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July 7, 2020

The Honorable Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5531-IFC
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically to http://www.regulations.gov

Re: Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program

Dear Administrator Verma:

AARP, on behalf of our nearly 38 million members and all older Americans nationwide, appreciates the opportunity to comment on this important interim final rule on policy and regulatory provisions in response to the COVID-19 public health emergency. AARP's comments will focus on several issues and areas to improve the response to COVID-19 including scope of practice, home health, testing, telehealth, nursing home data collection and reporting, and racial and ethnic disparities, with our comments generally in the order in which they appear in the rule.

Scope of Practice: Supervision of Diagnostic Tests by Certain Nonphysician Practitioners

AARP supports all clinicians' ability to provide care to the fullest extent of their education and training. The rule adds flexibility for nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse midwives (CNMs), and physician assistants (PAs) to supervise diagnostic tests, according to state law and licensure, throughout the public health emergency. AARP supports permanently extending this flexibility, which can reduce costs, maintain quality, and increase access, especially in rural and underserved urban communities.

Care Planning for Medicare and Medicaid Home Health Services

AARP supports Section 3708 of the CARES Act (P.L. 116-136), which authorizes NPs, CNSs, and PAs as eligible health care professionals who can order and certify patients for eligibility for home health services under Medicare and in the same manner and to the same extent under Medicaid. This change will improve access to home health services and potentially reduce costly admissions to hospital, sub-acute care, or nursing facilities. The new law will also help states meet their obligation under the Supreme Court's *Olmstead* decision to ensure that people with disabilities receive services in the most integrated setting appropriate to their needs.

Unfortunately, Medicare and Medicaid beneficiaries in many states may not fully benefit from the CARES Act provision unless those states make conforming changes to their state scope of practice/licensure policies as well as, potentially, Medicaid and private insurance laws. In states that maintain barriers, providers may be forced to locate a physician to make a home health referral, which is often a difficult task in health care shortage areas and rural regions. When this occurs, people continue to either go without care, or need to wait for days or weeks to obtain care, become more ill and end up in the hospital or a long-term care facility. This can also increase costs for beneficiaries, Medicare, and Medicaid.

Also, there is a good chance that an ordering or collaborating physician may not have direct knowledge of the patient. Approximately one-third of Medicare beneficiaries who received care from a Medicare clinician in 2018 received services from a nurse practitioner.[1] Requiring an order from a clinician who is unfamiliar with the person can result in an inappropriate or inadequate referral.

AARP requests that CMS encourage and help facilitate necessary state changes required to fully implement the Medicare and Medicaid home health access provisions and ensure that the maximum number of beneficiaries benefit from the new law. This will help ensure program integrity and maximize value for Medicare and Medicaid beneficiaries.

Flexibility for Medicaid Laboratory Services

AARP is pleased that CMS is exploring ways to make accessing COVID-19 tests easier for Medicaid beneficiaries and supports the proposal to allow flexibilities in how a Medicaid beneficiary receives their COVID-19 test. We are also pleased that states have the flexibility to provide Medicaid-covered testing for low-income individuals not enrolled in Medicaid. It is critical that we make it as easy and safe as possible for Medicaid beneficiaries and other low-income individuals to get tested, including covering testing methods such as self-collection of a specimen. We also appreciate that these flexibilities will be extended during future public health emergencies.

Multiple Medicare Telehealth Provisions

Under the interim final rule, CMS proposes a number of changes that would impact a Medicare beneficiary's ability to access services via telehealth. Opportunities for practitioners to utilize the technology to provide services and receive reimbursement naturally open up greater access channels

[1] Of the roughly 33 million Medicare beneficiaries that received care from a Medicare clinician in 2018, over 12 million received billable services from a nurse practitioner. *See*: https://www.cms.gov/files/document/2018-mdcr-physsupp-6.pdf

for patients. AARP supports improving access to affordable, high quality health care, and generally supports expanded access to telehealth to achieve those goals. We appreciate CMS' support for these efforts as well. We also urge CMS to encourage coverage and payment of telehealth services (including by removing unnecessary restrictions that limit beneficiary access) for eligible beneficiaries to improve accessibility and quality of care, allow individuals to remain safely in the community, and assist with care transitions from institutional to community settings, while maintaining consumer choice and protections. As access to telehealth is expanded, it will also be important to collect data on its use and quality.

Greater Access Through the Use of Audio-Only

CMS' interim final rule allows the use of audio-only as another means to deliver services to Medicare beneficiaries, such as allowing for some services on the eligible telehealth-delivered service list to be reimbursable if the modality used was audio-only phone. AARP suggests that CMS consider including more services via audio-only, as appropriate. During the current public health emergency, while temporary allowances in policy have led to more expansive use of telehealth, significant portions of the population do not have access to telehealth due to connectivity and/or access to the appropriate technology—or may not have the ability to effectively use technology or may prefer audio-only for other reasons such as privacy. The only — or most effective — means of communication for these segments of the population is the telephone. While AARP applauds the increased use of audio-only phone to deliver some services, AARP encourages the agency to consider further allowances in order to ensure Medicare beneficiaries have greater opportunities to access care, if needed.

COVID-19 Serology Testing

AARP appreciates that CMS seeks to clarify that serology tests are covered without cost-sharing under Medicare. While the technology for serology testing is still evolving, it is critical that Medicare beneficiaries have access to serology tests with no cost-sharing, just as those on commercial insurance do.

Requirements for Facilities to Report Nursing Home Residents and Staff Infections, Potential Infections, and Deaths Related to COVID-19

Nursing Home Reporting to CDC

The situation in our nation's nursing homes is tragic and dire, with the Kaiser Family Foundation reporting over 52,000 deaths in nursing homes and other long-term care facilities, representing 45 percent of all COVID-19 deaths nationwide. We believe more must be done to stem the loss of life and improve conditions in America's long-term care facilities.

AARP has been calling for increased transparency of COVID-19 cases in long-term care facilities. We appreciate the CMS guidance and this interim final rule that takes steps towards achieving greater transparency and ensuring nursing homes are better prepared to respond to the public health emergency. Under this interim final rule, a nursing home must report electronically in a standardized form suspected and confirmed COVID-19 infections among residents and staff, including residents previously treated for COVID–19, and total deaths and COVID–19 deaths among residents and staff, as well as other important information to the Centers for Disease Control and Prevention (CDC), at

least on a weekly basis. That information is provided to and made public by CMS. This reporting is in addition to state and local requirements.

AARP supports requiring that nursing home reporting to CDC includes both residents and staff, residents previously treated for COVID-19, total deaths and COVID-19 deaths, and that data is reported electronically in a standardized format to enable better use and comparison of the data.

Nursing homes must report whether the facility has access to COVID-19 testing while the resident is in the facility. We urge that facilities also report whether their residents and staff are being tested, and if so, the criteria for testing. Transparency would help ensure nursing homes are appropriately testing residents and staff and not simply avoiding public disclosure of COVID-19 cases at their facility. Nursing homes are required to also report whether they have staffing shortages. We strongly encourage CDC and CMS to define the meaning of a staffing shortage to ensure that facilities can answer questions consistently and the public is properly informed.

This interim final rule with comment is effective May 8, 2020. CMS guidance encourages, but does not require, nursing homes to report data prior to May 8. AARP urges CMS to modify this rule to require facilities to report data prior to May 8. This current data gap provides an incomplete national picture of COVID-19 in our nation's nursing homes and should be rectified. A national surveillance system should include complete and comprehensive data.

While the new reporting requirements are a necessary step, we believe that care facilities must also report publicly on a daily basis whether they have confirmed COVID-19 cases and deaths and that reporting should include demographic data. This should apply not only to nursing homes, but also to assisted living and other residential care facilities, which should also be included in this rule. Thus, for the current regulation, we urge daily collection and public reporting of data, not just weekly. The COVID-19 pandemic has shed light on the stark racial and ethnic disparities affecting health outcomes for communities of color across the country. There is a growing body of data that shows African Americans/Blacks and Hispanics are disproportionately impacted by the COVID-19 pandemic with higher rates of infection, serious illness, and death, but more data is needed. Furthermore, more data is needed to assess the impact of COVID-19 on the Asian American and Pacific Islander (AAPI) communities, as well as on American Indians and Alaska Natives. While racial and ethnic disparities long existed before this crisis, the ongoing coronavirus pandemic has sent a clear message—perhaps louder than ever—that now is the time to work collectively to address the systemic inequities, discrimination, and harmful social determinants of health that have led to these disparities.

In order to address health disparities across the country, including those occurring within nursing homes and other long-term care facilities, it is important that the federal government collect and publicly report on COVID-19 cases, deaths, co-morbidities, hospitalizations, and testing rates broken down into multiple demographic categories—while protecting patient privacy—including race, ethnicity, age, socioeconomic status, sexual orientation, gender identity, spoken/written language and disability. Data should also include venues such as hospitals, nursing homes, assisted living facilities, residential homes, and other locations. The information, disaggregated for all groups, should also be contrasted with 2019 numbers in order to truly understand the impact of COVID-19 on all communities. Collection, analysis, and regular public reporting of the detailed disaggregated information will help us effectively understand and respond to the crisis in a timely and focused way

so that we can improve outcomes and minimize the spread of the virus. We understand that CDC may be taking some steps regarding the collection of racial and ethnic data from nursing homes. AARP strongly urges CMS to include the collection and reporting of demographic data, including race and ethnicity, in this rule and finalize such changes as soon as possible. Such data will provide a clearer picture to help effectively minimize the spread of the virus and fight the high share of deaths in nursing homes and among communities of color.

Finally, we urge CMS to vigorously enforce the nursing home reporting requirements to ensure facilities report information in a timely and accurate manner. This will help ensure a more accurate understanding of COVID-19 and its effect on our nation's nursing homes, as well as their preparedness to respond to it.

Nursing Home Notification of Residents, Families and Representatives

Under the interim final rule, nursing homes are now required to notify residents, their representatives, and families by 5:00 p.m. the next calendar day following the occurrence of a single positive infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms that occur within 72 hours of each other. This information must include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and include any cumulative updates for residents, their representatives, and families within a certain timeframe.

CMS notes it does not expect nursing homes to make individual telephone calls to meet this notification requirement, but rather that facilities may use "communications mechanisms that make this information easily available to all residents, their representatives, and families, such as paper notification, listservs, website postings, and/or recorded telephone messages." To make this information easily available and accessible, CMS should help ensure that facilities provide written/verbal communications in the most common/preferred spoken languages in the community. While different communications mechanisms may be preferable to reach a particular facility's residents, their representatives, and families, AARP urges CMS to ensure that nursing homes clearly let individuals know how they will be communicating with them, so that residents, their representatives, and families know where to look for such information. Communications mechanisms should also help ensure prompt notification and avoid methods that take multiple days to reach individuals. We also encourage CMS to consider how it could require nursing homes to report more specifically what units or locations within the nursing home the infected individuals reside or work in without compromising such individuals' privacy. It would also be helpful for the nursing home to identify whether they are linked to an assisted living facility. CMS should also consider contact tracing and how it could be readily available and used in nursing homes.

COVID-19 Testing of Nursing Home Staff

While not a provision of this rule, the COVID-19 testing of nursing home staff is relevant to the nursing home reporting and notification requirements of this rule. While AARP strongly supports consistent testing for nursing home and other long-term care facility staff, it is also critical that those individuals are not forced to pay any cost-sharing for those tests. Moreover, it is still unclear at times which entity is responsible for covering the cost of COVID-19 tests for nursing home and other long-

term care facility staff and we ask CMS to clarify if this cost is to be borne by the nursing home, an individual's insurance, or another entity. We also ask that CMS clarify that in no instance should the nursing home or other long-term care facility employee be charged any cost-sharing for a COVID-19 test. It is also important that testing of nursing home staff and residents be prioritized, so that results are timely and COVID-19 is not further spread in these facilities that already have an enormous death toll. It is also important for employees to have access to treatment, if needed.

We appreciate recent action by CMS to reinstate the required reporting of staffing data by nursing homes based on payroll or other auditable data, including for the second quarter of 2020. We request that CMS ensure the reporting of this data for the first quarter of 2020, as well. AARP also urges CMS to reinstate as soon as possible the provisions CMS waived regarding training of certified nurse aides in nursing homes. These provisions are important to transparency and the quality of care in our nation's nursing homes.

Finally, we recommend that CMS require nursing homes to report specifically on how they are using Provider Relief Funds, including the $4.9 billion awarded to skilled nursing facilities, so that there is greater transparency and Congress and American taxpayers can understand how facilities are using this money. We believe that these funds should be used for testing, PPE, staffing, virtual visitation, and other items that directly relate to resident care and well-being, prevention, and treatment. Facilities receiving reimbursement to care for individuals with COVID-19 should also be required to meet appropriate criteria to ensure that they can provide quality care, such as accounting for a facility's history of compliance with Medicare and Medicaid conditions of participation including those related to infection control and emergency preparedness, the facility's current or past affiliation with the Special Focus Facility Program, and the facility's ability to treat high-severity residents, as applicable.

AARP appreciates the opportunity to comment on this important rule and COVID-19 issues affecting individuals and their families. If you have questions, please feel free to contact me or Rhonda Richards on our Government Affairs staff at 202-434-3770 or rrichards@aarp.org.

Sincerely,

David Certner
Legislative Counsel and Legislative Policy Director
Government Affairs