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Joint Committee on Elder Affairs 6/30/21 Hearing:
S.413/H.733 An Act to improve employer standards for Massachusetts nursing homes

June 30, 2020

Senator Patricia Jehlen
Joint Committee on Elder Affairs, Chair
Delivered by email: Patricia.Jehlen@masenate.gov

Representative Thomas M. Stanley
Joint Committee on Elder Affairs, Chair
Delivered by email: Thomas.Stanley@mahouse.gov

Dear Chair Jehlen and Chair Stanley:

Dignity Alliance Massachusetts (Dignity Alliance) is providing this testimony in strong support of **S.413/H.733 An Act to improve employer standards for Massachusetts nursing homes** in order to improve the quality of care, dignity, and quality of life of Massachusetts nursing home residents. Dignity Alliance is a broad-based group representing a wide range of stakeholders dedicated to transformative change to ensure the dignity of older adults, people with disabilities, and caregivers. We are committed to advancing new ways of providing long-term services, support, living options, and care while respecting choice and self-determination. Dignity Alliance works through education, legislation, regulatory reform, and legal strategies for this mission to become reality throughout the Commonwealth.

Dignity Alliance is in strong support of S.413/H.733 which impacts three main areas: strengthening protocols for nursing home licensing and other transactions to prevent harmful owners from acquiring a nursing home; creating a workforce annual survey to give workers a strong voice on issues impacting their lives and the lives of nursing home residents; and ensuring that facility finances will be used foremost to provide the best quality of life possible for residents. We implore you to stand up for these necessary improvements for the well-being of the Commonwealth's nursing home residents and caregivers.

Section 1 – Licensure Procedure and Suitability Requirements for Long-Term Care Facilities (105 CMR 153): Application for License (105 CMR 153.006) & Other Licensure Requirements (105 CMR 153.007)

We strongly support strengthening the licensure procedures and suitability requirements for obtaining a new nursing home license, transferring nursing home ownership, or selling a nursing home. We also strongly support providing more transparent, timely and complete public access to such information, and enhancing the regulation of MA nursing homes. Improvements called for by this legislation are quite extensive and include:

a. **Enhanced character and competency review of all applicants;**
b. **Comprehensive review of current finances and operations of any skilled nursing facilities or other related businesses owned or controlled by applicant;**
c. **Initial prospective annual operating budget; and**
d. **Attestation concerning any anticipated changes to facility's workforce or working conditions.**
e. **Provisional licensure (subject to bi-annual review and revocation) for original applicants not currently doing business in MA. Stakeholders shall recommend provisions subject to approval and amendment by the Department of Public Health.**

In addition to the perils that nursing home residents face from quality of care issues, in recent years, many nursing home residents are also at risk of experiencing poor care because of fundamental problems in the management, ownership, or financing arrangements under which an increasing number of nursing homes are operating. Skyline and Synergy facilities are two tragic examples.

- *Synergy closing nursing homes as troubles mount*[1] chronicles the devastating harm and impending closing of 10 Synergy Health Center nursing homes. The Synergy chain took foothold in MA at the end of 2012. Over the next few years, Synergy incurred repeated fines for resident deaths and injuries and has incurred more than $31 million in unpaid mortgage loans and other debts. Kay Lazar, Boston Globe reporter, brought this chain to the public's attention in May, 2015 and published 22 Boston Globe articles, sounding a loud alarm on the human and financial losses these facilities created.
- The Skyline nursing home failures brought pain and suffering to thousands in several states, including to the many residents of 5 Massachusetts nursing homes. According to this April 2019 Skilled Nursing News article, *Skyline Facilities in Massachusetts Placed in Receivership as Unpaid Bills Mount* [2], owners of five shuttered South Coast nursing homes should never have been able to get a foothold and impose such human and financial harm.

MA is long overdue for putting the proposed safeguards in place to prevent such harm from ever happening again to residents. It is imperative that MA implement and enforce strong requirements for nursing home licensure as called for in S.413/H.733.

We submit the following recommendations:

1. **Stop approval of licensee if DPH misses deadline!** If DPH does not notify the applicant/licensee of its suitability decision within the allotted time, suitability is automatically approved in the following two regulations. DPH must have ample review time, given the importance of an in-depth financial analysis, verification of facility affiliations in other states, etc. Automatic suitability based on the expiration of DPH review time should be deleted and replaced with language to extend DPH's review time as needed. (Continued)

Section 1 – Licensure Procedure and Suitability Requirements for Long-Term Care Facilities (105 CMR 153): Application for License (105 CMR 153.006) & Other Licensure Requirements (105 CMR 153.007) (Continued)

We submit the following recommendations: (Continued)

2. **Stop approval of licensee if DPH misses deadline! (Continued)**
   Regulations Affected:
   a. 153.006 (D) - Application for a License:
   "An application for an original license shall not be approved until an applicant has been deemed suitable by Department, or in case of transfer of ownership, applicant has been deemed suitable by Department or suitability review period has expired."
   b. 153.022 (A) - Transfer of Ownership:
   "…In the event that the Department fails to notify the applicant in writing of its decision regarding suitability within the prescribed timed period, the applicant shall be deemed responsible and suitable."
3. **Public Hearings – Opportunity for Public Comment.** To correct an inconsistent regulation and to further encourage public participation by standardizing the public timeframe for requesting a hearing to a full 14 days, we recommend increasing the time for petitioning a public hearing from within 14 days [153.007 (F), (2)(a) Hearings] to a period of 14 days, the same as 153.007(F), (1) Public Notice, (b).
4. **Receive public notice and other information regarding facility transaction:** To amplify the voice of residents in the public hearing process, include two citizen advocates to the list of organizations/individuals receiving public notices and other pertinent information. These new advocacy positions shall be representatives from at least two statewide citizen advocacy groups representing elders and/or persons with disabilities.
   Regulations Affected:

Original, Renewal, Other License	Transfer of Ownership	Voluntary Closure
153.007 (F)(1)(f): Provide 2 citizen advocates with copy of Public Notice.	153.022(B)(2): Provide 2 citizen advocates with copy of Public Notice.	153.023(A)(3): Provide 2 citizen advocates with copies of: notice of intent to close and draft closure plan.

5. **153.014 (A)-(H) Grounds for Denial/Revocation/Refusal to Renew a License to Operate LTC Facility; 153.020 Determination of Unsuitability/Refusal to Renew License/License Revocation/License Denial**

   a. 153.014 (H)(3) A felony involving the misuse of Medicare or Medicaid funds or the misuse of resident funds should not easily or quickly be absolved by a "formal settlement agreement or the application of previous regulatory provisions".

   b. The Determination of Unsuitability 153.020 and Penalties 153.024 (D) differ in the number of years an unsuitable applicant/licensee is prohibited from establishing or maintaining a LTC facility. But do we want to allow a convicted felon establish or maintain a LTC facility at all?
   Current language:
   - 153.020: unsuitable applicant/licensee shall not establish/maintain any LTC facility for 10 years.
   - 153.024 (D): If licensee has been convicted of, pleaded guilty or nolo contendere to, named felonies in 153.024 (D)(1)—(3), then licensee is prohibited from acquiring any additional facilities or increasing bed quota of any existing facilities for 5 years from date of conviction, guilty plea or admission, except with explicit permission of Public Health Council. (Continued)

Section 1 – Licensure Procedure and Suitability Requirements for Long-Term Care Facilities (105 CMR 153): Application for License (105 CMR 153.006) & Other Licensure Requirements (105 CMR 153.007) (Continued)

5. 153.014 (A)-(H) Grounds for Denial/Revocation/Refusal to Renew a License to Operate LTC Facility; 153.020 Determination of Unsuitability/Refusal to Renew License/License Revocation/License Denial (Continued)

We submit the following recommendations: (Continued)

The following recommendations addressing the issues in 153.014, 153.020, and 153.024 (Penalties) are from *Meaningful Safeguards: Promising Practices & Recommendations for Evaluating Nursing Home Owners* (Meaningful Safeguards). The March, 2020 report was developed by the Long-Term Care Community Coalition (www.ltccc.org) to evaluate nursing home owners and develop state licensure practices to improve accountability and integrity in the licensure process. The report offers essential principles for involving ownership disclosure**,** financial capacity**,** leases or subleases**,** character and fitness**,** management**,** change of ownership, and criminal liability**.** Promising practices from 15 states (including MA) are included in the report. Also, the Massachusetts Advocates for Nursing Home Reform www.manhr.org received a special acknowledgement along with four other organizations for assistance with the report.

Recommendations:

Pages 18 and 19 of Meaningful Safeguards discuss Character and Fitness of potential nursing home owners. Applicants must submit information regarding their character, experience, competency, and standing in the community. The Department shall deny a license to an applicant who has:

1. Falsified any information, data, or record required by the application.
2. Been convicted of any crime involving physical, sexual, mental, or verbal abuse or neglect.
3. Been convicted of any crime involving the misappropriation of property or financial abuse.
4. Permitted, aided, or abetted in the commission of any illegal act against a nursing home resident.
5. Demonstrated an inability or willingness to fully comply with state and federal requirements.
6. Had any direct or indirect ownership interest in a facility cited for five or more actual harm deficiencies or there or more immediate jeopardy deficiencies (or their state equivalents) in the past three survey cycles.
7. Been involuntarily terminated from the Medicare and/or Medicaid programs.
8. Engaged in activities that the state determines are detrimental to health, safety, and well-being of nursing home residents.

6. 153.024 (A)-(C) Penalties

Recommendations: 153.024 (A) & (B): Penalty levels are very low for license violations. We recommend reviewing them for a substantial increase as a deterrent.

153.024 (C) addresses violations against M.G.L. c. 111, Sections 71, 72, and 72C. Violations of those sections are penalized under Section 73 at a maximum penalty of $50 per day. Current legislation is filed to increase the $50 per day penalty to $20,965, the federal maximum daily civil monetary penalty rate: S.373 *An Act to prevent patient abuse and death in nursing homes*. We strongly recommend increasing the MA maximum penalty rate to the federal maximum of $20,965 to send the message that nursing homes must uphold their promise to provide quality care and treat residents with dignity. For additional background, see testimony in footnote[3] supporting S.373 and presented at the 4/8/19 Elder Affairs Hearing.

Section 2 – Standards for Long-Term Care Facilities (105 CMR 150)-Utilization Review 150.014: Facility Workforce Annual Survey

We strongly support requiring an annual survey of the facility's workforce to include, at a minimum, their views on: worker job satisfaction, quality of care at the facility, management practices, and effectiveness of any joint labor-management activities or other worker engagement. Worker survey results shall be public information accessible upon request to the Department of Public Health.

S413/H733 specifically address an annual survey of the facility's workforce. However, it's our understanding that initiating resident and responsible party surveys are also being considered. There are similar implementation issues with all three types of surveys, and all are critical to understanding how best to provide quality care for residents and how best to train and support the workforce. Consequently, we are including testimony on lessons learned from workforce, resident, and responsible party surveys.

Facility Workforce Survey

An annual survey of the facility's workforce is key for management to understand and address issues that impact staff, while also providing management with a better understanding of the needs of residents and their caregivers.

As a matter of fact, the Centers for Medicare and Medicaid Services (CMS) strongly supports employee satisfaction surveys to help nursing homes recruit, motivate and retain staff as a critical means to better resident health and quality of life. In a 2018 CMS educational series to help providers improve resident care, CMS included an employee satisfaction survey, along with materials ranging from tools for assessing the competency of staffers to instructional guides, training webinars, and technical assistance seminars. Offerings in the three-year initiative were paid for through civil monetary penalties collected from providers.

Further details on the free, anonymous CMS employee satisfaction survey materials follow[4]:

- **Anonymous employee satisfaction survey** to provide employees with an opportunity to share their perceptions about the nursing home workplace. Survey topics include: employee engagement and team building, job satisfaction, management and leadership, scheduling and staffing and training.
- **Implementation Guide and a Data Analysis Tool** to support managers in implementing the survey, as well as aggregating and interpreting survey results.
- **Employee Satisfaction Guide** to help nursing homes determine the most appropriate and helpful resources to address challenges relevant to a facility's specific needs and to stay up-to-date on the latest guidance.

We submit the following recommendation:

We recommend including management in employee surveys and breaking down the findings into a few major groups (possibly management, nurses, and all other staff[5]) to get an understanding of how perceptions may vary. In addition to learning workforce views on the stated objectives, differences in outcomes between management and the workforce could lead to a better understanding of recruitment and retention issues.

Continued

Section 2 – Standards for Long-Term Care Facilities (105 CMR 150)-Utilization Review 150.014: Facility Workforce Annual Survey (Continued)

Nursing Home Resident Survey

The initial nursing home resident survey dates back to 1985 when the National Citizens Coalition for Nursing Home Reform (NCCNHR, currently named The National Consumer Voice for Quality Long-Term Care www.theconsumervoicie.org) published "A Consumer Perspective on Quality Care: The Residents' Point of View" (Consumer Perspective). NCCNHR convened 400 residents in 15 states to describe their vision of quality nursing-home care. This seminal report became the basis for the 1987 Nursing Home Reform Act.

As you will see in the Consumer Perspective's Executive Summary[6], even though the report is 36 years old, the wants, needs, and concerns of nursing home residents remain the same. Here is a sample of resident comments, and any new survey should include these issues:

1. Staff was the most important issue and most often raised: having sufficient numbers of staff, positive staff attitudes, and well-trained and efficient staff.
2. Choices and the right to make them are primary markers of quality care. Food, when to get up, and when to go to bed were the major areas residents identified. Residents wanted freedom of choice in a wide spectrum of living situations: activities, food, roommate assignments, bathing schedules, personal care attendants, physicians, medication, and other dimensions of resident lives, including their desire for freedom to come and go within and outside the nursing home.
3. Environment that makes life safe and secure, both physically and emotionally.
4. As much independence as possible, whatever their level of ability, and they want the opportunity to help themselves whenever possible. If help is needed, residents say they would like it given cheerfully, with understanding.
5. Involvement in finding solutions is a right and important to self-determination.
6. Variety in food, and a wide range of fresh, well-prepared and tasty foods to choose from. Foods that provide for ethnic differences and for individual needs and wants. Residents wanted input into planning, advising and monitoring of nursing home food service.
7. Lots of activities, more than what they now have, and a variety to meet their wide range of interests and needs, including activities for less able residents. The responses given by residents reflect personal preferences and represent their diverse individual life experiences and capabilities. Social activities were primary, followed by games and activities outside the home. All indicated they want to take part in community activities and events. And they would like people from the community to participate in and to provide activities in the home. Residents discussed the need for activities during the evenings and on weekends.

Continued

Section 2 – Standards for Long-Term Care Facilities (105 CMR 150)-Utilization Review 150.014: Facility Workforce Annual Survey (Continued)

Responsible Party Survey

"Satisfaction With Massachusetts Nursing Home Care Was Generally High During 2005-09, With Some Variability"[7] is a study that analyzed the 2005, 2007, and 2009 MA nursing home satisfaction surveys completed by responsible parties for residents. The study was published in the August 2013 Health Affairs Journal www.healthaffairs.org, leading journal of health policy thought and research, and here are some of the findings:

1. Page 8: "…Previous research has suggested that although reports or residents and family members may be highly correlated, family members generally report higher satisfaction levels than do residents… Thus, although family member surveys are an alternative and easily used source of satisfaction information, they should not, in general, substitute for direct surveys of nursing home residents…"
2. Pages 8-9: "…The ability of state surveys to discriminate between nursing homes with different levels of resident-centered care may also vary…Our analyses of the first three biennial Massachusetts surveys showed that the average scores of satisfaction overall and with individual domains of care were approximately 4.0 – that is, they indicated some level of satisfaction on average – during each survey round. This finding may indicate a relatively high level of satisfaction with care in general that persisted throughout the period 2005-09. But it raises a potential concern: Is the survey used in Massachusetts able to identify facilities with the poorest patient-centered care, or to detect meaningful levels of improvement over time? Additional work is necessary to confirm whether the survey could be improved to increase its discriminatory power, or whether a ceiling effect is inherent and reflects the way family members perceive the care delivered to residents…"
3. Page 9: "…We also note that the scores reported for each domain of care in Massachusetts are averages of answers to a group of questions within the domain. Reporting domain-specific scores keeps the reported data relatively straightforward for lay consumers. However, reporting data at the aggregated level only may mask important but subtle variations in performance and reduce the discriminatory abilities of that data…"
4. Page 9: "… It is also conceivable that family members may be the best source of information when rating some areas of interest (such as communication between staff and family members) but not others (for example, respectfulness and friendliness of the staff toward residents), even if those family members are meaningfully involved in resident's care routines. Massachusetts might consider publishing ratings for subdomains in the future, such as those in which a facility does poorly or those likely to measure consumer evaluations in the most accurate way, in addition to the aggregated scores…"
5. Page 9: "…Although consumers' rating of nursing homes did not improve over the first three waves of the Massachusetts survey, the use of better data collection and reporting approaches in the future, together with broader use of consumer satisfaction data, may promote increasingly patient-centered nursing home care in the longer term."

Continued

Section 2 – Standards for Long-Term Care Facilities (105 CMR 150)-Utilization Review 150.014: Facility Workforce Annual Survey (Continued)

Resident and Responsible Party Surveys

In the early 2000's, resident and family surveys became more prevalent, and at the 2006 NCCNHR annual conference, Elma Holder, NCCNHR's founder, made the following comments on consumer (resident and responsible party) satisfaction surveys[8] that should be considered in the analysis of any new surveys:

1. **Residents and Responsible Parties (including Workforce overlap):**
   a. Surveys reinforced what we suspected – resident and responsible party satisfaction depends on the level of expectation which is relatively low. Common responses are "They're doing the best they can…"; "Given the staffing levels, they're doing OK". Consequently, many may respond positively to such surveys because they think the care is as good as can be expected. We need to raise the bar to help people break out of institutionalized thinking.
   b. All respondents are not educated on what good care practices are, so they really do not know what they should be demanding. Once consumers become more familiar with person-centered care, also called culture change, expectations for quality of care and quality of life for nursing home residents may change.
      - This issue may also be present with the Workforce --- does the Workforce know about consistent care assignments, collaborative management possibilities, etc.?
   c. Some respondents may be concerned about retaliation, so their replies are not as forthcoming as they should be.
      - This issue may also be present with the Workforce.
2. **Residents:**
   - ✓ Elma strongly recommended resident interviews in addition to doing a paper survey. She strongly stressed that there is no substitute for full, in-depth interviews with residents themselves.
3. **Responsible Parties:**
   a. Some responsible party respondents don't spend much time at the nursing home, so they literally don't see the problems.
   b. Some responsible party respondents may be in denial of problems at a facility due to guilt feelings stemming from their loved one residing in a nursing home.

Section 3 – Examination of Cost Trends and Financial Performance (as defined by 957 CMR 7.02)

We strongly support the examination of cost trends and financial performance of nursing homes (defined by 957 CMR 7.02) to be analyzed in nine areas: 1) gross and net patient service revenues, 2) other operating and non-operating revenue, 3) various trends dating back to 2010 (price , payer mix, case mix, utilization, and length of stay), 4) affiliations with other health care providers, 5) cost categories (i.e. general/administrative, nursing & salaries, building, capital, and other operating costs), 6) total spending on direct patient care as percent of total operation expenses [medical loss ratio], 7) operating costs and margin 8) occupancy rates, and 9) other relevant measures of financial performance and service delivery. The report and any policy recommendations shall be filed with the clerks of the House and Senate, Joint Committee of Ways & Means, and Joint Committee on Elder Affairs.

Section 3 takes a close look at the true financial status of nursing homes:

1. to ensure that MassHealth and other funds are being utilized to provide the highest practicable quality of care and quality of life, as pledged in their licensure requirements;
2. to ensure that a reasonable level of funds to support nursing home residents is consistently maintained through a medical loss ratio (discussed below);
3. to determine if there are MassHealth rate shortfalls, and if so, how best to address them; and
4. to better determine the allocation of public funds between nursing homes and community-based services.

Here is a sample of issues that underscore the need for the detailed financial review that S413/H733 require:

- "…On forms they submit to the state, nursing homes frequently report they are losing money. But that's only part of the story. A review of records from companies affiliated with the homes shows they are directing cash to subsidiaries and to help pay executives' six-figure salaries…"[9]
- The nursing home industry estimates that nationally, Medicaid only pays 89% of actual costs, but the Medicare Payment Advisory Commission shows a positive profit margin overall of about 1%. It should be noted that nursing home financial reports do not show hidden profits taken by owners.[10]
- According to this industry publication discussing how nursing home financial "returns remain strong", a senior managing director of an investment advisor organization stated about nursing homes: "I don't know another asset class on a stabilized level… where you can reap those kind of returns". He was referring to the skilled nursing capitalization rate of about 12.5%, which is considered a good return on investment. (The capitalization rate is the ratio of net operating income compared to the real estate value, in this case, the real estate value of the nursing home.)[11]
- Providers have wide latitude on how they utilize MassHealth funds and other revenue, since there are no limits on self-dealing transactions or contracts; no set minimum required to be spent on resident care; no set federal minimum on staffing levels; and no ceiling on administrative costs.

Continued

Section 3 – Examination of Cost Trends and Financial Performance (as defined by 957 CMR 7.02) (Continued)

In addition, problems have been identified in nursing homes with private equity investments. "When private equity firms acquire nursing homes, patients start to die more often, according to a new working paper published by the National Bureau of Economic Research… Total private equity investment in nursing homes exploded, going from $5B in 2000 to more than $100B in 2018. Many nursing homes have long been run on a for-profit basis. But private equity firms, which generally take on debt to buy a company and then put that debt on the newly acquired company's books, have purchased a mix of large chains and independent facilities — making it easier to isolate the specific effect of private equity acquisitions, rather than just a profit motive, on patient welfare. Those changes include a reduction in staffing, which prior research has found is the most important factor in quality of care. Overall staffing shrinks by 1.4%, the study found, but more directly, private equity acquisitions lead to cuts in the number of hours that front-line nurses spend per day providing basic services to patients… The study also detected a 50% increase in the use of antipsychotic drugs for nursing home patients under private equity, which may be intended to offset the loss in nursing hours. But that introduces its own problems for patients, because antipsychotics are known to be associated with higher mortality in elderly people…"[12]

As these reports and more show, the fiscal review and safeguards provided by S413/H733 are critical to the well-being of MA nursing home residents.

We submit the following recommendations:

1. We strongly support establishing a meaningful medical loss ratio. It's helpful that the September 2020 MA Nursing Facility Accountability and Supports Package 2.0 called for a minimum of 75% of revenue to be spent on direct care staff costs effective 10/1/20[13]. However, it is uncertain when this rate will terminate, and we recommend that a higher codified rate is necessary to support quality care:
   - It should be noted that in October, 2020, New Jersey passed a nursing home 90% medical loss ratio[14]. We also recommend a 90% rate for MA based on their law.
   - For comparison, the Affordable Care Act requires insurance companies to spend at least 80% or 85% of premium dollars on medical care, with the rate review provisions imposing tighter limits on health insurance rate increases.[15]
2. As of 10/5/20, nursing homes were required to submit the facility's average hours per resident per day (HPRD) as part of the Average Staffing Hours Incentive[16]. We recommend comparing the staffing statistics nursing homes submit for this Incentive to the payroll-based journal data facilities submit to CMS. Both sets of statistics represent actual staffing and should be the same. It would be prudent to understand any material inconsistencies between these staffing calculations, since as of 1/1/21, a nursing home that fails to meet an average of at least 3.58 HPRD will be subject to a 2% downward adjustment of the facility's standard rate for that calendar quarter[17]. We reported in our testimony for S.414/H.727 "An Act to ensure quality of care in nursing homes" that as of Q4, 2020 (latest CMS data available), 50% of MA nursing homes were staffed below the new 3.58 HPRD requirement. If this trend continues into Q1, 2021, there could be a substantial number of nursing homes subject to the 2% downward adjustment. Continued

Section 3 – Examination of Cost Trends and Financial Performance (as defined by 957 CMR 7.02) (Continued)

We submit the following recommendations (Continued):

3. To ensure transparency and accountability, we strongly recommend performing an audit of the more than $400M[18] authorized COVID-19 funding to nursing homes and to publicly report the outcome. We must understand the financial cost of the pandemic to ensure the best implementation of life-saving policies -- what financial support was necessary or not necessary, what financial support still may be needed, and how successful were these initiatives. A publicly reported audit is also supported in the 4/27/21 Baker-Polito Administration Press Release[19] announcing the second round of COVID-19 response funding of up to $130M for nursing homes.

   "…Public Reporting: All performance measures and funding use will be publicly reported using a mandatory reporting template, and the Commonwealth will provide consolidated information in the testing completion status by facility, COVID-19 case counts and mortality of staff and residents, and audit results. These reports will be due shortly after June 30, and the Commonwealth will then compile and deliver a public report…"

Thank you for the opportunity to provide testimony regarding so many important issues to protect nursing home residents and their caregivers. We must strive to make improvements to ensure the safety and dignity of all living and working in long-term care.

Sincerely,

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[1] *Synergy Health Centers closing nursing homes amid mounting bills, patient injuries and deaths*, Kay Lazar 11/2/18**,** https://www.bostonglobe.com/business/2018/11/02/synergy-health-centers-closing-nursing-homes-amid-mounting-bills-patient-injuries-and-deaths/m5PQV4d5WV4bLZ47902rNN/story.html

[2]*Skyline Facilities in Massachusetts Placed in Receivership as Unpaid Bills Mount*, Maggie Flynn, 4/30/19, *https://skillednursingnews.com/2019/04/skyline-facilities-in-massachusetts-placed-in-receivership-as-unpaid-bills-mount/.*

[3] April 8, 2019 Joint Committee on Elder Affairs Hearing on S.373: An Act to prevent patient abuse and death in nursing homes, Sen. Montigny. Testimony by Greater Boston Legal Services, on Behalf of our Clients, Massachusetts Advocates for Nursing Home Reform, and Aging Life Care Association-New England Chapter:

"To protect Massachusetts' 40,000 nursing home residents from the pain and suffering caused by violations of state nursing home regulations, we strongly support increasing the daily maximum MA penalty rate from $50 to the maximum daily rate of $20,965. While this increase is steep, it's important to note that the proposed maximum rate is set at the federal maximum daily rate:

A $20,965/day maximum penalty sends the message that nursing homes must uphold their promise to provide quality care and treat residents with dignity. A mere $50/day penalty is an extremely weak enforcement mechanism to ensure that state regulatory standards are met. And such a meager amount does not deter recidivism.

Furthermore, the $50/day maximum penalty does not give the MA Department of Public Health the ability to address serious issues based on scope (number of residents affected) and severity (level of harm or immediate jeopardy). In comparison, federal deficiency citations have been rated based on scope and severity for purposes of enforcement since 1995[1].

In addition, it's imperative for Massachusetts to have the independent ability to hold MA nursing homes accountable for any kind of harm, and of course egregious harm, to our vulnerable citizens. Sadly, federal oversight has weakened. On 3/6/19, the US Senate Finance Committee held a hearing entitled "NOT FORGOTTEN: PROTECTING AMERICANS FROM ABUSE AND NEGLECT IN NURSNG HOMES". In response to testimony, national advocates wrote a 10-page paper[2] outlining concerns. Advocates included the Consumer Voice, Long Term Care Community Coalition; Center for Medicare Advocacy; California Advocates for Nursing Home Reform; Justice in Aging, and National Association of State Long-Term Care Ombudsman Programs. One of the issues involved federal penalties. Here is an excerpt from their comments: "…Although CMS theoretically has a wide range of enforcement remedies, actual use of these remedies has been relatively narrow. One of the major reasons for inadequate enforcement is the failure to appropriately assign "scope and severity" levels. Most deficiencies are assigned a "no harm" severity level. In fact, in 2015 only 3.4% of all health violations[3] were identified as having caused any harm to a resident, despite the documented evidence on survey reports frequently showing otherwise.[4] The scope and severity levels are critical because they determine the enforcement remedies that can be imposed –and a no-harm level rarely leads to any enforcement action, let alone a meaningful enforcement action.

Inadequate nursing home oversight is further weakened by policy changes that CMS has already implemented. Many of these changes correspond to requests from the nursing home industry and were made without public notice or comment. In November 2017, CMS placed an 18-month moratorium on major enforcement of several key regulations that became effective that same month. Other changes lead to lower and less frequent fines. Examples include:

- Making per instance CMPs the recommended remedy rather than per diem fines in all but a few limited circumstances. The result is generally lower penalties imposed for noncompliance.
- Allowing CMPs to be optional instead of mandatory when Immediate Jeopardy does not result in serious injury, harm, impairment, or death.
- Changing how remedies are selected and factors to consider giving CMS Regional Offices (ROs) discretion. For instance, ROs can take into consideration whether the cited noncompliance is a one-time mistake or accident.

These changes are counterproductive. The threat of fines is a critical deterrent to abuse and substandard care, particularly when they are large enough to impact a facility's actions. Yet policy revisions are already having an effect: the average fine is now $28,405 compared to $41,260 in 2016…"[5]"

[1]*Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009 Through 2015*; Charlene Harrington, Ph.D. and Helen Carrillo, M.S., University of California San Francisco and Rachel Garfield, Kaiser Family Foundation; July 2017; page 23

[2]National Advocates response to NOT FORGOTTEN: PROTECTING AMERICANS FROM ABUSE AND NEGLECT IN NURSNG HOME 3/6/19 US Senate Finance Committee Hearing: https://theconsumervoice.org/uploads/files/actions-

and-news-updates/Post-hearing_statement-Not_Forgotten-Protecting_Americans_from_Abuse_and_Neglect_in_Nursing_Homes_final_(002).pdf

[3] Abt Associates for U.S. Centers for Medicare and Medicaid Services, "Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes." December 2001.

[4] Safeguarding NH Residents & Program Integrity: A National Review of State Survey Agency Performance, LTCCC (2015).

[5]Jordan Rau. Trump Administration Cuts the Size Of Fines For Health Violations In Nursing Homes. Kaiser Health News. March 15, 2019.

[4] Civil Money Penalty Reinvestment Program https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/LTC-CMP-Reinvestment: Components of employee survey materials:
CMPRP-Toolkit 1 – Employee Competency Assessments (ZIP)
CMPRP-Toolkit 2 – Employee Satisfaction Survey (ZIP)
CMPRP-Toolkit 3-Guide to Staff Satisfaction (PDF)

[5] *Meeting the Leadership Challenge in Long-Term Care – What You Do Matters*, David Farrell, Cathie Brady, Barbara Frank, 2011 (6th printing Feb. 2018), pages 169-70:
"…A key factor in the management team's ability to see staff's experience clearly was that the responses to the survey were tabulated for three groups: department heads, licensed staff (nurses), and non-licensed staff (LNAs, food service, and housekeeping staff). This allowed management to see how differently these three groups of staff experienced the workplace. The differences were striking. While department heads were aware that there were serious problems due to turnover and were dealing with the daily crises as best they could, the survey results indicated just how seriously the stress was affecting staff and that, in fact, the management team had different perceptions than the rest of the staff about the depth and nature of the problems…"

[6] *A Consumer Perspective on Quality Care: The Residents' Point of View*, Executive Summary: https://theconsumervoice.org/uploads/files/issues/resident_pers.pdf, National Citizens' Coalition for Nursing Home Reform, 1985.

[7] *Satisfaction With Massachusetts Nursing Home Care Was Generally High During 2005-09, With Some Variability*, Yue Li, Xueya Cal, Zhiqui Ye, Laurent Glance, Charlene Harrington, and Dana Mukamel, Health Affairs, August, 2016, https://www.healthaffairs.org/doi/10.1377/hlthaff.2012.1416.

[8] National Citizens' Coalition for Nursing Home Reform 10/22-24, 2006 31st Annual Conference: CARE Matters [CARE: Choice, Accountability, Rights Empowerment]. Oct. 23, 2006 session entitled Consumer "Satisfaction" --- Attainment, Measurement and Reporting. Presenters: Elma Holder, NCCNHR Founder, Geoff Lieberman, Executive Director, Coalition of Institutionalized Aged and Disabled, New York, NY; Judith Sangl, ScD., Health Scientist Administrator, Agency for Healthcare Research and Quality (AHRQ), Rockville, MD.

[9] Boston Globe, *A Pattern of Profit and Subpar Care at Mass. Nursing Homes*, Kay Lazar, 3/27/16 http://www.bostonglobe.com/metro/2016/03/26/profit-and-care-massachusetts-nursing-homes/JfpOM6rwcFAObDi2JLcAnN/story.html.

[10] *Protecting Seniors by Improving - Not Eroding - Nursing Home Quality Standards*, Congressional Briefing Hosted by the Seniors Task Force 6/4/18, pg 45, Nursing Home Financial & Accountability Issues, Charlene Harrington, Ph.D. https://www.medicareadvocacy.org/wp-content/uploads/2018/06/Briefing-Materials-6-2018.pdf

[11] *Perceived Risk Hides Potential Upsides for Skilled Nursing Investors*, Skilled Nursing News, Maggie Flynn, 4/15/18 https://skillednursingnews.com/2018/04/perceived-risk-outweighs-actual-risk-skilled-nursing-investors .

[12] *Private equity ownership is killing people at nursing homes, A new study describes the human toll of private equity firms buying up nursing homes,* Vox.com, Dylan Scott, 2/22/21 https://www.vox.com/policy-and-politics/22295461/nursing-home-deaths-private-equity-firms.

[13] Nursing Facility Accountability and Supports Package 2.0 - September 10,2020, Item 1. on page 2: https://www.mass.gov/doc/covid-19-nursing-facility-accountability-and-supports-package-20/download.

[14] New Jersey: **A4482** P.L. 2020, CHAPTER 89, approved September 16, 2020 Assembly, No. 4482 (Second Reprint): **"…3.**c.2. The direct care ratio shall require 90 percent, or such higher percentage as the commissioner may establish by regulation, of a facility's aggregate revenue in a fiscal year to be expended on the direct care of residents…"

[15] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Medical-Loss-Ratio.

[16] Standard Payments to Nursing Facilities 101 CMR 206.00, Mass. Register #15433 5/14/21 https://www.mass.gov/doc/101-cmr-206-standard-payments-to-nursing-facilities/download,
206.13 Average Staffing Hours Incentive: Effective 10/5/20, each nursing facility will be required to submit information on its staffing levels, including information demonstrating the facility's average hours per patient day it EOHHS on at least a bi-weekly basis, in the manner and format requested by EOHHS…
(2) Beginning January 1, 2021, a nursing facility that fails to meet an average of at least 3.58 hours per patient day,

in accordance with 101 CMR 206.13(1), will be subject to a downward adjustment equal to 2% of the facility's standard rate for that calendar quarter. The dollar amount resulting from this adjustment will be considered an overpayment pursuant to 130 CMR 450.235:Overpayments.

[17]Ibid.

[18] **COVID-19 Nursing Home Funding - Summary**	**$Millions**
4/27/20 Nursing Facility Accountability & Support https://www.mass.gov/doc/covid-19-nursing-facility-accountability-and-supports-package-20/download	
All MassHealth Nursing Homes	$50.0
* COVID-19 Isolation Units: COVID-19 patients from hospitals	50.0
Dedicated COVID-19 facilities	30.0
Phase I Total	130.0
Phase 2 – Required testing and infection control audits	130.0
4/27/20 Nursing Facility Accountability & Support: Phase 1&2 Total	**$260.0**
9/10/20 Nursing Facility Accountability and Supports Package 2.0 https://www.mass.gov/doc/covid-19-nursing-facility-accountability-and-supports-package-20/download	
MassHealth rate restructuring to promote high-quality sustainable industry – per policy recommendations of Nursing Facility Task Force	$82.0
Surge Funding, including staffing shortages	12.0-36.0
Surveillance testing through Dec.	Up to: 24.0
* COVID-19 Isolation Units: COVID-19 patients from hospitals	3.6
COVID-19 Response Efforts Oct. – Dec. 31, 2020	Up to: 63.6
9/10/20 Nursing Facility Accountability and Supports Package 2.0	$145.6
Combined Total	Up to: $405.6
* same initiative	

[19] Baker-Polito Administration Announces Further Support, Resources, and Accountability Measures for Nursing Facilities, Funding for Congregate Care Facilities During COVID-19, Governor's Press Office, 4/27/20, https://www.mass.gov/news/baker-polito-administration-announces-further-support-resources-and-accountability-measures-for-nursing-facilities-funding-for-congregate-care-facilities-during-covid-19: