LeadingAge New York **OPPOSE**

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

MEMORANDUM

S.4336-A

AN ACT to amend the public health law, in relation to directing the commissioner of health to establish a direct patient care ratio reporting and rebate requirement for nursing homes

This bill would establish a "direct patient care ratio" for nursing home expenditures, requiring at least 70 percent of the aggregate revenue to be spent on direct care of residents and at least 40 percent on staff wages and benefits and contracted or purchased staffing services. Eighty-five percent of the amount spent on contracted staff would be counted as direct care expenditures. Although not clearly described in the legislation, it appears that if a facility fails to meet the require patient care and staff wage expenditure ratios, it would be required to rebate to all payers the difference between the actual direct care and staff wage expenditures and the amounts required to achieve the ratios.

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. And, 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.

It is impractical and reckless to implement this type of legislation at a time when there are significant anomalies in revenue and spending due to the pandemic, and facilities are under extraordinary financial and operational stress. For example, huge pandemic-related costs such as those for staff testing and PPE, as well as any potential federal reimbursement to defray some of the costs, will skew typical nursing home cost structures and percentage spending by category for several years.

Further, the timing of the reporting and rebate requirements in the bill seem likely to result in increased financial unpredictability and instability for some facilities. If direct resident care ratios are to be calculated based on data pertaining to the prior year, those data will not be complete and will not accurately capture all expenses and revenues attributable to that year within the 6-month timeframe contemplated for calculation of the ratios and distribution of dividends to payers.[1] To the extent that rebates are required to be calculated by June of the following the year, they will inevitably be incorrect and require reconciliation in a subsequent year. Not only are payment arrangements that require reconciliation often subject to lengthy delays, it is unlikely that Medicare and commercial payers will agree to reconcile and repay rebates. Reliance on incomplete data and the absence of timely reconciliation will add to facility cash flow challenges.

More specifically, the bill's methodology for calculating the direct resident care and wage ratios triggers a number of unintended outcomes. First, 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 preclude, 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,

[1] E.g., Nursing homes were not notified of their January 2020 Medicaid rates until January 2021.

- 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.

Second, the bill does not clearly define the types of expenditures that must be included and excluded from direct care or staff wages and benefits costs and may prevent or discourage crucial expenditures. For example, it is unclear whether physician services would be counted as direct care spending. Similarly, it is unclear whether critical items such as recruitment and training of staff would be included in the direct care calculation. Nor does the bill indicate how PPE and testing expenditures would be categorized. Certainly, facilities should be encouraged to invest in these services, supplies, and activities and should not have to rebate funds to payers that were expended for these purposes.

Third, 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. This bill would impose restrictions on CCRC nursing home spending that may be contrary to the wishes of the "payers" (the CCRC residents) and could force a constant and unwanted cycle of rebates to and repayment from residents to carry out resident wishes. 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.

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