

**EXAMINING THE COVID-19 NURSING HOME CRISIS  
HEARING  
Health Subcommittee of the  
House Ways and Means Committee**

**June 25, 2020**

**TESTIMONY**

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I want to acknowledge the deaths of more than 50,000 nursing home residents and hundreds of nursing home staff from COVID-19. We grieve for residents, staff, and families who have been barred from visiting their relatives for more than three months.

These past several months have brought to fuller public awareness the deadly consequences of poor care, inadequate staffing levels, and treatment of regulations intended to ensure good care for residents as burdens on facilities that need to be eliminated. Although many of these problems in nursing facilities have been identified for decades, they have been made worse by recent deregulatory actions and the coronavirus pandemic. Essential changes are needed.

From its earliest days, the Trump Administration has taken steps to weaken and dismantle the regulations and guidance that have been developed over the past 30 years to implement and enforce the federal Nursing Home Reform Law.<sup>1</sup> Many of the most significant changes were made to the enforcement system, without notice and public comment. Now, during the coronavirus pandemic and national health emergency, the Administration has unilaterally decimated longstanding statutory and regulatory protections for residents. It has waived multiple resident protections and suspended surveys and enforcement for all but the most egregious violations. The Administration could not have implemented such changes unilaterally in non-emergency times. Many of these changes have been sought by the nursing home industry over the years.

**The 1987 Nursing Home Reform Law**

The Nursing Home Reform Law, enacted in 1987, is the federal law that governs nursing facilities that voluntarily choose to receive reimbursement from the Medicare and Medicaid programs. Nearly every facility in the country participates in one or both federal payment programs. The Reform Law made fundamental changes to all three components of federal law: the standards of care that nursing facilities must meet (called Requirements of Participation) in order to be certified for participation and reimbursement; the survey process by which state health departments determine whether facilities meet federal standards of care; and the

enforcement system, which authorizes a range of penalties for violations of federal care standards.

The Administration's undermining of the Reform Law began with the enforcement provisions, which the Administration could change, without public notice and comment, by rescinding and replacing Obama-era guidance documents for surveyors with guidance documents of its own. It has less authority to make unilateral changes to the Requirements and to the survey process, but it repeatedly asked nursing homes what they want and clearly signaled its intentions. It proposed and, in some instances, made, changes. It delayed enforcement of new Requirements and, in July 2019, published proposed changes to weaken the care standards; those proposed rules have not been made final. It has also proposed to reduce the frequency of surveys; such a change can only be made by amending the federal law.

### **Nursing Home Industry Requests**

The national nursing home association, the American Health Care Association (AHCA), the larger trade association that represents primarily for-profit facilities, and LeadingAge, which represents not-for-profit facilities, have called on the Administration to change all parts of the Reform Law. They were successful early on.

In a December 15, 2016 letter to then President-Elect Trump,<sup>2</sup> AHCA asked for regulatory relief in a variety of areas, and identified, by number, a single document that the Obama Administration had issued in 2016,<sup>3</sup> and asked for its repeal.<sup>4</sup> In October 2017, the Administration accommodated the request, as discussed below.

Throughout 2017, AHCA and LeadingAge sought relief from "burdensome regulations" from the Administration. In a March 9, 2017 letter to HHS Secretary Price, AHCA complained specifically about civil money penalties (CMPs), which it claimed were "being retroactively issued and used as a punishment."<sup>5</sup> AHCA suggested that "The purpose of issuing a CMP is to create a financial incentive to immediately resolve a jeopardy situation that may cause further adverse events to residents" and that CMS's recent sub-regulatory guidance allows the use of CMPs "for lower level deficiencies that did not result in any resident harm." Such retrospective use of CMPs is "punitive" and has led to "serious misuse of CMPs." AHCA described its long-term solution:

The current system is both punitive and combative. We need a system that is collaborative. We need fundamental change. There are a couple of ways that you could achieve this. One is to turn regulation back to the states. As CMS turns more payment flexibility to the states, it's time to do the same thing with respect to regulation. A major part of the problem has been federal employees overriding and demanding punitive treatment at the state level. A second way to achieve collaboration is to take the incentives to punish away from survey teams and instead incentivize them towards quality outcomes in buildings. The goal should be great treatment of patients, not to shut buildings down. We know you understand this and look forward to working with you on solutions.

LeadingAge similarly asked for regulatory relief from new Requirements and enforcement in a meeting with CMS Administrator Seema Verma in April 2017.<sup>6</sup> It has called for reevaluation of the use of CMPs altogether.<sup>7</sup>

### **Changes to federal regulations proposed and made by the Administration**

The Administration has been responsive to the nursing home industry, identifying resident protections as burdensome. Primarily through the Centers for Medicare & Medicaid Services (CMS), the federal agency with responsibility for regulating nursing facilities that participate in Medicare or Medicaid, or both, the Administration has proposed or made multiple changes to nursing home regulations and policies since January 2017. Some of the key changes are described below, in chronological order.

May 4, 2017: In the annual update to Medicare reimbursement for skilled nursing facilities, CMS announced that it was “currently reviewing the LTC requirements to balance the need to maintain quality of care while reducing procedural burdens on facilities.”<sup>8</sup> CMS identified three possible areas for revisions in the revised Requirements of Participation that were published on October 4, 2016, at 81 Fed. Reg. 68688. These areas were: the new grievance process for residents, quality assurance and performance improvement, and discharge notices (whether facilities must send copies of resident discharge notices to the ombudsman program).

June 8, 2017: CMS published proposed rules to allow pre-dispute arbitration agreements in nursing home admission contracts.<sup>9</sup> Preserving these agreements is an important issue to the nursing home industry. When the 2016 regulations prohibited mandatory pre-dispute provisions in contracts,<sup>10</sup> AHCA sued. A preliminary injunction prevented implementation of the rule.<sup>11</sup>

June 30, 2017: CMS announced that it would delay enforcement of certain Phase 2 Requirements of Participation, which had been published October 4, 2016, that were scheduled to go into effect on November 28, 2017.<sup>12</sup> These provisions included residents’ rights; freedom from abuse, neglect, and exploitation; baseline care plans;<sup>13</sup> various requirements for facility assessments; psychotropic drugs;<sup>14</sup> and others.

July 7, 2017: Replacing guidance issued in 2014,<sup>15</sup> CMS issued new guidance and an analytic tool<sup>16</sup> that directed use of (lower) per instance CMPs, rather than (higher) per day CMPs. CMS made dramatic limitations on per day CMPs, which would start at the time of the survey, rather than at the time when the facility’s noncompliance actually began, and which would not be used when the facility had a “good compliance history” or when only “a single isolated incident causes harm to a resident.”<sup>17</sup> The 2017 guidance and tool made other changes that were intended to reduce the imposition and size of penalties.

The changed guidance has resulted in a dramatic shift from per day to per instance CMPs.

In calendar year 2016, there were

1,966 per day CMPs, imposed for an average of 56.76 days, and totaling \$61,242.10

1,043 per instance CMPs, averaging \$3,677.32<sup>18</sup>

In calendar year 2019, after CMPs were adjusted for inflation,<sup>19</sup> there were

1405 per day CMPs, imposed for an average of 56.93 days, and totaling \$69,846.38

1813 per instance CMPs, averaging \$9969.08<sup>20</sup>

The shift in penalties from per day CMPs to per instance CMPs was recognized in December 2017.<sup>21</sup>

October 27, 2017: CMS proposed withdrawing S&C: 16-31-NH (Jul. 22, 2016), the surveyor guidance identified in AHCA's December 2016 to the President-elect, and revising policies on immediate imposition of remedies.<sup>22</sup> Among other changes, CMS proposed limiting the imposition of CMPs for immediate jeopardy deficiencies (the highest of four levels of severity by which deficiencies are classified) that reflect a "onetime mistake" or that do not reflect "intent" to harm; prohibiting imposition of CMPs for "past noncompliance;" uncoupling scope and severity of deficiencies from particular remedies; and reducing enforcement against the handful of the most poorly performing facilities in each state that are designated as Special Focus Facilities.<sup>23</sup>

October 27, 2017: CMS's revised guidance to delay, until after appeals, a nursing facility's losing the authority to conduct its own nurse aide training and competency evaluation program and allowing federal Regional Offices to waive the loss of nurse aide training authority entirely, on a case-by-case basis.<sup>24</sup> Nurse aide training was also identified in AHCA's December 2016 letter as a concern.

November 24, 2017: Four days before additional Requirements of Participation were to be implemented, CMS delayed any enforcement of eight of them, including baseline care plans, limitations on psychotropic medications, and requirements for sufficient and competent direct care staff to address residents' behavioral health needs.<sup>25</sup>

November 24, 2017: CMS announced a new survey process,<sup>26</sup> but, as of June 19, 2020, has never published a new process in the State Operations Manual.

December 14, 2017: CMS's Regulatory and Deregulatory Agenda announced CMS's intention to publish a proposed rule revising the Requirements of Participation for nursing facilities in June 2018, to reduce burdens on facilities and provide "flexibilities to facilities [and . . . ] major cost savings."<sup>27</sup>

January 2018: In its "Patients over Paperwork" initiative, CMS identified providers as its customers and addressed nursing facilities directly in the January issue: you said facilities were not ready to implement new Requirements effective November 2017 so "CMS directed LTC Facility surveyors to focus on education rather than discretionary penalties related to the implementation of specific new Requirements of Participation for 18 months." You said CMPs "are not applied consistently or fairly" so "CMS revised the CMP Analytic Tool" and reduced

penalty amounts “by moving to a per-instance CMP instead of per-day CMPS for past noncompliance that existed before the current survey and does not continue.”<sup>28</sup>

June 15, 2018: CMS made final the revisions it proposed in October 2017, replacing 2016 guidance to surveyors. The 2018 guidance limits CMPs to for immediate jeopardy deficiencies that result in “serious injury harm, impairment or death;” authorizes Regional Offices to impose remedies other than CMPs for immediate jeopardy deficiencies not resulting in serious harm and to consider whether the noncompliance resulted from a one-time mistake or intentional act to disregard resident health and safety.<sup>29</sup>

July 18, 2019: CMS published proposed changes to Requirements of Participation, including eliminating that requirement that a facility’s infection preventionist work at least part-time in the facility; easing requirements for the administration of antipsychotic drugs; removing all specific duties from a facility’s official overseeing the facility’s grievance process; eliminating enhanced professional credentials for dietitians; extending the time for facility assessments from one year to two; and more. One enforcement change creates a “constructive waiver process” that presumes a facility waives its right to appeal a penalty even if does not formally appeal, and nevertheless gives the facility the automatic 35% reduction in the civil money penalty.<sup>30</sup> CMS used the words “burden” or “burdensome” more than 100 times in the 32-page publication in the Federal Register.

July 18, 2019: CMS issued final regulations allowing pre-dispute arbitration agreements in nursing facilities.<sup>31</sup>

July 31, 2019: In a CMS podcast, the CMS Administrator describes the proposal in the President’s budget to conduct less than annual surveys at some facilities.<sup>32</sup>

August 28, 2019: The Administrator’s blog post describes a risk- based survey model that would “survey top performing facilities every 30 months, with no more than 36 months between surveys of any single facility.” The savings from not conducting annual surveys at these “top performing facilities” would be used “to strengthen our oversight and quality improvement efforts for facilities that are low performers.”<sup>33</sup>

## **Coronavirus Pandemic**

Since January 2017, the Trump Administration has taken multiple actions to undermine the Nursing Home Reform Law and its 30-year history. Now, during the coronavirus pandemic, it has undercut the Law even further, taking action to suspend decades-long resident protections that are required by law and regulations.

Following announcement of the public health emergency, CMS unilaterally made many significant changes to federal standards of care, survey, and enforcement.

March 4<sup>34</sup> (and revised March 9, March 13), 2020: Soon after HHS Secretary Alex Azar declared a public health emergency,<sup>35</sup> CMS began restricting visitors to facilities. By March 13, a complete ban extended to “all visitors and non-essential health care personnel, except for

certain compassionate care situations, such as an end-of-life situation.”<sup>36</sup> The ban included nursing home ombudsmen. CMS also cancelled communal dining and all group activities. Many residents have been largely confined to their rooms for months.

March 20, 2020: CMS suspended all standard surveys, for a three-week period since extended indefinitely, and authorized only two types of surveys: targeted infection control surveys and complaints or facility-reported incidents that the state agency triaged as immediate jeopardy (but only if surveyors have personal protective equipment).<sup>37</sup> At the same time, CMS suspended enforcement for all deficiencies except those classified as “immediate jeopardy” (less than 1% of deficiencies).<sup>38</sup>

March 28, 2020: CMS issued a document called “flexibilities” that waived multiple federal regulatory standards.<sup>39</sup> CMS waived federal regulations for nursing facilities that included regulations related to:

- Resident transfer and discharge rules (and allowing residents to be moved from their home to another facility, without prior notice and opportunity for a hearing, for purposes of grouping residents by COVID status). As *The New York Times* reported on June 21, 2020, some facilities have used the reduced oversight to discharge residents to homeless shelters and other inappropriate places in order to make room for COVID-19 residents, for whom they receive higher reimbursement;<sup>40</sup>
- Residents’ rights, including the right to participate in in-person resident groups, to eat in the dining room. (Many residents are largely confined to their rooms, with the doors closed);
- Requirement that facilities use only nurse aides who complete a 75-hour training program (some states require more hours of training) and are found competent. (AHCA has developed an on-line training program of eight hours and a competency evaluation program and multiple states have approved their use during the pandemic);
- Requirements that facilities submit data about resident assessments and staffing data (through the Payroll-Based Journal system). (CMS has said facilities may never be required to submit payroll-based staffing data for the period of the health emergency.);

### **What Needs to Be Done Moving Forward**

During the pandemic, many changes are needed. CMS needs to reinstate, as quickly as possible, resident protections that have been waived. Urgent issues are ensuring that residents are able to visit with their families and ombudsmen in person again; that residents have a voice in where they are moved, if they need to be transferred for the limited purpose of grouping residents by COVID-19 status; that residents be guaranteed the right to return to their facility at a later time; that residents and their families be given full and accurate information about their facility’s COVID-19 status. CMS must require facilities to report resident assessment and staffing data, retroactively to the beginning of the pandemic, and CMS must immediately reinstate a comprehensive survey and enforcement process.

For the longer term, many changes in nursing facilities are needed to prevent a repetition of the lethal effects of the coronavirus pandemic and to ensure, more fully, the promise and actual mandate of the 1987 Nursing Home Reform Law – that each resident receives the care and services to attain and maintain his or her “highest practicable physical, mental, and psychosocial well-being.”<sup>41</sup>

**First, all facilities must have sufficient numbers of well-trained, well-supervised, and well-compensated nursing staff.** The key single predictor of good quality of care and quality of life for residents is nurse staffing – both the professional registered nurses and licensed practical nurses and the certified nurse assistants. All facilities need registered nurses around the clock.

**Second, the survey and enforcement systems, which have failed to ensure that facilities fully meet federal standards of care, need to be significantly strengthened. Enforcement, now implemented on a facility-by-facility basis, should evaluate facilities on a corporate-wide basis. Dismantling of meaningful enforcement needs to be reversed.**

In July 2003, William J. Scanlon, Director, Health Financing and Public Health Issues, U.S. General Accounting Office, testified before the Senate Finance Committee about the GAO’s most recent nursing home report. Then stepping back to share his thoughts about six years of GAO reports on nursing facilities, he testified:

There has also been discussion over the last six years about a need to change the nature of the survey and enforcement process or to reduce our reliance on it as a means of assuring nursing home quality.

It has been suggested that the process should be less regulatory, surveyors less like policemen. Some suggest surveyors should play more of a consultative role, assisting nursing homes in understanding how to comply with Federal standards.

I agree that surveyors should not be regarded as policemen. They should be perceived as consumer representatives, reviewing whether the care Medicare and Medicaid programs are purchasing on behalf of their beneficiaries meets standards of minimal quality, something no different than what a corporation might do to check whether the goods it ordered from a supplier were of acceptable quality.

The analogy is apt, because surveys are only done for homes that voluntarily want to sell care to Medicare or Medicaid beneficiaries. Homes that do not are not surveyed.

I do find it hard to understand the idea that the nursing homes would need the consultative help of government surveyors in order to avoid deficiencies. The types of deficiencies we have been talking about involve practices so egregious, so lacking, that one does not have to be a health professional to instantly understand their inadequacy.

In our report in different hearings and in the examples that you have heard today, there have been cases of serious harm and other industry, and possibly death, when physicians’ orders were ignored, when residents were allowed to deteriorate due to malnutrition or dehydration with[out] any intervention, or because decubiti went undiagnosed, or even when diagnosed were not appropriately treated.

The nursing home industry is a \$100 billion a year industry, employing tens of thousands of health professionals. It is incongruous to me to think that it needs the

consultative assistance of a government surveyor to correct problems that every non-health professional in this room would instantly agree involved care that was simply and woefully lacking.

Most of us know from raising children about the basics required to sustain a human being, basics that some nursing home residents do not receive.

Some may say the survey and enforcement processes have proven inadequate to ensure nursing home quality, given the reports of continuing deficiencies over the last 6 years.

My perspective is different. I do not believe we have adequately implemented the survey and enforcement process we envisioned in OBRA 1987 [Nursing Home Reform Law], and further defined by HCFA [Health Care Financing Administration, predecessor to CMS].

The execution of survey and the enforcement actions that should follow them have been so lacking, we do not know how effective the process can be.<sup>42</sup>

The nursing home industry makes the same arguments about survey and enforcement that it made 17 years ago. Dr. Scanlon's analysis is as true today as it was in July 2003. We should listen to his guidance on survey and enforcement.

**Third, states must establish and enforce meaningful standards for who is eligible to operate a facility (i.e., receive a state license) and, independently, CMS must establish and enforce meaningful standards for who is eligible to receive Medicare and Medicaid reimbursement for care (i.e., receive federal certification).** At present, ownership and management of nursing facilities appear to shift with little public information and no effective oversight.

The collapse of Skyline Healthcare in 2018 and 2019 was the most visible and vivid example of the problem of allowing companies without adequate financial and management resources to take over facilities. This New Jersey company had a handful of facilities, but then, beginning in about 2016 or 2017, began to manage facilities across the country, primarily facilities that large chains decided not to run. In a period of little more than a year, Skyline Healthcare began operating between 100 and 120 facilities in eight states across the country. Then, within an equally short period, it stopped meeting payroll and paying vendors.<sup>43</sup> States went to court to get authority to take over the facilities – the legal term is receivership – in order to make sure that residents received care and food and medicine and supplies.

While other companies had gone into bankruptcy before and other owners had abandoned facilities before, there had never been such a large collapse, affecting so many states, so many facilities, and so many residents and staff. Skyline's collapse brought attention to the problem of who owns and who manages facilities – and whether are they qualified and competent to do so.

The *Philadelphia Inquirer* describes changes in the nursing home industry that led to this crisis for residents and states:

The nursing home industry in recent years has been engulfed in wholesale changes in operators as Golden Living and other large companies, often under regulatory and



financial pressure, abandon the business and lease bunches of facilities over to firms that emerge from nowhere.<sup>44</sup>

Meaningful standards of ownership and management are critical and these standards must be enforced. States and CMS cannot allow “firms that emerge from nowhere” to run nursing facilities without greater screening, monitoring, and accountability.

**Finally, we need to assure that facilities spend a reasonable proportion of reimbursement on care for residents – we need a medical loss ratio requirement, as the Affordable Care Act mandated for managed care companies.**<sup>45</sup> Facilities receive public reimbursement but are allowed to spend the reimbursement as they choose. We need to assure that the billions of dollars that facilities receive from Medicare and Medicaid are spent on the staff, food, supplies, and care that residents need.

## Conclusion

Not all facilities provide poor care, of course, but far too many do, as the pandemic has all too vividly shown. Improving quality of care and quality of life in nursing facilities that do not provide good care requires multiple efforts, simultaneously made – improving staffing, strengthening survey and enforcement processes, and making sure that individuals and companies that own and manage nursing facilities are prepared and competent to provide good care and spend their reimbursement on care. Residents and their families and taxpayers deserve no less.

The coronavirus pandemic has made all too visible the lethal consequences of poor care. We can and must learn from what has gone wrong and do better in the future.

Thank you for this opportunity to testify.

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<sup>1</sup> 42 U.S.C. §§1395i-3(a)-(h), 1396r(a)-(h), Medicare and Medicaid, respectively.

<sup>2</sup> <https://www.ihca.com/Files/Comm-Pub/AHCANCAL-Letter-TrumpAdmin-Attachments.pdf>

<sup>3</sup> CMS, “Mandatory Immediate Imposition of Federal Remedies and Assessment Factors Used to Determine the Seriousness of Deficiencies for Nursing Homes,” S&C: 16-31-NH (Jul. 22, 2016), revised 7.29.16, <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-16-31.pdf>.

<sup>4</sup> AHCA repeated its request in a March 9, 2017 letter to then-HHS Secretary Tom Price, <https://www.ihca.com/Files/Comm-Pub/AHCA-Final-Price-Ltr-3.9.17.pdf>.

<sup>5</sup> <https://www.ihca.com/Files/Comm-Pub/AHCA-Final-Price-Ltr-3.9.17.pdf>.

<sup>6</sup> Cheryl Phillips, “LeadingAge Urges Regulatory Reform at CMS” (Apr. 5, 2017), <https://www.leadingage.org/regulation/leadingage-urges-regulatory-reform-cms>.

<sup>7</sup> Letter to CMS Administrator Verma from Jodi Eyigor, Director, Nursing Home Quality & Policy, LeadingAge, (Sep. 16, 2019), <https://leadingage.org/sites/default/files/CMS-3347-P%20comments.pdf>.

<sup>8</sup> 82 Fed. Reg. 21014, 21089 (May 4, 2017).

<sup>9</sup> 82 Fed. Reg. 26649 (Jun. 8, 2017).

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<sup>10</sup> 81 Fed. Reg. 68688, 68790 (Oct. 4, 2016).

<sup>11</sup> *American Health Care Association v. Burwell*, 217 F.Supp.3d 921 (N.D. Miss. 2016).

<sup>12</sup> CMS, “Revision to State Operations Manual (SOM) Appendix PP for Phase 2, F-Tag Revisions, and Related Issues,” S&C: 17-36-NH (Jun. 30, 2017), <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-36.pdf>.

<sup>13</sup> The need for facilities to develop a care immediately after admission, instead of two weeks after admission, was made clear by a report from the HHS Inspector General in 2014, finding that many Medicare beneficiaries experienced adverse events or other poor outcomes within, on average, 15.5 days of admission. Office of Inspector General, *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries*, OEI-06-11-00370 (Feb. 2014), <https://oig.hhs.gov/oei/reports/oei-06-11-00370.pdf>.

<sup>14</sup> In 2011, the HHS Inspector General issued a report about the extensive misuse and overuse of antipsychotic drugs in nursing homes. Office of Inspector General, *Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents*, OEI-07-08-00150 (May 2011), <https://oig.hhs.gov/oei/reports/oei-07-08-00150.pdf>.

<sup>15</sup> CMS, “Civil Money Penalty (CMP) Analytic Tool and Submission of CMP Tool Cases, S&C: 15-16-NH (Dec. 19, 2014), <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-15-16.pdf>.

<sup>16</sup> CMS, “Revision of Civil Money Penalty (CMP) Policies and CMP Analytic Tool,” S&C: 17-37-NH (Jul. 7, 2017), at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-37.pdf>.

<sup>17</sup> <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/downloads/sfflist.pdf>.

<sup>18</sup> [https://qcor.cms.gov/enf\\_cmp.jsp?which=0&report=enf\\_cmp.jsp](https://qcor.cms.gov/enf_cmp.jsp?which=0&report=enf_cmp.jsp) (site accessed June 21, 2020).

<sup>19</sup> The Federal Civil Penalties Inflation Adjustment Improvements Act of 2015 (§701 of the Bipartisan Budget Act of 2015) required that civil money penalties be updated annually for inflation. CMS published the first updated CMPs in September 2016. 81 Fed. Reg. 61537 (Sep. 6, 2016).

<sup>20</sup> [https://qcor.cms.gov/enf\\_cmp.jsp?which=0&report=enf\\_cmp.jsp](https://qcor.cms.gov/enf_cmp.jsp?which=0&report=enf_cmp.jsp) (site accessed June 21, 2020).

<sup>21</sup> Jordan Rau, “Nursing Home Fines Drop As Trump Administration Heeds Industry Complaints,” *Kaiser Health News* (Mar. 15, 2019), <https://khn.org/news/nursing-home-fines-drop-as-trump-administration-heeds-industry-complaints/>.

<sup>22</sup> CMS, “Revised Policies regarding the Immediate Imposition of Federal Remedies – FOR ACTION,” S&C: 18-01-NH (Oct. 27, 2017), <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-18-01.pdf>.

<sup>23</sup> CMS, Special Focus Facility (“SFF”) Program, <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/downloads/sfflist.pdf>.

<sup>24</sup> CMS, “Clarification regarding Nurse Aide Training and Competency Evaluation Program (NATCEP/CEP) Waiver and Appeal Requirements,” S&C: 18-02-NH (Oct. 27, 2017), <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-18-02.pdf>.

<sup>25</sup> CMS, “Temporary Enforcement Delays for Certain Phase 2 F-Tags and Changes to *Nursing Home Compare*,” S&C: 18-04-NH (Nov. 24, 2017), <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-18-04.pdf>.

<sup>26</sup> CMS, “Preparation for Launch of New Long-Term Care Survey Process (LTCSP),” S&C: 18-05-NH (Nov. 24, 2017), <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-18-05.pdf>.

<sup>27</sup> CMS, “Requirements for Long-Term Care Facilities: Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction,” RIN: 0938-AT36 (Dec. 14, 2017), <https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=201710&RIN=0938-AT36>.

<sup>28</sup> CMS, Patients over Paperwork (Jan. 2018 newsletter), <https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/JanuaryPoPNewsletter011818.pdf>.

<sup>29</sup> CMS, “Final Revised policies Regarding the Immediate Imposition of Federal Remedies,” QSO 18-18-NH (Jun. 15, 2018), <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO18-18-NH.pdf>.

<sup>30</sup> CMS, “Medicare and Medicaid Programs: Requirements for Long-Term Care Facilities: Regulatory Provisions To Promote Efficiency, and Transparency,” CMS-3347-P. 84 Fed. Reg. 34737 (Jul. 18, 2019). California Attorney General Xavier Beccera opposed the proposed changes, <https://oag.ca.gov/system/files/attachments/press-docs/Nursing%20home%20regulations%20comment%20letter.pdf>, as did the Attorneys General of New York,

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Illinois, Maryland, Michigan, Nevada, and Oregon in a joint letter, [https://www.michigan.gov/documents/ag/CMS-3347-P\\_Comments-9-16-2019\\_666011\\_7.pdf](https://www.michigan.gov/documents/ag/CMS-3347-P_Comments-9-16-2019_666011_7.pdf).

<sup>31</sup> CMS, “Medicare and Medicaid Programs; Revision of Requirements for Long term Care Facilities: Arbitration Agreements,” 84 Fed Reg. 34718 (Jul. 18, 2019).

<sup>32</sup> *Episode 5: Nursing Home Strategy Part 1 – Strengthening Oversight* (Jul. 31, 2019), is available at <https://www.cms.gov/podcast/episode-5-nursing-home-strategy-part-1-strengthening-oversight>.

<sup>33</sup> “Ensuring Safety and Quality in Nursing Homes: Five Part Strategy Deep Dive” (Aug. 23, 2019), <https://www.cms.gov/blog/ensuring-safety-and-quality-nursing-homes-five-part-strategy-deep-dive>.

<sup>34</sup> CMS, “Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes,” QSO-20-14-NH (Mar. 4, 2020), <https://www.hhs.gov/about/news/2020/01/31/secretary-azar-declares-public-health-emergency-us-2019-novel-coronavirus.html>.

<sup>35</sup> CMS, “Determination that a Public Health Emergency Exists” (Jan. 31, 2020), <https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx>

<https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx>; CMS, “Secretary Azar Declares Public Health Emergency for United States for 2019 Novel Coronavirus” (Press Release, Jan. 31, 2020), <https://www.hhs.gov/about/news/2020/01/31/secretary-azar-declares-public-health-emergency-us-2019-novel-coronavirus.html>.

<sup>36</sup> CMS, “Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes (REVISED),” QSO-20-14-NH (Mar. 13, 2020), <https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf>.

<sup>37</sup> CMS, “Prioritization of Survey Activities,” QSO-20-20-All (Mar. 20, 2020), <https://www.cms.gov/files/document/qso-20-20-all.pdf>.

<sup>38</sup> CMS, *Nursing Home Data Compendium 2015 Edition*, p. 48, Figure 2.2.3 (most recent data, 2014), [https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/nursinghomedatacompendium\\_508-2015.pdf](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/nursinghomedatacompendium_508-2015.pdf).

<sup>39</sup> CMS, “Long Term Care Facilities (Skilled Nursing Facilities and/or Nursing Facilities): Flexibilities to Fight COVID-19” (March 28, 2020) (most recent update, June 12, 2020, <https://www.cnms.gov/files/document/covid-long-term-care-facilities.pdf>).

<sup>40</sup> Jessica Silver-Greenberg and Amy Julia Harris, “As Crisis Swirls, Nursing Homes ‘Dump’ Patients,” *The New York Times* (Jun. 21, 2020), <https://www.nytimes.com/2020/06/21/business/nursing-homes-evictions-discharges-coronavirus.html?searchResultPosition=1>,

<sup>41</sup> 42 U.S.C. §§1395i-3(b)(2), 1396r(b)(2).

<sup>42</sup> “Nursing Home Quality Revisited; The Good, the Bad, and the Ugly,” S. Hrg. 108-325 (Hearing before the Senate Finance Committee, p. 16 (Jul. 16, 2003), <https://www.finance.senate.gov/imo/media/doc/91231.pdf>).

<sup>43</sup> Harold Brubaker, “Questions about Willow Terrace owner after nursing home collapse in Nebraska and Kansas,” *Philadelphia Inquirer* (Apr. 12, 2018), <http://www.philly.com/philly/business/questions-about-skyline-healthcare-after-nursing-home-collapse-in-nebraska-and-kansas-20180412.html>; Lindy Washburn, “Thousands of nursing home patients nationwide affected by NJ company’s financial trouble,” *Northjersey.com* (Apr. 16, 2018), <https://www.northjersey.com/story/news/watchdog/2018/04/16/thousands-nursing-home-patients-could-affected-fast-growing-nj-nursing-home-company-trouble-nebraska/493643002/>.

<sup>44</sup> Harold Brubaker, “Questions about Willow Terrace owner after nursing home collapse in Nebraska and Kansas,” *Philadelphia Inquirer* (Apr. 12, 2018), <http://www.philly.com/philly/business/questions-about-skyline-healthcare-after-nursing-home-collapse-in-nebraska-and-kansas-20180412.html>.

<sup>45</sup> Charlene Harrington, Dana Mukamel, and Pauline Rosenau, *Improving the Financial Accountability of Nursing Facilities* (June 2013), <https://sph.uth.edu/rosenau/files/2011/12/Improving-the-Financial-Accountability.pdf>.