congregate settings where older adults and people with disabilities live, including group homes and assisted living facilities. The need for transparency, information, and data collection is equally as critical to protecting the safety and welfare of people in these settings as they are for residents of nursing facilities.

In conclusion, thank you to you and your colleagues for considering these comments, and for your work in providing for quality health care for older Americans and persons with disabilities.

Sincerely,



Kevin Prindiville
Executive Director