Framework for Nursing Home Reform Post COVID-19

California Advocates for Nursing Home Reform
Center for Medicare Advocacy
Justice in Aging
Long Term Care Community Coalition
Michigan Elder Justice Initiative
National Consumer Voice for Quality Long-Term Care

June 2021

FRAMEWORK for NURSING HOME REFORM POST COVID-19

Overview of Recommendations

California Advocates for Nursing Home Reform, Center for Medicare Advocacy, Justice in Aging, Long Term Care Community Coalition, Michigan Elder Justice Initiative, National Consumer Voice for Quality Long-Term Care

June 2021

To address the longstanding problems in the long-term care system, as well as those exposed by the COVID-19 pandemic, we provide a baseline framework with recommendations in six critical areas that need reform: (1) staffing and workforce; (2) regulation and enforcement; (3) ownership and management standards, transparency, and accountability for quality; (4) government payment systems, financial transparency, and accountability; (5) structural changes in the long-term care delivery system; and (6) nursing home redesign and rebuilding.

Areas for Congressional Action

Staffing and Workforce

- Ensure adequate staffing levels with requirements for minimum staffing standards, including Registered Nurse staffing 24-hours per day. (1.1)
- Provide living wages and benefits to recruit and retain nursing staff. (1.3)
- Require a full-time qualified Infection Preventionist in all facilities. (1.4)
- Increase required nurse aide training to a minimum of 150 hours and require enhanced training on infection control. (1.5)

Regulation and Enforcement

- Ensure that at least one family member or friend of the resident's choice be permitted to enter facilities and provide essential support for residents at all times during a public health emergency. (2.1.3)
- Increase the budget for survey and certification to permit increased survey frequency and more timely complaint investigations. (2.2.1)
- Amend Medicaid law to remove the provision that allows facilities to establish distinct part units. (2.2.4)
- Ban the use of mandatory pre-dispute arbitration agreements. (2.2.7)
- Request studies to identify and eliminate long-standing problems, including adverse events among Medicaid beneficiaries, efficacy of the Special Focus Facility program, and the characteristics of nursing homes most and least affected by COVID-19. (2.2.10)

Ownership and Management Standards, Transparency, and Accountability for Quality

- Improve ownership reporting to CMS to include all parent, management, and property companies and all related party entities. (3.1)

- Expand the authority of CMS to impose investigations and remedies across a corporation or organization when a pattern of poor care is identified. Require CMS to prepare an annual report on the quality of care in chains, assessing patterns in staffing, deficiencies, financial arrangements, and objective quality indicators. (3.2)
- Establish federal criteria for the purchase, change of ownership or management of any nursing home seeking Medicare and/or Medicaid certification. (3.3)
- Establish a centralized application unit for ownership and management evaluations and decisions including processes to work with state agencies, state attorneys general, and the Department of Justice. (3.5)

Government Payment Systems, Financial Transparency, and Accountability

- Prohibit nursing homes from engaging in related-party transactions for staffing, supplies, and/or services. (4.1)
- Incorporate a medical loss ratio on the combined administrative costs and profits of each nursing home, its related parties, and parent companies of 10 percent of net revenues per year. (4.3)
- Give CMS full access to IRS filings of all the entities involved in the ownership and operations of facilities as part of CMS audit oversight. (4.4)

Structural Changes in the Long-Term Care Delivery System

- Permanently reauthorize the Money Follows the Person program and give greater flexibility to design programs that will facilitate successful transitions. Provide greater support to individuals returning to the community. (5.1)
- Make HCBS a mandated service under Medicaid. (5.2)
- Establish certification standards and federal reporting requirements for residential care/assisted living facilities that accept Medicaid residents. (5.4)

Nursing Home Redesign and Rebuilding

- Revise Medicare and Medicaid payment policies to incentivize private rooms and bathrooms for all residents. Require renovations and new construction to include private rooms and bathrooms as a condition of federal or state financing support. (6.1)

Actions CMS Can Take Under Current Authority

Staffing and Workforce

- Require automatic and increasing penalties for repeated staffing deficiencies. (1.2)

Regulation and Enforcement

- Ensure survey and complaint investigations, as well as enforcement actions continue during a public health emergency. (2.1.1)
- Require facilities to maintain a 1-month supply of PPE for staff and residents. (2.1.2)
- Ensure surveyors and managers do not have conflicts of interest and do not provide consultation and training to facilities. (2.2.1)

- Restore per day civil money penalties as the default. Revise the process for determining scope and severity. (2.2.2)
- Develop specific criteria for states to use qualified temporary managers. (2.2.3)
- Give high priority and require minimum pre-established penalties for inappropriate discharges. (2.2.5)
- Expand and improve Care Compare by flagging nursing homes out of compliance with staffing requirements, adding staff turnover and retention measures, using Medicare claims-based information for quality measures, and expanding ownership information available. (2.2.6)
- Reinstate the 2016 regulations banning mandatory pre-dispute arbitration agreements. (2.2.7)
- Collect and publicly report nursing home data, including data on admissions, discharges, occupancy, deaths, and resident characteristics. (2.2.8)
- Establish greater coordination, cooperation and training with related federal and state entities and stakeholders. (2.2.11)

Ownership and Management Standards, Transparency, and Accountability for Quality

- Post to Care Compare facilities that are owned or operated by chains. (3.2)
- Establish an effective prior approval process and qualification criteria for changes in ownership or management. (3.4) Require that applications be reviewed and approved prior to any individual or entity being allowed to own or operate a facility. (3.6)

Government Payment Systems, Financial Transparency, and Accountability

- Amend Medicare cost reporting requirements to require nursing homes to provide an annual consolidated financial report of income from all sources. (4.2)
- Conduct a new rate-setting study of the time and skill levels needed to carry out all nursing activities that meet federal requirements for person-centered care. (4.5)
- Permit value-based purchasing only for facilities that have established a track record of meeting minimum standards including no findings of harm or immediate jeopardy in 3-years and only to support those who have implemented practices that exceed minimum standards for the benefit of residents. (4.6)

Structural Changes in the Long-Term Care Delivery System

- Require Medicaid coverage for HCBS for up to three months prior to the month of application. (5.3)

Nursing Home Redesign and Rebuilding

- Coordinate with leading experts and stakeholders to develop new standards for the design, renovation, and/or replacement of existing nursing homes and residential care facilities. (6.3) Standards for nursing home building designs should emphasize designs that reduce the spread of infection and enhance quality of care and quality of life. (6.4)

Framework for Nursing Home Reform Post COVID-19

The more than 1.2 million COVID-19 infections and 135,000 COVID-19 deaths of residents and staff in nursing homes[1], as well as the excess deaths resulting from isolation, neglect, and substandard care, were not inevitable. Inadequate staffing and failures to meet minimum safety standards, including basic infection control protocols, have long plagued the majority of U.S. nursing homes. As a result of longstanding failures by the states and federal government to effectively enforce minimum standards, the nursing home industry, which is increasingly operated by private equity firms, real estate investment trusts, private operators, and other for-profit entities with little knowledge about long-term care, is able to shortchange quality of care requirements. More robust federal and state enforcement and nursing home compliance with infection control and emergency preparedness regulations could have substantially reduced nursing home infections and deaths, and alleviated widespread, unnecessary suffering.

To address current and future waves of the pandemic, as well as the longstanding problems in the system which the pandemic exposed, our nation needs a framework for comprehensive nursing home reform. The purpose of this brief is to provide a baseline framework, with recommendations in **six critical areas that need reform: (1) staffing and workforce; (2) regulation and enforcement; (3) ownership and management standards, transparency, and accountability for quality; (4) government payment systems, financial transparency, and accountability; (5) structural changes in the long-term care delivery system; and (6) nursing home redesign and rebuilding.**

Recommendations

1. Staffing and Workforce

1.1 CMS must adopt numerical minimum staffing standards to meet the requirement for "sufficient" staffing in place since passage of the Nursing Home Reform Act of 1987. The minimum standards should be at least 0.75 RN hours per resident day (hprd), 0.55 LVN/LPN hprd, and 2.8 CNA hprd, for a total of at least 4.1 nursing hprd to meet the federal

[1] CMS COVID-19 Data. https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg/ [2] Centers for Medicare & Medicaid Services, Abt Associates Inc. *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes. Report to Congress: Phase II Final*. Volumes I–III. Baltimore, MD: CMS, 2001

requirements and adjusted upwards based on residents' needs.[2] [3] In addition, all nursing homes should be required to provide RN staffing on a 24-hour per day basis, rather than the 8 hours per day that is currently required. At the same time, Congress should eliminate nursing facilities' ability to waive the requirement that 24-hour licensed nursing services be provided in nursing homes; that waiver puts residents at risk for harm and poor care.

1.2 CMS must enforce existing staffing standards, which require facilities to have sufficient staff to meet the care, psychosocial, and dignity needs of the residents they admit. Research shows that staffing is the most important indicator of a facility's quality and safety. Nevertheless, insufficient staffing is a widespread and longstanding problem and almost every problem in nursing home care is traceable to staffing. To improve enforcement of minimum staffing standards, CMS should replace vague guidelines which classify staffing violations as "potential harm," "actual harm," or "immediate jeopardy," with automatic and increasing penalties for repeated staffing deficiencies. CMS must clarify that surveyors may base staffing deficiencies on resident care records as well as resident, family, and ombudsman documentation and interviews; surveyors are not required to personally and directly observe staffing violations in order to cite staffing deficiencies. Surveyors must be trained in investigative techniques. CMS should impose pre-established penalties for violations, including denial of payment for new admissions, until a facility achieves and sustains compliance with required staffing levels. CMS should consider imposing temporary management to achieve compliance.

1.3 Nursing homes must provide living wages and benefits to recruit and retain nursing staff. The minimum wages for nursing assistants should be raised by 15-20 percent per hour by 2022.[4] Benefits should include two weeks of paid sick leave, family leave, and health insurance to all staff. In addition, any nursing home with any infection outbreak should be required to pay hazard pay above regular wages in order to compensate for the risk to staff and ensure retention and recruitment of adequate staff during the outbreak. Any additional funding appropriated to nursing homes during an emergency must be used to support wages and benefits for care staff as well as other resident care costs, rather than to replace facilities' lost income or profits. In addition, nursing home employees should have a choice to organize a

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[2] Centers for Medicare & Medicaid Services, Abt Associates Inc. *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes. Report to Congress: Phase II Final*. Volumes I–III. Baltimore, MD: CMS, 2001

[3] Schnelle, J.F., Schroyer, L.D., Saraf, A.A., Simmons, S.F. Determining nurse aide staffing requirements to provide care based on resident workload: A discrete event simulation model. *JAMDA*. 2016; 17:970-977. In a follow-up to the 2001 Abt study, the authors found that if hours were adjusted for workload, 2.8 to 3.6 hprd of nurse aide care would be needed.

[4] Weller, C. Almeida, B., Cohen, M., and Stone, R. *Making care work pay.* LeadingAge LTSS Center at UMass Boston. (2020). Boston, MA. https://leadingage.org/sites/default/files/Making%20Care%20Work%20Pay%20Report.pdf

union and collectively bargain, free from management interference, and with penalties for violations.

1.4 CMS must establish regulations requiring each nursing home to have a full-time, qualified and trained infection preventionist whose only responsibility is infection prevention and ensuring that all staff consistently and correctly implement infection control protocols. The infection preventionist should be at least an RN with special infection control training.

1.5 Congress must increase minimum training requirements for certified nursing assistants to at least 150 hours and include enhanced training on infection control. The federal training requirement for nursing home assistants is 75 hours within four months of employment and passage of a state competency evaluation (including at least 16 hours of supervised practical or clinical training). Even 75 hours of training, established in 1987, is insufficient to protect the health and safety of residents. Because the federal standards are so low, a number of states require additional training for nursing assistants.[5] Yet even these standards are often lower than those required by states for manicurists, hairdressers, and others. Infection control violations have been widespread in part because nursing personnel and other staff were not familiar with and did not use standard infection control practices.[6] Staff need full training in care and in essential infection control practices.

2. Regulation and Enforcement

Persistent and widespread failures to enforce standards of care (on both the state and federal levels) have been widely documented over the years. The failure to hold nursing homes accountable for meeting the standards in the federal Nursing Home Reform Law exposed nursing home residents to the devastation that unfolded as COVID-19 swept through the country.

To address these issues, the first recommendations in this section (subsection I) focus on the need to ensure monitoring as identified by the lack of oversight during the COVID-19 pandemic. The recommendations that follow (subsection II) address some of the persistent deficiencies that have been exacerbated by both the COVID-19 pandemic and the regulatory retreat undertaken over the last several years.

2.1 To address the need for ongoing, meaningful monitoring and enforcement during a public health emergency as identified by lack of oversight during the COVID-19 pandemic:

[5] PHI National. Nurse assistant training hours by state. http://phinational.org/advocacy/nurse-aide-training-requirements-state-2016/

[6] Centers for Medicare & Medicaid Services. *CMS Announces Findings at Kirkland Nursing Home and New Targeted Plan for Healthcare Facility Inspections in light of COVID-19*. (March 23, 2020) [ONLINE] Accessed April 2020. https://www.cms.gov/newsroom/press-releases/cms-announces-findings-kirkland-nursing-home-and-new-targeted-plan-healthcare-facility-inspections

2.1.1 CMS must ensure that states carry out comprehensive survey activities, complaint investigations and enforcement activities regardless of the extent of the pandemic within a state or community. CMS must ensure that the state surveyors have access to the necessary personal protective equipment (PPE) and testing to carry out oversight responsibilities. CMS must also ensure full access of long-term care ombudsmen to residents.

2.1.2 CMS should issue penalties to facilities that fail to maintain a full complement of PPE for staff and residents for at least one month. In addition, CMS must ensure facilities have sufficient testing supplies and vaccines to test and offer vaccines to all residents and staff in accordance with CDC recommendations. CMS must impose pre-established penalties for non-compliance.

2.1.3 While requiring appropriate precautions to be put in place to prevent infections, CMS must require facilities to permit families to visit residents and must prevent facilities and local public health officers from limiting resident rights to access to family members. CMS must allow at all times at least one family member or friend to enter facilities and provide essential support and assistance for residents to prevent physical or psychosocial decline or distress. In addition, CMS should prohibit facilities from requiring visitors to sign releases of liability.

2.2. To address persistent deficiencies that have been exacerbated by both the pandemic and the efforts to roll back regulations over the last several years.

2.2.1 To address longstanding deficiencies in nursing home quality assurance and oversight, surveys and complaint investigations must be conducted in a frequency and fashion to ensure that the federal standards of care are achieved and sustained. All surveys must be as unpredictable in their timing as possible. Congress must increase the budget for greater federal and state regulatory oversight of nursing homes, including increasing survey frequency to at least one survey per facility every 6-12 months, more timely complaint investigations, and ensuring appropriate wages and benefits for state surveyors to attract and retain a highly qualified interdisciplinary surveyor and professional workforce. In addition, Congress and CMS must ensure that surveyors and managers not have conflicts of interest, including disallowing working in the nursing home industry for at least two years after leaving government service and being assigned to the same facility for consecutive surveys. State surveyors must continue to be prohibited from providing consultation and training for the nursing home industry or individual facilities. Survey agencies must increase the expertise of their managers and surveyors in geriatrics, pharmacy, chronic care management, dementia, mental health, disability management, and complaint investigation skills. Survey agencies and teams must consult with individuals with expertise and experience in law enforcement, infection control, financial auditing and accounting, and other disciplines useful for evaluating regulatory compliance.

2.2.2 CMS must restore per day civil money penalties as the default type of penalty. CMS must withdraw guidance issued by the Trump Administration that reduced enforcement actions for noncompliance. Part of the updated system must include a comprehensive revision of the process for determining scope and severity of deficiencies so that poor resident outcomes are actually identified and appropriately sanctioned. Specifically, CMS must impose penalties for non-compliance with staffing requirements, life safety, emergency preparedness, infection control requirements, quality of care standards, quality of life requirements, and residents' rights. Penalties for non-compliance must exceed the cost of compliance (to avoid penalties being viewed by facilities as the cost of doing business) and must be pre-established at a level sufficient to achieve prompt and sustained compliance and must include using the state's authority to place bans on all resident admissions until compliance is achieved and sustained.

2.2.3 CMS must develop specific criteria for states to use qualified temporary managers and require states to broadly implement the use of temporary managers to protect the safety of residents. CMS must establish procedures, including establishing a list of potential managers to draw from when necessary, ensuring that operators with a recent history of poor care (i.e., ownership interest in facilities with low staffing and/or violations identified as causing resident harm) are prohibited from operating facilities. Temporary managers must be highly qualified because the imposition of temporary management generally occurs when a facility is in distress.

2.2.4 To prevent discrimination against low-income persons who are Medicaid-eligible and who may be disproportionately racial minorities or other classes protected by civil rights statutes, Congress must explicitly prohibit discrimination against admission of persons who are eligible or will be eligible for Medicaid and amend federal law (42 U.S.C. Section 1396r(a)) to remove the provision that allows facilities to establish a distinct part unit for Medicaid. The law must require any certified nursing home to dually certify all beds for both Medicare and Medicaid reimbursement.

2.2.5 CMS must give a high priority to the investigation of inappropriate discharges and issue minimum pre-established penalties at a level that will ensure compliance. At the same time, CMS must impose an automatic ban on admissions for any facility that has been ordered by a state agency or administrative law judge to allow a resident to return but refuses to immediately comply with the order.

2.2.6 CMS must expand and improve its Care Compare website by flagging nursing homes that are out of compliance with staffing requirements, adding staff turnover and retention measures as required under the Affordable Care Act, using Medicare claims-based information rather than facility-reported data for quality measures, expanding ownership information, including parent company and related party names, and providing financial data. CMS must provide comparative data about penalties (as it does for deficiencies and staffing information) so that

users of the website will know if an enforcement action in the state is common or rare. CMS must identify facilities that are under Corporate Integrity Agreements with the HHS Office of Inspector General and must include information about how to contact the facility's Monitor under the Corporate Integrity Agreement.

2.2.7 CMS must reinstate the 2016 regulations that ban mandatory arbitration agreements that limit residents' ability to seek recourse in the courts in case of harm or death resulting from facility negligence or abuse or other violations of quality of care or quality of life standards.

2.2.8 CMS must collect and publicly report nursing home data on admissions, discharges, occupancy, involuntary discharges, resident deaths, and cause of deaths. Summary data on residents must be made public, including age, race, ethnicity, gender, primary language, medical condition, disability status, and acuity levels from its existing resident assessment data.

2.2.9 Congress must request studies to identify and eliminate longstanding problems, including: the incidence of adverse events among Medicaid beneficiaries in nursing homes; the efficacy of the Special Focus Facility Program; and the characteristics of nursing homes that were most affected by the COVID-19 pandemic, or did not report any COVID-19 cases among residents during outbreaks in their community.

2.2.10 Congress must request studies to identify policies in federal programs that have created structural or de facto barriers to equal access to quality of care for racial and ethnic minorities, including: federal and state policies that allow facilities to discriminate against persons seeking admission based on their race, ethnicity, religion, income, disability, source of payment, or geographic location; disparate and inequitable quality of care and treatment of minorities in facilities with a common owner or manager, including especially nursing homes that are predominantly one race; and changes in policy, including hospital discharge practices, Medicaid certification requirements and surveys, necessary to ensure equal access to nursing homes that provide quality care.

2.2.11 CMS and state agencies must establish greater coordination, cooperation, and training opportunities with related entities, including state attorneys general, district attorneys, county health departments, ombudsmen, consumer advocacy groups, elder justice coordinators, law enforcement, and federal agencies such as the Department of Justice and HHS Office for Civil Rights, to ensure appropriate enforcement and compliance using all available enforcement tools and mechanisms.

3. Transparency and Accountability for Nursing Home Ownership and Management

3.1 CMS must improve ownership reports and enforce the requirement that all nursing homes owned or operated by individuals, trustees, or corporations fully and accurately report owners and operators with 5 percent or greater ownership. The ownership report must include all parent, management, and property companies, and all other related party entities. Companies must be required to provide a complete organizational chart for each nursing home chain to CMS. This information must be made available to the public. Copies of lease arrangements and management agreements with unrelated parties must also be reported to CMS. Failure to provide complete and accurate data must result in pre-specified daily penalties until the information is provided.

3.2 CMS must redesign its regulatory and enforcement approach to focus on nursing home chains within and across states. CMS's Care Compare website must present information not only for individual facilities but also for all facilities within each chain organization and prepare an annual report on the quality of care in chains that assesses patterns in staffing, deficiencies, financial arrangements, and objective quality indicators. Congress must give CMS explicit statutory authority to impose remedies across a corporation or organization when a pattern of poor care is identified. When the government initiates an investigation of a facility that is part of a chain, it must also launch an investigation of the other facilities owned or operated by the company to determine whether there is a pattern of neglect and abuse and noncompliance that would trigger penalties against the company, including whether such facilities that have a predominantly minority population provide quality of care comparable to the chain's facilities that have a predominantly white population.

3.3 CMS must establish federal requirements specifying the minimum criteria for the purchase, change of ownership or management of any nursing home that seeks to participate in Medicare and/or Medicaid. The criteria must prevent individual or corporate owners from the purchase, operation, or management of another facility if they have a history of owning or operating facilities in any state with low staffing, poor quality care (such as having immediate jeopardy citations, multiple harm citations in any facility, disparate treatment of minority residents, and/or deficiencies that include violations of infection control, abuse and neglect, and substandard care). Companies with corporate settlements with state attorneys general or the HHS Inspector General for fraud or worthless services must be barred from purchasing or managing additional nursing homes until their Corporate Integrity Agreement conditions are completed.

3.4 CMS must establish an effective prior approval process and strong qualification criteria for changes in ownership or management to ensure that: 1) applicants have the expertise and experience to meet federal quality of care, life safety, and emergency service requirements to

safely operate a nursing home, 2) applicants meet minimum financial standards for the purchase of management of a nursing home including 12 months of financial reserves and appropriate insurance (i.e., a business bond in each state in which the entity owns or operates nursing homes), 3) ownership and management changes at every level of the corporation are reviewed, 4) applicants are in compliance with state and federal nondiscrimination statutes, and 5) the public has meaningful opportunities to have a voice in the approval decisions. As part of this ownership or management change process, a new application for license/certification or change of ownership or management must be made at least 120 days in advance of the proposed date of change along with a public and employee notice of a proposed change.

3.5 CMS must establish a centralized application unit for ownership and management evaluations and decisions including processes to work with state agencies, state attorneys general and the US Department of Justice. The unit must: 1) collect and analyze financial and quality data on licensee applicants (both within the state and in other states as necessary), 2) complete a comprehensive analysis of the suitability of the ownership and management changes with a seven-year look-back based on CMS criteria, and 3) provide meaningful opportunities for the public to have a voice in the change or ownership and management decisions. The evaluations must apply to all persons and entities that have a five percent or greater ownership interest including, but not limited to parent, property, and management companies, subsidiaries, and related-party companies.

3.6 No person, entity, or trustee should be allowed to operate or manage a long-term health care facility unless and until their application has been reviewed and approved. CMS must establish minimum per day penalties for any owner or operator that has not received prior approval for a licensee or a change of ownership and automatic denial of payments. CMS must prohibit the current practice of allowing individuals, partnerships, or companies with interim management agreements to take over control of facilities while change of ownership applications are pending and must give the state the authority to ban admissions at any facility that is operated or managed by an entity that is not licensed.

4. Government Payment, Financial Transparency, and Accountability

4.1 As a condition of federal certification, CMS must prohibit nursing homes from engaging in related-party transactions for staffing, supplies and/or services, including but not limited to management services. As a business practice, many nursing homes enter into contracts in which the same persons or entities are on both sides of the transaction. In general, these transactions disguise a nursing home's true profitability, since an expense to the facility also is income to the related party on the other side of the transaction. CMS must prohibit nursing homes from conducting related-party transactions.

4.2 CMS Medicare cost report requirements must be amended to require each Medicare-certified nursing home to provide an annual consolidated financial report of income from all sources, including data from operating entities (license holders) and all organizations and entities related by common ownership or control. As discussed above, related-party transactions must be prohibited. But, if those transactions continue to be allowed, it will be vital to require inclusive cost reporting.

Each nursing home must be required to submit an annual audited consolidated financial report prepared by a certified public accounting firm within six months of the end of each fiscal year. The annual financial audit report must be prepared using Generally Accepted Accounting Principles (GAAP) as well as the Financial Accounting Standards Board's (FASB) financial reporting requirements. Statements must be prepared using the accrual basis and must include an income statement, a balance sheet, statement of changes in equity, and a cash flow statement.

Cost reports must include a detailed flowchart outlining the entire organization's corporate structure, incorporating all related-party entities as well as unrelated management and property companies. Required metrics for general oversight must incorporate bed days, case-mix scores by day, unit and payer, and nursing hours provided defined by nursing class (RN, LPN, CNA, and nursing administration) and further refined by total hours paid, as well as by productive hours.

4.3 A medical loss ratio ceiling must be placed on the combined administrative costs and profits of each nursing home, its related parties (if allowed), and parent companies of 10 percent of net revenues per year. This combined maximum would be on all net revenues regardless of funding source, including Medicare and Medicaid. Expenditures over the ceiling would be forfeited proportionately to the payers at the end of each year. Financial controls must also limit expenditures for capital costs, leases, and management fees. Rate-setting should be based on legitimate costs with reasonable profits.

4.4 CMS must create a system for conducting annual joint Medicare and Medicaid audits, including home office and related party payer audits, in order to administer the medical loss ratio ceiling for administrative costs and profits. As part of the audit oversight, CMS must be given full access to IRS filings of all the entities involved in the nursing home operation.

4.5 To establish appropriate Medicare and Medicaid rates, CMS must conduct a new rate-setting study of the time and skill levels needed to carry out all nursing activities that meet federal requirements for person-centered care (using a combination of observations and simulation models based on high-performing nursing homes). The study should determine the time required for RNs, LPNs, and CNAs to perform both direct and indirect care in a respectful and dignified manner, including tasks to assess, plan, manage, supervise and provide individualized, person-centered care for residents with different acuity levels, and required nurse administrative and supervision time.

4.6 Value-based purchasing programs should only be available to facilities that have an established track record of meeting minimum standards, including no findings of harm or

immediate jeopardy deficiencies in the last three years, and only to support those who have implemented practices that exceed minimum standards for the benefit of residents, e.g. facilities that provide more than 4.1 hours of care per resident per day and have at least one RN on duty 24 hours a day.

5. Structural Changes in the Delivery System

As recognized by the Supreme Court in its 1999 *Olmstead* decision, the over-reliance on nursing homes for long-term care services and supports is a disservice to the public and, in fact, illegal. *Olmstead* established that the unjustified institutional isolation of people with disabilities is a form of discrimination under Title II of the Americans with Disabilities Act (ADA) of 1990. Though states have been required for over 20 years to implement *Olmstead's* holding that individuals cannot be unnecessarily institutionalized, states have largely been lax in executing plans. The following recommendations speak largely to the need to realize the Supreme Court's holding and greatly improve access to non-institutional care options.

5.1 Congress and the Biden Administration must make an immediate renewed effort to expand and improve the Medicaid Money Follows the Person program to facilitate moving nursing home residents to less restrictive settings when appropriate. Congress must permanently reauthorize the programs and give greater flexibility to design programs that will facilitate successful transitions to appropriate living arrangements. Greater support must be provided to individuals returning to the community by, e.g., assigning a team to support a resident throughout the transition process, and creating paid peer mentoring programs or support groups. Individuals who wish to transition should receive priority access to low-income housing.

5.2 Congress should pass legislation to require that Medicaid guarantee access to home and community-based services (HCBS) programs as an alternative to nursing home care. The federal government and states should work cooperatively to plan and provide access to housing and quality services for low-income individuals with disabilities with the goal of eliminating waiting lists in states and facilitating greater integration between HCBS and basic health and medical services. Low-income individuals with disabilities should be given the highest priority access to low-income housing to avoid inappropriate nursing home use.

5.3 Medicaid policies should be changed to require Medicaid coverage for HCBS for up to three months prior to the month of application. CMS policies should allow payment for HCBS services before a service plan is finalized to make policies comparable to those for nursing homes.

5.4 Congress and CMS should establish certification standards and federal reporting requirements for residential care/assisted living facilities that accept Medicaid residents. Standards should require access for beneficiaries without regard for their race, ethnicity, sexual orientation, gender, or disability. Individuals deserve to receive the same quality of care and services as that which is required for Medicaid beneficiaries in nursing homes and other

settings. Requiring that states conduct annual surveys and complaint investigations of these facilities, with a multi-disciplinary survey team, is essential to safeguarding residents and the integrity of the public funds paying for their care. In addition, both states and CMS should be required to post robust public information on these facilities, including the results of surveys, plans of correction (if imposed), staffing, ownership, and other information collected by the state or federal government.

6. Downsizing, Redesigning, and Rebuilding Nursing Homes

6.1 Priority must be placed on providing private rooms and bathrooms for all residents. The federal government should revise Medicare and Medicaid regulations and payment policies to incentivize private rooms and bathrooms for all residents. Require that renovations to current long-term care facilities and new construction must include private rooms and bathrooms as a condition of federal or state financing support for building or renovations. Financing support should favor funding of locally owned and operated non-profit and government facilities (rather than financing for investor-owned for-profit nursing homes). Providers should be required to show the need for the buildings in the communities that they propose serving and demonstrate how the project will ensure nondiscrimination and promote equal access and quality for minority group members.

6.2 In coordination with planning to improve access to HCBS services, states should assess the population needs for long-term services and supports and control the licensing of long-term care facilities and certificate of need programs. Equal access to appropriate, quality services, including services for racial and ethnic minorities, must be ensured and increased attention paid to access to services in rural, inner-city, and low-income areas.

6.3 In coordination with leading experts and stakeholders, the federal government should develop new standards for the design, renovation, and/or replacement of existing nursing homes and residential care facilities to protect the health and safety of residents and promote quality of care, quality of life, and equitable access to quality care. The new standards should update standards to protect residents during earthquakes, hurricanes, fires, storms, power outages, infectious disease outbreaks, and other disasters.

6.4 Standards for nursing home building designs should emphasize designs that reduce the spread of infection and that enhance quality of care and quality of life. Design standards should include, but not be limited to clusters of 8-12 single rooms, and configurations with adequate common space that appear homelike and residential. Residents must be able to bring personal furniture and display meaningful objects. Buildings should have adequate natural light, easily accessible outdoor spaces, pathways for walking and places for private family/group events. The locations of facilities should be accessible and well-integrated into local communities. Plans should also take into account the physical, clinical, and psychosocial needs of residents as well as the work environment for caregivers, and the social environment for family members, friends and caregivers. These up-to-date structures should capitalize on advances in information technology to aid and assist caregiving and prevent isolation for

residents as well as protect the health and safety of residents and caregivers. All new buildings and any renovations affecting 25% or more of a facility's space and/or monetary value should be required to meet these design requirements.