U.S. House of Representatives Select Subcommittee on the Coronavirus Crisis

"Examining Long-Term Care in America: The Impact of the Coronavirus in Nursing Homes"

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Chairman Clyburn, Ranking Member Scalise, and distinguished members of the House Select Subcommittee on the Coronavirus Crisis: thank you for the opportunity to testify today on this important topic. I am a Professor of Health Care Policy at Harvard Medical School. I am here today speaking in my capacity as researcher who has studied nursing home quality for twenty-five years.

Residents, their families, and their caregivers have long known that US nursing home care is broken. Yet this issue has gone largely unnoticed among the broader population. COVID changed everything. As one family member recently stated,[1] "The pandemic has lifted the veil on what has been an invisible social ill for decades."

In my testimony, I will review how COVID has "lifted the veil" by briefly reviewing the impact of COVID on nursing homes. COVID was truly a "crisis on top of a crisis" in nursing homes, suggesting we need system level reforms to address both the immediate and long-standing crises. I will discuss some two short-term solutions that could be undertaken to improve care: increasing vaccination and bolstering staffing. I conclude by discussing some recent reforms put forward by a National Academies of Sciences, Engineering and Medicine committee of which I was a member.[1]

I will make my best effort to differentiate between comments and recommendations today that are my own, and those that reflect consensus findings and recommendations from the National Academies report. For a full description of the National Academies' findings and recommendations, I would refer the committee to the report itself, which is available at www.nationalacademies.org/nursing-homes. Although all the National Academies' recommendations are important, I will focus my testimony on the specific recommendations related to financing and payment and quality assurance.

The Impact of COVID on Nursing Homes

COVID has completely devastated nursing homes in the US.[2] After accounting for the gap in federal data at the start of the pandemic,[3] there have been over 1.2 million COVID cases among nursing home residents leading to roughly 172,000 COVID-related fatalities. There were many additional pandemic-related deaths among nursing home residents due to gaps in medical in medical care and increased morbidity.[4]

Efforts to stem this plague took a huge toll.[5] Nursing homes were in all-out lockdown for over a year at the start of the pandemic. Visitors were banned. Family members were unable to see their loved ones. Communal dining and activities at the facilities were canceled. Many residents were unable to enjoy fresh air.[6] Even in nursing homes that did not experience a COVID outbreak in 2020, our research indicates residents suffered increased weight loss and depression.[7]

Working conditions have always been challenging in nursing homes, but this has been magnified during the pandemic.[8] Over 1.3 million staff have had confirmed Covid cases, and over 2,600 staff have died from Covid, making nursing home caregiver the most dangerous job in America.[9] Many staff did not receive hazard or hero pay or any additional benefits during the pandemic.[10] Many nursing homes experienced severe staff shortages[11], with limited access to personal protective equipment[11] and rapid Covid testing[12]. The jobs are so low paid that staff often work in multiple facilities,[13] which contributed to the virus spreading across facilities. Since the start of the pandemic, the nursing home workforce has declined by over 344,000 workers (or 10.2%) according to the Bureau of Labor Statistics.

Nursing homes have also experienced a major decline in patient census.[14] Since the start of the pandemic, national census has declined by over 170,000 residents (or 13%). In particular, nursing homes are struggling to attract higher-revenue, short-stay Medicare patients,[15] which has exposed longstanding issues in how nursing home services are structured and financed.[16] Nursing homes predominantly care for two groups: post-acute Medicare patients and long-stay Medicaid residents. Medicare is a generous payer, while Medicaid often pays below the cost of caring for these frail and medically complex individuals. Thus, the economics of nursing home care hinges on admitting enough short-stay Medicare patients to cross-subsidize the care of long-stay residents paid by Medicaid. Nursing homes that are predominantly dependent upon Medicaid are poorly resourced, have lower staffing levels, are in the poorest neighborhoods, have the most quality problems and are most likely to close.[17]

With the decline in Medicare admissions during the pandemic, more nursing homes are relying on Medicaid, which has led to heighted concerns around closures.[18] The risk of bankruptcy is exacerbated in many for-profit nursing homes where ownership and operations are separated. The owner has control of the facility's most valuable financial asset (the real estate), while the operator has a very stringent lease agreement and must continue to make payments in the context of increasing costs related to COVID and declining revenues.

A key question in directing policy resources is determining what factors were associated with COVID-19 outbreaks in nursing homes. In a systematic review of 36 peer-reviewed studies examining this issue,[19] our research team concluded "larger bed size and location in an area with high COVID-19 prevalence were the strongest and most consistent predictors of facilities having more COVID-19 cases and deaths." The more staff coming in-and-out of the building, the more likely there will be a COVID outbreak.[20] COVID outbreaks were not consistently associated with the share of Medicaid recipients, the star rating of the facility, a record of infection control violations, chain membership, or for-profit ownership. COVID outbreaks were largely a function of "where you were located" versus "who you were" as a facility.[21] This does not suggest there was nothing that could have been done to prevent COVID outbreaks. Rather, it suggests that policymakers needed to adopt a system-level approach to address this problem.

Back in 2020, I testified to this Committee that "it didn't have to be this way."[22] I provided a series of system-level solutions to protect nursing home residents and their caregivers. Thankfully, today we have COVID vaccinations and treatments that were not available then. However, there are still immediate and longer-term system-level reforms that would help fortify the nursing home industry. I will first discuss a couple of short-term steps—increasing vaccinations and supporting staff—before turning to longer-run payment and regulatory reforms that the government could undertake.

Short-Term Reforms

Increase Resident and Staff Vaccinations

Given the concentration of cases and deaths in long-term care facilities, residents and staff were prioritized for receipt of the COVID vaccine beginning in December 2020. The Federal Pharmacy Partnership for Long-Term Care Program contracted with CVS and Walgreens to distribute and administer the vaccine. The program was delayed in implementation given the logistical challenges of visiting 30,000 nursing homes and assisted living facilities and vaccinating millions of residents and their caregivers. Ultimately however, more than 7.9 million doses were administered through the federal program.

Despite the federal program, many staff refused to get vaccinated. In our early study of nursing home vaccination data,[23] we found 60.0% of staff and 81.4% of residents were fully vaccinated as of July 18, 2021. The lowest vaccine coverage was among CNAs, who constitute most direct caregivers. We found that nonprofit and nonchain nursing homes, facilities with higher Medicare star ratings, and facilities with longer-tenured staff achieved greater vaccine coverage, suggesting that organizational characteristics, including ownership structure, quality, and ability to retain staff, may be key in facilities' ability to vaccinate residents and staff. However, our findings also suggested that facilities were also subject to broader challenges to vaccine acceptance in the community because facility coverages were strongly associated with county-wide vaccination coverage and staff coverage was strongly associated with 2020 presidential election voting patterns.

Today, the most recent CMS data (https://data.cms.gov/covid-19/covid-19-nursing-home-data) suggest 87.3% of residents and 86.9% of staff have completed their primary COVID vaccination. These rates are relatively strong. However, nursing home residents and staff still lag in getting their booster doses. 57.3% of residents are up to date with their vaccines, while only 42.9% of staff have completed their booster doses. These rates are unacceptably low.

Why is it important to get staff fully vaccinated? Our research suggests vaccinated nursing home staff save resident lives.[24] In the presence of high community prevalence of Covid-19, we found nursing homes with low staff vaccination coverage had higher numbers of cases and deaths than those with high staff vaccination coverage over the summer of 2021.

In August of 2021, the federal government declared it would mandate COVID-19 vaccinations for all nursing home staff. Some states began mandating vaccinations that fall, and the Federal

mandate became effective in early-2022. A key concern with the mandates was that many staff would choose to leave the profession rather than become vaccinated.

Earlier this year, we published a study on the experience from twelve states that mandated staff vaccinations ahead of the federal requirement.[25] Our findings suggest that state-level vaccine mandates were associated with increased staff vaccination coverage without increases in reported staffing shortages. Vaccination increases were largest when mandates had no test-out option and were also larger in Republican-leaning counties, which had lower mean baseline vaccination rates. These findings support the use of state mandates for booster doses for nursing home employees because they may improve vaccine coverage, even in areas with greater vaccine hesitancy.

Given this context, I would make the following two recommendations:

Mandate Booster Doses for Staff: It is time to extend the initial federal vaccine mandate to include booster doses. Over half (57%) of all staff are not fully vaccinated and would benefit from this increased protection. The existing evidence[25] suggests concerns of widespread staff departures in the context of vaccine mandates were unfounded.

Vaccine Clinics for Nursing Homes with Low Vaccine Rates: The Federal Pharmacy Partnership for Long-Term Care Program provided access to clinics at every US nursing home. Since that initial rollout, the US had taken a very decentralized approach to vaccine distribution with each nursing home distributing their own vaccines. Some nursing homes have thrived under this model, while others have not. To ensure all residents and staff have access to vaccines, I would recommend vaccine clinics for any facility with low booster vaccine rates for staff and residents. This measure would complement the first recommendation (booster mandate for staff).

Improve Staffing

Nursing home staff are paid relatively poorly for incredibly demanding work. Certified nurse aides (CNAs) who provide over 90 percent of direct resident care are often paid at or near minimum wage — the same wages as entry-level workers in retail establishments or fast-food chains. Registered nurses and licensed practical nurses who work in nursing homes are often paid below their counterparts who work in hospitals and other health care settings. Moreover, nursing home staff often lack essential benefits, like health insurance and paid sick leave. That means nursing home workers are incentivized to come to work even when sick, which made absolutely no sense during a pandemic.

Nursing homes are also very hierarchical workplaces with lower-level staff having little autonomy and control in their jobs. Not surprisingly, being undervalued and unempowered makes it hard to recruit and retain individuals to work in nursing homes. The result is that many facilities around the country often have dangerously low levels of staffing.[26] Additionally, the average U.S. nursing home was recently found to have an annual staff turnover rate of 128 percent.[27] This suggests an average facility's staff completely changes over the course of a year, and many nursing homes have even higher turnover rates — as much as 300 percent — suggesting the staff changes every four months. If some part of good nursing home quality

depends on the relationship between staff and residents, it's hard to see how those relationships can develop when staff keep changing. As noted above, the staffing situation has only gotten worse during the pandemic.[28]

There are several things we can do to improve this situation. Here are a set of staffing-related recommendations that could be achieved in the short-term:[29]

Increase minimum staffing levels. One solution would be to increase the number of direct care workers by raising the federal minimum staffing standards in nursing homes. The federal standards are relatively low and have not been updated in over 30 years.[30] Many states set staffing levels above the federal standards and these state policies have generally been found to increase staff.[31] The Biden Administration recently put a minimum staffing standard forward as part of a broader set of nursing home reforms.[32]

Increase staff pay and benefits. Another idea is to raise minimum wages to increase nursing home staff pay. Many certified nurse aides would see their hourly wages increase under the $15 minimum wage proposed by the Biden administration. In the absence of a broader minimum wage hike, policymakers could also increase wages specifically for nursing home and other long-term care workers.[33] Importantly however, relative wages have increased more for nursing home workers than any other health care profession, but nursing homes have also experienced the largest relative decline in the size of the workforce.[34] Taken together, these trends suggest further increases are necessary and it is going to take more than higher wages to recruit and retain workers.

Provide career advancement. Beyond putting more money into wages, policymakers might also consider ways in which they could provide financial support to allow additional education and training to certified nursing assistants and licensed practical nurses seeking upward mobility within a facility. For example, some nursing homes and states currently have ladder programs that provide nursing assistants with financial support in seeking nursing degrees. These programs could be expanded through direct reimbursement via Medicare and Medicaid.

Create a better work environment. Improving wages and benefits is a necessary but insufficient step towards valuing nursing home caregivers;[34] we also need to value the work these individuals do and the individuals that do it. If you can believe it, this might be harder than increasing staffing standards and wages. Finding additional money is one thing — changing the culture around nursing home staffing is another.

There are nursing home models such as the Green House Project that include "empowered staff" as one of the core tenets of their philosophy.[35] In a traditional nursing home, direct care workers say they have very little control over their job and basically must do what their superiors tell them to do. In a Green House home, the team of direct care workers have more autonomy including setting their own schedules, finding replacements for absent staff, determining resident assignments, and deciding how the work will be shared. Not surprisingly, there is emerging evidence that low-wage workers value "dignity at work."[36] Better working conditions leads to more invested and happier staff members, which in turn leads to better care for residents. In fact,

one study indicated that Green House nursing homes had markedly lower rates of Covid infections and deaths than traditional nursing homes.[37]

Unfortunately, it's hard to mandate staff empowerment through policy. But in the short-term, policymakers can improve conditions for staff — and by extension, for residents — through policies that facilitate better wages and benefits for caregivers. In the longer-term, shifting the culture of nursing homes is going to require deeper changes in what we all want from nursing homes for ourselves and those who provide care for us. To do that, we will have to shift how we finance and pay for nursing home services and how we oversee the delivery of care. These types of reforms will be part of the longer-term changes offered below.

A Long-Term Path Forward

The recent National Academies committee on which I served concluded that the way in which the United States finances and regulates care in nursing home settings is **ineffective, inefficient, fragmented, and unsustainable**. I have not found much disagreement on this conclusion among different stakeholders. However, there is a lot of disagreement on how to fix things. The recommendations from the National Academies report around financing and payment, quality assurance and transparency and accountability provide one roadmap forward towards an effective, efficient, coordinated, and sustainable model of nursing home care.

Financing and Payment Reforms
The National Academies committee strived to create a more rational and robust financing system.[38] We recognized that the current approach to financing nursing home care is highly fragmented, with Medicaid paying for long-stay care, Medicare paying for post-acute care, and hospice being covered under a separate Medicare benefit. We offered the following recommendations:

Study of a federal long-term care benefit: To create a more rational approach to financing nursing home care that would address these significant shortcomings, the National Academies report included a recommendation about moving toward a federal long-term care benefit by studying how to design such a benefit and then implementing state demonstration programs to test the model prior to national implementation.

Adequacy of Medicaid payments: The fragmented financing system leads nursing homes to rely on higher payments for Medicare services to cross-subsidize lower Medicaid payments—an inefficient and unsustainable arrangement. In general, states are required by law to provide assurances (and sometimes evidence) that Medicaid payments are adequate to provide access to high-quality care. Nursing home payment rates, however, are not subject to this requirement. To ensure adequate investment in caring for long-stay nursing home residents, our study committee recommended the use of detailed and accurate financial information to ensure payments are adequate to cover comprehensive nursing home care.

Specific percentage of Medicare and Medicaid payments for direct-care services: The National Academies committee also recommended designation of a specific percentage of

Medicare and Medicaid payments for direct-care services (as opposed to non-care costs such as lease payments).

Value-based purchasing initiatives for long-term care: For short-stay post-acute nursing home care, the National Academies committee called for extending current bundled payment arrangements to all conditions to advance value-based payment based on quality, not quantity of services.

Demonstration projects on alternative payment models: The National Academies committee recommended demonstration projects to explore the use of alternative payment models for long-term nursing home care, separate from the bundled payment initiatives for short-stay post-acute care.

Quality Assurance

The National Academies committee also recognized the need to design a more effective and responsive system of quality assurance.[38] Although federal oversight standards and processes are uniform across states, considerable variation exists in the implementation of routine inspections, in the imposition of sanctions, and in the investigation of complaints. The survey process also often fails to identify serious care problems, to fully correct and prevent recurrence of problems, and to investigate complaints in a timely manner.

State surveys and CMS oversight: The National Academies committee provided recommendations to ensure state survey agencies have adequate resources and recommendations for the oversight of state survey performance. Despite the prominent role of nursing home oversight and regulation, the evidence base for its effectiveness in ensuring a minimum standard of quality is relatively modest. The regulatory model needs significant improvement, but there is little consensus (or evidence) to suggest which approaches would ultimately lead to improvement in the quality of care. Our committee recommended developing and evaluating strategies to improve quality assurance activities.

Enhancing the Long-Term Care Ombudsman Program: The Long-Term Care Ombudsman Program's sole mission is to serve as an advocate for residents and work to ensure they receive quality care. Although some studies have shown this program has had a positive impact, there is considerable variation across and within states in terms of resources, funding, and staff and volunteer coverage. To meet federal and state requirements and provide nursing home residents and their families with optimal support, the Administration for Community Living in the U.S. Department of Health and Human Services should advocate for increased funding and resources to hire additional paid staff; train staff and volunteers; bolster infrastructure; make data publicly available; and develop summary metrics to document the effectiveness of the program.

Eliminate Certificate-of-Need Laws and Construction Moratoria: As part of quality assurance, some states maintain certificate-of-need requirements to regulate expansions in the health care market. The requirements employ a need-based evaluation of all applications for new construction or additions to existing facilities. Some states also implement construction moratoria that prohibit the building of new health care facilities. Despite their intent, such regulations do not appear to control Medicaid nursing home spending and may harm consumers

by limiting their choices and access to care. States should immediately eliminate certificate-of-need requirements and construction moratoria for nursing homes to encourage potential innovative care models and foster robust competition to expand consumers' choices and improve quality.

Transparency and Accountability

A key goal of our National Academies work was to increase the transparency and accountability of finances, operations, and ownership. Our committee recognized that a key barrier to effective nursing home oversight has been lack of transparency regarding nursing home finances, operations, and ownership. CMS makes some ownership information available (and more has been made public recently), but these data are incomplete; often difficult to use; and do not allow for assessment of quality across facilities owned or operated by the same entity. Moreover, there is little transparency regarding the practice of some nursing homes to contract with related-party organizations that are also owned by same the nursing home corporation. Increased transparency and accountability are needed to more fully evaluate both how Medicare and Medicaid payments are spent and how ownership models and spending patterns impact the quality of care.

Increase Financial and Ownership Transparency. The National Academies committee recommended collecting, auditing, and making detailed facility-level data on the finances, operations, and ownership of all nursing homes publicly available in real time in a readily usable database that allows for the assessment of quality by common owner or management company.

In summary, the pandemic has lifted the veil on nursing home care in America. We have an opportunity to address problems that we have ignored for far too long. The time to act is now. The urgency to reform the ways in which care is financed, delivered, and regulated in nursing home settings is undeniable. I look forward to working with the members of this Subcommittee on this effort. Thanks.

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