April 28, 2020

Seema Verma
Administrator, Centers for Medicare & Medicaid Services
U. S. Department of Health and Human Services
200 Independence Avenue S.W.
Washington DC 20201
VIA E-MAIL

Re: Request for CMS Action to Better Protect Nursing Facility Residents

Dear Administrator Verma:

We write on behalf of the approximately 1.3 million Americans currently living in nursing facilities. As you are well aware, the current COVID-19 pandemic has put nursing facility residents at great risk of infection, illness and death. The first significant outbreak in the United States took place in a Seattle-area nursing facility and, to this point, COVID-19 infections have occurred in thousands of long-term care facilities across the country. The evidence of COVID-19's danger is legion but unnecessary to cite here: we are all well aware of our situation's unprecedented severity.

We appreciate the efforts that the Centers for Medicare & Medicaid Services (CMS) has made to prevent the spread of COVID-19 among nursing facility residents. But more action is needed. We make six recommendations, all aimed at offering more protection to residents, while better retaining residents' ability to make decisions regarding their health care and place of residence. We discuss our recommendations in detail in an attached memorandum, and summarize them below.

1. CMS should ensure that facility residents, their families, and the general public know whether and to what extent a facility's residents and staff members have contracted COVID-19. CMS's actions in this area -- primarily guidance released on April 19 – fall short. Broad public disclosure is vital, and must happen as soon as possible.

2. CMS should ensure that nursing facilities are competent to provide care for residents with COVID-19. Particularly when CMS and the states emphasize placing COVID-positive residents together in a specific facility or wing, CMS must ensure that facilities have the necessary staff, training, and equipment.

3. CMS should ensure that nursing facilities actively coordinate and facilitate telephone calls, video conferences and other communications between residents and their family members and friends. In-person visitation in nursing facilities has been virtually eliminated, pursuant to CMS instructions. Residents are desperately isolated, and often need significant assistance in order to simply speak with their family and friends.

4. CMS should ensure that transfers of residents are made collaboratively with residents and their representatives, to the greatest extent possible. Through regulatory waivers, CMS currently is allowing a resident to be moved with no advance notice whatsoever, for transfers to a facility dedicated to the care of COVID-positive, or COVID-negative, residents. Residents deserve more respect, and greater attention to their needs and preferences.

5. CMS should guarantee a resident's right to return to a nursing facility, and facilitate access to Medicaid home and community-based services. Given the risks presented by nursing facilities, many residents are considering a move to live with family members. To facilitate such moves, residents should have a right to return to the facility, if in the future the resident wishes to return. Also, CMS and state Medicaid programs should facilitate access to home and community-based services to assist residents' families in providing care at home.

6. CMS should protect access for Medicaid-eligible residents. Some federally-certified nursing facilities are not certified for Medicaid, or only certified for Medicaid in certain rooms within the facility. As a result, residents in the "wrong" facility or the "wrong" room are forced to leave when they spend down their savings to Medicaid eligibility levels. To prevent such involuntary transfers, all federally-certified facilities should be deemed to have complete Medicaid certification during this emergency.

We recognize and appreciate the many actions that you and your colleagues have taken in response to the current pandemic. We respectfully suggest our recommendations herein deserve your quick attention, for the good of those many Americans living in nursing facilities.

Sincerely,

Alzheimer's Association
Alzheimer's Impact Movement
American Association for Justice Nursing Home Litigation Group
American Association on Health and Disability
American Society on Aging
Association for Community Affiliated Plans
Autistic Self Advocacy Network
California Advocates for Nursing Home Reform
Center for Medicare Advocacy
Community Catalyst
Easter Seals
Elder Justice Coalition
Foundation Aiding The Elderly (FATE)
Justice in Aging

Lakeshore Foundation
Long Term Care Community Coalition
Medicare Rights Center
National Academy of Elder Law Attorneys
National Association of Councils on Developmental Disabilities
National Association of Local Long-Term Care Ombudsmen
National Association of Social Workers
National Association of State Long-Term Care Ombudsman Programs
National Consumer Voice for Quality Long Term Care
National Council on Independent Living
National Disability Rights Network
Service Employees International Union
United Spinal Association
Women's Institute For A Secure Retirement

State Organizations/Programs
Alliance for Better Long Term Care – Rhode Island Long-Term Care Ombudsman Program
Arkansas Long-Term Care Ombudsman Program
California Elder Justice Coalition
California Long-Term Care Ombudsman Program
Center for Elder Law & Justice (NY)
Colorado Long-Term Care Ombudsman Program
Empire Justice Center (NY)
Friends of Residents in Long Term Care (NC)
Kansas Long-Term Care Ombudsman Program
Michigan Elder Justice Initiative
Michigan Long-Term Care Ombudsman Program
Minnesota Long-Term Care Ombudsman Program
Mobilization for Justice (NY)
New Mexico Long-Term Care Ombudsman Program
New York Legal Assistance Group (NYLAG)
North Dakota Long-Term Care Ombudsman Program
Nursing Home Victims Coalition (TX)
Voices for Quality Care (MD) (DC)

RECOMMENDATIONS

1. **CMS should ensure that facility residents, their families, and the general public know whether and to what extent a facility's residents and staff members have contracted COVID-19.**

Across the country, there has been a considerable amount of secrecy regarding the presence of COVID-19 in nursing facilities and other long-term care facilities. This is unacceptable, not to mention dangerous. In one particularly egregious example, 17 deceased residents were found in body bags in a small "holding room" of a New Jersey nursing facility. In another tragic situation, 40 residents died in a Virginia nursing facility.

Facility residents should have a right to know the facility's COVID-19 status, as should many others, including residents' family members, facility staff members, ombudsman program representatives, state surveyors, hospitals, and the general public. We emphasize that transparency regarding the presence (or absence) of COVID-19 in a facility would not require any disclosure of a particular individual's status.

Some states – including California, Georgia, and New Jersey – already are posting facility-specific lists that list the numbers of residents and staff members with COVID-19 infections.

We recognize that CMS on April 19 took some steps towards disclosure and transparency. Those steps, however, are insufficient. First, CMS has not yet released any details, nor any start date. Second, the CMS guidance speaks only to disclosure to residents, their representatives, and the Centers for Disease Control and Prevention (CDC), and does not address notice to the public. We understand from conversations with CMS staff of an intent to post information (or a link to the information) on Medicare's Nursing Home Compare website; we support using Nursing Home Compare as a means of making the information available.

<u>Recommendations for Disclosure and Transparency</u>

- Nursing facilities should be required to disclose the existence of new COVID-19 infections, along with the total number of residents and staff (listed separately) who have infections. This disclosure would be posted in the facility, at the facility entrance, and on any facility website, and made via e-mail or text message to resident's family members, the long-term care ombudsman program, the state's protection and advocacy organization, the local public health department, and the state survey agency.
- State survey agencies should be required to post a daily, facility-specific list with 1) the number of new infections, 2) the number of residents with infections, 3) the number of staff members with infections, 4) the number of COVID-related fatalities from the facility, and 5) the total number of fatalities from the facility, regardless of cause. For better understanding COVID-19, this information should include gender, ethnicity, and

age, at a minimum. The information would be sent daily to the CMS regional office, which would forward the information weekly to the CMS national office.
- CMS should post each state's facility-specific list. This list should be easily accessible from Medicare's Nursing Home Compare website.

2. CMS should ensure that nursing facilities are competent to provide care for residents with COVID-19.

Of course, under current regulatory standards, every federally certified nursing facility must be capable of infection prevention and control, but CMS and states should be doubly sure of competence in the current pandemic. Florida, Maryland, Ohio and other states have created "strike teams" to provide assistance and oversight to at-risk facilities.

Recent CMS guidance speaks to the value of housing COVID-positive residents together in some circumstances. For such policies to be effective, the state must identify those nursing facilities that are most appropriate to accept admissions, whether from other nursing facilities or from hospitals. We note the risk of failing to take such steps – we have received reports of low-quality facilities admitting COVID-positive residents, trying to boost their low occupancy rates.

In addition, the state should take aggressive steps to ensure that **all** facilities have adequate competence in infection prevention and control. We are troubled by CMS's report in a recent conversation with advocates that handwashing was cited as a deficiency in 36 percent of facilities that were recently targeted for infection control and prevention surveys. CMS guidance calls for infection control surveys, but evidently without public disclosure of the results. This is unacceptable. Residents and the general public deserve to know of any cited deficiencies. Relatedly, residents deserve to know information about facilities' staffing levels, since low staffing levels often result in negligent care.

<u>Recommendations to Improve Quality of Care</u>

- CMS should encourage state-level "strike teams." The Maryland strike teams include members of the National Guard, representatives of local and state health departments, the Maryland Institute for Emergency Medical Services Systems, and hospital systems. The state is using three types of strike teams: testing teams, assistance teams, and clinical teams.
- State survey agencies, with input from the long term care ombudsman program, should determine and publicly announce which facilities are to be considered dedicated to the care of COVID-positive residents. Preference should be given to converting recently vacated nursing facilities into COVID-focused facilities, if such facilities are available and appropriately staffed and equipped.

- CMS should announce criteria for those facilities that are to be dedicated for the care of COVID-positive residents. Those criteria should include:
    - Private rooms.
    - Around-the-clock presence of registered nurses. (Federal nursing facility law otherwise requires a registered nurse only eight hours daily.)
    - Staffing of nurses and nurse aides to the level of at least 4.1 hours per resident per day.
    - A person identified as infection preventionist on a full-time basis.
    - Adequate personal protective equipment.
- Additionally, the criteria should **exclude** those facilities that:
    - Are operating under waivers of federal minimum nurse staffing levels.
    - Provide poor quality care. This would include Special Focus Facilities (SFF), SFF candidates, or rated at one or two stars (of a possible five stars) overall rating under Medicare's Nursing Home Compare website.
    - Due to demonstrated poor quality of care, were under one of the following remedies when use of these remedies was suspended in March 2020:
        - Denial of payment for new admissions.
        - Civil money penalties exceeding $5,000.
    - Have an abuse icon on Nursing Home Compare.
- CMS should post information regarding infection control surveys, including information regarding any deficiencies or enforcement remedies.
- CMS should require nursing facilities on a daily basis to:
    - Post staffing levels before the beginning of each shift inside the facility (already required) and on the door at the facility entrance (suggested but not required in CMS's Memorandum QSO-20-28-NH).
    - Report these staffing levels to the state survey agency, the state long term care ombudsman program, and CMS. In turn, the survey agencies would publish these staffing levels on their websites.

3. CMS should ensure that nursing facilities actively coordinate and facilitate telephone calls, video conferences and other communications between residents and their family members and friends.

Under current CMS guidelines, in-person visitation has been almost eliminated. Isolation, loneliness and depression are obvious risks.

We hear from many family members that too many nursing facilities are not facilitating telephone conversations with residents, nor providing updates to family members on how the resident is doing. Some facilities are saying that they will only provide updates if there is a significant change in a resident's condition. This is not sufficient in a time when families have much to worry about and cannot visit in person. CMS guidance (specifically, Memorandum

QSO-20-28-NH) lists many important ways that a facility could facilitate communication, but discusses these as things that a facility should "consider," rather than as requirements.

Recommendations to Improve Communication

- CMS should require facilities to assign a staff person to assist residents in making social contact with family members and friends through phone calls, e-mail, and/or video chat. Residents and families should be assisted to connect at least weekly. This communication should continue regardless of a resident's COVID status.
- CMS should require facilities to provide at least weekly updates to families/resident representatives on the resident's status.

4. CMS should ensure that transfers of residents are made collaboratively with residents and their representatives, to the greatest extent possible.

Under federal statute and regulation, a nursing facility generally must give a 30-day written notice, with an opportunity to appeal, before transferring a resident against the resident's will. *See, e.g.*, 42 C.F.R. § 483.15(c). Recent CMS guidance (COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers) waives the advance notice requirement to allow residents to be placed with other residents who have the same diagnosis, i.e., either with or without COVID-19. CMS explains that the advance notice requirement is waived only in three specific situations:

1. A resident with respiratory infection symptoms (or a confirmed diagnosis of COVID-19) is transferred to a facility that is dedicated to the care of such residents;
2. A resident without respiratory infection symptoms and without a confirmed diagnosis of COVID-19 is transferred to another facility that is dedicated to the care of such residents; or
3. A resident without respiratory infection symptoms and without a confirmed diagnosis of COVID-19 is transferred to another facility for 14-day observation for any signs or symptoms of a respiratory infection.

We understand the potential benefits provided by grouping residents based on their status of being either COVID-positive or COVID-negative (assuming there is sufficient and accurate testing to make those determinations), and also understand why a 30-day notice (or even a 7-day notice) will often be impractical in today's reality. But there are better alternatives than that set forth by the current CMS waiver guidance, which provides for no advance notice whatsoever. Under the current guidance, the resident and/or representative receive written notice only **after** the transfer has taken place, even though notice obviously would be pointless at that time. We understand that these types of no-notice transfers were recently implemented in Massachusetts, with residents' family members not even knowing where the residents had been moved.

Also, the CMS guidance provides no specification on how a facility is determined to be "dedicated" to the care of one type of resident. This is a weakness in the guidance – the undersigned organizations know, through painful real-world experience, that facilities can be too quick to claim that that they are, or are not, qualified to provide a certain type of care, in order to justify a self-serving involuntary transfer, or to seek hospital patients with desirable forms of reimbursement. Facilities should not be able to self-designate, to both 1) protect against improper transfer and 2) ensure a high level of competence among those facilities that are designated to care for COVID-positive residents.

In the same vein, we note that the CMS guidance gives no indication as to why, when a resident is being transferred from one facility to another for observation, the second facility is more appropriate than the first. As mentioned, the CMS guidance speaks about the importance of grouping residents with a like diagnosis together but, in the "observation" situation, it can be presumed that neither the first facility nor the second is dedicated to the care of residents with a positive COVID-19 diagnosis. In our recent experience, most discussions of "observation" have arisen in the context of a hospital patient seeking to be transferred to a nursing facility. It is unclear to us how a transfer for an observation stay is even useful in the context of an involuntary transfer from a nursing facility to another nursing facility.

<u>Recommendations Regarding Transfer</u>

- CMS should require that a resident receive as much advance notice as possible before transfer to another facility, with a preferred notice of at least 72 hours. Equivalent notice must be provided to the resident's representative or other family member, and the long-term care ombudsman program. Transfer will work more smoothly if facility representatives, state surveyors, and long-term care ombudsman program representatives have an advance conversation with a resident and his or her representative, to discuss options and make plans. The State of Connecticut currently is facilitating conversations along these lines in these exact types of situations.
    - CMS should require the original facility to give the new facility copies of all important information regarding the resident, including but not limited to the assessment, care plan, physician orders, and contact information for family and friends, and to ensure that medications, durable medical equipment, and personal items and clothing are moved simultaneously with the resident to the new facility.
    - CMS should require the new facility to inform the resident's family and friends as soon as possible of the new residence, and immediately take steps to set up a telephone call and/or video conference between the resident and family/friends.
    - CMS should require, at all steps in the process, that the original and new facility take steps to facilitate conversations between the resident and family/friends.
- CMS should require that state survey agencies (preferably in consultation with key stakeholders including the long-term care ombudsman program) be responsible for

determining that a facility is "dedicated" to the care of COVID-positive or COVID-negative residents.
- CMS should eliminate the involuntary transfer justification based on a 14-day observation, since it is unclear why any one nursing facility would be better than another in evaluating a resident for respiratory infection symptoms.
- Involuntary transfers for reasons other than grouping residents with and without COVID-19, as described above, should be prohibited.

5. CMS should guarantee a resident's right to return to a nursing facility, and facilitate access to Medicaid home and community-based services.

Because of the risk presented by living in a nursing facility, many residents and their families are considering the option of the resident moving in with family members. Recently, in fact, the Director of the Los Angeles County Health Department encouraged such moves for families able to provide the necessary care at home.

Families could more easily consider and carry out such transfers if they knew that nursing facility care remained an option, whether in the short term or in the future. Also, of course, such transfers would be much more achievable if Medicaid-funded home and community-based services were facilitated to assist family members, in the case of residents financially eligible for Medicaid.

<u>Recommendations to Assist Nursing Facility Residents to Move In with Family Members</u>

- CMS should require nursing facilities to allow a resident to move back to the facility, if the resident leaves by his or her own initiative during the emergency, and seeks to move back no later than six months after the last day of the emergency. If the facility has no vacancy at the time the resident wishes to return, the facility must offer the next available vacancy.
- CMS should provide funding and guidance (possibly through an Appendix K waiver modification for home and community-based services) to facilitate Medicaid-funded home and community-based services for Medicaid-eligible nursing facility residents moving in with family members during the emergency.

6. CMS should protect access for Medicaid-eligible residents.

Some nursing facilities are certified for Medicare reimbursement but not Medicaid reimbursement. Also, in some states, nursing facilities are given the option of seeking Medicaid certification only for a "distinct part" within the building. This allows those facilities to establish a ceiling on the number of Medicaid-reimbursed residents that the facility will have at any one particular time.

As a result, in no-Medicaid or limited-Medicaid facilities, some residents are forced to leave when they have "spent down" to Medicaid eligibility levels, because they are not residing in a Medicaid-certified room. The current pandemic is no time for such evictions, or for such discrimination against Medicaid-eligible residents.

Recommendation to Protect Medicaid-Eligible Residents

- CMS should require all federally-certified nursing facilities to accept Medicaid reimbursement as if the facility had complete Medicaid certification. To limit unnecessary evictions, all residents present in a facility during the emergency are able to access Medicaid reimbursement from that facility at any time, during and after the emergency, as long as the resident at that time is financially and clinically eligible for Medicaid coverage of nursing facility care.