July 9, 2020

Honorable Liz Krueger
New York State Senate
State Capitol Building, Room 416
Albany, NY 12247

RE: Senate Recommendations on COVID-19 Response in LTC Facilities and Agencies

Dear Senator Krueger:

I am writing on behalf of LeadingAge New York to provide feedback on the Senate's recent letter to Governor Cuomo which offers recommendations on controlling virus outbreaks and protecting those receiving services in long term care settings. While we support some of these recommendations, we believe others are unnecessary and/or should be modified to accomplish the stated goal of enhancing providers' preparedness to contain the spread of COVID-19 and other communicable illnesses and protecting vulnerable residents and patients. In any case, the cost of these mandates should be supported by governmental payers.

LeadingAge New York represents over 400 not-for-profit (NFP) and publicly-sponsored providers of long-term and post-acute care (LTPAC) and senior services throughout New York State, including nursing homes, adult care facilities and assisted living, home care agencies and other home and community-based services providers, continuing care retirement communities, housing providers and managed long term care plans.

Overall Context

The Senate's recommendations would result in a series of new mandates on top of many pre-existing and COVID-19-related federal and state requirements that nursing homes, ACFs and home care agencies are struggling to align and satisfy in the face of exorbitant new costs and overwhelming revenue losses. The letter recommends "…that the Department of Health use existing resources, wherever possible, to assist facilities with the increased costs stemming from additional requirements resulting from the public health crisis." In the current budget reality, which includes roughly $1 billion in long-term care cost-containment actions in State Fiscal Year (SFY) 2021 (all funds), rising to approximately $2 billion in SFY 2022, this is tantamount to imposing unfunded mandates on a system of care that is already significantly stressed.

The federal Provider Relief funding being distributed under the Coronavirus Aid, Relief and Economic Security (CARES) Act is insufficient to fully offset COVID-19-related costs and revenue disruptions, and some providers such as ACFs have not been able to access any of this relief funding. The exorbitant

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costs associated with weekly staff testing in nursing homes and ACFs have, to date, not been covered by health plans or government funding sources. While personal protective equipment (PPE) has at times been unavailable at any price, when providers can purchase it, the costs are several times higher than they were prior to the pandemic. These providers have also incurred significantly higher staffing costs during the pandemic related to backfilling work time missed due to staff quarantine requirements, added staff time needed to closely monitor residents and patients and provide care for COVID-positive individuals, and hourly pay premiums resulting from hazard pay, increased overtime, and use of more expensive per diem and staffing agency workers.

As indicated in LeadingAge NY's testimony before the Legislature in Jan. 2020 – prior to the pandemic – New York's NFP and public LTPAC providers were already struggling financially. We reported that some NFP ACFs serving Supplemental Security Income (SSI) recipients are on the brink of closure, several NFP nursing homes had closed or were sold, and many home care agencies are incurring losses. We also discussed the serious staffing challenges our LTPAC providers are facing, compounded by shortages of key personnel such as nurses. Unfortunately, rather than ameliorate these issues, which became far more dire by March, the final budget resulted in deep cuts to LTPAC services and no relief. Through their longstanding missions, our members are committed to ensuring the health and safety of the people they serve and to maintaining the highest possible quality of life for these individuals. However, as a principal funder and regulator of LTPAC services, New York State bears a responsibility for ensuring that providers have sufficient resources to be successful in accomplishing these objectives.

In this regard, recent history validates the current inadequacy of resources allocated to LTPAC services and the steady depletion over time of government funding for the sector that pre-dates the pandemic:

- While neighboring states are supplementing Medicaid funding in recognition of the increased costs caused by the pandemic, nursing homes in New York are facing cuts that lower funding by $108 million annually. This is on top of rate decreases exceeding $120 million that homes experienced in the last 6 months of 2019.
- According to a national study, New York's nursing home Medicaid rates cover only 79 percent of the daily cost of care, creating an average $64.18 per day shortfall. As a result, 60 percent of NFP and 86 percent of public nursing homes had already incurred operating losses in 2018.
- 72 percent of certified home health agencies (CHHAs) have negative margins, and the median margin is -12 percent.
- The ACF SSI daily rate is $41.63 per day, which covers only half of the average daily cost of care according to 2015 figures – that gap has only grown with minimum wage and other cost increases.
- To maintain quality direct care staff, nursing homes and home care agencies must increase compensation by 2-3 percent annually. At the same time, the Legislature has eliminated Medicaid inflation adjustments in each of the last 12 years. Based on the Consumer Price Index, a Medicaid dollar in 2008 is worth only 72 cents today.

Comments on the Senate's Specific Recommendations

1. **In addition to mandating testing for Nursing Homes, and Adult Care Facilities (ACF) once a week, require Home Care Providers to also be tested once a week, and require complete testing of all Nursing Home, ACF and Home Care staff and residents when outbreaks occur, as well as contact tracing procedures when a positive result is discovered.** *While staff testing is an important aspect of infection control, it is very expensive and there is presently no source of funding to pay for it. There are approximately 185,000 workers in New York's nursing homes and ACFs and, according to the Paraprofessional Health Institute, approximately 210,000 home care workers. At an estimated cost of $125 per test, it would cost about $50 million to administer one test per worker for all these individuals. A similar amount would be required to test all residents and patients in nursing homes, ACFs and home care. Is the State of New York prepared to underwrite these costs?*

   In addition, testing is imperfect, with false positive and persistent positive results resulting in costly and unnecessary staff furloughs and quarantines. Sometimes entire households are quarantined for successive 14-day periods due to persistent positives, even though there is no evidence based on Centers for Disease Control and Prevention (CDC) guidance that these individuals are infectious. Thus, testing can worsen staffing shortages and lead to loss of income for entire households. Currently, the requirement to test home care (and hospice) workers entering nursing homes and ACFs is resulting in agencies refusing to serve these residents and creating barriers to needed care. Contact tracing should be used if there is an outbreak at a residential facility or evidence of spread among home care clients. Testing residents and staff that do not have contact with a positive case is oftentimes unnecessary and ill-advised.

2. **Provide daily public updates on the number of confirmed cases of COVID-19 in residents and staff with the percentage of infection in each category, deaths in the facility, and death of residents transferred to hospitals by facility, and by county.** *Nursing homes and ACFs are currently submitting daily surveys and weekly staff testing surveys through the Department of Health's Health Electronic Response Data System (HERDS). Nursing homes are also required to report data weekly to the CDC through the National Healthcare Safety Network (NHSN) system on: (1) counts of residents and facility personnel with suspected and laboratory positive COVID-19; (2) counts of suspected and laboratory positive COVID-19 related deaths among residents and facility personnel; (3) staffing shortages; (4) status of PPE supplies; and (5) ventilator capacity and supplies for facilities with ventilator dependent units. Accordingly, a new facility mandate is not needed.*

3. **Require facilities to report the above information through electronic means or otherwise to family members and legal guardians in a way best suited to reach them, as well as to the Long Term Care Ombudsmen's Program (LTCOP), including the LTCOP with responsibility for the facility.** *Nursing homes and ACFs are already subject to state requirements to notify family members or next of kin within 24 hours of a resident testing positive or suffering a COVID-19 related death. LTC ombudsmen and other members of the public already have access to the Nursing Home COVID-19 Public File which includes detailed facility-specific data reported by nursing homes through the CDC's NHSN system on COVID-19 resident impacts and other data elements (see: https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg). We do not support*

further mandates for nursing homes and ACFs to report data to additional parties when they are already readily available to the public.

4. **Establish a SWAT team to provide immediate assistance to help facilities to support and protect residents and staff when the infection rate hits a DOH-established metric, or when there is a significant increase in complaints.** *Other states have made available teams to provide infection control and staffing support to nursing homes. If done properly, with competent and trained personnel and sufficient government funding/staffing support, this can be helpful. The Centers for Medicare and Medicaid Services (CMS) recently updated its Toolkit on State Actions to Mitigate COVID-19 Prevalence in Nursing Homes (see: https://www.cms.gov/files/document/covid-toolkit-states-mitigate-covid-19-nursing-homes.pdf) which includes a section on Infection Control "Strike Teams". For example, Maryland launched statewide strike teams in April 2020 comprised of the National Guard, state and local health department representatives, emergency medical services clinicians, and doctors and nurses from local hospital systems. The strike teams provide on-site medical triage, supplies, and equipment to overburdened nursing homes in order to slow the spread of the virus. These strike teams are activated in response to requests from nursing homes, local health departments and Maryland Department of Health infectious disease experts.*

5. **Deploy qualified people back into facilities to do the important work of LTCOP volunteers while they are unable to physically enter facilities. Allow DOH inspections teams back into facilities to conduct needed inspections beyond those that constitute immediate jeopardy. Provide PPE to those who are entering facilities for these purposes. Furthermore, the DOH should reevaluate its entire nursing home inspection system.** *The LTCOP is following the guidance issued by CMS on March 13, 2020 which restricts visitation by families, non-essential health care personnel and other individuals. Under this guidance (CMS Memo QSO-20-14-NH), ombudsman programs are not on the list of entities with an exception to visit. The Commissioner of Health has indicated that the state is currently working on ways to expand the LTCOP's volunteer base and provide them with options to communicate with residents that are less reliant on in-person visits, steps which we support.*

   State surveyors have had no problem gaining access to facilities and performing infection control focused surveys, complaint investigations and complete inspections. Inspection teams need to be properly supplied and trained in donning and doffing of PPE. In this regard, we have received reports of inspection staff arriving without PPE and exiting COVID-positive units wearing their PPE, potentially exposing other residents and staff. Facility resources are under significant stress from COVID response, testing, surveys, reporting, NYS Attorney General audits and DOH survey inspections. All these administrative requirements divert direct care resources from caring for residents who need support more than ever, given the elimination of group activities and family visiting. Government agencies should be mindful of duplication of inspection and survey efforts, and the potentially negative effects of recurring inspections on resident care. We agree the survey process needs to be reevaluated and have documented significant regional inconsistencies in facility citations. While administration of the survey process is under the state's purview, the actual process is mandated at the federal level by CMS.

6. **Require all Nursing Homes and ACFs to report to DOH daily staffing levels, and if staffing levels fall below a metric determined by DOH, prohibit the Nursing Home or ACF from accepting new**

residents. *Nursing homes are already required to report their staffing levels through CMS's Payroll-Based Journal system. Section 6106 of the Affordable Care Act (ACA) requires facilities to electronically submit direct care staffing information (including agency and contract staff) based on payroll and other auditable data. These data, when combined with census information, are used to report on the level of staff in each nursing home. ACFs do not report on their daily staffing levels. They are not medical facilities, and most of them do not directly provide nursing and other professional healthcare services (these are typically provided by individual home care agencies or under contract). Any additional daily reporting requirement will put a further strain on staffing. As it is, facilities have had to pull people away from their typical duties to meet the many new mandates around testing and reporting.*

We seriously question the basis for setting a minimum staffing "metric." Every day, individual nursing homes and clinicians make staffing decisions based on each resident's condition, acuity, and individual care plan. Each resident is unique, with needs that can change rapidly and that demand differing types of assistance (e.g., residents with dementia may require more supervision and activities and fewer medical interventions). Every nurse and member of the care team has different expertise and experience. No two nursing homes are the same. Extensive research has found that the combination of higher levels of nurse education, the use of evidenced-based criteria and an effective mix of staff are all critical to quality care. CMS' final Requirements of Participation, the first major overhaul of the federal nursing home regulations in 25 years, included a number of significant revisions related to staffing determinations, staff competencies, education and in-service training requirements. In the rulemaking, CMS evaluated and expressly rejected the idea of setting minimum staffing ratios for nursing homes.

7. **Require DOH to establish a protocol to enable residents to leave the nursing home during a pandemic, and require DOH to establish a protocol for residents' return. Bedhold fees to be paid by residents or their families must be waived for the duration of the declared state of emergency.** *Nursing home residents have always been permitted to leave and return for short periods of time. However, to protect other residents from possible infection, those who leave may be subject to isolation requirements.*

   Nursing homes cannot be expected to hold beds without being paid for them. Existing Public Health Law § 2808(25) provides for Medicaid payment for up to 10 days of therapeutic leave per resident per year. There are fixed costs that must be covered, regardless of whether a bed is occupied, and requiring facilities to hold unknown numbers of beds for indefinite periods of time would be financially disastrous. Moreover, during a pandemic, when nursing home beds may be needed for post-acute care, it doesn't make sense to require facilities to reserve empty beds for potentially long periods of time for residents who have moved out. As it is, we are concerned that Chapter 114 of the Laws of 2020, which requires nursing homes to have a pandemic emergency plan in place, could be interpreted to require nursing homes to reserve residents' rooms without payment during any period of hospitalization.

8. **Require each nursing home to employ a qualified, full-time infection preventionist throughout the COVID-19 crisis. Require adult care facilities to, at a minimum, immediately consult with an infection control preventionist to plan and implement an infection control plan.** *This is*

unnecessary and unworkable. Federal regulations at 42 CFR § 483.80(b) already require each nursing home to designate one or more individual(s) as the infection preventionist(s) (IPs) who are responsible for the facility's infection prevention and control plan. Under the current regulations, the IP must: (1) have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; (2) be qualified by education, training, experience or certification; (3) work at least part-time at the facility; and (4) have completed specialized training in infection prevention and control. Is the Senate suggesting qualifications that go beyond the federal regulations and, if so, on what basis? Nurses with advanced infection control training exist, but they are not available in many communities and even when available, would require a substantial financial investment by facilities that are already challenged by reductions in revenue, skyrocketing expenses, Medicaid cuts and stagnant SSI payments. Every facility has had or will soon have an infection control survey by the state. If the state deems their policies and procedures are lacking and, in the case of nursing homes are noncompliant with federal requirements, the state can cite one or more deficiencies and mandate a plan of correction.

9. **Require the DOH and State Office for the Aging, in consultation with experts in long-term care representing facilities and consumers, to create a reimagining plan for future pandemics similar to plans to be made for hospitals, and to address underlying vulnerabilities exposed by the crisis to reexamine staffing levels, infection prevention, inspections protocols, and the impact of such protocols on resident mental health and well-being.** *LeadingAge NY would support and actively participate in a collaborative effort to learn from experience of the past few months and address the lack of resources provided to nursing homes and other long-term care providers, including the lack of PPE and staffing support. We would also support a thorough review of inspection protocols and consideration of the impacts of regulatory waivers and whether some should be continued in the long-term. It would be critical to involve DOH's Office of Health Emergency Preparedness which has a primary focus on emergency response. This pandemic has revealed the results of several years of insufficient state investment and unfunded mandates in the LTPAC services space.*

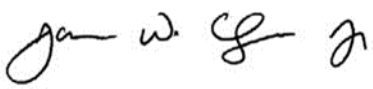
We strongly oppose the proposal to repeal Public Health Law Article 30-D – the *Emergency or Disaster Treatment Protection Act*. It promotes public health, safety and welfare by removing the fear of reprisal for health care providers and individual caregivers who are treating high-risk individuals while trying to contain the spread of COVID-19. Repeal of the Act would subject these providers to civil and criminal liability for care they provided during the pandemic, even if they acted in good faith despite circumstances beyond their control such as PPE and testing shortages, staffing disruptions, and changing governmental directives. Without this important liability protection, there could have been more preventable deaths from the pandemic due to fear of reprisal for all the decisions and activities associated with treating COVID patients. Furthermore, there are indications that liability insurers are planning to exclude COVID-related claims from facilities' coverage at renewal (often with retroactive impact for "claims made" policies). As a result, if Article 30-D is repealed, providers will potentially be entirely exposed to significant risk for claims related to good faith care provided in accordance with state directives during an emergency.

Throughout the pandemic, our NFP and public member nursing homes, ACFs and other senior services providers been engaged in selfless and heroic work, caring for individuals who are particularly vulnerable to this devastating virus. They have been working under extraordinarily challenging

conditions, with reduced staff and fewer resources than other healthcare provider types that were prioritized at the height of the pandemic. Our members have not shied away from their residents or from the hardest cases during this pandemic. Repeal of the Act would denigrate the heroic efforts of individual caregivers and facilities and hasten the financial decline of many of the state's NFP and public LTPAC providers.

Thank you for your consideration of our comments and recommendations. We await your response.

Sincerely,



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