

The National Academies of Sciences (NAS) has established a new Nursing Home Committee to “examine how our nation delivers, finances, regulates, and measures the quality of nursing home care with particular emphasis on challenges that have arisen in light of the COVID-19 pandemic.”¹ NAS identifies “significant challenges” remaining since the 1986 report by the Institute of Medicine (IoM), NAS, *Improving the Quality of Care in Nursing Homes*. Among other issues, the new Committee intends to consider

the impact of current oversight and regulatory structures (including enforcement and penalties) on care quality and outcomes, which may include examination of: the meaningfulness of the current five star rating system and how it is interpreted by consumers and clinicians; and /or the validity, efficiency, and effectiveness of the current survey and certification structures and methods, including inspection standards, training of surveyors, and their adherence to standards.

Recommendations of the Center for Medicare Advocacy, California Advocates for Nursing Home Reform, and the Michigan Elder Justice Initiative

The COVID-19 pandemic has brought to public attention longstanding problems in nursing homes, chiefly related to nurse staffing, and has highlighted the negative results of changes in the nursing home industry since the IoM’s 1986 report *Improving the Quality of Care in Nursing Homes*. However, these issues do not require a fundamental rethinking of the 1987 Nursing Home Reform Law. The Law was based, in large part, on the IoM report’s findings and recommendations, supplemented by multiple Congressional hearings and the Campaign for Quality Care (a resident advocacy-initiated effort, which included all organizations interested in nursing home care and reviewed the IoM’s 1986 recommendations in order to ensure that their recommendations and best state practices were incorporated into federal law).

The Center for Medicare Advocacy, joined by California Advocates for Nursing Home Reform and the Michigan Elder Justice Initiative, urge the Nursing Home Committee to focus its work on three issues – nurse staffing (levels, competencies, training, salaries and benefits, and working conditions) and two issues that the pandemic has dramatically brought to public view: the lack of rules governing how facilities spend their Medicare and Medicaid reimbursement, allowing facilities to raid public funding for private gain; and the virtual abdication by states and the federal government of any responsibility for determining and controlling who is eligible to own and manage nursing facilities, allowing private equity firms, real estate investment trusts, and private owners who are interested only in profits and self-dealing to buy, sell, and operate facilities and businesses with impunity.

The framework of the Nursing Home Reform Law remains sound.

The Reform Law’s framework addresses the standards of care that facilities voluntarily choose to meet in order to be eligible for reimbursement from the Medicare or Medicaid programs, or both;

¹ National Academies of Sciences, Engineering, and Medicine, “The Quality of Care in Nursing Homes” (Project Information), <https://www8.nationalacademies.org/pa/projectview.aspx?key=52176>

the public survey process to determine whether facilities comply with those standards; and the enforcement system's collection of penalties that may, and, in some instances, must be imposed for violations of care standards and the process for imposing them. This framework and its implementation, through detailed regulations and informal guidance, remain fundamentally sound.

The ongoing validity of the current standards of care is underscored by the comprehensive evaluation of the Requirements of Participation undertaken by the Obama Administration, which looked back at 25 years' experience with the standards. After several years' study, followed by notice and comment rulemaking, the Administration published final regulations in October 2016. These rules implemented the vast majority of the Requirements immediately (that is, within 30 days) because the Requirements were either identical to the existing regulations or so similar to existing regulations and surveyor guidance that no delay in implementation was needed. To be sure, there were some significant improvements in the 2016 Requirements, including the requirement that nursing facilities develop and implement a baseline care plan within 48 hours of a resident's admission (to ensure that a facility completes and implements a sufficient assessment and care plan promptly so that staff can provide appropriate care before a more comprehensive care plan is completed several weeks after admission), and the requirement for a new position of infection preventionist (to be responsible for full implementation of a facility's infection prevention and control program). Largely, however, the Administration's lengthy and careful analysis found that the standards of care developed in 1992 remained the right standards to use and enforce going forward.

An unannounced survey, conducted on a 9-15 month cycle, provides a comprehensive baseline evaluation, supplemented and complemented by complaint surveys at unpredictable times to respond promptly to new or emerging problems. The Reform Law requires surveyors to be trained and competent before conducting surveys. The survey portion was the least controversial part of the Reform Law.

Imposing penalties for noncompliance is the third essential component of the Reform Law, but the least enforced part, largely because of industry opposition. It makes little sense to have meaningful standards of care and to conduct surveys to determine compliance with those standards, but then to ignore deficiencies that surveyors identify and the Centers for Medicare & Medicaid Services cites. That state of affairs is largely where we are today, when most deficiencies lead to no consequence whatsoever, as the Government Accountability Office found in its May 2020 analysis of infection control deficiencies from 2013-2017.² The GAO reported that 82 percent of facilities had been cited at least once with infection control deficiencies in the five-year period 2013 through 2017, with 48 percent of facilities cited in multiple years. However, for more than 99 percent of the deficiencies, there was no financial penalty at all. We see, in the pandemic, the consequences of ignoring infection control practices and deficiencies.

The Committee should endorse the Nursing Home Reform Law and support reversal of actions and policies undertaken by the Trump Administration to weaken and dismantle the enforcement system.³

² *Infection Control Deficiencies Were Widespread and Persistent in Nursing Homes Prior to COVID-19 Pandemic*, GAO-20-576R (May 20, 2020), <https://www.gao.gov/assets/710/707069.pdf>

³ See Toby S. Edelman, "Deregulating Nursing Homes," *Bifocal*, Vol. 39, No. 3, p. 31 (Jan.-Feb. 2018), [final-bifocal_39_3.pdf \(americanbar.org\)](https://www.americanbar.org/files/other_publications/special/bifocal_articles/2018/01_2018_03_31_edelman_deregulating_nursing_homes.pdf); testimony of Toby S. Edelman at Hearing before House Ways and Means Committee, Subcommittee on Health, "Examining the COVID-19 Nursing Home Crisis," (Jun. 25, 2020),

Staffing is the key issue where better standards are needed.

For decades, the understaffing of nursing facilities has been documented and decried. The four-volume study prepared for the federal government (mandated by the Reform Law as a compromise, when Congress declined to enact staffing ratios in the Reform Law) documented that more than 90 percent of facilities failed to provide sufficient nursing care either to prevent avoidable harm or to meet the requirements for care mandated by the Reform Law.⁴ Staffing levels have not significantly changed in the two decades since the report was written, despite the increasing frailty and acuity of residents.

The coronavirus pandemic has only highlighted the dire consequences of inadequately staffing nursing facilities. Study after study documents that facilities without sufficient nursing staff have both more cases of COVID-19 and more deaths from the virus.⁵ For example, a study of all 215 Connecticut nursing facilities documented that 20 additional minutes of registered nurse time per resident per day was correlated with 22% fewer COVID-19 cases and 26% fewer COVID-19 deaths.⁶

The direct care workforce also needs to be strengthened. Paraprofessional workers need a living wage⁷ and comprehensive benefits, including paid sick leave.⁸ The virus has been spread to residents and staff by infected but asymptomatic workers working in multiple facilities, often because they earn such low wages, minimum wage or just above minimum wage, that they need multiple jobs to try to make ends meet and pay their bills. They frequently lack health insurance and paid sick leave, leading them to work when sick.

The Committee needs to call for meaningful nurse staffing ratios at all levels and for improved salaries, benefits, and working conditions for the paraprofessional workforce.

https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/Toby%20Edelman_Tesimony.pdf

⁴ CMS, *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios* (2001)

⁵ Multiple studies cited in CMA, “Studies Find Higher Nurse Staffing Levels in Nursing Facilities Are Correlated With Better Containment of COVID-19” (CMA Alert, Aug. 13, 2020),

<https://medicareadvocacy.org/studies-find-higher-nurse-staffing-levels-in-nursing-facilities-are-correlated-with-better-containment-of-covid-19/>. See also Jose F. Figueroa, Rishi K. Wadhwa, Irene Papanicolas, et al,

“Association of Nursing Home Ratings on Health Inspections, Quality of Care, and Nurse Staffing With COVID-19 Cases,” *JAMA Network* (Aug. 10, 2020), [Association of Nursing Home Ratings on Health Inspections, Quality of Care, and Nurse Staffing With COVID-19 Cases | Geriatrics | JAMA | JAMA Network](https://jamanetwork.com/jama-network/full/2020/08/10/association-of-nursing-home-ratings-on-health-inspections-quality-of-care-and-nurse-staffing-with-covid-19-cases).

⁶ Yue Li, H Temkin-Greener, S Gao, X. Cai, “COVID-19 infections and deaths among Connecticut nursing home residents: facility correlates,” *Journal of American Geriatrics Society* (2020),

<https://onlinelibrary.wiley.com/doi/epdf/10.1111/jgs.16689>

⁷ LeadingAge recently released a report finding that paying a living wage to the direct care workforce could pay for itself, just by improving care for residents. *Making Care Work Pay: How Paying at Least a Living Wage to Direct Care Workers Could Benefit Care Recipients, Workers, and Communities*,

https://leadingage.org/sites/default/files/Making%20Care%20Work%20Pay%20Report.pdf?_ga=2.118488393.1154178586.1601481977-1021098696.1598989890

⁸ PHI, *Caring for the Future: The Power and Potential of America’s Direct Care Workforce* (Jan. 12, 2021), reached through a link at [Caring for the Future: The Power and Potential of America’s Direct Care Workforce - PHI \(phination.org\)](https://phination.org/caring-for-the-future-the-power-and-potential-of-americas-direct-care-workforce).

Federal laws must prohibit or at least restrict/reduce provider self-dealing.

Jordan Rau of Kaiser Health News reported in *The New York Times* three years ago that nearly three-quarters of all nursing facilities in the country buy goods and services, such as therapy services, management services, medications, and rent, often at inflated prices, from companies that they own and control.⁹ The result of these related party transactions is that facilities are able to hide profits as the cost of doing business. Rau described two New York owners whose family trusts took \$40 million of the \$145 million that their facilities received as reimbursement over an eight-year period – a 28 percent profit margin. Rau reported Kaiser Health News’s analysis that found facilities engaging in these practices have fewer nurses and aides to provide care to residents, “higher rates of patient injuries and unsafe practices,” and twice as many complaints as other facilities.

Just last month, Debbie Cenziper and colleagues at the *Washington Post* documented the self-dealing of California’s largest nursing home operator, Brius Healthcare Services, whose nursing facilities paid \$103 million to related companies in 2018 for supplies, administrative services and financial consulting, and rent, among other services.¹⁰ Care at many Brius facilities was so poor that, in 2014, then-Attorney General Kamala Harris took an unprecedented step of filing an emergency motion in bankruptcy court in an effort to prevent the court from giving Brius additional facilities. Harris’s motion called the company a “serial violator of rules within the skilled nursing industry.”

The *Naples Daily News* reported in 2018 that Consulate Health Care, the largest nursing home operator in Florida and sixth largest operator in the country (with 210 facilities and 22,059 beds in 21 states), founded in 2006 and owned by the Atlanta-based private equity firm Formation Capital, designed its facilities “to appear cash-strapped.”¹¹ The article described the chain’s individual facilities as “essentially empty shells, they pay rent, management and rehabilitation service fees to Consulate or Formation Capital-affiliated companies.” One Consulate facility paid \$467,022 in management fees and \$294,564 in rent to two companies owned by Consulate and Formation Capital. Forty-eight of Consulate’s 77 Florida nursing facilities had one or two stars, the lowest ratings, on the federal website *Nursing Home Compare*. In “an unprecedented action” in January 2018, the state threatened to close 53 of the corporation’s 77 Florida facilities under a state law that authorizes revocation of state licenses for serious violations at facilities under common ownership.¹²

⁹ Jordan Rau, “Care Suffers as More Nursing Homes Feed Money Into Corporate Webs,” *The New York Times* (Jan. 2, 2018), <https://www.nytimes.com/2018/01/02/business/nursing-homes-care-corporate.html?searchResultPosition=9>

¹⁰ Debbie Cenziper, “Profit and Pain: How California’s largest nursing home chain amassed millions as scrutiny mounted,” *Washington Post* (Dec. 31, 2020), <https://www.washingtonpost.com/business/2020/12/31/brius-nursing-home>

¹¹ Ryan Mills and Melanie Payne, “Neglected: Florida’s largest nursing home owner represents trend toward corporate control,” *Naples Daily News* (May 31, 2018), <https://www.naplesnews.com/story/news/special-reports/2018/05/31/floridas-largest-nursing-home-owner-part-growing-national-trend/581511002/>

¹² Ryan Mills and Melanie Payne, “Neglected: Florida’s largest nursing home chain survives despite legacy of poor patient care,” *Naples Daily News* (May 31, 2018), <https://www.naplesnews.com/story/news/special-reports/2018/05/31/neglected-fraud-and-abuse-nursing-homes-florida/542609002/>

More than 25 years ago, in 1994, Jon Robertson formed Phoenix Health Group and acquired nursing facilities in California. The *Los Angeles Times* reported in 1997, “As the money began to roll in from Medicare and Medi-Cal payments to the more than 300 residents at the facilities, Robertson, who had long displayed a fondness for life’s pricier pleasures – from Harley-Davidson motorcycles to diamond rings – began to spend conspicuously.”¹⁸ In 1996, Robertson checked into a rehabilitation center in Phoenix to deal with a cocaine addiction. Robertson also “served prison time and owed \$150,000 in restitution to the IRS for filing a false tax return as president of another nursing home management company.”¹⁹ Robertson’s California facilities provided poor care for residents and were cited with numerous deficiencies. The company filed for bankruptcy and abruptly closed its facilities.

Despite this record and sometime after his drug rehabilitation and prison sentence, Robertson formed a new company, Utah-based Deseret Health Group. Multiple states gave Robertson’s new company licenses and the federal government certified the facilities for Medicare and Medicaid reimbursement. In early May 2015, Robertson repeated his pattern from California. Deseret abruptly stopped paying for food, medical supplies, and workers’ wages and benefits in at least seven nursing facilities owned by the company in Kansas, Minnesota, Nebraska, and Wyoming. States pursued court receiverships or otherwise took control of the facilities to protect residents and ensure they received food and medications.²⁰

More recently, New Jersey-based Skyline Healthcare took over management of more than 100 facilities across the country in little more than year, beginning in late 2015. Almost as quickly as it acquired facilities, Skyline began to default, failing to pay vendors and staff. Again, states across the country were required to go to court to get receiverships in order to be able to pay vendors and staff and provide residents with food and medications.²¹

During the coronavirus pandemic, Portopiccolo Group, a private equity firm with a record of poor care (nearly 70 percent of Portopiccolo facilities have ratings of one or two (of five) on the federal website), short staffing, and coronavirus outbreaks, bought at least 22 nursing facilities, with “scant scrutiny” from state regulators in Maryland and Virginia.²² As in the facilities it already owned, Portopiccolo reduced operating expenses (reducing cleaning supplies and personal protective equipment) and reduced workers’ benefits. The results were, inevitably, poorer care for residents.

¹⁸ Eric Slater, “Entrepreneur Fades From View as Empire Collapses,” *Los Angeles Times* (Oct. 23, 1997), <https://www.latimes.com/archives/la-xpm-1997-oct-23-mn-45876-story.html>

¹⁹ The Associated Press, “Utah company facing bankruptcy; nursing home residents in limbo,” *The Salt Lake Tribune* (May 13, 2015)

²⁰ See, e.g., H.B. Lawson, “Nursing home faces closure,” *The Saratoga Sun* (May 6, 2015), [Nursing home faces closure - The Saratoga Sun](#)

²¹ Laura Strickler, Stephanie Gosk and Shelby Hanssen, “A nursing home chain grows too fast and collapses, and elderly and disabled residents pay the price,” NBC Nightly News (May 19, 2019), <https://www.nbcnews.com/health/aging/nursing-home-chain-grows-too-fast-collapses-elderly-disabled-residents-n1025381>

²² Rebecca Tan and Rachel Chason, “An investment firm snapped up nursing homes during the pandemic. Employees say care suffered,” *Washington Post* (Dec. 22, 2020), https://www.washingtonpost.com/local/portopiccolo-nursing-homes-maryland/2020/12/21/a1ffb2a6-292b-11eb-9b14-ad872157ebc9_story.html

The Committee must address the issue of nursing home ownership and management and call for the enactment and enforcement of appropriate standards for state licensure and federal certification.

Conclusion

Staffing is the critical factor that makes good care possible. Unless facilities have sufficient professional and paraprofessional staff and treat all staff well, care will not improve. Improving staffing is absolutely necessary, but it is not sufficient.

In addition, states and the federal government need to limit licensure and certification, respectively, to owners and managers that are knowledgeable about and demonstrate commitment and the financial capacity to provide high quality care to residents. Finally, public reimbursement must be spent on care for residents and not diverted to management fees, overhead, and excessive profits.

Many of these issues have been raised before.²³ The Committee now has the opportunity to dramatically improve care for residents and working conditions for workers by addressing these issues.

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Jan. 13, 2021

²³ “Buying and Selling Nursing Homes: Who’s Looking Out for the Residents?” (CMA Alert, May 23, 2018), <https://medicareadvocacy.org/buying-and-selling-nursing-homes-whos-looking-out-for-the-residents/>