ASSEMBLY COMMITTEE ON HEALTH
ASSEMBLY COMMITTEE ON AGING

Nursing Home Quality of Care and Patient Safety and Enforcement

Testimony

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19th Floor, 250 Broadway
New York, NY

Introduction

I am Dan Heim, Executive Vice President of LeadingAge New York (LeadingAge NY). Thank you for the opportunity to appear before the Assembly Health and Aging Committees to discuss nursing home quality of care and patient safety and enforcement.

Founded in 1961, LeadingAge NY is the only statewide organization representing the entire continuum of not-for-profit, mission-driven and public continuing care, including nursing homes, adult care facilities, assisted living programs, continuing care retirement communities, home and community-based services, adult day health care, senior housing, and managed long term care plans. LeadingAge NY's approximately 400 provider and plan members serve an estimated 500,000 New Yorkers of all ages annually.

During the last decade, there have been unprecedented changes in nursing home care brought about by changing demographics, evolution of the nursing home care model, changing government policies and marketplace dynamics. We appreciate the Assembly's interest in exploring nursing home quality and oversight, as well as the broader environment within which New York's nursing homes operate. This examination is timely, given current developments at both the state and federal level affecting nursing home ownership, operations, quality of care, oversight and finances.

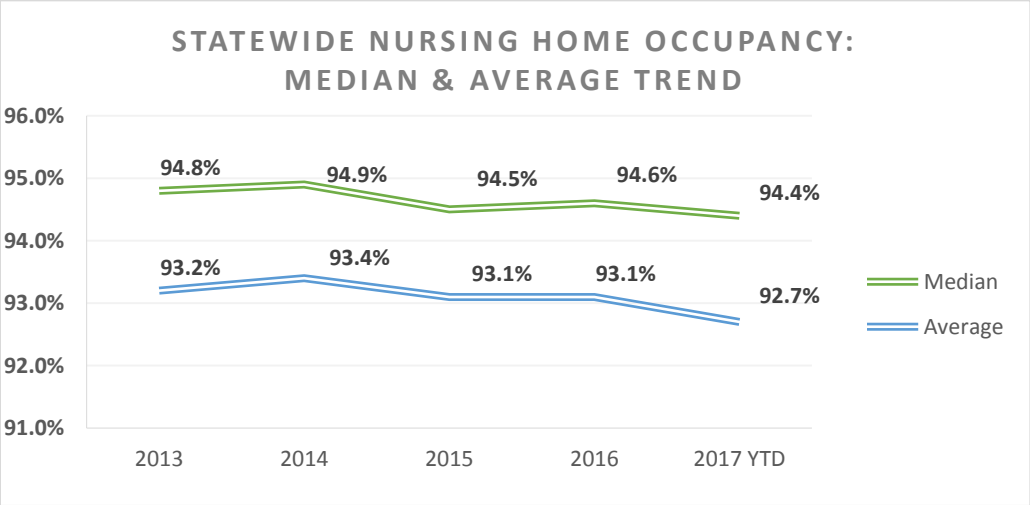
With this introduction in mind, I plan to focus on the following areas in my testimony:

- Nursing home occupancy and capacity trends
- Short-stay nursing home care
- Finances and ownership trends
- Medicaid managed care and value-based payment
- Infrastructure
- Quality trends and 5-Star ratings
- Survey process
- Requirements of Participation (RoPs)
- Long Term Care Ombudsman program
- Staffing ratios

Nursing Home Occupancy and Capacity Trends

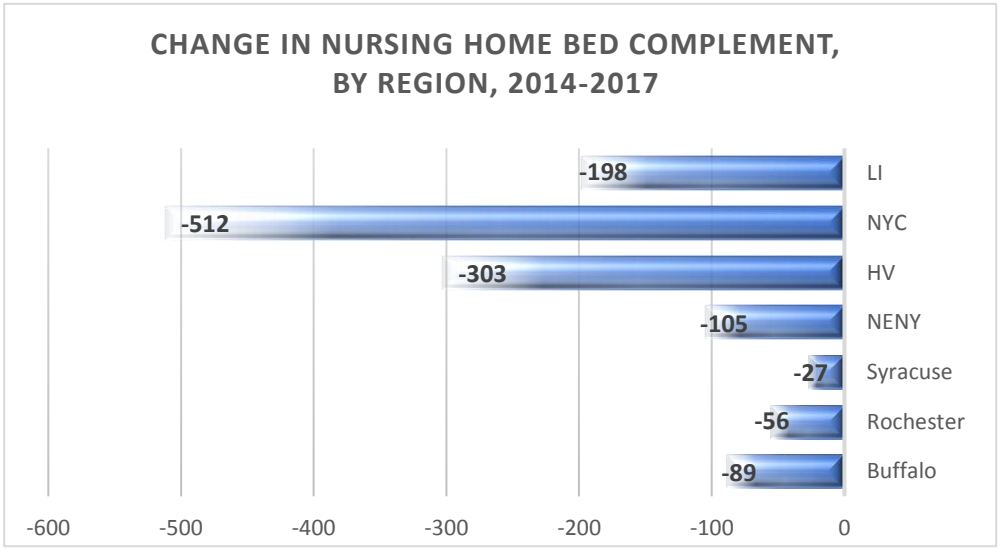
LeadingAge NY periodically analyzes the Nursing Home Weekly Bed Availability data collected by the Department of Health (DOH) since 2009. DOH requires each nursing home to electronically file data on its licensed nursing home beds and availability by bed category on a weekly basis. The Nursing Home Weekly Bed Census data is the most recent data available on occupancy.

As shown in the figure below, statewide nursing home occupancy declined modestly during the 5-year period from 2013 to 2017 (year-to-date). Average occupancy fell from 93.2 percent to 92.7 percent, a decrease of about 0.5 percent. Median occupancy fell by approximately 0.4 percent during the same period.



We also examined changes in occupancy at the facility level between 2016 and 2017 (year-to-date). Statewide, 45 percent of all homes have had a higher average occupancy in 2017 than in 2016; and 47 percent have seen higher occupancy in 2017 than in 2015.

In terms of capacity, another 1,290 nursing home beds were taken off line in the State between 2014 and 2017 (year-to-date) due to nursing home closures and bed reductions. As shown below, New York City experienced the largest net loss in total beds (512 beds) followed by the Hudson Valley region (303 beds).



<u>Current Relevance:</u> DOH – through its Regulatory Modernization Initiative – has convened a Long Term Care Need Methodologies and Innovative Models Workgroup. Among other things, the group is examining the State's need methodology for nursing home beds. While there is limited unmet need for nursing home beds, the methodology should provide some flexibility for strategic additions of beds in underserved areas or where specialized needs exist.

Short-Stay Nursing Home Care

Traditionally, nursing homes were seen primarily as the service providers for individuals whose physical and cognitive needs required constant clinical oversight and assistance from nurses, aides and other caregivers. These long-term residents typically did not improve or stabilize to the point where they could take care of themselves and return to the community, and oftentimes resided in the facility for multi-year periods of time. Over the last several years, the long-term resident population has increasingly become more multi-morbid, frail, functionally limited and likely to be suffering from Alzheimer's or other dementias.

Increasingly, nursing homes are cost-effectively serving another distinct population. These patients are admitted with injuries, acute illnesses or post-operative care needs for recovery in an environment outside of a hospital. When these short-stay patients are admitted to the nursing home after a qualifying three-day minimum inpatient hospital stay, the Medicare Part A benefit covers the service. While post-orthopedic rehabilitative care may be the most prevalent short-stay service offered in the nursing home setting, facilities are increasingly serving patients with post-acute medical needs.

LeadingAge NY previously analyzed nursing home resident assessment data for the period 2011-14, and isolated those resident stays that are considered long-stays (i.e., greater than 100 days) under patient assessment coding rules. For New York State, we found that the total number of long-stay episodes declined by 4.5 percent between 2011-14. During the same period, the average length of stay (ALOS) in these episodes also fell from 341.7 days to 335.7 days, for a decrease of 1.7 percent. We also reviewed patient assessment data over the same time period to examine the prevalence of short-stay episodes (i.e., 100 days or less) and ALOS within these episodes. Statewide, the total number of short-stay episodes increased by 4 percent. During the same period, the ALOS in these episodes modestly increased from 27.5 days to 28.3 days, for an increase of 3.2 percent.

Nursing home cost report data provide further evidence of this phenomenon. As shown in the figure below, Medicare (which covers short-stay post-acute care) paid for 14.9 percent of all resident days in New York State in 2015, representing a 17 percent increase since 2010. Of the statewide Medicare days in 2015, 27 percent were covered by Medicare managed care plans. Medicare managed care penetration has increased significantly throughout the State since

2010. On a statewide basis, Medicare accounts for most new admissions; approximately 92 percent of admissions come from the hospital; and admissions per bed average 2.3 per year.

2015 PAYER AND ADMISSION FIGURES

Region	Medicare as % of All Days	% of Medicare Days from Medicare Managed Care	Medicare Admits as % of All Admits	% Admits from Hospital	Admits per Bed per Year
BUFFALO	14.5%	55.7%	57.0%	92.1%	2.4
ROCHESTER	11.6%	52.7%	57.8%	90.4%	1.9
CENTRAL NY	12.9%	23.5%	65.2%	91.4%	2.0
NORTHEAST NY	11.8%	30.7%	51.3%	88.6%	1.9
HUDSON VALLEY	17.4%	13.9%	70.4%	91.7%	2.5
NEW YORK CITY	14.1%	27.3%	50.9%	92.7%	2.1
LONG ISLAND	20.7%	15.4%	68.3%	91.9%	3.2
STATEWIDE	14.9%	27.1%	59.6%	91.8%	2.3

Source: LeadingAge NY Analysis of 2015 RHCF-4 Cost Report Data

<u>Current Relevance:</u> These data demonstrate dropping ALOS and increasing turnover of residents/patients in New York's nursing homes. Increased resident turnover not only adds to the administrative and clinical complexity of providing services, it increases the likelihood of vacant bed days which in turn adversely affects facility occupancy rates. Governmental payment policies and increased managed care enrollment are driving shorter lengths of stay and greater resident/patient acuity.

Finances and Ownership Trends

Nursing homes are facing mounting financial pressures, which have been a major driver of changes in the ownership composition of New York's nursing homes, and also likely explain the 80 or more nursing home closures that have occurred in New York State since 2000.

The results of a national study show the average nursing home in New York was underpaid by Medicaid by a projected 17.1 percent in 2015 (a gap of $48.43 per resident day) compared to its actual cost of care.[1] DOH previously found that nearly one-quarter of the nursing homes in New York State were in serious financial condition. The average operating margin of these financially-challenged homes was -7.4 percent, versus a national average operating margin of

[1] Eljay, LLC & Hansen Hunter & Co., PC, A Report on Shortfalls in Medicaid Funding for Nursing Center Care. April 2016.

+3.6 percent.[2] Based on LeadingAge NY analysis of Medicaid cost reports, 46 percent of New York's not-for-profit nursing homes and 91 percent of governmental homes lost money on operations in 2015.

Medicaid remains the predominant payer, responsible for approximately 75 percent of the state's nursing home residents and a driving factor in operating performance. Medicaid has not made a cost-of-living adjustment to its payment prices since 2008, despite annual increases in the costs of salaries and benefits, food, utilities, insurance and other goods and services. Increases in costs associated with new mandates and growing accounts receivable due to increased managed care enrollment have contributed to financial pressure on these providers.

The ownership distribution of nursing homes in New York State has changed markedly over the last decade. As shown below, there were 65 less not-for-profit nursing homes in 2017 than in 2006 (a 23% decrease), a 47 percent decrease in the number of government-operated facilities, and a 15 percent increase in for-profit operated facilities. The total number of nursing homes fell by 41 (6% decrease) during this period.

Change in NH Ownership Distribution: 2006-17

Sponsor	2006	2014	2017	Percentage Change: 2006-17
For-Profit	322	350	371	15.2%
Not-for-Profit	283	237	218	-23.0%
Governmental	53	37	28	-47.2%

<u>Current Relevance:</u> Financial pressures – driven by stagnant Medicaid payments, inflationary cost increases and added mandates – are taking a toll on nursing home finances and leading to significant changes in nursing home ownership distribution. Not-for-profit and governmental facilities are declining in number, and independently-operated facilities are giving way to multi-facility ownership structures.

Medicaid Managed Care and Value-Based Payment

Beginning in 2015, Medicaid beneficiaries aged 21+ who enter a nursing home for long-term care must enroll in a Managed Long Term Care (MLTC) plan if they are also eligible for Medicare or a mainstream Medicaid Managed Care (MMC) plan if they are Medicaid-only eligible. This phase-in is still underway, and has caused operational and financial difficulties for both nursing homes and plans. Value-based payment (VBP) – a construct that emphasizes value over volume

[2] New York State Department of Health, "New York State Medicaid Redesign Team Waiver Amendment," 2012.

and shared savings between providers and plans – is largely unworkable among the long-term care population in nursing homes.

MLTC and MMC plans are required to pay nursing homes the benchmark (i.e., fee-for-service) rate for each day of care. While mainstream plans can bill for a separate nursing home rate, MLTC plans are unable to do so and are instead paid based on a blended rate methodology which combines the generally lower cost of community care with the higher cost of nursing home care. Faced with inadequate payments for the Medicaid nursing home benefit and growing numbers of nursing home enrollees, some MLTC plans have reduced their provider networks and are under pressure to select network providers simply on price rather than quality or consumer preference. This will, in turn, adversely affect enrollee choice and is impairing the financial ability of nursing homes to provide needed care.

MLTC and MMC plans must meet network adequacy requirements by contracting with a minimum of 2-8 nursing homes per county (each county's minimum is dictated largely by population). However, some nursing homes have no managed care contracts, which threatens their ongoing existence. Others have only a couple of contracts and may be adversely affected by plan network narrowing or plan financial issues. Still others have multiple contracts, which multiply the administrative overhead needed to address contracting issues, obtain needed authorizations and secure timely payments.

Medicaid VBP has been touted as the opportunity to bring additional dollars into the nursing home sector and other provider sectors in the absence of an inflationary factor. However, there is no viable VBP model that can be applied broadly to nursing home services in a Medicaid context. Essentially, most individuals who are receiving long-term care in a nursing home cannot be safely and appropriately served in another setting. Even if a plan is successful in transitioning a nursing home resident to a lower cost setting, its premiums would be reduced accordingly. Perhaps more importantly, the savings attributable to preventing avoidable hospital use for MLTC residents in nursing homes would accrue to Medicare, not Medicaid. Ironically, if MLTC plans succeed in keeping nursing home residents out of the hospital, the plans will incur higher costs by paying for more Medicaid days and the nursing home would expend more resources to augment its clinically complex care and be paid at the lower Medicaid rate instead of the Medicare rate.

<u>Current Relevance:</u> The transition of the Medicaid long-term nursing home population into MLTC and MMC is still in process, and is causing considerable disruption to beneficiaries, plans and nursing homes. In this context, the limited value-added that can be offered by Medicaid-only plans to nursing home enrollees and the significant barriers to VBP for this population raise serious questions about whether the transition of this population and the long-term nursing home benefit should be restructured or reconsidered entirely.

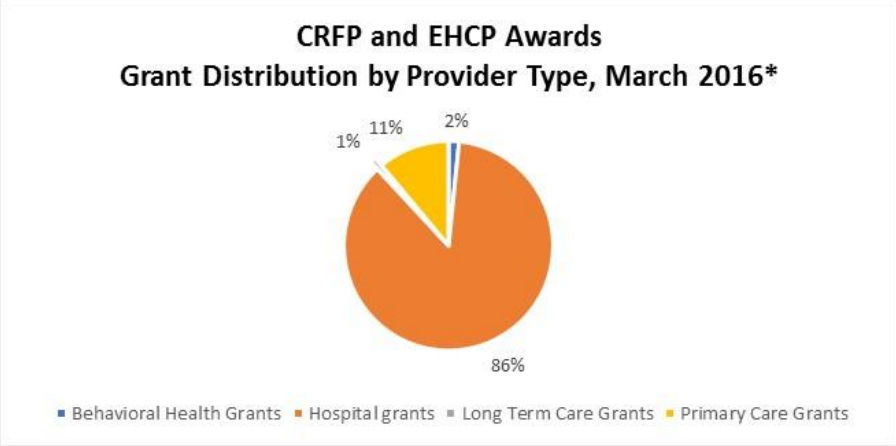
Infrastructure

Many of the state's nursing homes were built two or more decades ago, and are inefficient, outdated, institutional in nature and/or not configured to meet the needs of patients who need complex care, memory support and behavioral health services. With an excess of nursing home beds in some areas of the state, providers are seeking to "rightsize" their facilities and/or offer needed nursing home alternatives such as assisted living.

Nursing homes also seek to introduce or expand specialty programs such as restorative care units, neurobehavioral services, neurodegenerative units, in-facility dialysis and outpatient therapies. Providers are also interested in creating more home-like environments through the establishment of Green Houses/small houses and neighborhoods within existing facilities. Still other providers seek to continue unique missions – such as serving rural communities – through merger or affiliation with other long-term care providers.

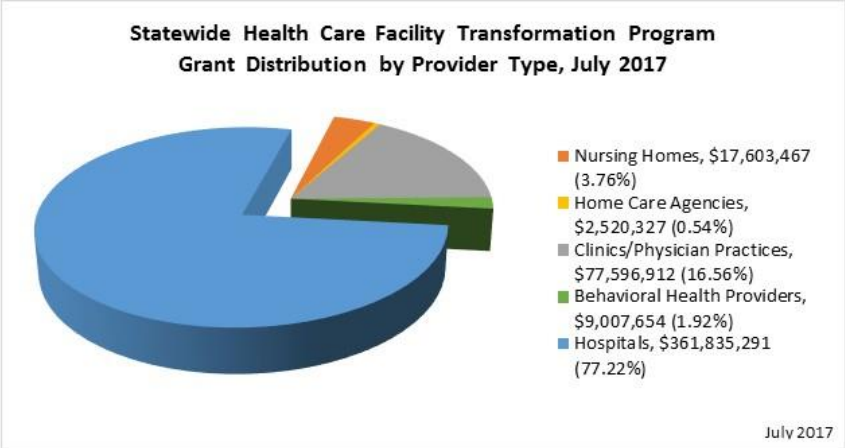
The need for investment in electronic health record adoption and health information exchange is also pressing. Nursing homes have not had access to federal health information technology meaningful use incentives and only negligible access to state funding for needed capital. As a result, they lag hospitals and physician practices in electronic health record adoption and health information exchange.

However, years of losses from serving Medicaid beneficiaries often prevent these organizations from accumulating the capital needed to make these transformational investments. Despite the compelling need for strategic investments in nursing home and other long-term/post-acute care (LTPAC) services, acute and primary care providers have consistently been awarded the vast majority of funding available under recent grant opportunities. The chart below illustrates that acute and primary care providers were awarded 97 percent of the Capital Restructuring Financing Program and Essential Health Care Provider Program funding, with nursing homes and other LTPAC providers receiving only 1 percent.



Note: Awards are categorized based on the licensure or principal services of the awardee.

This trend continued under Phase I of the Statewide Health Care Facility Transformation Program (HCFTP), with 94 percent of funding awarded to hospitals, clinics and physician practices. DSRIP funding distributions have also been heavily weighted towards hospital and primary care.



<u>Current Relevance:</u> Efforts to meet key objectives around delivery system reform, VBP, population health management, and changing LTPAC consumer needs and preferences will be compromised if nursing homes are unable to achieve information technology milestones or to make other critically needed investments to improve efficiencies, update services in response to changing demands, and optimize quality. The majority of the remaining HCFTP funds should be invested in the LTPAC service system.

Quality Trends and 5-Star Ratings

There are many theories on how best to measure and interpret quality in nursing home settings. One well-regarded framework for analyzing quality in health care settings states that quality is composed of three interacting elements – structure, process, and outcomes.[3] Structure refers to institutional characteristics such as the amount and nature of staff, while process refers to what is done to and for the resident (e.g. use of restraints, indwelling catheters, and psychoactive drugs), and outcome refers to what happens to the resident (e.g. development of pressure ulcers, frequency of falls, and hospitalizations).

In this vein, the NYS Nursing Home Quality Initiative (NHQI) is an annual quality and performance evaluation project focused on nursing home quality of care. Nursing homes are awarded up to 100 points for quality and performance measures in the components of Quality (70 points based on 14 quality measures (QMs), including two staffing measures), Compliance (20 points based on nursing home inspections and submission of data), and Efficiency (10 points based on potentially avoidable hospitalizations). The points are summed to create an overall

[3] Donabedian, A. 1966. *Evaluating the quality of medical care*. The Milbank Memorial Fund Quarterly 44(3).

score for each facility, and each facility is ranked into one of five quintiles to determine eligibility for funding distributions. The $50 million in annual funding is derived by applying rate reductions to all eligible nursing homes.

Based on the latest three years of results (i.e., 2015-2017), there have been statewide improvements in nine of the QMs, less favorable performance in two of the QMs, no change in one QM and insufficient data for the remaining two QMs (the 2017 staffing measures are still being calculated). In each of the three years, over 90 percent of individual nursing homes improved their quintile ratings for one or more of the QMs.

The health inspection rating from the nursing home 5-Star Quality Rating System is utilized in the NHQI. The Centers for Medicare & Medicaid Services (CMS) created the 5-Star system with the intent to help consumers compare nursing homes more easily and to help them decide which facilities to consider. The system assigns each nursing home a rating of between 1 and 5 stars, with 5-star ratings denoting much above average quality and 1-star ratings denoting quality much below average. The overall rating is made up of separate ratings for: (1) health inspections; (2) staffing; and (3) QMs. The health inspection (i.e., "survey") rating is the foundation for the 5-star rating, counting for over half of the overall rating.

The 5-Star system incorporates a variety of structure, process and outcome measures. However, it has significant limitations as a "measure" of quality due to inconsistencies in administration of the survey process and the somewhat arbitrary assignment of certain percentages of facilities to each rating category. Nonetheless, while originally intended to help guide consumers, the 5-Star ratings are now increasingly used by regulators, financiers, managed care plans and other payers, and provider networks to select which nursing homes they will consider having relationships with.

Current Relevance: The NHQI and 5-Star rating systems attempt to measure quality across facilities. In the case of the NHQI, no payment adjustments have yet been made during the first four years of the program, due to litigation. Facilities that invested in and achieved quality results have yet to see any increased funding. With regard to the 5-Star system, nursing homes may not even be able to obtain sufficient referrals or receive Medicare and Medicaid funding in the future if they do not have at least a 3-star rating. However, these ratings are largely dependent on the integrity of the survey process.

Survey Process

Nursing homes certified by Medicare and/or Medicaid are required to meet over 180 regulatory standards intended to protect residents. DOH conducts certification inspections every nine to 15 months at each nursing home, as well as post-survey revisits to ensure that any deficiencies are corrected. Surveys also are conducted based on complaints received by DOH. The major categories of review in the nursing home inspection process are: administration; quality of care;

resident rights; dietary services; physical environment; and other services (e.g., dental, pharmacy, and specialized rehabilitation).

During a Standard Health Inspection in a nursing home, inspectors review the quality of the care provided by the facility. Inspectors observe resident care, staff/resident interaction, and environment; and review medical records and other documentation. Using established protocols, the team interviews a sample of residents and family members about their life within the nursing home, and interviews caregivers and administrative staff. In a Life Safety Code Inspection, the team will review whether the life safety code requirements as established by the National Fire Protection Agency are met.

While DOH has made some inroads into promoting consistency in the survey process across its seven survey regions, significant variations still exist. As shown in the table below:

- The number of deficiencies per facility ranged between 2.5 for New York City and the Hudson Valley regions to 9.6 for the Central region, a 284 percent range.
- The number of deficiencies per 100 beds ranged between 1.0 for New York City to 6.3 for the Central region, a 530 percent range.
- Two regions – Rochester and Central – had no zero deficiency surveys, while 34.1 percent of the facilities in New York City had zero deficiencies.

Nursing Home Survey Deficiency Counts:
Most Recent Periodic Health Survey for Each Home Through Mid-July 2017

Region	Number of Homes	Number of Beds	Total Deficiencies Cited	Average Number of Deficiencies per Home	Average Number of Deficiencies per 100 beds	Median Number of Deficiencies per Home	Number of Homes with 0 Deficiencies	Percent of Homes with 0 Deficiencies
Buffalo	73	10,244	460	6.3	4.5	5	3	4.1%
Rochester	60	8,795	403	6.7	4.6	6	0	0.0%
Central NY	81	12,344	776	9.6	6.3	8	0	0.0%
Northeastern NY	65	9,163	380	5.8	4.1	5	1	1.5%
NYC	170	45,190	431	2.5	1.0	2	58	34.1%
Hudson Valley	86	13,388	212	2.5	1.6	2	20	23.3%
Long Island	77	15,962	377	4.9	2.4	4	7	9.1%
Statewide	612	115,086	3,039	5.0	2.6	4	89	14.5%

While the State's NHQI program accounts for this variation by calculating survey ratings on a regional basis, the 5-Star rating system assigns survey ratings by state, not by region. As previously noted, the Inspection rating is the foundational element of the 5-Star system.

<u>Current Relevance:</u> CMS is initiating a new survey process beginning Nov. 28, 2017, which will incorporate the new federal Requirements of Participation being implemented in Phases 1 and 2

(more information below). The new process will build on the features of the two different survey processes currently in use ("Traditional" and "Quality Indicator Survey"). While this holds the potential to make the process more consistent and objective, it will require considerable training and preparation for implementation, and be a learning process for surveyors, facilities, states and CMS. Surveyors and providers should receive the same training so that the expectations are consistently communicated and clearly understood.

Requirements of Participation (RoPs)

Consolidated Medicare and Medicaid RoPs for nursing homes were last comprehensively updated in 1991. The RoPs were substantially revised in 2016 to reflect major advances over the past several years in the theory and practice of service delivery and safety. Major themes of the RoP revisions are person-centered care, quality, facility assessment/ competency-based approach; alignment with federal priorities; comprehensive review and modernization; and implementation of legislation. Due to the enormity of the changes, the RoPs are being implemented in 3 phases, with Phase 2 taking effect Nov. 28, 2017.

The RoPs make major changes to the nursing home requirements affecting multiple areas of facility operations, at a time of major shifts in federal and state payment policies, quality expectations and provider-payer relationships. These changes are necessitating significant revisions to facility policies and procedures; developing and conducting training; hiring or otherwise acquiring needed expertise; assessing preparedness; and planning for all associated compliance costs. Regulators will also need time to thoroughly understand the proposed changes, incorporate the interpretive guidance, modify survey processes, ensure surveyors are properly trained and otherwise be able to objectively and consistently evaluate facility compliance.

<u>Current Relevance:</u> The additional staffing, credentialing, training, systems and contractual relationships that are required for compliance will add to the financial stresses that nursing homes are experiencing from ongoing Medicare and Medicaid cuts, since the final regulation did not specifically provide for funding of the compliance costs by federal and state governments. Ironically, without such funding, the proposed requirements could force facilities to divert limited financial and staffing resources from resident care to the increased administrative requirements the RoPs will impose.

Long Term Care Ombudsman Program

The Long Term Care (LTC) Ombudsman Program is intended to be an advocate and resource for persons who reside in nursing homes as well as assisted living and adult care facilities (ACFs). Ombudsmen are charged with helping residents and their families understand and exercise their rights and effectively address concerns related to their health, safety and quality of life. This includes receiving, investigating and resolving complaints made by or on behalf of

residents, promoting development of resident and family councils, and informing stakeholders about issues and concerns impacting residents of LTC facilities.

The Older Americans Act, administered by the federal Administration on Aging, requires each state to establish an Office of the State LTC Ombudsman. In New York, the program is administered within the NYS Office for the Aging, and provides advocacy services through a network of 15 regional programs. Each regional ombudsman program has a designated ombudsman coordinator who recruits, trains and supervises volunteers who are regularly present in nursing homes and ACFs.

In general, LeadingAge NY members report that they have good working relationships with the ombudsman program and local volunteers. However, in the last 2-3 years there have been changes in the entities that administer the regional ombudsman programs as well as the regional ombudsman coordinators. Member facilities report to us that there are inconsistent expectations and oversight of the ombudspersons who interact with their facilities, specifically on the level of involvement of the ombudsman with the facility (e.g., number of visits, etc.), communications with the facility, and the degree of cooperation between the ombudsman and the facility in investigating and resolving concerns.

Current Relevance: Under the new RoPs, nursing homes must provide the ombudsman with copies of notices of discharge issued when residents are hospitalized, transferred to an emergency room, or discharged at the nursing home's initiative. This may increase the number of notices that ombudspersons receive, which could have a bearing on their workload. Given the potential for increased activity and the changes made by the RoPs in several areas, it is even more important to ensure that there is consistent oversight and administration of the ombudsman program within and across regions. NYSOFA recently published a proposed rule in the NYS Register – which remains open for public comment – intended to align the State LTC Ombudsman program regulations with the federal requirements.

Staffing Ratios

Legislation has been proposed in New York State (A.1532/S.3330) which would create specific staffing ratios for nurses and other direct-care staff in nursing homes and hospitals. However, the available research does not reflect that high staffing levels produce higher quality of care or quality of life. In fact, the most likely outcomes of this legislation would be higher Medicaid costs, further competition for already limited staffing, and less quality of life programming for nursing home residents.

From a public and fiscal accountability standpoint, nursing homes are already responsible for ensuring adequate staffing. For example:

- Staffing is already one of three domains used by CMS in the 5-Star rating system;

- The State's NHQI program includes two staffing measures: the CMS 5-star staffing rating and level of temporary contract/agency staff; and
- The Federal government requires every nursing home to post in a prominent, public place the numbers of licensed and unlicensed direct care staff on duty for every shift.

In the Oct. 2016 publication of the final regulation updating the RoPs for nursing homes[4], CMS evaluated comments pertaining to the agency's decision to not include nurse staffing ratios in the final rule and stated as follows:

> "We agree that sufficient staffing is necessary, along with the need for that staff to be competent in delivering the care that a resident requires. We also agree that all of these factors are associated with quality of care. However, we do not agree that we should establish minimum staffing ratios at this time. As discussed in the preamble to the proposed rule, this is a complex issue and we do not agree that a "one size fits all" approach is best."

The staffing standards proposed in this legislation would conservatively cost an estimated $1 billion annually to implement in New York's nursing homes, a large sum that nursing homes would simply be unable to absorb and that would fall predominantly to Medicaid to cover.

Although nursing is one of the most rapidly growing fields, nursing education cannot keep up with the current demand; some schools are only able to admit about 25 percent of the applicants. Universities cite cuts in funding and subsequent loss of staff positions as the cause of their inability to meet the needs of the numbers of potential students applying (add to that the aging-out of the nurses qualified to teach). There simply are not enough licensed nursing staff to fill the ratios as proposed under this legislation.

Current Relevance: Rather than mandating specific staffing ratios, the State should seek to encourage prospective professionals and paraprofessionals to enter the long-term care field, promote recruitment and retention efforts, assist nursing education programs that are struggling, help to support the cost of nursing education, and promote the field of nursing in general.

Conclusion

Our testimony intends to provide an overview of multiple environmental factors affecting the delivery of nursing home care. Any discussion of nursing home quality of care, patient safety and enforcement needs to be placed in the broader context of the current environment, which is characterized by a bewildering volume and pace of change:

[4] *Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities*, 81 FR 68688 Page: 68688-68872, Oct. 2016.

- residents and their needs and expectations are changing;
- the nursing home custodial care model has evolved into two distinct models: a short-term post-acute care service and a long-term care model for frail elderly and disabled people;
- Medicaid fee-for-service is being replaced by managed care, fundamentally changing the payment mechanism for the largest nursing home payer;
- Medicare managed care and payment arrangements such as accountable care organizations and episodic payments are changing how nursing homes are utilized and paid for post-acute care;
- Medicare fee-for-service is considering a major change to how nursing home payments are calculated;
- Both Medicaid and Medicare are moving towards value-based payment, which is very volume dependent and largely unworkable in a Medicaid context;
- CMS has substantially revised the nursing home requirements of participation, and is initiating a new survey process later this month;
- Various, non-overlapping sets of nursing home quality measures are being used for payment and oversight by the 5-Star Rating System, the CMS Quality Reporting Program, the Medicare Value-Based Purchasing program, the NYS Nursing Home Quality Initiative, Medicaid and Medicare managed care plans and other payers;
- New York is seeking to restructure the entire service system through the Delivery System Reform Incentive Payment (DSRIP) program; and
- New York has made or is considering major changes affecting conditions of employment including increasing the minimum wage, enacting Paid Family Leave and changing employee scheduling practices.

LeadingAge NY and its membership remain dedicated to ensuring that high quality nursing home care is available throughout New York State to individuals who need short-term post-acute care as well as LTC services. We believe that there is a strong nexus between quality of care, oversight and payment, and suggest that any new policy consider these factors holistically.

As always, we are available to provide additional information and support to the Assembly Health and Aging Committees on nursing home quality of care, patient safety and enforcement. Thank you again for the opportunity to testify.