Ways & Means Committee
Health Sub-Committee

Examining the COVID-19 Nursing Home Crisis
June 25, 2020

Statement for the Record

LeadingAge and our partners, the Visiting Nurse Associations of America (VNAA) and ElevatingHOME, on behalf of our nearly 6000 nonprofit aging services members who provide affordable senior housing, long-term health care and personal assistance to older persons and persons with disabilities, thank the committee for its commitment to understanding the impact of COVID-19 on nursing homes and for the opportunity to offer analysis and proposals for the committee to consider.

As Rep. Beyer noted, we have known for months that COVID-19 disproportionately affected older persons, persons with compromised health, and persons in crowded, enclosed settings. Somehow as a society we failed to realize that that description applies perfectly to nursing homes and assisted living communities. Failure to prioritize aging services settings is a failure of our federal, state and local public health systems and must be compensated for in future legislation, as well as understood by rigorous analysis of data associated with this virus.

We have developed **Five Essential Actions** and **two over-arching recommendations** that encompass our response to the issues raised at the hearing, and which must be included in the next COVID-19 relief package. Funds provided by the March 27th *Coronavirus Aid, Relief, and Economic Stability (CARES) Act* and April 24th *Paycheck Protection and Health Care Enhancement Act* provided a down payment toward meeting the immediate needs of aging services providers; much more is needed now and in the foreseeable future if we are to avoid the terrible consequences addressed in the hearing.

Based on our members' experiences in navigating the measures created by the previous coronavirus relief efforts, we strongly advocate that aging service providers be treated separately and independently. Nursing homes are part of a collective entity, encompassing long-term care settings (like nursing homes, assisted living, memory care), continuing care retirement communities, adult day, home and community based services (HCBS), hospice, home health, and both publicly-financed affordable senior housing and privately financed housing, all in service to the most vulnerable populations -- older persons, persons with health conditions, and minorities.

To help understand lessons learned and the impact on older persons and the settings where they live, **our first over-arching recommendation is that Congress establish a bi-partisan, bi-cameral Commission on the Future of Aging Services.** The COVID-19 crisis has cast a spotlight

on the longstanding gaps in aging and long-term care services in the United States. While HHS has created a commission to study nursing homes, we strongly believe that there needs to be a study of the broader field of aging services, to address housing, home and community-based care, the effective use of technology, as well as congregate living. What are the gaps in financing, services, housing that must be addressed to avoid future disasters? This Commission would identify these gaps and develop immediate actionable steps to better serve older Americans and prevent the kind of loss we have experienced in the pandemic.

Our **second over-arching recommendation is that Congress mandate one single source for reporting data,** whether by nursing homes, assisted living, hospitals or any other entity. Having to report to CDC as well as multiple state and local agencies is a huge administrative burden that takes away from resident care and leads to confusing, contradictory data that will not be useful for future preparedness planning.[1]

Congress must mandate a singular reporting mechanism with uniform measures. Essential to any examination of the factors underlying the impact of COVID-19 on nursing homes and older persons generally, is accurate data. We agree that nursing homes should report diagnoses, deaths, PPE supply, etc. We also strongly support collecting demographic data on race, ethnicity, gender and disability.

Five Essential Actions

The only way to stop this unraveling catastrophe is to provide significant additional targeted relief, which includes:

1. **IMMEDIATE ACCESS TO AMPLE AND APPROPRIATE PERSONAL PROTECTIVE EQUIPMENT (PPE) FOR ALL PROVIDERS WHO SERVE OLDER AMERICANS.**
2. **ON DEMAND AND FULLY FUNDED ACCESS TO ACCURATE AND RAPID-RESULTS TESTING FOR OLDER ADULTS AND THEIR CARE PROVIDERS.**
3. **ASSURANCE THAT STATES WILL CONSIDER THE HEALTH AND SAFETY OF OLDER AMERICANS AS THEY REOPEN.**
4. **FUNDING AND SUPPORT FOR AGING SERVICES PROVIDERS ACROSS THE CONTINUUM OF CARE.**
5. **ENSURE PANDEMIC HERO PAY, PAID SICK LEAVE, AND HEALTH CARE COVERAGE FOR THE HEROIC FRONTLINE WORKERS WHO ARE RISKING THEIR OWN LIVES SERVING OLDER PEOPLE DURING THIS CRISIS.**

1. IMMEDIATE ACCESS TO AMPLE AND APPROPRIATE PERSONAL PROTECTIVE EQUIPMENT (PPE) FOR ALL PROVIDERS WHO SERVE OLDER AMERICANS.

[1] See, https://leadingage.org/regulation/health-disparities-highlighted-covid-19-data?_ga=2.37817255.528499505.1594144395-1123818582.1593651621, a compilation of the studies on COVID in nursing homes as of June 23, 2020.

Reliance on traditional infection control is inadequate for responding to COVID-19. As we know, this infection is spread by air – coughs, sneezes, singing, anything that spurts out of the mouth or nose into the air – so while important, traditional infection control methods (hand washing, use of sanitizers) were never sufficient to prevent COVID from entering nursing homes nor from preventing spread once there.

There has been a lot of discussion about infection control lapses over the years, some serious and some not. But the reality is that nursing homes needed good PPE to prevent the spread of COVID, to treat residents properly, and to protect their staff. This is the cascading effect of lack of PPE. Listening to the healthcare workers at this hearing and at the Select Subcommittee hearing earlier this year is a stark reminder that front line workers are the ones at risk and it is not and should not be their responsibility to find the gloves, masks and gowns and eye protection they need. In a pandemic, where there are widespread shortages of necessary protective equipment, it must be the responsibility of the public health system and cannot be considered the sole responsibility of providers.

Our providers report that by February, before the first outbreak in the US, they were informed that there were inadequate supplies of PPE. Members have had to find new suppliers, hope that they were not being ripped off because vendors were requiring payment in full up front for shipments from overseas, hope that their shipments were not being diverted by other bigger players. Our LeadingAge board chair, who is from one of the hotspots, Northern New Jersey, reported early on that she would meet her new vendor in parking lots in the middle of the night and pray that her faith-based nonprofit community would get what they ordered in time. And still, they could not get adequate supplies of necessary PPE.

This is ridiculous; as Rep. Jayapal is reported to have said, this is like the Hunger Games[2]. Only real people are dying.

We strongly believe that responding to this pandemic was the federal government's responsibility; state and local government and individual healthcare providers do not have the bandwidth or funds or wherewithal to replace the massive, coordinated response demanded by this national health care disaster.

Since March 17, LeadingAge has communicated with Congress and the Administration each month to demand that nursing homes and other aging services providers be prioritized for PPE. This has not happened. We implored Congress to demand the Administration invoke all the

[2] https://www.msn.com/en-us/news/politics/rep-jayapal-trump-s-coronavirus-response-is-like-the-hunger-games/ar-BB14lL6B)

powers available to manufacture and distribute adequate and effective PPE. This authority has not been invoked in any meaningful sense.

Interestingly, we can see the impact of this non-response on the ability or lack thereof of FEMA and HHS to distribute PPE to nursing homes. It was not until mid-April, six weeks after Kirkland, that the Administration announced it would ship a 2-week supply of PPE to nursing homes by July. Aside from the obvious fact that there are more than two weeks between April and July, no one should look the proverbial gift horse in the mouth and so our members anxiously awaited their shipments. The first shipments did not go out until early May; the last shipments probably will have gone out by this filing. The shipments reflected the abysmal state of access to PPE even by FEMA – many nursing homes received too little (e.g., 10% of what they used in a week, based on some non-transparent formula), equipment that was not appropriate (e.g., child-sized gloves; non-N95 masks), and equipment that was mysterious at best (gowns that FEMA assured LeadingAge were state of the art, but came with sleeves sewn shut or as tarps without head openings or arms). We have spoken with the lead staff at FEMA and believe they did the best they could with what they were able to find, but that just confirms the inability of the Administration to perform as they promised and it is now months into the pandemic.

2. ON DEMAND AND FULLY FUNDED ACCESS TO ACCURATE AND RAPID-RESULTS TESTING FOR OLDER ADULTS AND THEIR CARE PROVIDERS.

Second only to the lack of PPE in controlling the pandemic in nursing homes and other congregate living communities is the need for accurate, fast tests, both for staff and residents.

As we noted in a letter to Congress dated May 28, testing is a critical component to ensuring identification and treatment of aging services clients, residents, and staff with COVID-19 and protection of others near them. We strongly urge Congress to establish a federally administered and financed aging services testing program for staff, and to ensure that older adults are in fact covered by their public or private insurance for all tests they need.

To be effective, employee testing must include reimbursement for providers to cover the ancillary costs of acquiring and administering tests and, as needed, repeated testing. It is not clear that private health insurance will cover repeat testing, and our members who are self-insured must cover the costs themselves. Additional PPE must be procured to support increased testing. To be useful and effective testing in aging services organizations must be fast and accurate so providers can move quickly to stop widespread infection.

In addition, providers will need support to hire additional "surge staffing" to compensate for vacancies when COVID-19-positive staff must self-quarantine. Nonprofit aging services providers simply do not have the funds or budgeted resources to cover these unplanned and

ongoing expenses. As a result, additional federal funding to ensure adequate staff coverage is critical for all aging services providers.

The national program must include quick access to testing for staff of affordable senior housing as well. While affordable senior housing providers are not health care providers and won't administer tests, staff must have access to the free testing authorized by the CARES Act, and as noted above, insurance must cover all tests for residents.

We support the specific allocation of money for testing as proposed in Heroes Act (H.R. 6800); however, we strongly voice the need for aging services providers to be allocated their own testing fund of $10 billion dollars.

We urge Congress to include these provisions from the Heroes Act in the next COVID-19 relief package:

- Require the Secretary of HHS to quickly update the COVID-19 strategic testing plan from the Paycheck Protection and Health Care Enhancement Act.
- Require the Centers for Disease Control and Prevention to coordinate with all levels of government to establish and implement a national evidence-based system for testing, contact tracing, surveillance, containment, and mitigation of COVID-19.
- Require the President to appoint a Medical Response Coordinator to coordinate federal supply and distribution of medical supplies and equipment.

3. **ASSURANCE THAT STATES WILL CONSIDER THE HEALTH AND SAFETY OF OLDER AMERICANS AS THEY REOPEN.**

Nursing homes, assisted living, continuing care retirement communities and senior housing never closed; our residents however, have long been confined to their rooms or apartments to protect them from contracting the virus which is so devastating to older persons, especially those with compromised health. As outside communities begin to re-open restaurants, shops, gyms, and the like, this return to "normal" will inevitably have an impact on communities that have tried to isolate their residents from the virus. Re-opening unfortunately does not mean that the virus has disappeared; and the challenges experienced in states like Florida, Arizona, Texas and California are sobering.

The impact on employees of re-opening will be a huge challenge to them and to providers. It is unrealistic to assume that staff will self-isolate while the rest of their communities are out and about, even though being out and about is still quite dangerous. It is not terribly realistic to tell employees that they cannot take vacations to the beach or other places that are open. Here, too, access to accurate, fast testing becomes critical. However, we anticipate that employees will not be immune from exposure to COVID-19 as communities "re-open" and therefore our

staffing challenges will be exacerbated. Reopening magnifies the nexus between testing, access to PPE, workforce policies, and managing risk from community spread.

Visitation is another critical issue. For nursing homes and other congregate living settings, our members face a Hobson's Choice – the devastating impact of isolation on residents resulting from loss of personal contact with family and friends vs. continuing to protect residents from infection by continuing to prohibit personal visitation. CMS guidelines lean toward the latter. However, the pressure to allow visitation will only accelerate and the balance between safety and the physical and mental consequences of isolation will need to be addressed and understood. There is no completely safe answer.

Our members understand that continued isolation is neither desirable nor feasible and have come up with creative ways to allow visitation – whether through "drive-through" visits, or outside visits with masks and distancing. An unanswered question is how to accommodate residents who have COVID-19. Access to PPE and accurate fast testing is critical to allowing safe visiting, as is supporting the ability use televisitation, such as through the ACCESS Act.

4. **FUNDING AND SUPPORT FOR AGING SERVICES PROVIDERS ACROSS THE CONTINUUM OF CARE.**

Although not the subject of this hearing, most older persons live outside of nursing homes and assisted living. Support for low income and market rate senior housing, home and community-based services, adult day programs, PACE programs, and senior centers is critical to ensure that the older persons living and served by these programs are not left behind.

We refer the Committee to our correspondence to Congress dated March 17, April 3, May 5 and June 15 for recommendations to address these services and settings. The centerpiece of our request is to provide specific funding for aging services as a whole. These settings and programs require PPE, testing, expanded broadband access to provide telehealth and televisitation.

We urge Congress to create a dedicated $100 billion fund, within the Provider Relief Fund, for all aging services providers, $1.2 billion fund to support affordable senior housing providers, and at least $10 billion for testing to augment the general $75 billion contemplated to be allocated to the Public Health Fund by the Heroes Act.

We urge Congress to include the following Provider Relief Funding provisions from the Heroes Act in the next COVID-19 relief package:

- Create more structure and oversight for the Provider Relief Fund and related funding distribution to ensure that appropriate amounts of money are sent to the right providers with clear directions as to what the money can and cannot be used for;
- Allocate funding for states to establish strike teams to help with clinical care, infection control or staffing;
- Create a skilled nursing facility (SNF) payment incentive program for COVID-19--only facilities.

We also urge Congress to address needed expansion and protections for the Medicaid program, which is the primary payer both for nursing home long-stay residents and for home and community-based services. In this regard, we encourage Congress to include the following provisions from the Heroes Act in the next COVID-19 legislative package:

- Increase the Federal Medical Assistance Percentage (FMAP) from 6.2 percentage points as enacted under Families First to 14 percentage points, from July 1, 2020 through June 30, 2021.
- Increase the FMAP specifically for home and community-based services by an additional 10 percentage points.
- Prevent the Secretary of Health and Human Services from finalizing the Medicaid Fiscal Accountability Regulation (MFAR) until the end of the COVID-19 public health emergency. The proposed MFAR if finalized would cut federal Medicaid funds when they are most needed.
- Maintain eligibility maintenance of effort provisions included in Families First to prevent states from restricting eligibility for Medicaid HCBS.
- Eliminate cost-sharing for Medicaid beneficiaries for COVID-19 treatment and vaccines.

We also ask Congress to include the following additional provisions in future COVID-19 legislation:

- A maintenance of effort requirement for provider rates to protect access to Medicaid.
- Direct federal funds to Medicaid adult day services providers to keep them operational.
- Permanently extend the Money Follows the Person program and HCBS spousal impoverishment protections.
- Suspend FMAP reductions for Medicaid home health/personal care electronic visit verifications.
- Further prevent the issuance of a final MFAR for at least two years following the end of the COVID-19 public health emergency.

5. **ENSURE PANDEMIC HERO PAY, PAID SICK LEAVE, AND HEALTH CARE COVERAGE FOR THE HEROIC FRONTLINE WORKERS WHO ARE RISKING THEIR OWN LIVES SERVING OLDER PEOPLE DURING THIS CRISIS.**

As was noted at the hearing, nursing home employees are on the frontlines of this pandemic and especially direct care workers are underpaid. Many of our members have been using their reserves to provide additional compensation to staff in recognition of the risks associated with working in nursing homes and other aging services settings. We strongly support the House-passed Heroes Fund. We urge Congress to include additional support during this public health emergency. Nursing homes are almost completely publicly funded, through Medicare and Medicaid.

We urge Congress to include these provisions from the Heroes Act in the next COVID-19 relief package:

- Implement a Heroes Fund that provides pandemic hazard pay for aging services workers in the form of additional pay for frontline workers.
- Temporarily ease certain immigration-related restrictions to allow immigrant physicians, nurses, and critical health care workers to better assist in the fight against COVID-19.
- Add 'caring for adult family members' to 'caring for children' as grounds for leave.
- Make all employers eligible for payroll tax relief for paid leave.
- Allocate $850 million in funding for childcare and adult day health care through the social services block grant.

Conclusion

We agree that we cannot allow our older adults and the people who serve them to be treated with lack of dignity and respect, or to be demonized because of their age or frailty or race or nationality or gender. We appreciate this Committee's strong commitment to working on behalf of older Americans amid the COVID-19 crisis and we stand with you to act urgently to provide the support older adults and aging services providers so desperately need and deserve.

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