

Testimony before the House Aging & Long-Term Care Committee

On the COVID-19 Pandemic

Mike Ray, President/CEO

Green Hills Community, West Liberty, Ohio

May 28, 2020

Chairman Ginter, Vice-Chair Swearingen, Ranking Member Howse and members of the House Aging & Long-Term Care Committee, thank you for providing this venue to hear from Ohio's aging services providers, regarding the profound impact the COVID-19 pandemic has had on our work. My name is Mike Ray, and I am the President and CEO of Green Hills Community, a non-profit life plan community located in Logan County that is home to 270 older adults across multiple care settings, including independent living, assisted living and skilled nursing care. We serve another 300 clients each week throughout Logan, Champaign and Hardin Counties through our childcare, adult day care, home health and hospice programs. Green Hills Community is a member of LeadingAge Ohio.

Today, I would like to provide an overview of what the past few months have been like for Ohio's long-term care providers.

Early days

As we watched the first cases of COVID-19 develop in the state of Washington, we realized outbreaks would uniquely impact nursing homes. While the rest of the country looked at Wuhan, Italy, and later, New York City in order to understand the magnitude of the threat, our attention turned to Life Care Center in Kirkland, Washington, which eventually experienced 37 fatalities. While Ohio scrambled to establish overflow facilities in convention centers, long-term care facilities were clamoring for equal attention: our residents were most at-risk of harm from the virus, but we couldn't even get priority designation for PPE shipments from Amazon.

Early on in the crisis, as hospitals worked to free-up their beds for an anticipated surge, nursing homes were heavily pressured to accept patients whose COVID-19 status was unknown: at that point testing wasn't sufficiently available to test all hospital discharges. Many nursing homes either limited or stopped taking admissions to protect their existing resident populations, recognizing that their current levels of PPE were insufficient. Our advocacy association, LeadingAge Ohio, of which Green Hills Community is a member, requested a transparent sharing of data across all providers to understand the risk and how best to respond. There was a lack of understanding by local and state officials about why long term care facilities were hesitant to accept patients being discharged from hospitals without the proper testing. With limited PPE and insufficient amounts of disinfectant and hand sanitizer, individual facilities recognized the risk to their existing residents and staff. In response to this, our state nursing home associations wrote a letter in our defense, noting that foisting patients onto unprepared, under-supplied nursing homes was in fact a recipe for a hospital surge.

Less than six weeks into the crisis, it had become apparent that in Ohio, the curve was flattened and there would not be a surge on hospitals. Instead, the path of COVID-19 would wind its way slowly through the population, causing outbreaks in nursing homes and other congregate settings

at different times over the coming months and possibly years.

Ohio nursing homes were hopeful that this realization would translate into additional support for congregate settings. We hoped for a new strategy for responding to the crisis that would place congregate settings at the forefront and see a surge in support through more PPE, additional testing, and staffing support..

Instead the DeWine Administration announced they would release data about nursing homes by publishing a list of long-term care facilities and their count of total COVID cases. The industry immediately responded, asking that the data be provided across all health care facilities and requested the state ensure the accuracy of the data to avoid creating more stress and anxiety for residents, families and employees.

As predicted, the initial list of facilities had to be taken down, because it was so fraught with errors and inaccuracies. It did, in fact, create stress for those facilities that had incorrect data posted, costing them time and resources to manage through the communications and easing concerns.

The reason that nearly two-thirds of Ohio's COVID-related fatalities occurred in long-term care is simple: the average nursing home resident in Ohio is over eighty years old and has multiple chronic conditions which place them at higher risk for mortality related to COVID-19. Further complicating this is that they reside in close proximity to one another and need care that cannot be delivered at a safe social distance with a virus that is more contagious than others. Ohio's assisted livings and nursing homes do not need scrutiny and criticism for these factors which are out of their control. They need a concerted, statewide strategy to ensure they can all access the support they need.

Financial Impact

Before I close today, I want to share the financial impact that has compounded this crisis for long-term care facilities:

- **PPE:** Prior to the pandemic, it was possible to find an N-95 respirator mask for under a dollar apiece. By April, they were priced at \$5 to \$7 each. Right now, disposable isolation gowns are in short supply. A colleague recently shared that single-use gowns are now going for \$9 each. They cost about 25 cents each about a year ago.
- **Staffing:** All long-term care providers have had to dramatically adjust their staffing in ways that drive up costs. Staff must now be dedicated to screening other employees for symptoms at the beginning of their shift. The end of congregate dining means that meals must be delivered directly to rooms. This is particularly challenging for residents who require feeding assistance, which used to be done by one staff person assisting multiple residents in a dining room. Activities used to be built around group events and gatherings, but now are predominately done one-on-one with residents in their rooms. If – or rather, when—a resident is diagnosed with COVID-19, they are typically cohorted in a designated area of the facility, which is specifically staffed to serve this population, further stretching human resources. Finally, some providers have implemented “hazard pay” when they do have a positive case detected in their community.
- **Testing:** those communities that have had a positive case of COVID-19 — over 200 statewide to-date — have typically made outlays to pay for testing. While Medicare has paid for testing for its beneficiaries, it only allows labs to bill for testing—not providers. Because providers have not always had pre-existing arrangements with labs which included billing, providers have footed some of these bills. Furthermore, long-term care facilities that have chosen to test their staff have to work through individual insurance

requirements. While commercial insurers are required to pay for testing, some have declined to do so when the beneficiary is asymptomatic, which is often the case.

- **Census:** Most nursing homes make their margins on short-term rehabilitative Medicare stays, and typically lose money on long-term residents, particularly those who are Medicaid beneficiaries. When elective surgeries and procedures were suspended, so were the rehab stays that they would have required. Others chose to opt for home health instead of skilled nursing rehab during the state of emergency, to reduce their risk of exposure. This drop in census has compounded financial pressures on skilled nursing facilities. In a preliminary model of lost revenue, the accounting and consulting firm CliftonLarsonAllen demonstrated an impact of between \$268 and \$468 million to Ohio nursing homes during the initial months of the crisis. This figure does not account for the increased costs of staffing, additional PPE, and special equipment that nursing homes have incurred to transition to a new, socially distanced way of providing care.

LeadingAge Ohio estimates that the cumulative impact of all these pressures translates into a 20 to 30% hit on nursing homes' bottom lines. While providers have received relief payments from the Medicare program, Ohio's Medicaid program has yet to provide material support to long-term care facilities.

How We Have Responded

Today, we are witnessing the catastrophic effect of those early challenges: as the rest of Ohio moves forward, long-term care related deaths are rapidly outpacing deaths in the rest of the population. We've heard Director Acton note that cases lag exposure by 1-2 weeks, and deaths lag cases by an additional 2-4 weeks. As such, the recent surge in long-term care deaths directly reflect the support we weren't receiving in early- to mid-April.

We have no reason to believe that these numbers will diminish, at least in the near-term. We have not solved the testing conundrum, we still have inconsistent levels of partnership with local health departments and hospitals across the state, and though PPE supplies have improved, it only takes a cluster of cases to throw any facility into shortage again.

Despite this, we're in a much better place than we were just a few months ago. We have adapted rapidly to new expectations, have integrated new infection control measures, the PPE stores are slowly being built, and in some areas of the state, new partnerships with local coalitions are emerging. Knowledge is power, and we have learned much about how to treat this disease and how not to treat it. Our staff's initial fear has given way to resolve and determination.

Where there were no easy solutions, we have been developing new strategies to fill gaps. For example, when long-term care providers couldn't get access to timely testing, central Ohio developed a solution built on a philanthropic partnership, staffed by volunteers, that has successfully administered over 2,600 tests to long-term care residents and staff. When one of my colleagues was working through a contingency staffing plan in case of an outbreak that would force their employees to quarantine at home, they found a willing partner in their local hospice agency that was experiencing very low staffing needs due to reduced and cancelled visits.

Much of our success to-date has happened because of the providers working together to solve problems and develop responses without the resources anticipated being available in a public health crisis. LeadingAge Ohio has been engaged in conversations with staff from the Ohio Departments of Health, Medicaid, Department of Aging and the Governor's office multiple times weekly, and while our concerns seem to be well-understood, neighboring states are now on second

rounds of financial relief, and Ohio has yet to announce their plans.

We respectfully ask members of the committee to elevate our request for increased reimbursement to the nursing facility and assisted living waiver per diem rates to offset the high costs of PPE, increased staffing, and added communication technology; and while today's hearing is focused on long-term care facilities, I would be remiss not to mention that some of these costs—specifically those related to PPE and communication technology—have also been born by home- and community-based providers. Furthermore, we believe COVID-positive individuals should be reimbursed at a special rate, regardless of whether the nursing facility is designated as a health care isolation center.

Thank you for your time and consideration today. I am happy to answer any questions you might have after my colleague finishes her remarks.