**Nursing Home Quality Agenda**

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. At the same time, growing financial pressures – driven by stagnant Medicaid payments, inflationary cost increases and added mandates – are taking a toll on nursing home finances and leading to unplanned reductions in capacity and significant changes in the nursing home ownership distribution.

Any discussion of nursing home quality of care should be placed in the broader context of the current environment, which is characterized by a bewildering volume and pace of change and other formidable challenges:

* residents and their needs and expectations are changing;
* the nursing home custodial care model has evolved into two distinct models: short-term post-acute care and a long-term care for frail elderly and disabled people;
* 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 making a major change to how nursing home payments will be determined, significantly changing the financial incentives of the current system;
* Both Medicaid and Medicare are moving towards value-based payment, which is very volume dependent and largely unworkable in a Medicaid context;
* The Centers for Medicare and Medicaid Services (CMS) has substantially revised the nursing home requirements of participation, and initiated a new survey process;
* 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; and
* With the backdrop of a full employment economy and significant recruitment and retention challenges, New York has made or is considering major changes affecting conditions of employment including further increasing the minimum wage, increasing Paid Family Leave benefits 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 long term care (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.

The recommendations below are categorized in three major and intersecting domains – workforce; oversight; and program and funding. While not identified below as a recommendation, we believe that the way nursing home care is characterized in the media has a major bearing on all three domains below. Negative perceptions of nursing homes affect their ability to recruit and retain high quality workers; contribute to public calls for greater oversight of the field; and erode public support for adequate funding through Medicaid and other programs.

Consider the litany of negative stories from the *Buffalo News* which have focused on examples of adverse resident outcomes and out-of-town ownership of facilities with quality issues. These stories, we believe, contributed to the passage of Ruthie’s Law, an Erie County statute that purports to impose additional reporting requirements and fines on nursing homes, which are prohibited by the NYS Public Health Law. Erie County nursing homes are facing increased legal liability, which is only being reinforced by the media coverage.

In addition to addressing underlying concerns with the oversight system, the State could play an important role by publicizing quality success stories, provider efforts to reimagine care delivery, and positive experiences that residents, families and direct care workers have every day.

**Workforce**

Nursing home quality of care is dependent on sufficient staffing and the competence of the staff in delivering resident care. Legislation has been proposed in New York State 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 specific levels of staffing 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.

Rather than mandating specific staffing ratios, the State should support worker recruitment and retention efforts; facilitate more efficient use of personnel; seek to encourage prospective professionals and paraprofessionals to enter the LTC field; and support patient care technologies. This includes working with national groups and the federal government on immigration policies to increase the supply of direct care workers.

* ***Recruitment and retention funding:*** Provide dedicated funding from the proceeds of the sale of Fidelis to Centene to nursing homes throughout the state to underwrite evidence-based recruitment, onboarding, training and retention projects/initiatives.
* ***Minimum wage:*** Provide adequate funding to address the effects of the minimum wage increase, including recognizing the effect of wage compression on other salary bands.
* ***Advanced training initiative (ATI):*** Extend eligibility for the ATI program to facilities with staff retention rates that are above the median retention rate of their region. The current statewide median retention rate excludes many facilities with better than average retention rates from consideration.
* ***Equivalency and vocational support:*** Provide additional funding to expand High School Equivalency offerings for individuals interested in paraprofessional jobs and Career and Technical Education opportunities for individuals interested in LTC careers.
* ***Medication technicians:*** Allow nursing homes throughout the state to utilize specially trained nurse aides in lieu of nurses for routine medication passes, making more efficient use of nurses and providing a career ladder option.
* ***Feeding assistants:*** Align state regulatory requirements on the use of feeding assistants with the most current federal regulations [42 CFR §483.60(h)] and training requirements [42 CFR §483.160] to expand use of this program and provide a career ladder option.
* ***CNA training:*** Utilize maximum state flexibility (e.g., amount and timing of fines, etc.) in decisions about whether to institute bans on offering certified nurse aide (CNA) training

programs. CNA bans also affect a facility’s ability to offer administrator-in-training programs, another training initiative that should be supported.

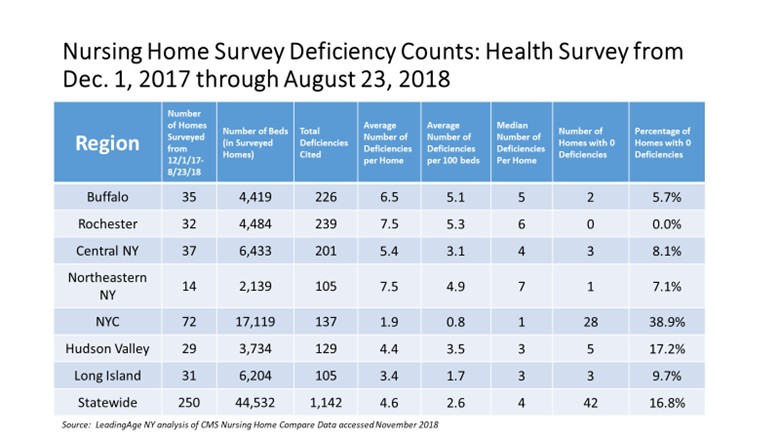
* ***Background checks:*** Work with law enforcement agencies to expedite completion of criminal background checks for CNAs and avoid delays that are costly and disruptive to nursing homes.
* ***Costly mandates:*** Reject legislation and/or regulations that will create added workforce challenges including imposing arbitrary minimum staffing ratios and expanding call-in pay regulatory requirements.

**Oversight**

Nursing homes certified by Medicare and/or Medicaid are required to meet over 180 regulatory standards intended to protect residents. DOH is required to conduct 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).

A facility’s survey rating is the foundational element in its Five-Star rating in CMS’s *Nursing Home Compare*. 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. Accordingly, there is a direct linkage between the integrity of the survey process and access to referrals and funding. Furthermore, how the survey and investigation process is conducted and portrayed contributes to negative media coverage and an increasingly difficult legal environment.

While the new survey process holds potential for enhancing objectivity, persistent variations in survey findings by region should be addressed. As shown below, the average number of deficiencies per 100 beds was 563 percent higher in the highest region (5.3) than in the lowest region (0.8). Differences in actual quality of care alone simply cannot explain those differences.



* ***Joint training and quality:*** The State should initiate joint provider-surveyor training on new and existing requirements of participation and survey protocols, and expand survey quality control efforts to further ensure consistent administration of the process.
* ***Blackout dates:*** The state should honor “blackout” dates and avoid conducting surveys on certain religious holidays and when administrators are out of town for certain limited reasons (e.g., receiving educational credits, on vacation, etc.).
* ***Survey frequency:*** Reduce the frequency of annual surveys for facilities with favorable survey outcomes and increase the frequency of surveys for facilities with poor surveys.
* ***Dispute resolution:*** Revise the Informal Dispute Resolution (IDR) process to incorporate best practices such as incorporating neutral third-party administration of the program, providing facilities with adequate time for filing requests, and providing IDR program statistics and specific feedback to facilities on the disposition of their requests. If a surveyor identifies a deficient practice, a facility should have an equal and credible opportunity to contest it.
* ***Timeframes:*** Adhere to federal timeframes on state surveys and adhere to defined timeframes for completion of state investigations and “closing out” surveys to ensure timely follow up on issues and reduce operational uncertainty.
* ***Establishment actions:*** Revoke operating certificates of established operators that demonstrate persistent records of poor care, and deny establishment approval to applicants who have a record of poor care and extend this to related parties.

**Program and Funding**

Over time, the long-term nursing home resident population has become more multi-morbid, frail, functionally limited and likely to be suffering from behavioral issues. Nursing homes are also cost-effectively serving growing numbers of short-term patients with injuries, acute illnesses or post-operative care needs. While post-orthopedic rehabilitative care may be the most prevalent short-stay service offered now, facilities are increasingly serving patients with post-acute medical needs and Medicare’s new payment system will reinforce that trend. In short, governmental payment policies and increased managed care enrollment are driving shorter lengths of stay and greater resident/patient acuity.

Providers are facing mounting financial pressures, a major driver of changes in ownership composition and facility closures. Medicaid remains the predominant payer 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, and other goods and services. Increases in costs from new mandates and growing accounts receivable due to increased managed care enrollment have added to the financial pressures.

Many of the state’s nursing homes were built two or more decades ago, and are outdated, institutional and/or not configured to meet the needs of patients who need complex care, memory support and behavioral health services. With excess 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 and create more home-like environments. The need for investment in electronic health record adoption and health information exchange is also pressing. However, years of losses from serving Medicaid beneficiaries often prevent these organizations from accumulating the capital needed to make these transformational investments.

* ***Behavioral health:*** Develop program regulations and enhanced Medicaid reimbursement for residents who have behavioral health, mental health and/or substance abuse issues. Existing programs and funding do not provide adequate support for addressing the needs of these populations.
* ***High clinical needs:*** Develop program regulations and enhanced Medicaid reimbursement to support increased development of specialty units with the clinical capacity to prevent avoidable hospital and emergency room use.
* ***Access to services:*** Create a rural/small facility provider Medicaid rate add-on to preserve essential access to services.
* ***Community focus:*** Prioritize access to the Statewide Health Care Transformation and Vital Access Provider programs for community (i.e., locally-owned and operated) nursing homes.
* ***Rightsizing:*** Establish an enhanced nursing home rightsizing program that encourages planned voluntary downsizing of facilities and addresses key issues such as the 300+ bed peer group rate differential.
* ***Quality pool:*** Expand the current $50 million Nursing Home Quality Initiative with funds derived from outside of the existing Medicaid funding base.
* ***Life safety code:*** Provide support through accelerated Medicaid depreciation reimbursement and/or the Statewide Health Care Transformation program for life safety code-related upgrades facilities need to make.
* ***Statewide pricing:*** Analyze the possibility of replacing the RUG-III classification system used for Medicaid rates with the Patient Driven Payment System Medicare is adopting for Oct. 1, 2019 implementation.
* ***NAMI collection:*** Revisit the state’s proposal to take over collection of Net Available Monthly Income (NAMI), thereby increasing overall collection rates and relieving facilities of an administrative burden. In the meantime, ensure that facilities can collect full budgeted NAMI amounts: (1) for short-stay residents; and (2) when a guardian has been appointed.