Rep. James E. Clyburn
Select Subcommittee on the Coronavirus Crisis
2157 Rayburn House Office Building
Washington, D.C., 20515

September 23, 2022

Chairman Clyburn,

Thank you for the opportunity to share my thoughts regarding the impact of the COVID-19 Pandemic on the residents and staff of nursing homes. Let me start by pointing out that anyone who suggests that the previous Administration or the nursing home industry did everything possible to protect and value the lives of vulnerable older adults is not telling the American people the truth. **The OIG reported in June of 2021 that there were 169,291 more nursing home deaths than would normally have been expected during 2020.**[1] During this time period, the Centers for Medicare and Medicaid (CMS) put out multiple Press Releases touting the efforts of the federal government to protect nursing home residents, many of which began with "Under the leadership of President Donald Trump." **I will walk through the early months of the pandemic and describe how the Administration and the nursing home industry ignored the pleas of both experts and caregivers. The result was 169,291 more deaths than normal in 2020 alone.**

John F Kennedy quoted the historian Toynbee, *"that a society's quality and durability can best be measured by the respect and care given its elderly citizens."* How did our country measure up during the first several months of the pandemic? If we take measure by words and platitudes, we would think that we did everything right. The previous Administration and the nursing home industry have used many of the right words. Those words that didn't help George Chin, an 80-year-old man who died in a nursing home from COVID-19 on April 22. George's son Simon reached out to me and wanted to know if his father's death was preventable. The unfortunate answer was yes. The words that the prior Administration and the nursing home industry have used since March of 2020 fall flat in the wake of the tragic deaths that occurred in nursing homes across the United States. We could have and should have done more.

I am the Immediate Past President of the California Association of Long Term Care Medicine (CALTCM, www.caltcm.org). Our organization represents the medical voice of long-term care in California. We value excellent and individualized medical care, a team approach, and the integration of medical science with personalized care. We exist to provide quality education for long term care professionals, as well as to promote effective medical leadership, the ethical delivery of care and the rights of patients. Our mission is to promote quality patient care across the long-term care continuum. On a personal note, I am a geriatrician, and the editor-in-chief of a major geriatric medicine textbook. At the onset of the pandemic I was also the Medical Director of Eisenberg Village, a nursing home on the campus of the Los Angeles Jewish Home. Previously, I was the Director of the nursing home arm of our state's CMS contracted quality improvement organization, Health Services Advisory Group (HSAG). And I was first the chief medical officer, then the CEO of a company that oversaw the operations of the largest nursing

home chain in California. I resigned from that position on November 6, 2018. My views and comments are my own and are based on that body of experience.

I first want to recognize and thank the incredible people who serve on the front lines in nursing homes. They are incredibly caring and compassionate human beings, many of whom barely make a living wage. Media accounts of nursing home care all too often ignore their efforts. Too many have now given their lives unnecessarily due to the lack of immediate action to this pandemic on the part of the federal government, the states, the counties and the nursing home industry.

On February 29th, with the news of the outbreak of COVID-19 in a Washington state nursing home, the experts in geriatrics and long-term care medicine knew what was coming. Many of us did everything in our power to sound the alarm. Unfortunately, while our voices may have been acknowledged, they were not actually heard in a timely fashion. We must all live with the consequences of that. While I will share what I believe went wrong, I'd rather focus first on what needed to happen to protect the lives of nursing home residents. While we need to learn from our mistakes, I did not believe that casting blame, or making excuses, would help save lives. We needed to take action, but after two and half years, it is time to learn from what happened and to begin the hard work of taking actions that will make a difference in the future.

The experts knew early on that COVID-19 would ultimately make its way into most nursing homes despite our best efforts. However, what has always mattered is how the facilities were prepared and how they responded. Articles and data that suggested no correlation of outbreaks with survey findings or star rating status were limited by the fact that the lack of abundant PPE and readily available testing at the beginning of the pandemic made even the highest quality facilities vulnerable to the virus. Furthermore, there was a lack of accurate and comprehensive data, not the least of which was related to the fact that CMS had chosen not to focus on collecting accurate national data from as early as February of 2020. **To this day, CMS's count of nursing home deaths only began in May of 2020, leaving today's official totals as an undercount**.[2,3] The epidemiologists will ultimately sort out the actual number of nursing home residents who lost their lives due to COVID-19. In the meantime, we have studies that document an undercount, including the OIG report that documented 169,291 more nursing home deaths than expected in 2020 alone.[4]

CALTCM's "Long Term Care Quadruple Aim for COVID-19 Response," posted on our website on April 17th, 2020, described the four key elements to combatting this deadly virus.[5] It started with the need for every nursing home to have an abundance of Personal Protective Equipment (PPE). States and nursing home operators struggled to overcome the challenges brought on by pandemic supply chain dynamics to bring sufficient PPE to every nursing home. The federal government, whose prompt and effective response was so desperately needed, failed to surmount this challenge and make PPE a priority for nursing facilities. This issue persisted well into the pandemic.[6] On the other hand, there is little question but that the real estate owners and REITs behind the senior housing industry had the ability to leverage their significant assets to acquire PPE. Many chose to wait for a timely government response, which didn't happen. While everyone was complaining about the lack of PPE and the inability to acquire it, nursing home residents and their direct care workers were infected with the virus and died. The single most

important intervention in nursing homes was an abundance of PPE. As a clinician, I didn't care who took responsibility for the acquisition of PPE. **Without PPE, COVID-19 couldn't be stopped.**

The second element of the Quadruple Aim was readily available testing. It was clear early on that nursing home staff were a major vector for transmission of the virus.[7] Testing of all staff was critical to protecting both the residents and the staff themselves.[8] Telling nursing homes to come up with a plan for testing was never an appropriate policy. **The federal government should have used its clout and resources to assure that testing was performed and that labs prioritized the processing of the tests. The industry should have similarly supported testing by actions rather than words. Blame and excuses did not save lives. Testing would have.**

Stellar infection prevention was the third element of the Quadruple Aim. Many state and county departments of public health worked tirelessly to oversee and train nursing facilities to provide stellar infection control. Unfortunately, that approach was always going to be insufficient if the nursing home industry wasn't fully on board with embracing the role of individual facility infection preventionists (IPs) to their fullest extent. On March 13, CALTCM recommended to the California Department of Public Health (CDPH) that the Governor of California mandate that every nursing home be required to make their already designated infection preventionist full-time. In April we made a similar recommendation to CMS. We are thankful that CDPH ultimately made this recommendation part of every nursing home's mitigation plan and that California passed legislation to require every nursing home in the State to have a full-time infection preventionist.[9] We must, however, continue to do everything possible to support the role of the facility IP. Prior to this pandemic, CMS was actually in the process of reducing the requirements for IPs![10] COVID-19 dramatically demonstrated the shortsightedness of this plan. **Effectively impacting the operations of nursing homes requires a paradigm shift that begins with a focus on the improved delivery of clinical care. The requirement of a full-time IP is a step in the right direction**.

The fourth and final element of our Quadruple Aim was that nursing homes must operate in their emergency preparedness mode. This is essentially a proxy for excellent leadership and management. If COVID-19 has shone a light on one thing, it's the inherent weaknesses in the management structure of nursing homes. Nursing homes are complex small businesses, delivering care to frail older adults with multiple chronic illnesses. They are literally mini-hospitals, but with far fewer resources. Nursing home administrators are not prepared to run a hospital and should not be expected to have the skills necessary to manage a facility during a pandemic. More importantly, running a "mini-hospital" should require the full engagement of physicians competent in the care of complex, frail, older adults. For the past 40 years, the American Board of Post-Acute and Long-Term Care Medicine (www.abplm.org) has provided a certification for nursing home medical directors. Only a fraction of medical directors in nursing homes around the state are certified or fully engaged with their facility leadership team. The negative impact of this has been amplified by COVID-19. **California passed a law in 2021 requiring all nursing home medical directors in the State to become certified by 2027**.[11] **Congress should consider establishing the same requirement nationwide.**

Whether in dealing with COVID-19, or trying to provide quality care in the future, it is essential that the clinical experts be actively involved in the day-to-day operations of nursing homes. Medical directors must also be allowed to perform their duties without undue influence from nursing home ownership. Many medical directors appear to be hired only because they can drive admissions to the facility and improve census. They often have no formal knowledge of geriatrics or long term care medicine, nor an understanding of the complex regulatory framework under which nursing homes operate. Early in the pandemic, one of my esteemed colleagues lost their medical director position to be replaced by a hospitalist. There should be no quid pro quo related to admissions, and **medical directors should be free to provide leadership regarding the delivery of care without fear of losing their position.**

Over the last several years, we have seen too many sham contracts for nursing home medical directors that remain hidden unless they are investigated. For these reasons, professional and stakeholder organizations across post-acute and long-term care have asked CMS to maintain a registry of medical directors at nursing homes across the country. I believe this would be an easy thing to implement, but citing difficulty in logistics, CMS has continued to deny these requests. It's time to change that and provide transparency and gravity to this important role. Imagine the impact of CMS having been able to reach out to all nursing home medical directors in the early months of the pandemic? The Nursing Home Disclosure Act has been introduced to create such a registry.[12] **I see no reason that CMS couldn't create one under their existing authority**.

I continue to believe that a significant number of the nursing home deaths brought on by this virus were preventable. If there is an overarching message from the COVID-19 Pandemic, it's the need to actively engage experts in geriatrics and long-term care medicine in the policy and decision-making processes that impact the lives of older adults. To the clinical experts this pandemic has never been about control, money or power. It's only been about saving lives. All of CALTCM's efforts during this pandemic have been through volunteerism on the part of our many dedicated clinicians, with literally thousands of hours of our time that have benefited long-term care residents statewide and beyond. AMDA, The Society For Post Acute and Long Term Care Medicine is also a small organization without significant resources. I would venture to say that AMDA, CALTCM and other AMDA state affiliates provided more effective scientifically based guidance and resources in 2020 than CMS and CDC combined.

Starting in early March 2020, CALTCM provided weekly free COVID-19 webinars on a variety of clinical and non-clinical topics relevant to long-term care, featuring numerous statewide and national experts and leaders.[13] On March 5, we proposed Leadership and Management Training for nursing homes across the state, with a specific focus on infection prevention. On March 25, CALTCM proposed the formation of a statewide support and guidance center to oversee the development of COVID-19 positive skilled nursing facilities. **We also shared our proposal with CMS in early April**. Our model could have provided the necessary incident command structure to help deliver best practice information to all nursing homes across every state, and in doing so relieve the pressures on nursing homes and hospitals battling the virus. On April 17, we posted a White Paper delineating this proposal.[14] We published a paper describing this approach in July 2020.[15] We were never given an opportunity to engage in a meaningful discussion of this proposal at either the state or federal level.

Another example of the lack of engagement with the experts in geriatrics and long-term care medicine was regarding testing. First, let me be absolutely clear. **The experts understood the role of asymptomatic spread in nursing homes by the end of March.** The CDC published a paper in the *New England Journal of Medicine* pointing this out.[16] No one from the prior Administration or the nursing home industry can reasonably and credibly say that by the end of March they were not aware of this fact. We were actively promoting widespread testing of nursing home and assisted living staff and residents by late March, 2020, when testing began to become readily available. In fact, in late March, the Chief Medical Officer of the Los Angeles Jewish Home, Dr. Noah Marco, was able to get 500 testing kits from the City of Los Angeles. We used them on staff and residents of our facility and shared the rest of them with another nursing home in dire need of testing in Los Angeles. We were able to demonstrate the already evidence-based impact of asymptomatic spread of the virus by nursing home staff and made a major push to get the Los Angeles County Department of Public Health to test all staff and residents of nursing homes in the County. Nevertheless, efforts to assure that testing happened in nursing homes across the state and country continued to founder. CALTCM convened an expert panel towards the end of April. **That panel produced testing recommendations that were published on May 31st in a peer reviewed journal.**[17] Prior to publication, we shared our recommendations with the California Department of Public Health, CMS and the CDC, and shortly thereafter most of our recommendations were finally codified by these entities. **To suggest that this guidance existed prior to June 2020 is to provide a revisionist history of the pandemic.**

Our struggle to assure the widespread testing of nursing home staff and residents was hampered by the fact that neither CMS nor the CDC developed actionable recommendations as to how to bring about this testing. Considering that the CDC understood the risk of asymptomatic spread of the infection in March, the fact that they never made testing in nursing homes, where the largest percentage of deaths occurred, their highest priority, made no sense. It is yet another example of how not engaging the experts in geriatrics and long term care medicine led to a greater loss of lives.

To claim that CMS and the prior Administration provided optimal guidance during the early months of the pandemic is to completely ignore the facts. Some former government officials and nursing home industry representatives would have you believe that they were literally helpless in the face of COVID-19. Nursing home industry leaders bemoaned the lack of personal protective equipment (PPE) and testing. "We've been pleading for testing for months," they said. "No one knew about asymptomatic transmission of this virus." "Who could have known how deadly this virus would be for older adults living in nursing homes?" **The implication was that the industry was helpless in the face of this pandemic, and that the government was doing everything possible to help. For the most part, this is a false narrative, created by both the prior Administration and some in the nursing home industry to hide the fact that they both failed.** The quality of a nursing home does matter when it comes to the care delivered in that facility.[18,19] Inadequate staffing does matter in the face of battling a deadly virus.[20,21] However, if you go to battle without guns and body armor, the size of your army is irrelevant. Fighting COVID-19 without PPE was akin to trying to bring down missiles with a bow and arrow. In the very beginning, that being the first week or two of March, we didn't fully understand asymptomatic transmission. In the very beginning, we didn't fully

comprehend how this virus might spread through the air. That was true. But that was before the CDC set foot in Life Care of Kirkland in Washington. **Once they evaluated that tragic outbreak, they knew what was happening.**[22,23]

There are also those who continue to put forth inaccurate and out of context statements related to Dr. Anthony Fauci and mask recommendations. In a February 5th, 2020 email (five weeks before the WHO declared COVID-19 to be a global pandemic), Dr. Fauci stated, with the knowledge available to him at the time, "Masks are really for infected people to prevent them from spreading infection to people who are not infected rather than protecting uninfected people from acquiring infection. The typical mask you buy in the drug store is not really effective in keeping out virus, which is small enough to pass through the material. It might, however, provide some slight benefit in keeping out gross droplets if someone coughs or sneezes on you. I do not recommend that you wear a mask, particularly since you are going to a vey (sic) low risk location. Your instincts are correct, money is best spent on medical countermeasures such as diagnostics and vaccines."[24] A Forbes article noted that on March 8, 2020 'During an interview with *60 Minutes*—an interview Trump and his allies cite as an example of when the doctor was wrong—Fauci says "there's no reason to be walking around with a mask," though adds he's not "against masks," but worried about health care providers and sick people "needing them," and says masks can lead to "unintended consequences" such as people touching their face when they fiddle with their mask.'[25] By March 31st, Dr. Fauci's opinion had changed, again documented in the Forbes article, 'Fauci says he is in "very active discussion" with health officials about reversing guidance on mask use when the U.S. gets in a "situation" where it has a sufficient mask supply, and explains that experts were beginning to believe that Covid-19 spreads in the air among asymptomatic people who do not cough or sneeze.'[26,27,28] Ironically, Dr. Robert Kadlec, Assistant Secretary of Preparedness and Response, began developing a plan in February of 2020 to provide masks for every American.[29] His plan was never carried out by the Administration, missing a golden messaging opportunity for the American people. The context is essential in truly understanding the herculean efforts made by Dr. Fauci.

What happened at the nursing home in Kirkland, Washington was inevitable. Worldwide ageism had literally obfuscated the fact that COVID-19 was laying waste to nursing homes around the world. No one really cared. By the middle of March, however, we knew. The stories from Spain and Italy were coming out. Our very own government experts had thoroughly evaluated the Kirkland tragedy, all while wearing full Hazmat suits. It seems it was ok for them to protect themselves, but not the residents and staff of nursing homes across the country! **By the end of March, the lethal nature of this virus, and the ability for it to quickly spread within the confines of a nursing home or a church choir practice, were well known. Why the CDC and CMS didn't act on this information is something that deserves further investigation.**

There is no question or doubt. Without abundant PPE, the battle against COVID-19 in nursing homes was lost. The experts have never disagreed with that assessment. Without PPE, the quality of the facility is irrelevant. That is the main case where quality doesn't matter. Once you supply abundant PPE, the story changes. Once you assure that nursing staff wear masks all the time and have the necessary equipment to significantly reduce their own accidental transmission of the virus, the results start changing. We know from initial surveys of nursing homes around the country, that many were caught without adequate PPE. In early March, in fact, many

facilities, out of fear of running out of PPE, minimized its use. **CMS, with their guidance, focused more on preserving PPE than it made efforts to assure adequate PPE in every nursing home**. Little mention was made of testing, and even **in the first months of the pandemic, the need to do widespread testing of staff was minimized**, except in the context of "opening up."

To fully respond to statements that suggest the previous Administration did everything in its power to protect nursing homes residents, **it's instructive to review the Press Release's that came out of CMS**. On Feb 06, 2020, in the Press Release entitled "CMS Prepares Nation's Healthcare Facilities for Coronavirus Threat," Administrator Seema Verma stated, "We are working diligently to ensure surveyors and health care providers across the country understand and comply with critically important guidelines that are designed to stop the spread of infectious diseases and keep patients free from harm," in regard to the nations nursing homes.[30] The reality was that **CMS focused from the beginning on doing the same things that they'd done for years**. **There was no actual change in strategy or recognition that this strategy wouldn't work**.

On March 04, 2020, in "CMS Announces Actions to Address Spread of Coronavirus," it was stated that "CMS is issuing a call to action to health care providers across the country to ensure they are implementing their infection control procedures, which they are required to maintain at all times."[31] **CMS chose to focus the existing flawed inspection system on infection control procedures, despite the fact that even five star facilities were known to have infection control lapses**.[32] **What was needed was an effective approach to changing behavior in nursing homes throughout the country**. No effort to bring about such change was forthcoming. Nursing home residents were soon dying from COVID-19 across the United States. And, not just in New York.

The same press release went on to refer to the following guidance, "The decision to discharge a patient from the hospital should be made based on the clinical condition of the patient. If Transmission-Based Precautions must be continued in the subsequent setting, the receiving facility must be able to implement all recommended infection prevention and control recommendations."[33] **This guidance firmly placed decision making in the hands of unprepared facilities, if not in the hands of state and local public health officials, all of whom had little understanding of nursing homes, nor of a growing global pandemic**.

The March 09, 2020, press release, "CMS Issues Clear, Actionable Guidance to Providers about COVID-19 Virus," focused on "screening, treatment and transfer procedures healthcare workers must follow."[34] CMS Administrator Seema Verma was clearly focused on optics, rather than bringing about sustainable and implementable change to nursing homes in the face of the building tragedy, with the statement that "CMS is laser focused on protecting patients, no matter where they are receiving care. We are receiving up-to-the minute information about COVID-19 and are in turn, making necessary updates to our requirements and sharing that information with our providers throughout the healthcare system. America's patients and providers should rest secure knowing that we are taking aggressive precautions to safeguard your health."[35] **All the CMS guidance at this point was focused on what nursing homes "should" do, but didn't tell them what they must do, losing weeks and months in relation to getting facilities to actually**

bring about effective change. CMS also continued to say that **"A nursing home can accept a resident diagnosed with COVID-19 and still under Transmission-Based Precautions for COVID-19 as long as the facility can follow CDC guidance for Transmission-Based Precautions**."[36]

On March 13, 2020, in "CMS Announces New Measures to Protect Nursing Home Residents from COVID-19," the Administration continued to put out language that made it seem as they were doing something.[37] **In fact, the nursing home admission guidelines continued to state that it was acceptable for a nursing home to accept a discharge from the hospital!** The primary focus was on directing "nursing homes to significantly restrict visitors and nonessential personnel, as well as restrict communal activities inside nursing homes."

"As we learn more about the Coronavirus from experts on the ground, we've learned that seniors with multiple conditions are at highest risk for infection and complications, so CMS is using every tool at our disposal to keep nursing homes free from infection," said CMS Administrator Seema Verma. "Temporarily restricting visitors and nonessential workers will help reduce the risk of Coronavirus spread in nursing homes, keeping residents safe. The Trump Administration is working around the clock to ensure the continued safety of America's health care system, particularly nursing homes."

By March 13, many nursing homes around the country were aware of the risk of COVID-19 and were already taking these precautions. Unfortunately, as these were not mandates, there were still facilities that didn't. There was also not clear direction not to take patients possibly infected with COVID-19 from hospitals.

Ironically, the CMS press release stated "There have already been reports of large numbers of cases of COVID-19 spreading quickly through nursing homes, such as the Life Care Center in Kirkland, Washington. The spread of COVID-19 in a nursing home can amplify or seed further spread to other facilities when patients are transferred and when staff and visitors come and go. According to CDC, visitors and health care personnel who are ill are the most likely source of introduction of COVID-19 into nursing homes, necessitating today's change in guidance to restrict visitors and personnel."[38] **Despite this statement, CMS did little to impact the fact that many nursing home staff would come to work ill, or would work multiple jobs.**

On March 23, 2020, with "CMS Announces Findings at Kirkland Nursing Home and New Targeted Plan for Healthcare Facility Inspections in light of COVID-19," CMS announced "an enhanced, focused inspection process, informed in part by the Agency's experiences on the ground in Kirkland, and close coordination and input from the Centers for Disease Control and Prevention (CDC). This focused inspection process will be provided to all inspectors and facilities, and used on a national scale. Critically, this focused inspection process includes a self-assessment tool for providers to employ."[39] **To those of us working on the front lines at the time, this was the height of ignorance, arrogance, and hypocrisy. Once again, the focus on inspections was just doing the same thing that CMS had done ineffectively for years.** They weren't doing anything to actually effect change in the operations of nursing homes across the country. A subsequent Los Angeles Times article pointed out how these inspections were not

only ineffective, but in many cases were followed by outbreaks at the facilities that had recently passed the inspections.[40]

Also, on March 23, 2020, "Kirkland, Washington Update and Survey Prioritization Fact Sheet," continued their totally tone deaf guidance. "Based on lessons learned from Kirkland and in response to frontline clinicians, CMS has developed a targeted, streamlined survey process. This new process is three-pronged. First, CMS will continue its responsiveness to Immediate Jeopardy; second, CMS will work with the Centers for Disease Control and Prevention (CDC) to identify areas at risk of COVID-19 spread to ensure providers are compliant with longstanding federal infection control requirements; third, CMS is rolling out a voluntary self-assessment tool so providers can review their own compliance with federal infection control requirements."

By March 23rd, CMS understood asymptomatic spread and should have understood the importance of testing of all staff and residents in nursing facilities across the country, yet did not put this into their guidance. Nor had they changed their guidance to prevent nursing homes from admitting patients who might be infected with the virus.

On Apr 02, 2020, "Trump Administration Issues Key Recommendations to Nursing Homes, State and Local Governments," in a continued pattern of literally fiddling while nursing homes across the country were burning, put out additional recommendations that did little to impact nursing homes.[41] Despite noting that "Nursing homes (also known as "skilled nursing facilities" under the Medicare program and "nursing facilities" under Medicaid; or "long-term care facilities") have become an accelerator for the virus because residents, who are generally vulnerable to complications from the virus, are even more so in an enclosed environment like a nursing home," CMS focused on their guidance "to restrict visitors, helping prevent introduction of the virus into these facilities," and implement, "new, focused infection control surveys."[42] For the first time CMS announced that "Medicare is now covering COVID-19 testing when furnished to eligible beneficiaries by certified laboratories." This was the first noting of testing by CMS in regard to nursing homes, but there were no recommendations regarding testing staff and residents other than to say that "CMS/CDC urges State and local leaders to consider the needs of long term care facilities with respect to supplies of PPE and COVID-19 tests." This was literally an unfunded non-mandate. **Urging state and local leaders to consider supplies of PPE and tests had no practical value during a global pandemic.**

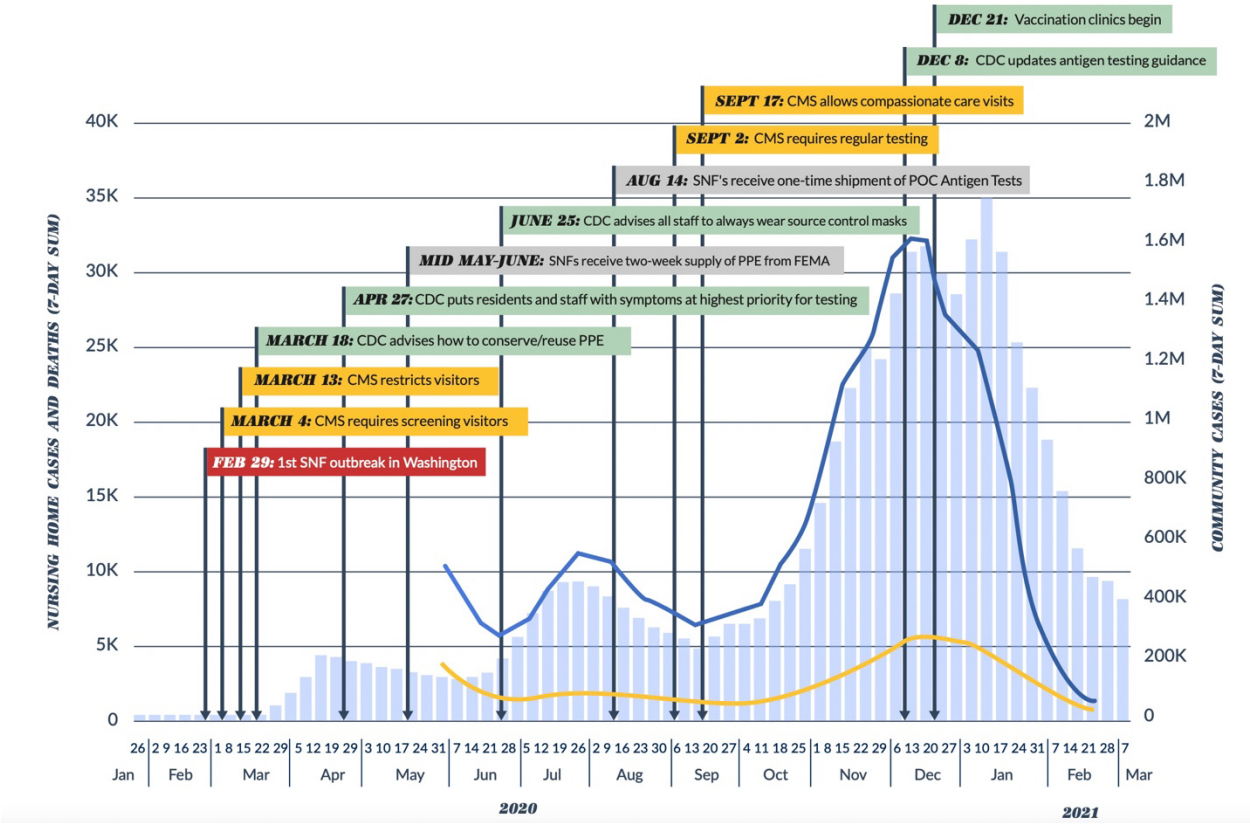
As a clinician observing what was happening on the front lines of nursing homes the additional guidance that "Nursing homes should ensure all staff are using appropriate PPE when they are interacting with patients and residents, to the extent PPE is available and per CDC guidance on conservation of PPE," was horrifying in the wake of CMS and CDC staff wearing hazmat suits during their inspections.

CMS also suggested that "To avoid transmission within nursing homes, facilities should use separate staffing teams for residents to the best of their ability, and, as President Trump announced at the White House today, the administration urges nursing homes to work with State and local leaders to designate separate facilities or units within a facility to separate COVID-19 negative residents from COVID-19 positive residents and individuals with unknown COVID-19 status." **I sent my proposal regarding COVID-19 positive facilities to CMS on April 8th.**

There was never any attempt to engage the experts in geriatrics and long term care medicine to actualize this recommendation.

On April 19, 2020, in "Trump Administration Announces New Nursing Homes COVID-19 Transparency Effort," "(CMS) announced new regulatory requirements that will require nursing homes to inform residents, their families and representatives of COVID-19 cases in their facilities."[43] This requirement did not do anything to acknowledge COVID-19 cases in nursing homes in February, March or April, missing an important opportunity to understand what had been going on for the previous three months. The remainder of this press release was simply focused on repeating previous actions and platitudes in the context of acting as if CMS and CDC were implementing effective interventions. Nursing home residents continued to die.

A timeline published by the American Healthcare Association (AHCA) corroborates the timeline that I've included in these comments.[44]



The excessive number of nursing home deaths at the beginning of the pandemic was not limited to New York and California. Any narrative that tries to focus on these states is absurd. In fact, looking at COVID-19 deaths in nursing homes per capita across all states is quite informative, with New York and California having less than half the nursing home death rates of Texas and Louisiana, for example. Nevertheless, we must take all deaths in all states seriously if we are to develop effective and implementable solutions in the future.

It is true that many Governors, lacking in guidance from the federal government, made poor decisions early in the pandemic. One example was an ill-advised California Department of Public Health (CDPH) mandate via AFL 20-32 issued on March 30, 2020, which stated, "SNFs shall not refuse to admit or readmit a resident based on their status as a suspected or confirmed COVID-19 case." In other words, even if a nursing home had no known or suspected cases of COVID-19, when a hospital deemed that a COVID patient was medically stable, the facility was obligated to accept the patient in transfer, no questions asked. Several other CALTCM leaders and I, along with other stakeholders including CAHF, CANHR and others, were unified in opposing this potentially deadly policy. Why on earth would a facility willingly introduce a highly contagious and deadly virus into its vulnerable population when they had no cases? Thankfully, although after the fact, CDPH walked that policy back a few days later in response to the stakeholder and media backlash. The key point is that if CDPH had engaged CALTCM and other geriatrics and long term care medicine experts before issuing such a mandate, it is improbable that it would have been issued in the first place, and then they would not have been in a position to have to reverse their policy**. It is unfortunate that this type of decision had to fall to the state and county public health officials, when the clinical staff at the CDC knew it was wrong.** One of the most frustrating aspects of the first several months of the pandemic was the mixed and often conflicting guidance frontline providers received from various governmental agencies. **That conflicting guidance started at the federal level (as I have already pointed out) and was a direct reflection of the lack of engagement with the clinical experts.**

Both the nursing home industry and resident advocates have long complained about the survey process. I believe that they are both right. It is time to develop an effective oversight and quality improvement process. The focus of surveys must be on improving the delivery of care and protecting the quality of life of the residents. In the Summer of 2020, CMS announced an enhanced approach to regulatory enforcement, or essentially stepping up the penalties to nursing homes. CALTCM and I strongly disagreed with this approach. We support active oversight but believe that it is critical for CMS and the state Departments of Public Health to engage the clinical experts, as well as resident advocates including the ombudsmen, in developing new and more effective processes for carrying out federally mandated surveys. CALTCM and AMDA convened two groups of experts to deliver recommendations regarding this process. The AMDA recommendations were published in December 2020.[45]

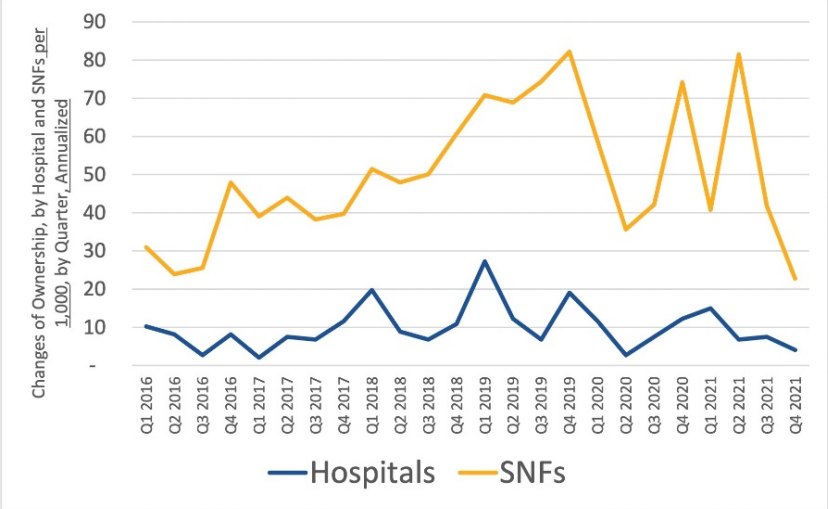
There is little disagreement regarding the fact that the financial structure of nursing homes is not conducive to maximizing scarce resources while providing quality care to residents. In my opinion, the separation of real estate, operations and management is a contrivance that leads to unmanageable pressures. The additional pressure from liability insurance costs compounds these pressures. If we are going to reform the nursing home industry, it is time to bring transparent change to the ownership maze and consolidate nursing home ownership so that the full focus can be on delivering care to the residents. I was co-author of a paper in February 2021 that made recommendations related to nursing home transparency.[46] Many of our recommendations became part of the President's Plan for nursing home reform.[47] Early in the pandemic I made a recommendation to help take the pressure off the nursing home operators during that challenging time. I suggested that nursing homes be exempted from paying rent and liability insurance premiums for a period of six months. The costs of this would have been borne by the real estate owners and the insurance companies. I believed that it was time for them to do their part while

we figured out how the nursing home industry could survive and come out stronger than it was before.

Fortunately, **there are immediate steps that the Administration can take in regard to transparency.** In 2010, as part of the Affordable Care Act (ACA), Congress passed legislation designed to address the lack of transparency in nursing home ownership. Section 6101 of the ACA was designed to address the complicated and opaque ownership structure of nursing homes by requiring detailed and public disclosure of owners, managers, and other parties involved in ownership and operation of a nursing home. The law required a detailed organizational structure of nursing homes. This information was required to be made available to the public. **More than 12 years after its passage, regulations have not been finalized and Section 6101 has not been implemented. During this period, nursing home residents' risk of harm has increased by some unscrupulous owners and operators.**

Ownership of SNFs has changed significantly in the last decade, as identified by the Assistant Secretary for Planning & Evaluation (ASPE) in a recent report[48]:

Figure 1. Changes of Ownership, by Hospital and SNFs per 1000, by Quarter (Annualized), 2016-2021



Increasingly, non-transparent, complex nursing home ownership structures and private equity investment firm ownership have fueled concerns about the safety and quality of care provided in nursing homes. For instance, recent studies and articles about private equity ownership of nursing homes have shown:

- Increases in short-term mortality of Medicare patients by 10%[49]
- Increases in care costs, emergency department visits, and hospitalizations[50]
- Higher rates of COVID diagnoses[51]
- Severe declines in direct care provided to residents.[52]

Ownership of nursing homes by private equity firms has been a focus of several studies, with data suggesting a higher risk to the health of nursing home residents. These disturbing findings make it essential that both the federal government and residents, their families, and other consumers have access to reliable information regarding who controls and manages a

facility's operations and finances. Current public nursing home ownership information displayed on Care Compare is vague, making it difficult, and in some cases impossible, to accurately identify which entities and individuals are exercising managerial, operational, and financial control.[53] **Often, complex legal structures are used to disguise who owns a nursing home and thus shield owners from public accountability and liability.**

Additionally, Section 6104 of the ACA, requiring the reporting of financial information, has not been implemented as directed by federal law. This key provision requires SNFs to report their expenditures in four categories: spending on direct care, indirect care, administrative expenses, and capital expenses – essential information for understanding how nursing homes are spending the tens of billions of dollars of taxpayer dollars they receive each year. It also confers a responsibility for CMS to examine these data to look for patterns of spending that are associated with higher and lower quality of care.

With enactment of Sections 6101 and 6104, Congress was mandating that CMS examine nursing home ownership and expenditure information. However, since these sections have not been implemented, it is unclear whether, or how, CMS is examining this information. What auditing is being done of ownership and financial data to assess their integrity and accuracy? Has there been any attempt to examine whether ownership trends (e.g., non-profit status, private equity ownership) are associated with higher or lower reported expenditures in these categories? As the nursing home industry proclaims the inadequacy of Medicaid rates, and its inability to provide quality care without additional resources, what other financial data are needed to assess the adequacy of resources and how they are spent?

In February 2022, President Biden announced a set of ambitious and historic nursing home reforms, one of which was the promulgation of unimplemented regulations from the ACA.[54] Twelve years after the ACA, we have even more data showing how who owns and operates a nursing home can be a matter of life and death for nursing home residents. **It is essential that CMS implement Sections 6101 and 6104 of the ACA to protect nursing home residents.**

I want to close by reiterating the fact that the California Association of Long Term Care Medicine and other experts in geriatrics across the country would relish the opportunity to assist in the future development of policy related to the health and wellbeing of frail older adults. This is what we've spent our lives training for. **Many of us were inconsolable as the federal government, the Departments of Public Health and many counties made decisions without the full input of the clinical experts during the first 3 months of this pandemic**. If wildfires were raging through the country, we would all expect the President to be standing next to a fire chief every day. COVID-19 has been a medical emergency that is particularly deadly to frail older adults. The President, Secretary of Health and Human Services, Director of CMS, Governors and Mayors should have been standing with the experts in geriatrics and long term care medicine on a daily basis. So should every governmental agency that impacts the lives of our most vulnerable citizens.

It is time to learn from the mistakes made in 2020 and subsequently, and to develop a structure that allows for the development of expert-driven policy. The government and industry must fully engage experts in geriatrics and post-acute and long-term care medicine to

protect our vulnerable elders as this pandemic continues to run its course. **We need the help of the Select Subcommittee in assuring that we are active participants in the policy and decision-making processes that impact the lives of older adults.** If clinical experts and specialists in post-acute and long-term care medicine had been fully engaged and heard from – such as serving on federal, state or local COVID19 task forces – from the start, many lives could have been saved. **The 169,291 more nursing home resident deaths that occurred in 2020 represent the tip of the iceberg. We cannot and should not accept these deaths**. We must do something to prevent further deaths in the future. Thank you for your attention to these critically important matters and your concern for our precious, vulnerable elders.

Respectfully submitted,

Michael R. Wasserman, MD, CMD

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