LeadingAge New York **OPPOSE**

SENIOR HOUSING | ASSISTED LIVING | ADULT CARE FACILITIES | HOME CARE | RETIREMENT COMMUNITIES
ADULT DAY HEALTH CARE | PACE/MLTC | NURSING HOMES

MEMORANDUM

A.5685-A (Gottfried)

AN ACT to amend the public health law, in relation to establishing a required resident care spending ratio for nursing homes

This bill would establish a resident care spending ratio for nursing home expenditures, requiring at least 70 percent of operating revenue to be spent on resident care. It specifically excludes administrative costs as well as capital costs, rent and debt service from the definition of resident care. In addition, at least 60 percent of the required resident care spending would need to be spent on direct care provided by RNs, LPNs and certified nurse aides. For purposes of the calculation, only eighty percent of the amount spent on contracted staff would be counted as direct care expenditures. A provider who fell short of the two thresholds would be required to remit the shortage amount to the state in a time and manner established by regulations.

LeadingAge New York opposes this bill. We do not object to the goal of ensuring that nursing home revenues are dedicated to purposes that serve residents -- our members are not-for-profit long-term care providers that dedicate all of their resources to serving their mission. However, this bill would impose impractical and inflexible spending restrictions that do not take into account real-world demands on providers and the needs of residents. This bill threatens to disincentivize, if not preclude, payments for physician services and critical investments in nursing home physical plants and operations to support infection prevention and control and the quality of life of residents. Moreover, the legislation is over-broad in its scope, yet does little to address the state's concerns about preventing the diversion of funds from resident care to for-profit entities related to nursing home operators.

The first spending year subject to the bill's requirements would be 2022. While the direct impact of the pandemic may have diminished by then, unless considerable resources are allocated to assist recovering providers, facilities will remain under extraordinary financial and operational stress for a number of years. It would be imprudent to implement any mandatory spending provision without ensuring appropriate funding.

However, even with appropriate funding, the thresholds established by the bill are untenable. Requiring that a nursing home spend 70 percent of revenue on items that exclude administrative and capital costs may leave providers unable to meet their capital debt obligations. Homes, even those with negative margins and no revenue available, would be forced to increase spending to meet the established proportion because reducing spending on capital obligations is not an available option.

The requirement that 60 percent of minimum resident care spending be dedicated to direct care costs provided by RNs, LPNs and Aides ignores staffing arrangements that rely more heavily on physicians, nurse practitioners and therapy staff. Such a threshold would be impossible to meet during a pandemic or other health emergency when extraordinary circumstances (such as large increases in spending on items such as staff testing and PPE), would dilute the *proportion* of spending dedicated to nursing, even if *gross* spending on nursing increases. The provision is too rigid and could impede necessary reorganization of care in the case of a future emergency.

The bill's methodology for calculating the resident and direct care ratios triggers a number of unintended outcomes. By including capital expenditures in the calculation, the bill overlooks the fact that the capital component of Medicaid nursing home rates is spent on reported capital costs and is not reallocated to any other purpose. The capital reimbursement thus increases overall revenue, making it harder for a facility with high capital costs to achieve the patient care spending threshold, but is not intended to be used for staffing costs. Preventing facilities from allocating capital reimbursement to their capital costs would discourage, if not prevent, nursing homes from making crucial health and safety investments in their buildings including:

- Upgrading HVAC and air filtration systems that support control of airborne infections,
- Converting semi-private rooms to private rooms,

- Adding more private bathrooms,
- Creating structural separations among units to support cohorting,
- Adding entrances and exits,
- Developing safe visitation spaces,
- Creating more homelike environments.

Moreover, this requirement would threaten the ability of facilities to make debt service payments on existing capital projects, which in some cases are funded through financings backed by the State.

The bill's discounting of expenditures for contracted staffing is not properly targeted. The goal of preventing payment of inflated rates and diversion of funds to related staffing agencies is laudable. However, this provision would penalize facilities that are forced to rely more heavily on costly staffing agency personnel to supplement employed staff in response to emergency situations, such as COVID-related absenteeism, without directly addressing the state's concern about routine payment of inflated rates to related entities. Instead of discounting payments for all purchased or contracted staff services, the bill should require disclosure of relationships between nursing homes and staffing vendors and target any limitations to arrangements within the provider's control.

Finally, this bill is overbroad and should not include within its scope pediatric nursing facilities, continuing care retirement community (CCRC) nursing facilities, or hospital-based nursing facilities. CCRC nursing homes serve residents who purchased homes and a continuum of long-term care services within the CCRC campus. These nursing homes receive little or no Medicaid reimbursement and are designed to promote reliance on private pay arrangements. CCRCs are actively governed by their well-informed and highly-engaged residents, who have paid for their homes and coverage of their long-term care needs in the CCRC. They should have the right to determine how their money is spent on their nursing home. Including CCRC nursing homes under these provisions would be unwise and entirely counterproductive to the state's fiscal interest in encouraging private payment for long-term care services.

Specialty facilities, specifically pediatric homes, have cost structures that may not be comparable to geriatric units making the proposed thresholds inappropriate. For example, a highly medicalized facility may spend more on staffing in gross terms than other facilities, but may utilize high-cost equipment, materials and supplies resulting in staffing expenses that as percentage of revenue may not meet established thresholds. Similarly, hospital-based facilities have different cost structures and cost allocation and reporting conventions than free standing nursing homes. Applying thresholds developed for free-standing geriatric homes to pediatric facilities and hospital-based facilities would be inappropriate.

For these reasons, LeadingAge NY opposes this bill and urges that it be rejected.

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