

**COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515**

February 25, 2021

Elizabeth Richter
Acting Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 1244

Re: Reinstatement of COVID-19 waivers and other pressing administrative changes in skilled nursing facilities

Dear Acting Administrator Richter:

The COVID-19 pandemic has ravaged our nation's nursing homes, accounting for 37 percent of deaths nationwide, while only representing five percent of cases.¹ In some states, nursing homes account for more than half of the deaths. This outcome was avoidable and reflects the persistent effort on the part of the Trump Administration to degrade and eliminate mechanisms of nursing home oversight and enforcement. Although the vaccination effort is underway across the nation, with an initial focus on nursing home staff and residents, the pandemic will continue to have detrimental effects on the health and safety of our most vulnerable residents for the foreseeable future.

During 2020, I sent a number of letters to the Trump Administration with specific requests about regulatory actions the former administrator could have taken to better protect nursing home residents and their families during the pandemic. Many of those requests went unanswered and unheeded. Today, I write to encourage the Centers for Medicare & Medicaid Services (CMS), under new leadership, to take swift and decisive action to ensure additional unnecessary deaths do not continue to accrue due to COVID-19 or other patient safety and human rights violations.

Reinstatement of COVID-19 waivers

From the beginning of the pandemic, the Trump Administration bungled its COVID-19 response in nursing homes, offering unclear guidance and using its 1135 authority to waive

¹ *State COVID-19 Data and Policy Actions: Metrics in Long-Term Care Facilities*, KAISER FAMILY FOUNDATION (Feb. 17, 2021), <https://www.kff.org/coronavirus-covid-19/issue-brief/state-covid-19-data-and-policy-actions/#long-term-care-cases-deaths>.

requirements vital to patient health. Thus, I recommend the Biden Administration contemplate the following:

- *Immediately ensure all standard facility quality and safety surveys are reinstated with robust enforcement.* On March 4, the Trump Administration issued guidance to state surveyors, suspending a majority of survey activities in nursing homes, which likely exacerbated the outbreaks and associated lack of oversight and enforcement in those facilities. It was not until August when the Administration began reinstating some routine inspections, although it appears these activities are still limited due to the pandemic.
- *Reinstate the following staffing and training requirements, the waiver of which are detrimental to patient safety:*
 - In March, CMS waived the nurse aide training requirement, which requires a minimum of 75 hours of training (42 CFR § 483.152) within four months of employment and passage of the state’s competency evaluation program.
 - CMS used its 1135 waiver authority to modify the training requirements for paid feeding assistants in 42 CFR §§ 483.60(h)(1)(i) and 483.160(a) – reducing training from a minimum of eight hours to a minimum of one hour in length.
 - CMS waived requirements in § 483.30(e)(4) that prevent a physician from delegating a task to non-physician providers. Under the waiver, physicians can delegate tasks to other provider types, including, for example, nurse practitioners or physician assistants. At this juncture, there seems to be no good reason for this continued exemption from physician performance of these tasks.

Other important COVID-19-related actions

In addition to reinstating certain 1135 waivers, there are a number of other important COVID-19-related policies CMS could act on immediately to provide additional clarity to nursing home residents, their families, and public health experts on the current situation in nursing homes:

- *Release clear guidance on in-person and televisitation policies, updated regularly to comply with COVID-19 data.* Throughout the pandemic, in-person visits with nursing home residents have been limited to control infections. While this change was necessary to infection control efforts across nursing homes, it has been detrimental to the health of nursing home residents, isolating them further and eliminating a fundamental mechanism of oversight on the part of families.² It is time for data-driven national leadership on this issue, with clear and regularly updated guidance provided to nursing homes on how to most effectively to initiate televisitation – both phone-based and through video technology, to the extent possible – as well as clearly defined circumstances that allow for in-person visitation, based on local COVID-19 infection rates. This guidance must also account for compassionate care situations to ensure maximum flexibility, when

² Joseph E. Gaugler, *Family Involvement in Residential Long-Term Care: A Synthesis and Critical Review*, 9:5 AGING AND MENTAL HEALTH at 105-118.

possible. It is imperative that nursing home residents have the ability to communicate with their families throughout the course of this pandemic.

- *Fix gaps in reporting on both staff and patient COVID-19 nursing home data.* A Ways and Means staff analysis I described in my August letter to CMS found 12.4 percent of the Nursing Home COVID-19 Public File data fields were missing, including over three percent of the data related to COVID-19 cases and deaths of both facility workers and staff.³ Furthermore, the reporting requirements outlined in the agency’s May 8, 2020, interim final rule (85 FR 27550) do not align with existing mandatory and standardized staffing data through the Payroll-Based Journal (PBJ) system, which is reported as staffing hours per resident per week.^{4, 5, 6} According to the Nursing Home COVID-19 Public File data dictionary, nursing homes are not required to report any information on staffing hours per resident; rather, they must self-report whether or not the facility is experiencing staffing shortages – a significantly less comprehensive measure of staffing capacity in nursing facilities.^{7, 8} These data issues must be reconciled to best inform public health officials responding to COVID-19 outbreaks. Additionally, I request the agency contemplate incorporating vaccination reporting, broken out by staff and residents (including receipt of first vs. second dose) into the nursing home reporting requirements.
- *Publicly report COVID-19 demographic data in in nursing homes.* Through CMS’s Minimum Data Set, the agency already collects demographic information on nursing home residents, including race, ethnicity, and primary language. These data must be crosswalked with the COVID-19 data the Centers for Disease Control and Prevention collects through the National Healthcare Safety Network and publicly reported to address significant data gaps and further inform our nation’s public health response to the health inequities the pandemic has so clearly articulated.

Additional administrative actions that require immediate attention

Beyond COVID-19, many changes the Trump Administration implemented in the nursing home sector significantly degraded oversight and patient safety. In 2016, CMS published

³ Richard E. Neal, *Letter to CMS Administrator Verma ‘RE: Improving COVID-19 Nursing Home Data Collection and Reliability’*, COMMITTEE ON WAYS AND MEANS (Aug. 4, 2020), https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/08%2004%2020_COVID_SNF_Data%20Letter%20to%20CMS_FINAL.pdf.

⁴ 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 85 Fed. Reg. 27550 (May 8, 2020).

⁵ *Changes to Staffing Information and Quality Measures Posted on the Nursing Home Compare Website and Five Star Quality Rating System due to the COVID19 Public Health Emergency*, CTRS. FOR MEDICARE & MEDICAID SERVS. (June 25, 2020), <https://www.cms.gov/files/document/qso-20-34-nh.pdf>.

⁶ *Find & Compare Nursing Homes, Hospitals & Other Providers Near You*, MEDICARE.GOV, <https://www.medicare.gov/NursingHomeCompare/Data/Staffing.html> (last visited Feb. 18, 2021).

⁷ *COVID-19 Nursing Home Data Set*, CTRS. FOR MEDICARE & MEDICAID SERVS. (updated Feb. 18, 2021), <https://data.cms.gov/Special-Programs-Initiatives-COVID-19-Nursing-Home/COVID-19-Nursing-Home-Dataset/s2uc-8wxp>.

⁸ Barry S. Fogel, *Data Driven Solutions for COVID-19 In Skilled Nursing Facilities: MDS ‘Section Y’*, HEALTH AFFAIRS BLOG (July 27, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20200723.64590/full/>.

a Final Rule, “Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities” (CMS-3260-F), which updated the federal standards of care for facilities.⁹ Over the last four years, the Trump Administration hampered implementation of the enhanced Requirements, and its “Patients over Paperwork” initiative undid much of the progress made under the Obama Administration in enforcement by prioritizing reductions in provider burden over consumer protections. Specifically, I ask the Biden Administration consider quickly acting on the following:

- *Reinstate requirement that civil money penalties (CMPs) be imposed against nursing homes for all deficiencies on a per-day basis as the default penalty.* The Trump Administration reversed the Obama-era per-day fining practices in July 2017 (from per-day to per-instance fines), which, for example, resulted in CMS issuing a single fine for two-thirds of all inappropriate antipsychotic citations that would have previously resulted in a per-day fine.¹⁰
- *Reinstate Obama-era safety requirements that required pharmacists to report irregularities in antipsychotic overuse, established a 14-day PRN (pro re nata or “as needed”) limitation on psychotropic drugs, and implemented behavioral health measures that were targeted to enhance person-centered care.*¹¹
- *Reinstate ban on pre-dispute binding arbitration agreements.* In July 2019, the Trump Administration released a final rule, “Medicare and Medicaid Programs; Revision of Requirements for Long Term Care Facilities: Arbitration Agreements” (CMS-3342-F) that repealed the Obama Administration’s vital ban on pre-dispute binding arbitration agreements in nursing homes.¹² It is critically important that the Biden Administration address this policy immediately, as pre-dispute, binding arbitration agreements are a violation of patient rights, threatening the safety and quality of care delivered to all nursing home residents.

In 2012, CMS established the voluntary National Partnership to Improve Dementia Care in Nursing Homes to reduce the misuse of antipsychotics in nursing homes – but it has not lived up to its promise, and the Trump Administration degraded initial efforts. According to a Ways and Means staff report released in July 2020, entitled, *Under-Enforced and Over-Prescribed: The Antipsychotic Drug Epidemic Ravaging America’s Nursing Homes*, approximately 20 percent of all skilled nursing facility residents in the U.S. – about 298,650 people every week – received some form of antipsychotic medication in the fourth quarter of 2019, while only about

⁹ Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities 81 Fed. Reg. 68688 (Oct. 4, 2016).

¹⁰ Jordan Rau, *Trump Administration Cuts the Size of Fines for Health Violations in Nursing Homes*, NATIONAL PUBLIC RADIO (Mar. 15, 2019), <https://www.npr.org/sections/health-shots/2019/03/15/702645465/trump-administration-cuts-the-size-of-fines-for-health-violations-in-nursing-hom>.

¹¹ *Temporary Enforcement Delays for Certain Phase 2 F-Tags and Changes to Nursing Home Compare*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Nov. 24, 2017), <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-18-04.pdf>.

¹² Medicare and Medicaid Programs; Revision of Requirements for Long Term Care Facilities: Arbitration Agreements 84 Fed. Reg. 34718 (Sept. 16, 2019).

two percent had qualifying conditions for such drugs.¹³ Anecdotal reports suggest that the use of antipsychotics in nursing homes due to reduced staffing levels have only increased during the pandemic.¹⁴ Beyond the changes outlined above, I recommend the Biden Administration:

- *Provide additional guidance to surveyors* – and ensure appropriate oversight and enforcement – so that antipsychotic deficiency citations are appropriately cited as “Actual Harm” (Level Three) or “Immediate Jeopardy” (Level Four) with sufficient fines (see CMP regulatory change above).
- *Track the falsification of psychosis diagnoses* to avoid inappropriate antipsychotic citations through better oversight and data. The data used to track antipsychotics use in nursing homes through the National Partnership program is misleading and should be changed. Currently, CMS removes from its data short-stay residents or those with a psychosis diagnosis, which is particularly detrimental to CMS’s efforts to track the recent increases in false psychosis diagnoses in nursing homes. If possible, it would also be helpful to present these data in both a risk-adjusted and non-risk-adjusted manner to better inform the public.

Finally, the Provider Enrollment, Chain, and Ownership (PECOS) data are key to ensuring program integrity and patient safety in nursing homes. This is a vital resource for states, regulators, and patient advocacy groups to track common owners in nursing homes, which have been linked to reductions in staffing and significant quality/patient safety issues, including COVID-19 outbreaks.^{15, 16, 17} A cleaner and more widely available PECOS data would better help track the relationship between ownership and quality of care.¹⁸ Therefore, I recommend the Biden Administration:

- *Immediately modify the underlying PECOS data* to make it more usable and ensure researchers are more easily able to obtain the *complete* dataset for the purposes of better tracking nursing home ownership arrangements and their relationship to COVID-19 outbreaks and overall quality.

¹³ *Under-Enforced and Over-Prescribed: The Antipsychotic Drug Epidemic Ravaging America’s Nursing Homes*, U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON WAYS AND MEANS MAJORITY (July 2020), https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/WMD%20Nursing%20Home%20Report_Final.pdf

¹⁴ Kim Samuel & Jane Buchanan, *Another COVID Risk — Overuse of Psychotropic Drugs on Seniors in Care*, HUMAN RIGHTS WATCH (Jan. 15, 2021), <https://www.hrw.org/news/2021/01/15/another-covid-risk-overuse-psychotropic-drugs-seniors-care#>.

¹⁵ David C. Grabowski et al., *Low-Quality Nursing Homes were More Likely than Other Nursing Homes to be Bought or Sold by Chains in 1993—2010*, 35:5 HEALTH AFFAIRS at 907—14 (2016).

¹⁶ Charlene Harrington et al., *Nurse Staffing and Coronavirus Infections in California Nursing Homes*, 21:3 POLICY, POLITICS, & NURSING PRACTICE at 174 (July 2020).

¹⁷ Debbie Cenziper et al., *Profit and Pain: How California’s Largest Nursing Home Chain Amassed Millions as Scrutiny Mounted*, WASHINGTON POST (Dec. 31, 2020), <https://www.washingtonpost.com/business/2020/12/31/brius-nursing-home/>.

¹⁸ Charlene Harrington et al., *These Administrative Actions Would Improve Nursing Home Ownership and Financial Transparency in the Post COVID-19 Period*, HEALTH AFFAIRS BLOG (Feb. 11, 2021), <https://www.healthaffairs.org/doi/10.1377/hblog20210208.597573/full/>.

Given the continued devastating situation in nursing homes across the United States, there are many other additional long-term policies that merit further consideration. The suggestions presented above reflect what I believe to be the immediate steps that ought to be taken to ensure CMS is meeting its obligation to effectively oversee the care delivered to nursing home residents in the short-term during the pandemic. In the future, I welcome the opportunity to discuss ways we can work together to improve the quality of care delivered in nursing homes across the country and ensure patient safety.

Thank you for your attention to this important matter. If you have questions, please contact Rachel Dolin with the Ways and Means Committee Majority staff at Rachel.Dolin@mail.house.gov or 202-225-3625.

Sincerely,

A handwritten signature in blue ink, appearing to read "Richard E. Neal". The signature is fluid and cursive, with a prominent initial "R" and a long, sweeping underline.

Richard E. Neal
Chairman