20 May 2020

Royal Commission into Aged Care Quality and Safety
Email: ACRCenquiries@royalcommission.gov.au

Dear Commissioners,

Re: Aged Care Regulatory Framework

The Royal Commission has not yet given any indication of the nature of the regulatory changes it will be advising and we are concerned that as a result of the suspension of hearings that they might not do so.

This letter is to enquire whether the Royal Commission intends to publish a consultation paper canvassing input on proposed reforms to the regulatory system?

It is also to:

1. Express our deep concern at the delay in critically analysing Australia's regulatory system and the policies on which they were based to assess their contribution to the problems the Commission has detected. In our view, understanding where underlying philosophy and policy has impacted the management and regulation of aged care in ways that have worked well and where they have failed, should have been the starting point to any discussion of remediation. A deep analysis was required to understand why failures had occurred.

   We consider this to be so elementary and the policies so flawed and out of step with community values and expectations, that we wonder if there is some taboo that bars government appointed and funded inquiries from examining policy. We cannot understand how it will meet the promises made in its interim report titled 'Neglect' in this way. This analysis has been glaringly absent from recent Commission hearings and is being avoided. In our view this seriously compromises their utility.

   The Commission's own *Background Paper 8 - A History of Aged Care Reviews*, described the failure of multiple previous inquiries, which also failed to do an analysis of policy. The paper asked why, but then did not give the obvious answer – why?

2. Highlight the threat of ideological intractability in those with power. When belief and identity are so tightly bound together that failure is inconceivable, then evidence, logic and even criminal convictions can be denied or explained away. Nothing actually changes until their hold on power is broken.

We also inform the Commission of a recent webinar in the USA, which is relevant to regulatory effort in Australia:

3. An important item addressed in the webinar is the assessment of new owners of nursing homes with a view to blocking unsuitable owners, a critical problem neglected in Australia since 1997. It presses for an assessment of character and for transparency in each assessment.

A. The problem for the Royal Commission

Clearly what will define this Royal Commission will be the regulatory changes that it advises, particularly:

1. The extent of restructuring recommended for the management of the sector. The centralised control and the complex process driven structure for aged care disempowers, alienates, undermines and discourages the engagement and ownership that those involved in care need to have as they form caring relationships. Local bodies, professions, community including families and providers who are responsible for care, would all benefit from a reach down, support, educate and empower model that gives them a sense of ownership. Bottom/Up integration of services would ensure that those most involved in care locally have real input into policy and identify with what was being done. Instead they have been left out in the cold.
2. The way the Commission addresses the deeply flawed distant and seldom present oversight and regulation of the sector. It too should work seamlessly within and in support of the same local government and community groups. They need to be empowered and have ownership of the process if they are to have confidence in it.

The Commission's agenda: The Commission has been publishing discussion papers setting out its proposals and then inviting comment. They have not yet done so in regard to the *1997 Aged Care Act* and the patterns of thinking on which it is based. We are not aware of any critical examination of the market-based *Aged Care Roadmap* or the *Living Longer Living Better* reforms. These are the same reforms endorsed under the National Aged Care Alliance's Blueprint, submitted to the Commission by the NACA Secretariat in January 2019. Aged Care Crisis is particularly interested in responding and contributing to the debate on these matters.

As we indicated in our previous submissions, we are concerned that a Commission appointed by government will not have the courage to grasp the nettle and challenge the applicability of the core political beliefs that underpin current policy in aged care. As we have previously indicated, these beliefs create perverse incentives that challenge the community values required when providing care.

The legal team supporting the Commission is the same team of lawyers that the government employs to act on its behalf and protect its interests. We can understand that it is difficult for a legal team that has spent years defending a particular system and its patterns of thinking. It is now faced with a situation in aged care that requires a critical and independent forensic examination of those same patterns of thought and the policies based on them. Doing this would show just how inappropriate they are and how badly they have failed.

On its website, the Menzies Research Centre lists the current Prime Minister as one of the three Liberal Prime Minister's since Menzies that have embraced its principles. The centre is one of the credible and powerful Australian think tanks affiliated to the neoliberal Mont Pelerin Society. The one size fits all free market they support is clearly unsuited to the sector and is a major root cause of structural failure.

We are concerned that the Commission is shrinking from contentious issues and will instead rubber-stamp the changes that government has already made or tinker with them. This is what happened in the USA in the 1990s. It did not work then and it is clear that it will not work now either.

B. The threat of ideological intractability

In Europe, half of all COVID 19 deaths were from nursing homes. In the USA, where distancing was delayed and community spread widespread, one estimate[1] describes the incidence as *"More than 10,000 long-term care facility deaths"*, another as 16,000 including staff.

The low incidence of community-related spread and its successful control in Australia, saw comparatively little spread into nursing homes. The examples of rapid spread and many deaths in northern Tasmania and in Newmarch House in Sydney show what might have happened.

A recent article in *The Australian* from the Executive Director of the Menzies Research Centre used this success in keeping coronavirus out of most of our nursing homes as evidence to deny and minimise the extent of the problems in aged care[2]. It mounted a savage attack on the ABC, particularly of its exposure of the failures in care - essentially blaming the ABC for the Commission's finding of neglect. It discounted and minimised the Commission's findings.

A board member of LASA adopted a similar approach in an article criticising the Prime Minister's response to isolation procedures adopted by the industry[3]. We agree that the Prime Minister's comments were inappropriate, but so were the board members attempts to downplay industry's failures.

Far from confirming the neoliberal systems utility, the nursing home failures in addressing coronavirus in Australia and globally expose the system's inherent weaknesses and the reasons for its failures. Both the Royal Commission and the senate have asked for coronavirus submissions. We will therefore address these matters and the regulatory failures they expose further in a separate submission.

Ideological intractability in the USA

There have been massive failures in care followed by the collapse of two large commercial operators in the USA. We note that Richard Mollot, Executive Director of *Long Term Care Community Coalition,* the group who did the report on state regulations described below, was very critical on twitter of the provider organisations in the USA for denying their culpability for what has been happening in nursing homes. This has now been exposed by the pandemic.

---

1 The Crisis Raging Inside America's Nursing Homes. Barron's | Financial and Investment News, 24 April 2020 https://bit.ly/3cl9MXB

2 Coronavirus: Perhaps our aged-care system is not in so much crisis. Nick Cater The Australian 13 April 2020 https://bit.ly/35WWyxX

3 PM's Comments Highlight Disconnect Between Government & Aged Care Sector Hellocare 23 April 2020 https://bit.ly/35M8qm5

In (**Figure 1**), The Long Term Care Community Coalition was responding to the linked article *'The Crisis Raging Inside America's Nursing Homes'*, which was very critical of US Nursing Homes and the lack of oversight during the pandemic[4].

In (**Figure 2**), they were referring to industry organisations and to the linked press report[5] *'Our patients are dropping like flies': 16,000 dead - - '*

This industry denial often by attacking the messenger in both countries is classic behaviour for an ideology in power when it is confronted by its failures. This has happened many times before. As in the USA, the structure of our political system and the revolving door in aged care in Australia ensures that this power dominates.

We saw a similar problem when the Health Care scandals were exposed and prosecuted in the USA in 1991. The failure to recognise and address the problem of ideological intractability and the power of the market in vulnerable sectors saw a similar process of denial.

The many market failures, scandals and frauds in the health and aged care sectors over the next 15 years were a consequence. This included re-offence by the main culprit, which pleaded guilty to criminal charges in the early scandal.

The problems persist and as recently as 2018, $2.5 billion of the $2.8 billion recovered under the *False Claims Act*, was still being recovered from health care related companies that had rorted the system[6].

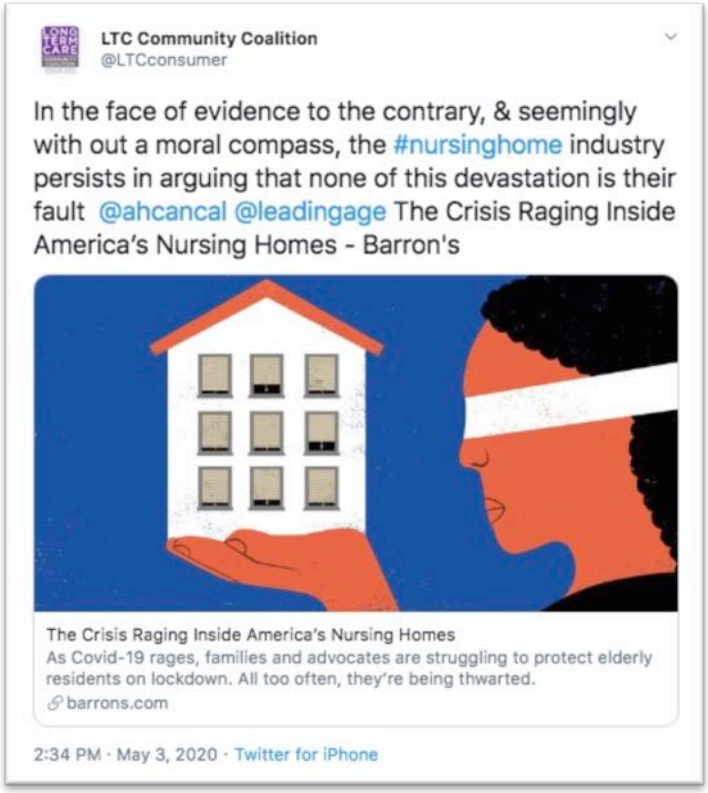

***Figure 1**: https://twitter.com/LTCconsumer/status/1256804206926692353*

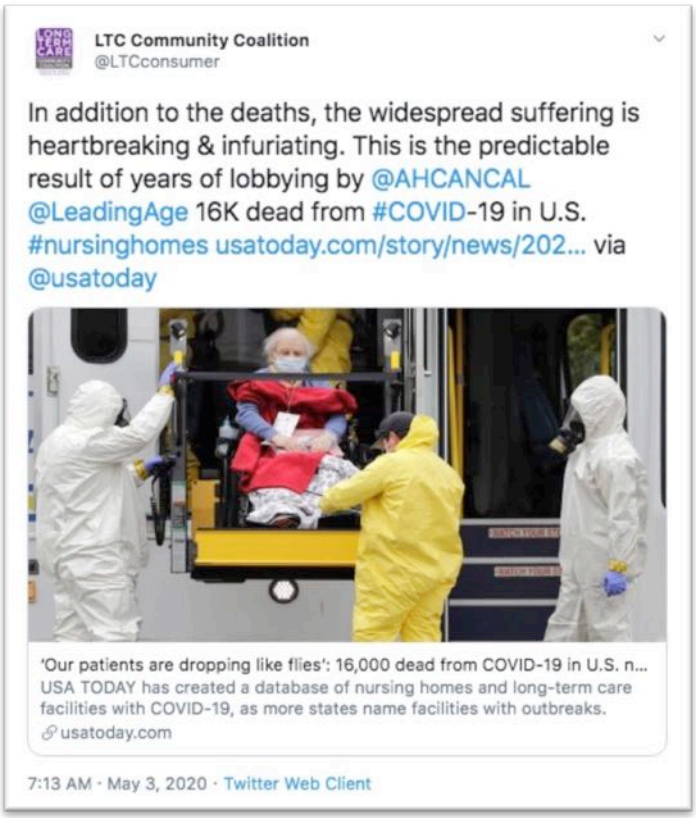

***Figure 2**: https://twitter.com/LTCconsumer/status/1256693303959003137*

---

4 The Crisis Raging Inside America's Nursing Homes. Barron's | Financial and Investment News, 24 April 2020 https://bit.ly/3cl9MXB

5 'Our patients are dropping like flies': 16,000 dead from COVID-19 in U.S. nursing homes USA Today 1 May 2020 https://bit.ly/2WHnP31

6 Justice Department Recovers Over $2.8 Billion from False Claims Act Cases in Fiscal Year 2018 US Dept. Justice https://bit.ly/2yl99IY

At the same time there is another hospital scandal in pediatric cardiology where multiple children died[7] and many stories of bankruptcies[8]. The real people who are misused and suffer the consequences seldom get recompense.

Data collection and better oversight in aged care in the USA has seen staffing and so overall care remain superior to that in Australia, but by itself this is not sufficient. There is wide variation and, as in Australia, large profit focused providers are a major problem. Fraud and exploitation still occur too often. Corporate webs have used related party transactions to accomplish this and evade regulation[9]. We should learn from the USA but it is not a model to slavishly follow.

C. Regulation of owners

A webinar conducted by *'The Long Term Care Community Coalition'* (LTCCC) in the USA and the report on which it is based, examine state regulations that grant nursing homes licenses to operate. Its recommendations must be seen in the relevant contexts in the USA and then Australia.

Background and relevance of the report and webinar

USA: Since the first study in 1986, many studies in the USA have shown that for-profit nursing homes staff poorly and provide poorer care than non-profits. The larger for-profit chains were the worst but when private equity entered the sector, they performed most poorly of all. There have been multiple scandals over the years.

The USA did collect and publish data. This resulted in overall improvements, but large numbers of providers still understaffed and performed poorly. It was not the actual provider, but the type of owner that was most closely associated with poor care. As in Australia the power of the sector, lobbying, donations and a revolving door inhibited reform.

Within the last few years there have been two massive aged care corporate collapses – Skyline Healthcare and HRC ManorCare. One involved private equity. Many residents had been victims of their poor care. The intent of the report was to develop regulations that would adequately vet and exclude unsuitable owners from the sector.

UK: The UK has also had its share of scandals. The big private equity groups and BUPA Healthcare featured prominently. There have been two massive financial collapses, Southern Cross (2011) and more recently Four Seasons. Both were related to private equity ownership. HC-One[10] which bought most of Southern Cross and half of BUPA is owned by FC Skyfall LP, a complex corporate web based in the Cayman Islands. It has had its failures in care and is now in financial difficulty.

---

7 UNC Children's suspends complex heart surgeries after report raising safety concerns 18 June 2019 : https://bit.ly/369XHIP
Michael Bloomberg took control of Johns Hopkins with his billions. Then, death rates skyrocketed at a children's hospital. The Healthcare Channel 21 Dec 2019 https://thehcc.tv/2019/12/21/under-new-leadership-johns-hopkins-creates-a-disaster-at-tampa-childrens-hospital/

8 Philadelphia Hospital Collapse Highlights Health Care 'Anarchy' Bloomberg 16 Jul 2019: https://bloom.bg/2ZdE9eN

9 Care Suffers as more nursing homes feed money into corporate webs, Kaiser Health News, 31 December 2017, http://bit.ly/2GSKLDT (related party transactions in the USA) Unmasked: Who owns California's nursing homes? The Sacramento Bee 9 Nov 2014 http://media.sacbee.com/static/sinclair/Nursing2/index.html (the consequences for care as money is siphoned away)
Britain's care homes are being turned into complex financial instruments Open Democracy UK 11 March 2016 http://bit.ly/2rG65FM

10 HC-One, Wikipedia https://en.wikipedia.org/wiki/HC-One
Mapped: the care homes with the most complaints in Scotland, The Ferret, 30 May, 2017: https://bit.ly/2WJ2xmY
Care home provider HC-One sounds alarm over £265m loans, The Telegraph, 2 May 2020: https://bit.ly/2yePQ9T

Australia: Australia differs from both in that owners once required a measure of character (probity requirements) before a license to operate in health and aged care could be provided. It was not usually these regulators that detected problems. It was when they were supplied with data by citizens during the 1990s that state regulators acted responsibly to contain the risks they created. They did so, even when they were under strong political and market pressure to grant licenses.

A study by Jenkins and Braithwaite[11] in Australia in 1993 confirmed the greater incidence of failures in care in for-profit owned nursing homes in Australia. It found that:

> "... A significant source of non- compliance is pressure on senior management from proprietors to reach financial goals that can only be attained by cutting corners on quality of care. This source of non- compliance is stronger among for-profits than non- profits in a sample of 410 Australian nursing homes ..."

In spite of this and convincing data from the USA showing the impact of owners, probity requirements in Australia were repealed in 1997. The sector was liberalised and turned into a free market. Probity reviews were replaced with an 'Approved Provider' process. New owners who were not providing the hands on care themselves did not even have to apply to operate in the sector. No further studies comparing the two types of owners were done until 2014 when the findings were confirmed. This thorny issue had been avoided for 21 years.

It was claimed that it was the actual provider and not these 'passive investors' who determined care. Staffing data were in confidence. Government regulators controlled the data, claiming that there was no difference in performance between ownership types. While staffing levels remain secret, several studies of the limited outcome data available since 2013 have confirmed the poor performance of for-profit providers. Some non-profit owners do not seem to be far behind.

Between 1998 and 2011, information to support objections to the operation of four large multinationals planning to enter aged care was supplied to the federal health department. This was on the basis that their past conduct showed they were not of good character. In each instance, the department indicated that it did not have the powers to regulate owners as they did not have to seek approval to own a company that was already approved.

Of these four companies, one entered bankruptcy before entering aged care, one private equity group did not buy, and another private equity group sold within a year making a large profit. The only one that remains is BUPA. As the Commission is aware, it has been in the newspapers for all the wrong reasons. Half of its nursing homes have recently failed standards. When it bought Amity Health in 2006 the department was supplied with worrying data because of concerns that it was unsuitable. The risk that something like this might happen was predictable. We have the same problem as the USA and the UK.

Filtering out unsuitable entities

This problem of unsuitable owners had already been pressed in the USA in 2007 but little action followed.

Professor David Zimmerman gave testimony[12] to the hearing *"Nursing home transparency and improvement"*[13] before the Senate Select Committee on Aging, United States Senate in 2007.

---

[11] Jenkins A and Braithwaite J 'Profits, pressure and corporate lawbreaking' in Crime, Law and Social Change 20: 221-232, 1993 http://bit.ly/2YFvazZ

[12] Testimony of David R. Zimmerman, Ph.D. Department of Industrial and Systems Engineering University of Wisconsin–Madison Senate Select Committee on Aging November 15, 2007 https://www.aging.senate.gov/imo/media/doc/hr183dz.pdf

Rapidly developing problems and lack of transparency in the private equity and for-profit corporate webs responsible had recently been exposed by investigative journalists.

Zimmerman stressed the importance of total transparency in corporate and nursing home ownership. He urged that ownership in all its complexity be disclosed and carefully vetted. He emphasised the importance of owners (landlords) and the need to include them in any assessments. He stressed the importance of verifiable staffing transparency with every nursing home reporting staffing information in a standard format. He pressed for the focus of regulation to move from its focus on individual facilities to include *"nursing home corporations and networks"* with attention to *"corporation's policies and procedures that govern the system of care"*. Regulators should have *"the authority to take corrective action with respect to corporate entities if there are problems at individual facilities"*.

He describes the consequences of corporations appointing leaders to achieve goals, but denying them the resources to do so. He recognised the difficulties in meeting these goals.

We urge the Commission to read this short but important submission. It deals with important issues.

Report by The Long Term Care Community Coalition

The webinar examining state regulation on 21st April 2020 is from the *The Long Term Care Community Coalition*. The webinar is based on the report of an investigation by the coalition into USA state regulations governing the issuing of licenses for owners of nursing homes. It was assisted by a number of state community advocacy groups.

It pressed for open disclosure and transparency to all interested parties when applying for licenses and for financial capacity to be carefully evaluated before granting licenses.

The issue of particular interest in the webinar was the strong advocacy for the introduction of a measure of character to determine suitability to operate and a strategy to ensure transparency of the process.

Related material:

1. **Webinar:** Promising Practices for Evaluating Nursing Home Owners (1 hour plus): https://bit.ly/35mDIFi
2. **Accompanying PowerPoint slide presentation:** https://bit.ly/3cHgM17
3. **LTCCC Licensing requirements template:** Essential Principles for Nursing Home Licensing Requirements: https://bit.ly/2ybIBQ9 ***(see attached)***
4. **Report:** Meaningful Safeguards: Promising Practices & Recommendations for Evaluating Nursing Home Owners: https://bit.ly/2YBOPnl

The material in these related items is repetitive and it is not necessary to listen and read it all. The attached Essential Principles describe the proposals. If information is required in regard to the current regulations in US states, then the PowerPoint presentation slides are detailed and specific. Both summarise the report, which gives more detail.

---

[13] Nursing Home Transparency and Improvement, United States Senate: https://www.aging.senate.gov/hearings/nursing-home-transparency-and-improvement

The only speaker to add much to this was the final speaker, Executive Director of *Long Term Care Community Coalition*, Richard Mollot[14]. He spoke to the slides and stressed the importance of the proposed measures of character and the importance of informing and involving citizens when investigating that. That information with relevant transcript is in Appendix 1.

1. **00:00 --- Richard Mollot: Introduction** *(Slides 1 to 4)*
   About LTCCC and the serious problems in Skyline Healthcare and HRC ManorCare
2. **8:80 --- Dara Valanejad: State regulations** *(Slides 7 to 36)*
   A brief review of the US situation including the role that states play in licensing facilities. The talk describes the more promising assessments done by some states including some assessing character. It then summarises key findings from this review.
   This speaker simply reads from the presentation slides and it is quicker to read the slides
3. **37:13 Richard Mollot: The Essential Principles for Government Licensing Requirements** *(Slides 37 to 51)*
   The speaker talks selectively to the slides and emphasises the importance of an assessment of character, of engaging all interested parties in the assessment, of transparency and of input from citizens with an interest. (*See Appendix 1 for summary of first part and then transcript about character*)

The research did not assess the extent to which the states enforced the regulations already in place, but the report itself does comment that states have *"significant power to protect residents from bad actors"*. Elsewhere it says that in spite of a statutory duty to residents *"the government continues to demonstrate little appetite to intervene in the industry's business"*.

There is actually a long history in the USA of revolving doors, regulatory capture, lobbying, political donations and convenient social engagement of providers and politicians at state level. Regulatory effectiveness has been compromised. Politicians have been able to fire state regulators and we recall claims that providers who did not like the assessments they had done arranged for this. One state attorney general, when presented with evidence of health care fraud in 1993, admitted that the company was too powerful in the state to prosecute.

Measuring character is something that is relatively new in the USA. While the measure of character and fitness was not the first recommendation in the report, it was obviously seen as critically important and Mollot said as much at the webinar. As important was that *"any individual may request a public hearing*" and that if requested *"the Department shall conduct a hearing"*. This was clearly intended to enable the transparency needed to counter the problems referred to in the previous paragraph.

This is an issue that needs attention in Australia too.

Medical Loss Ratios[15]**:** The Commission may also be interested in The Long Term Care Community Coalition's advocacy for *"requiring providers to use designated percentages of reimbursement on resident care"*. This is to counter the many providers who have developed strategies that enable them to divert funds from care to profit. Corporate webs and related party transactions are commonly used for that purpose.

---

[14] Long Term Care Community Coalition (LTCCC): https://nursinghome411.org/about-ltccc/

[15] Medical Loss Ratios for Nursing Homes: Protecting Residents and Public Funds (LTCCC): https://nursinghome411.org/joint-statement-medical-loss-ratios-for-nursing-homes-protecting-residents-and-public-funds/

Related matters: Health care and aged care integration

Another lengthy webinar was conducted by the National Academies of Sciences, Engineering and Medicine (NAS) - "***Keeping Nursing Home Residents and Staff Safe in the Era of COVID-19: A Webinar***"[16].

While this webinar is about the response to the Coronavirus crisis, which may not be relevant for the Commission, we think that the way that Maryland in the USA had structured its aged care system differently is of interest. It had already done so and integrated its health and aged care systems when the crisis broke. Maryland already had a system where its local hospitals were reaching down into its nursing homes to help and support. It had adopted a different approach to providing clinical care to other states and was ready to respond rapidly. The presentation by Michele F. Bellantoni near the end of the presentation describes this. We have copied that section from the transcript into Appendix 2.

Their efforts were unsuccessful because of the limited number of test kits available and the large numbers of asymptomatic residents and staff who could not be tested. There has been strong criticism of the federal government and some states tardy response to the pandemic in nursing homes[17]. Providers have been accused of hiding information[18].

---

16 "Keeping Nursing Home Residents and Staff Safe in the Era of COVID-19", NAS, Webinar, 22 April 2020: https://bit.ly/2VvI0CG

17 Advocates demand stronger federal action as nursing homes engulfed by pandemic ABC News 3 May 2020 https://abcnews.go.com/US/advocates-demand-stronger-federal-action-nursing-homes-engulfed/story?id=70473082

18 Nearly 100 people may have died from coronavirus at a nursing home in New York City CNN 3 May 2020 https://edition.cnn.com/2020/05/02/us/isabella-geriatric-center-coronavirus-nyc/index.html

D. Appendices

Appendix 1: Richard Mollot's comments (LTCCC) Essential Principles for Government Licensing Requirements

Introductory overview
Summary:

Mollot briefly described the corporatization of aged care by some who came to the sector to suck money out and provided very poor care. They were very poorly prepared for the Coronavirus pandemic. He was concerned about the sort of people running these companies. Federal government took a very hands off approach and left registration and licensing to the states.

Application process: *Slide 39-40*
Summary:

Mollot stressed that applications should specify ownership structure and that there should be a penalty for deception. He explained why this was important, yet difficult to determine and indicated that *Nursing Home Compare* was sometimes inaccurate.

Financial Capacity: *Slides 41-42*
Summary:

Mollot indicates why this is obviously important and reads the slides. He stressed the need for a comprehensive review of capacity and of any past issues. He describes what happened with the 2nd largest US company, HRC ManorCare, when it was purchased by Private Equity - hence the importance of ensuring financial integrity.

He stressed the importance of requiring an adequate security bond for each nursing home using the example of Skyline where *"they hadn't paid their staff per month they hadn't paid vendors for months and some of those cases as we hear too often I remember that some of the staff were actually buying supplies for their residents before the facilities closed down".*

Character and Fitness:

Full transcript
Slide 43

Character and fitness, this has always been frankly the biggest issue for me because what I at least, you know, have looked at and reviewed some of the state's reviews of nursing home prospective owners, often times they're showing that they're going to make a profit. I mean it doesn't include of course the chain I just spoke about, but the quite often there is they made seven eight hundred thousand dollars in one year they're planning on clearing 1.2 million dollars in year two about the same or more in year three etc so I'm not so worried, I am worried about the finances of course and that's important.

But to me it's really the character and encompasses some of the things that Dara (Dara Valanejad previous speaker) spoke about and found in terms of you know, was there abuse allegations in the past that were found to have been criminal allegations where there were criminal indictments etc.? Have there been issues where a facility has been where the owners have been held accountable in the past?

So some of the essential principles here is that the one of course the applicant must submit information regarding their character, their experience in the industry, their competency and their standing in the community – we could have got a lot of that from New York actually.

The Department of Health's shall deny a license to any applicant who has falsified any information data or record required by the application, been convicted of any crime including physical, sexual, mental, verbal abuse or neglect and been convicted of any crime involving the misappropriation of property or of financial abuse - - - continue with character and competency so let me just go back up again so make sure that I caught that.

Slide 44:

Okay, so I'm talking about denying a license to any applicant, so in addition a license should be denied if it was founded permitted aided or abetted in the commission of any illegal act against the nursing home resident; if they demonstrated an inability or willingness to fully comply with state and federal requirements; if they had any direct or indirect ownership interest in a facility that's been cited for five or more actual harm deficiencies or three or more immediate jeopardy deficiencies; or their state equivalent in the past three survey cycles. We've talked about this of this kind of issue a lot in the past and we surely will again in the future we have a lot of materials on this but reach out to us if there's something that you would like further explanation on.

But we really want to get an idea of the history, of the performance of these facilities in a meaningful way. So these are some of the criteria, you know sometimes someone has one deficiency, that may be one thing, but if you've had a series of deficiencies, especially when they've identified harm or immediate jeopardy, that should be a red flag.

In addition, they should be denied if the prospective owner has been involuntarily terminated for Medicare and our Medicaid programs in any capacity and if they've engaged in activities that the state determines are detrimental to the health, safety and well-being of nursing home residents.

Change of Ownership:

Full transcript
Slide 45 and 46:

*In respect **to change of ownership** here are some of the basic principles again that we think should be in both state and federal law:*

- *Licenses cannot be transferred between owners;*
- *Applicants must notify the state their intent to acquire nursing home at least three months 90 calendar days before the change of ownership*
- *Applicants must publish notice of their intent to acquire a nursing home 90 days before the effective date of the change of ownership;*
- *The notice must include the names and addresses of any individual or entity with the prospective ownership interest in the facility;*
- *It must describe any planned changes to the facility's operations and must indicate that any individual may request the public hearing or submit comments to the department on the change of ownership within 21 calendar days over the licensees notification;*

So we really want to get in here that there is the ability for the public to have knowledge about what's going on and also to speak out to contribute to their experiences with the owner or prospective owner to the decision-making process.

Slide 47:

I think this is lastly in regard to change of ownership:

A copy of the notice of change of ownership must be provided to the following:

- *every resident in the facility and/or the residents representative;*
- *the facility's resident and family councils where they have them;*
- *each staff member of the facility;*
- *both the state and the local long term care Ombudsman programs;*
- *members of the General Court who represent the city or town where the facility is located;*
- *any 501(c)(3) nonprofit organization that advocates for nursing home residents in the city or the town where the facility is located; and*
- *a representative of the local official to the city or town where the facility is located;*

So we really want people to know what's going on. This shouldn't be hidden behind closed doors.

Additional Resources:

Full transcript
Slide 48 - 50:

And then lastly I'm going to talk about some additional resources that we have here as I mentioned before and are mentioned as well. We charted this all out for basically by each state so all the information that are presented before it's available and in a chart so that you can see and you can use this information

We really want people I think - - this is a - - has a potential to be a very meaningful way, especially going forward what I hope, in the months and maybe years ahead, will be reassessing who gets to purchase nursing homes, who gets to provide care to people who need 24-hour a day 7-day nursing care and monitoring, and who gets to be entrusted with that.

I think it's clear at least from our perspective, that we as a society need to do a better job and so this, I hope will provide people with the tools to advocate for that in their states and in their communities.

We also put together again, as I was just talking about some of the essential principles of nursing home licensing requirements, those are also on a separate resource document that you can use and I'm done. I'm going to wrap it up I thank you all very much for joining us today.

Appendix 2: Michele F. Bellantoni

Selected Transcript "***Keeping Nursing Home Residents and Staff Safe in the Era of COVID-19: A Webinar"***

Timeline Track 26:16 to 33:50:

Thank you, Terry. And thank you to Dr. Katz for setting the stage. I'm going to speak about the role of geriatric medicine and leadership in post acute care.

The planning for our response here in Maryland began years ago what Dr Chisholm are described as our Maryland response for emergencies.

Here at Hopkins Argo team was founded in 2009 but the responses were not to nursing facilities, but for hurricanes here in Maryland, our most common environmental disaster.

But we've also been planning in the post acute care sector through our health systems here in Maryland, the Maryland Hospital Association has brought together the hospital systems and the skilled nursing facilities and we've had summits on post acute care transitions in care from hospitals to skilled nursing facilities and skilled nursing facilities to hospitals and these summits have brought the leaders of these healthcare sectors together to partner and challenges.

For example, in Maryland in February we rolled out a uniform form that's used for transfers from skilled nursing facilities to hospitals, a single form that is one page that has pre populated by the facilities with key contact information and facilities capabilities of managing ill patients, including their access to diagnostic studies radiology studies and their treatments availability of intravenous medications and this form is put into a red folder and handed off to the EMAS who then hand it off to the medical providers of the emergency room. And this form is completed by the emergency room providers when it's appropriate for a resident to return to the skilled nursing facility.

With the ability to do a warm handoff through telephone contact easily having this information available. So these partnerships have begun before COVID and now those partnerships are put into play through what (Dr) Katz described as our responses with hospital teams including hospital teams with geriatric medicine expertise.

Assisting the medical directors and the directors of nursing in the skilled nursing facilities so partnerships, understanding the patient population goals of care and implementing safe practices for prevention and treatment. And as Dr. Katz has so pointed out of treatment is important and in the skilled nursing facilities.

We've also been working on interoperability of even our electronic health records as many of our skilled nursing facilities use a single type of electronic record and the interfaces that are possibly between hospital and skilled nursing facility.

We've also been using best practices in early April, the American Medical Directors Association held the annual meeting virtually with over 1,200 registrants, many of whom are either medical directors of skilled nursing facilities and assisted livings, or their practitioners, nurse practitioners physicians, physician assistant directors of nursing in these populations and key Symposium on best practices of managing COVID testing as Dr. Katz described co hoarding of residents with active symptoms, all of those issues were addressed in early April at a time when across the country skilled nursing facilities were …

… preparing for what we're now seeing which is so many if not almost all facilities, having to respond to COVID management.

We've continued this type of ongoing education and sharing of best practices here in Maryland, our mid Atlantic Medical Directors Association, led by our president Dr John Loom of Genesis skilled nursing facilities.

Having weekly conferences on Thursday evenings at 7 to 8pm and attended by almost 100 medical directors and practitioners here in our area describing what they're experiencing. And it was, in fact, during last week's call that we got to hear that some of the responses of our strike teams were not adequate.

That, well, we came in and we provided PPE (Personal Protective Equipment) briefly and evaluations ongoing access to PPE became an obvious issue for sustainability of our skilled nursing facilities that were accepting COVID positive patients. After that call, the next morning, the leaders of Johns Hopkins Medicine (Baltimore, Maryland) were informed of this and our strike team leadership were informed of this, and that quickly changed to provide the adequate access for people to have an ongoing established management of COVID in our skilled nursing facilities.

Another opportunity was identified through this weekly call small assisted livings were not being serviced by the strike teams and the next day after that call. They were indeed serviced by the strike teams because assisted living groups also with asymptomatic spread of COVID diagnosed by Dr. Katz, and her work. Also needed the appropriate PPE for their staff and education.

Because an assisted living and 30 residents that would would otherwise have come here to our hospital would have overwhelmed, our ability to manage code in our acute care setting - - - So these partnerships of skilled nursing facilities and hospital systems that began before COVID19 have served us very well here in Maryland.

Our organizations have medical directors who are leaders in this post acute care field. Nationally, the American Medical Directors Association locally. The Mid Atlantic Medical Directors Association have supported the leaders in our post acute care settings.

To continue to manage COVID in this setting, and I want to say one more important point, and that is the importance now of assisted living in group home in the post acute care and community sectors as an area for response needed for COVID19 management. And then finally, the importance of working with our media to understand our environment of post acute care.

We've seen family members on the news that have expressed their concern or remorse for the care of their of their loved ones in a setting where they cannot visit, and many do not have access to virtual visits and how important it is that we tell our story of the dedicated workers and post acute and long term care.

Many of whom are working without the PPE that we've had so luxuriously here in the hospital setting to manage this condition and so telling our story in a positive way, is so important for us to continue this great work that we're doing.

And I'll turn it back to Terry.

Attachment: *'Essential Principles for Nursing Home Licensing Requirements'*

LONG TERM CARE
COMMUNITY COALITION
Advancing Quality, Dignity & Justice

Essential Principles for Nursing Home Licensing Requirements

Following are essential principles for government licensing requirements which, we believe, provide a baseline framework for improving accountability and integrity in the nursing home licensure process. The principles incorporate some of the promising practices identified in our report, **Meaningful Safeguards: Promising Practices & Recommendations for Evaluating Nursing Home Owners**, as well as practical ideas to address known and longstanding shortcomings in the effectiveness of current government policies. Please note that these principles are a starting point for developing or improving laws and regulations, not a comprehensive model for licensing requirements.

Policymakers are encouraged to use this language as a template for developing meaningful nursing home requirements on the state and federal levels. Consumers and the general public are encouraged to call on their state and federal leaders to adopt these principles to ensure both nursing home safety and the integrity of the public programs (Medicare and Medicaid), which pay for a majority of nursing home services.

In situations where changing laws or regulations is impractical, we encourage state and federal agencies to adopt these principles, to the greatest extent possible, to address growing concerns about inadequately vetted nursing home providers.

The Long Term Care Community Coalition (LTCCC) is a nonprofit, nonpartisan organization dedicated to improving quality of care, quality of life, and dignity for elderly and disabled people in nursing homes, assisted living, and other residential care settings. Please visit our website for more information on our work; the latest data on nursing home staffing and quality; and free resources for consumers and other stakeholders on residents' rights, dementia care, and more.

www.NursingHome411.org

Any person acting individually or jointly with other persons to build, own, establish, or operate a nursing home shall submit an application for licensure to the state's Department of Health. No individuals or entities may operate a nursing home without a license approved by the Department. Licenses must be renewed annually. Current licensees are subject to the same requirements as first-time applicants. The Department shall deny licenses to any applicant who has not timely submitted a complete application and provided the Department with additional information, as requested.

A. Application. The application shall be under oath. The submission of false or misleading information shall be a felony under [applicable state law]. The application shall contain the following information:

1. The identities of any individuals or entities having a direct or indirect ownership interest whatsoever in the facility, whether the interest is in the profits, land, or building.
2. The identities of any individuals or entities having a direct or indirect interest in the management of the facility or the provision of services at the facility.
3. The name and location of the facility. Every facility shall be designated by a permanent and distinctive name. The name shall not be changed without prior written notice to and approval from the Department. A separate license shall be required for each facility when more than on facility is operated under the same ownership.
4. A list of every licensed facility of any state (including the District of Columbia) or territory in which the applicant has or had any percentage of interest in the ownership, management, or real property of that facility. Entities must disclose any facility in which members (as individuals or in connection with a previous entity) have or previously had any percentage of interest in the ownership, management, or real property of that facility.
5. In the case of a change of ownership, the disclosure of any relationship or connection between the old licensee and the new licensee, and between the old operator and the new operator, whether direct or indirect.

B. Financial Capacity. The Department shall deny a license to any applicant who fails to demonstrate a financial capacity to operate a nursing home.

1. Applicants must submit a detailed budget for three years of operations, prepared in accordance with generally accepted accounting principles. Applicants must submit evidence of access to sufficient capital required to operate the facility in accordance with the budget and the facility assessment, as required by 42 C.F.R. § 483.70(e).
2. Applicants must disclose any financial failures directly or indirectly involving any individuals or entities identified in the application that resulted in a bankruptcy, receivership, assignment, debt consolidation/restructuring, mortgage foreclosure, cooperate integrity agreement, sale, or closure of a nursing facility, the land it sits on, or the building in which it is located.
3. Applicants must disclose the identities of any individuals or entities having an interest in the mortgage, note, deed of trust, or other obligation secured in

whole or in part by the equipment used in the facility, or by land on which or building in which the facility is located.

4. If the Department suspects or determines that a licensee is insolvent or shows a tendency towards insolvency, the Department shall have the right to request additional financial information, data, and records. Licensees must submit the requested materials within ten calendars day of receiving the Department's written request.
5. Any financial information, data, or records submitted to the Department shall be open for inspection and may be released in any judicial or administrative proceeding brought under the federal Nursing Home Reform law.
6. Applicants must disclose all vendors providing services at the nursing home. Identified vendors shall be requested to submit letters identifying whether the nursing home is paying bills on-time or not at all.
7. Applicant must purchase and maintain a surety bond for each facility operated in the state. The bond value must be a minimum of $1,000,000 per 100 certified beds.

C. Leases or Subleases. Applicants must submit a copy of any executed contract conveying the legal right to the facility premises, including leases, subleases, rental agreements, deeds, and any amendments to those contracts within 30 days of the effective date. Applicants must disclose the identities of any individuals or entities having an interest in the lease or sublease of the land on which or building in which the facility is located. The Department shall deny a license to any applicant whose lease or sublease is above fair market value.

D. Character and Fitness. Applicants must submit information regarding their character, experience, competency, and standing in the community. The Department shall deny a license to any 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 three 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.

E. Management. Each applicant shall provide an official copy of any executed management contracts between the applicant and the individual or entity managing the facility or providing nursing home services. Applicants must demonstrate that the individuals or entities managing a facility have the education, training, and experience to provide for the health, safety, and wellbeing of residents.

1. The Department must receive an organizational chart showing the relationship (e.g., common ownership) between the applicant or licensee, contractor, and all related organizations.
2. Applicants and licensees must notify the Department of any changes to a management contract within 60 days of the effective date of those changes by submitting the new or revised management contracts. The applicant or licensee must notify the residents and their representatives thirty days before the effective date of a new or revised management agreement.
3. Applicants and licensees may not give the manager responsibilities that are so extensive that the licensee is effectively relieved of responsibilities for the daily operations and provisions of services at the facility. If an applicant has done so, the application shall be denied. If a licensee has done so, the Department shall determine that a change of ownership has occurred.

F. Change of Ownership. Licenses cannot be transferred. A license is issued to the individual(s) or entities named in the application and for the facility identified in the application. The license immediately becomes void and must be returned to the Department when there has been a change of ownership. Applicants including after the following events have occurred:

1. The sale of the facility's title;
2. The lease or sublease of the land on which or the building in which the facility is located; and
3. The licensee has given the manager of the facility extensive responsibilities for the daily operations and provisions of services at the facility.

Applicants must notify the Department of their intent to acquire a nursing home at least 90 calendar days before the change of ownership. Because nursing homes owners may not operate a facility without a license, the Department shall either approve or deny an application before the effective date of change of ownership.

Applicants must publish notice of their intent to acquire a nursing home 90 days before the effective date of the change of ownership. The notice must include the names and address of any individual or entity with a prospective ownership interest in the facility. The notice must describe any planned changes to the facility's operations. The notice must indicate that any individual may request a public hearing or submit comments to the Department on the change of ownership within 21 calendar days of the licensee's notification.

A copy of the notice must be provided to the following:

- Each resident and, if applicable, the resident's representative;
- The facility's resident council;
- The facility's family council;
- Each staff member of the facility;
- The Office of the State Long-Term Care Ombudsman;
- The Office of the Local Long-Term Care Ombudsman;
- The members of the General Court who represent the city or town where the facility is located;
- 501(c)(3) Citizen advocacy Organizations the support nursing home residents in the city or town where the facility is located;
- A representative of the local officials of the city or town where the facility is located.

If requested, the Department shall conduct a hearing no later than 45 days before the effective date of the change of ownership. The Department shall provide notice of the public hearing at least 14 calendar days before the date of the hearing. The notice must include the date, time, and location of the public hearing. The Department shall make special accommodations for individuals with disabilities.

G. **Criminal Liability**. Failure to adhere to the change of ownership requirements shall be a felony under [applicable state and federal law] for both individuals and entities.

Conclusion

Federal and state policymakers must take steps to protect nursing home residents from the ongoing cycle of toxic ownership within the nursing home industry. Given that Medicare certification depends on state licensure, states have a unique opportunity to impose meaningful requirements on individuals and entities owning or operating a nursing home. The

Long Term Care Community Coalition encourages policymakers to use our findings and the baseline principles to improve licensing requirements for the welfare of current and future residents and the financial integrity of the nursing home system. For more information about nursing home ownership and quality, please visit www.NursingHome411.org.

Note: Improving licensing and certification requirements is only one approach to holding nursing home owners and operators accountable. **Additional measures must be taken to ensure that public funds are being used effectively and residents are receiving quality care.** For example, LTCCC also supports the implementation of a medical loss ratio in nursing homes. To learn more this measure, please read our Issue Alert, "Medical Loss Ratios for Nursing Homes: Protecting Residents and Public Funds."