LeadingAge New York

October 4, 2021

Jeffrey A. Kraut
Chair, Public Health and Health Planning Council
Angel Gutierrrez, M.D.
Chair, Committee on Codes, Regulations, and Legislation
c/o Executive Secretary, Public Health and Health Planning Council
Empire State Plaza, Corning Tower, Room 1805
Albany, New York 12237

Re: 21-13 Addition of Section 415.34 to Title 10 NYCRR (Nursing Home Minimum Direct Resident Care Spending) and 21-20 Amendment to Sections 415.2 and 415.13 of Title 10 NYCRR (Minimum Staffing Requirements for Nursing Homes)

Dear Mr. Kraut, Dr. Gutierrrez, and members of the Public Health and Health Planning Council:

I am writing on behalf of the members of LeadingAge New York (LANY) -- non-profit and public providers of long-term and post-acute care services -- to offer comments on two proposed regulations: (i) the addition of section 415.34, requiring nursing homes to spend a specified percentage of their operating revenue on resident care; and (ii) the amendment to sections 415.2 and 415.3 imposing minimum nursing hours per day requirements in nursing homes.

These regulations are the by-product of legislation purportedly designed to improve the quality of care in nursing homes. We share this goal. However, neither the legislation nor the regulations will have the desired effect and, in fact, will yield unintended consequences that will negatively impact residents and staff. We would like to take this opportunity to provide a dose of reality and ask PHHPC and DOH to partner with us to attempt to turnaround the State's flawed approach to regulating and financing nursing home care. Nursing home residents -- our parents, grandparents, friends and neighbors -- deserve more than these regulations can offer.

We cannot begin to improve staffing and quality in New York's nursing homes without addressing the inadequacy of nursing home reimbursement. New York's Medicaid nursing home rates are based on 2007 costs, with no cost-of-living increase since 2008. Not only has the State failed to raise rates to keep up with rising costs, it has actually imposed significant cuts. In fact, in 2020, during the pandemic, the State cut nursing home rates by $168 million annually, while most states increased funding for nursing homes.[1] As a result of these reimbursement policies, 40 percent of New York's facilities have a lower Medicaid operating rate today than they did in 2016. The minimum hours regulations reference funding available to address staffing shortfalls. However, those funds -- $64 million (state share) -- will not even restore nursing homes to the rates they were receiving in 2019. According to a 2018 report commissioned by the American Health Care Association, New York's nursing home Medicaid rate falls short of costs by $64 per resident, per day – the largest shortfall of all the states surveyed –indicating that New York's nursing home Medicaid rate is among the worst in the country.[2]

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[1] These cuts include a 1.5 percent across-the-board cut to Medicaid payments as well as reductions to capital reimbursement. The $64 million included in the 2021-22 State Budget for nursing home staffing is barely a third of the $168 million in annual Medicaid cuts imposed on nursing homes in 2020. Musumeci, M. State Actions to Sustain Medicaid Long-Term Services and Supports During COVID-19. Kaiser Family Foundation. Aug. 26, 2020.
[2] Hansen Hunter & Company, "Report on Shortfalls in Medicaid Funding for Nursing Center Care," Nov. 2018. New York's $64 per day shortfall represents the largest shortfall of the 28 states the report analyzes.

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Whether it is the intention of the State or a product of inattention, the inadequacy of New York State's Medicaid rates is forcing providers that want to deliver high quality care to leave the market. Since 2014, approximately 20 nursing homes have consolidated or closed, and approximately 50 public and NFP nursing homes have been sold to for-profit entities. Moreover, during the pandemic, one non-profit nursing home in Westchester has closed, two upstate homes have announced fall closures, at least two are for sale in New York City, and several on Long Island have been sold or are in sale negotiations. We fully expect these numbers to grow.

The State's Medicaid rates simply do not allow for payment of competitive compensation to recruit nurses and aides away from hospitals and physician practices in a highly competitive labor market. Draining facilities of funds based on arbitrary formulas will not enable them to hire more staff. Nor will it help them to create the vibrant communities and homelike environments with strong infection prevention controls that represent the highest quality in nursing home care.

70/40 Direct Care Minimum Spending Regulation

Our members dedicate the overwhelming majority of their revenue to resident care. However, the minimum spending legislation and the associated regulation are blunt instruments that misunderstand or overlook important elements of nursing home finances and operations. Sadly, they will impede nursing home investments that would benefit residents and staff and will interfere with nursing homes' ability to comply with ever expanding state and federal policies. At the same time that the State is imposing this direct care spending requirement and limiting the amount that facilities can spend on administration, the State and federal governments continue to impose onerous administrative requirements on nursing homes, without raising rates to cover the added costs. The daily and weekly HERDS surveys, weekly NHSN surveys, and twice weekly staff testing are just a few examples.

The most egregious aspect of this statute and regulation is its apples-to-oranges approach to capital spending and reimbursement. Approved capital expenditures are reimbursed in Medicaid nursing home rates on a pass-through basis via the capital component of the rate. Under the regulations, capital expenditures are excluded from the direct care category. However, capital reimbursement is *included* in revenue, with the exception of "the average increase in the capital portion of the Medicaid reimbursement rate from the prior 3 years." Although the scope of this exclusion is not clarified in the regulations, it appears that only incremental capital reimbursement over a brief timeframe is excluded from the calculation of the spending ratio.

As a result, during a pandemic involving an airborne, highly contagious virus, *this regulation actually discourages, if not outright prevents, facilities from making capital improvements that support infection control.* The Green House model facilities have been particularly successful in preventing outbreaks in their homes,[3] and we know that the Department requires COVID-based cohorting of residents and socially-distant visitation. Yet, this regulation will discourage, if not prevent, facilities from creating smaller units or small house models to control the spread of disease, from upgrading their HVAC systems, from creating separate cohort-specific break rooms for staff, and from expanding spaces for visitation or staff testing. If the State

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[3] Zimmerman, S. Nontraditional Small House Nursing Homes Have Fewer COVID-19 Cases and Deaths. *JAMDA, Mar. 2021.*

truly wanted to strengthen infection prevention for residents and staff, it would not have enacted this legislation. If it cared about creating homelike environments for residents, it would not have enacted this legislation.

The Department just released a $208.3 million transformation grant RFP, of which a minimum of $23.1 million must be allocated to nursing homes. Will the nursing homes that receive these grants be able to accept them without running afoul of the 70/40 rule? The regulation authorizes facilities to apply for a waiver to have certain "revenues and expenses excluded from the calculation of the facility's total revenue and total expenditures." As described in more detail below, grants like these, as well as other one-time or non-recurring revenue, should be excluded from the 70/40 calculation as a general rule. An application for a waiver should not be required.

In the three days since the regulations were first posted, we have also identified a number of more technical flaws in the regulation that should be clarified or corrected prior to publication. We may identify additional concerns or defects once we have more time to review the regulations (as it just became publicly available on Friday evening). The following are the issues identified to date:

- The definition of "Direct Resident Care" does not appear to include security and medical records which are necessary for proper resident care and safety.
- The definition of "Contracted Out" is over-broad and could be interpreted to include per diem employees. The intent of the statute was to discount expenditures for individuals retained through a staffing agency or a related company, not individuals directly employed by the facility --there is no 15 percent profit margin built into the wages paid to a per diem employee.
- The definition of "Revenue" should be clarified. The intent of the statute and regulation appears to be to compare direct care expenditures with *patient or resident care* revenue. However, the definition of "Revenue" may inadvertently bring in other operating revenue, such as investment income, grants, and revenues from other non-patient care activities. Since these funds are not paid as reimbursement for resident care, it is unclear why they should be paid to the State if they are not spent on resident care. As noted above, these non-patient care revenues should be excluded from the calculation by definition and should not require an application and demonstration that they are exceptional or unexpected.
- The definition of "Revenue" similarly appears to include reimbursable cash receipts assessments, effectively levying a fee on a tax reimbursement. Reimbursement for the assessments should not be included in "Revenue."
- The regulation appears to count distributions from the nursing home quality pool (which is funded through withholds from the Medicaid rates) as "Revenue" for purposes of the minimum spending ratio. These distributions, as well as a 1percent supplemental payment are typically paid in late fall, but are sometimes delayed by many months (they were paid in January 2021). If the payments are delayed, they could end up being reported in the following year's cost reports, resulting in artificially inflated revenues in the following year that don't align with the reporting year's expenditures. As a result, high quality facilities that receive distributions will be forced to pay them back through no fault of their own.
- Retroactive payments made in response to successful rate appeals should also be excluded from the definition of "Revenue." If reported in the year they are received, the funds will not align with expenditures and may trigger a recoupment. Facilities should not be penalized by the State's delays in keeping rates current

- The regulation does not address how the recoupment paid by a facility will be counted in the year it is paid to the State. If it is not counted towards qualifying costs for the year it is paid, the facility may be subject to a double penalty.
- The regulation does not explain how minimum spending will be calculated for hospital-based nursing homes which do not file the standard cost report.

Minimum Hours

The minimum hours regulation, like the minimum spending regulation, is a well-intentioned attempt to regulate away a problem that cannot be solved through regulations alone. Our members from Long Island to Buffalo are experiencing the worst staffing shortages in memory. In an effort to cover shifts and recruit and retain staff, they are paying signing bonuses, retention bonuses, and shift differentials. They are paying therapy staff to perform CNA functions. They are seeking the services of staffing agencies at exorbitant rates, but the staffing agencies cannot meet their needs. Notably, even though they have no choice but to expand their use of staffing agencies at unaffordable rates, these expenditures will not be fully counted for purposes of their 70/40 minimum spending requirement. The staffing agency expenses are discounted by 15 percent in the calculation of the minimum spending amount.

In order to fill vacant shifts, CEOs and Administrators are working evenings and weekends to feed residents, change linens, mop floors and do anything they are legally-authorized to do to care for the residents. Executives in some organizations are taking the CNA training to fill in on CNA shifts. They want to staff their facilities at the levels required by this regulation, but they simply cannot. They are already suspending admissions and closing units. Some are considering transferring residents.

These measures are enabling facilities to remain in operation for the short-term, but staff are weary, and at some point the extra money will not be enough to entice them to take on more hours. And, the added expense is not sustainable. As noted above, Medicaid rates were not covering costs before the pandemic, and they certainly cannot support inflated staffing agency fees and signing bonuses.

Even with the signing bonuses, there no applicants for vacant positions. Staffing shortages are driven in part by demographics and in part by market forces. The percentage of our population over age 65 and over is rising rapidly, while the percentage between 18 and 64 is shrinking.[2] Vacancies in nursing homes remain unfilled for months at a time. The minimum hours regulation will not create nurses and CNAs to fill these positions.

Even if there were people to fill vacant positions, the law's reliance on an arbitrary "one-size-fits-all" allocation of hours for nurses and CNAs to ensure high-quality care is misguided. It does not take into account varying levels of acuity and resident needs. Several LANY members, based on prior years' data, exceeded the minimum aggregate staff hours, but had higher than the required hours for RNs and LPNs and lower than the required hours for CNAs. Given financial constraints, the regulations would force these facilities to lay-off nurses in order to hire more CNAs. Similarly, facilities that serve a higher than average percentage of residents with dementia, who are ambulatory and require more social activities and supervision than clinical care, will have to lay off recreation and art therapy staff to hire more CNAs. Neither the facility administrators nor the residents' families would view this as a way to improve the quality of life of the residents.

Notably, the Department's August 2020 report on minimum staffing levels did not endorse the use of staffing ratios, stating:

> [O]pinion and published studies differ as to whether mandating specific, statewide nurse-to-patient ratios is the most effective approach to achieving those goals. While some studies find a correlation between nurse-to-patient ratios and patient outcomes, others found little to no correlation, especially in California, which is the only state that currently mandates minimum ratios. In addition, issues such as nurse workforce availability, cost, and limits on flexibility of the workforce exist that may challenge strategies that establish minimum nurse staffing levels.[4]

The report concluded:

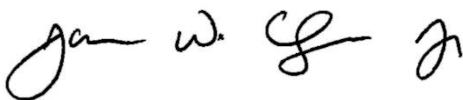
> Maintaining a nursing workforce that effectively meets the needs of patients requires a comprehensive approach to address today's multifaceted and complex healthcare delivery challenges. While the Department supports measures to improve quality of care and patient outcomes, the COVID-19 pandemic has only highlighted the need to maintain workforce flexibility.

In addition, we have identified the following flaws in the regulations:

- The regulation allows for reduced penalties if there are extraordinary circumstances that prevent the facility from complying with the regulation. However, even in the face of extraordinary circumstances, facilities must pay at least $300 per day for non-compliance. This is a steep penalty for facilities to pay for circumstances beyond their control. Draining facilities of funds during a pandemic will not support improved care or quality of life for residents.
- Under the regulation, in order for a labor shortage to qualify as a mitigating factor, the facility must demonstrate that it has closed units, suspended admissions or transferred residents. Transferring residents is a drastic step that is very distressing to the residents and their families. The State should not incentivize a decision to transfer residents.
- When executives or therapy staff fill CNA or nursing shifts, their hours may not be captured in the payroll-based journal data, and the facility may be fined even if the hours requirements were met.

Thank you very much for your consideration of these issues.

Sincerely yours,



James W. Clyne, Jr.
President and CEO

Cc: Colleen Leonard

[4] Study of Nurse Caregiver Minimum Staffing Levels and Other Staffing Enhancement Strategies and Patient Quality Improvement Initiatives, NYS Dept. of Health, Aug. 2020.

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