

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

A National Tragedy: COVID-19 in the Nation's Nursing Homes Hearing of the Senate Finance Committee March 17, 2021

Justice in Aging appreciates the opportunity to submit a written statement for the record. Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. We have decades of experience with nursing homes and other forms of long-term services and supports, with a focus on the needs of low-income enrollees and populations that have been marginalized and excluded from justice such as women, people of color, people with disabilities, LGBTQ individuals, and people with limited English proficiency.

Focus of this Statement: Breaking Through the Persistent Public Policy Impasse.

In the past month, Congress has convened two hearings addressing the need for nursing home reform: the Senate Finance Committee hearing (March 17), and a hearing on Examining Private Equity's Expanded Role in the U.S. Health Care System, convened by the Oversight Subcommittee of the House Ways and Means Committee (March 25). These hearings have highlighted the persistently poor care provided to this country's nursing home residents. Unfortunately, these problems are anything but new.

As testimony in the Finance Committee hearing demonstrated, the COVID-19 pandemic has exacerbated preexisting problems within nursing homes, including, but not limited to, inadequate staffing and slipshod infection prevention and control practices. The results have been horrific, with approximately 175,000 deaths among residents and staff of long-term care facilities,¹ along with residents being isolated from family members and friends for an entire year.

Many observers have suggested that now, finally, is the time for reforming our nursing home system. But reform is far from assured. Change will require that Congress break through the gridlock that has stymied nursing home public policy for several decades.

To a great extent, the public policy impasse on nursing home reform stems from one central dynamic: providers claim that improvement is impossible, due to allegedly insufficient

¹ The COVID Tracking Project, [The Long-Term Care COVID Tracker](#) (reviewed March 31, 2021).

WASHINGTON

1444 Eye Street, NW, Suite 1100
Washington, DC 20005
202-289-6976

LOS ANGELES

3660 Wilshire Boulevard, Suite 718
Los Angeles, CA 90010
213-639-0930

OAKLAND

1330 Broadway, Suite 525
Oakland, CA 94612
510-663-1055

Medicaid rates. Although they may concede (for example) that facility staffing levels are too low, they resist efforts to establish national staffing minimums, based largely on arguments that Medicaid rates do not support adequate staffing levels. As a result, nursing homes continue to staff at dangerously low levels, which in turn leads to resident injuries and death — before, during and after the pandemic.

In an effort to contribute to public policy solutions, this statement focuses on one important aspect of the current problem: service providers both a) claiming that Medicaid rates are inadequate while b) organizing their finances in such a way that makes it virtually impossible to determine appropriate rates. These counterproductive practices are part of the dynamic that has made nursing home reform an oxymoron for many years.

Nursing Home Residents Suffer Due to Inadequate Staffing Levels Linked to Low Wages.

Short staffing is a longstanding problem in nursing homes. A recent report found that 48.2% of direct-care workers earned less than a living wage, with approximately 56% relying in part on public assistance.² Another study found nursing staff turnover rates of 94% (mean) and 128% (median) over the course of a single year.³

Not surprisingly, poor staffing has consequences. A study mandated by the federal Nursing Home Reform Law determined appropriate staffing levels based on facility quality measures, with the recommended levels specific to nurse aides and nurses, and short-term and long-term resident stays in the nursing home. That analysis found that 52 percent of nursing homes failed to meet any of the recommended staffing levels, while a full 97 percent of the nursing homes failed to meet at least one of the recommended levels.⁴

Numerous studies have confirmed this commonsense conclusion: low staffing levels lead to poor resident care. Specific study results include findings that low staffing levels are connected to avoidable hospitalizations, more deficiencies, and poorer nurse aide performance.⁵

² Christian Weller et al., LeadingAge, [Making Care Work Pay: How Paying at Least a Living Wage to Direct Care Workers Could Benefit Care Recipients, Workers, and Communities](#), at 8, 10 (2020).

³ Ashvin Gandhi et al., [High Nursing Staff Turnover in Nursing Homes Offers Important Quality Information](#), Health Affairs, vol. 40, no. 3 (March 2021).

⁴ CMS, Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes; [Overview of the Phase II Report: Background, Study Approach, Findings, and Conclusion](#), at 5 (2001).

⁵ See, e.g., William Spector et al., [Potentially Avoidable Hospitalizations for Elderly Long-Stay Residents in Nursing Homes](#), Medical Care, vol. 51, no. 8, at 673 (Aug. 2013) (low staffing linked to avoidable hospitalizations); Nicholas Castle et al., [Caregiver Staffing in Nursing Homes and their Influence on Quality of Care: Using Dynamic Panel Estimation Methods](#), Medical Care, vol. 49, no. 6, at 545 (June 2011) (better staffing linked to better quality); Nicholas Castle et al., [Nursing Home Deficiency Citations for Safety](#), J. Aging and Social Policy, vol. 23, no. 1, at 34 (Jan. 2011) (low staffing correlated to deficiencies cited by survey agency); John Schnelle et al., [Relationship of](#)

In related findings, studies also have shown a relationship between quality and the staffing levels for *registered nurses*. Current federal law requires only that a nursing home employ a registered nurse for eight hours daily.⁶ Studies have shown that higher staffing levels for registered nurses lead to better care for residents.⁷

Not surprisingly, the ongoing pandemic has only made adequate staffing more consequential. Studies in both Connecticut and California found that higher staffing of registered nurses allowed nursing homes to better limit the spread of COVID-19.⁸ Also, these quality of care problems have fallen particularly hard on persons of color. The Connecticut study, for example, found greater COVID-19 spread among nursing homes with higher percentages of residents of color.⁹ Furthermore, the same principal author studied nationwide data and found that nursing homes with a greater percentages of residents of color were more likely to suffer COVID-19 cases and deaths.¹⁰ The New York Times reached similar conclusions, noting a “striking racial divide” in how COVID-19 afflicted those nursing home with high percentages of Black and Latino residents.¹¹

Notably, provider associations acknowledge to a certain extent the inadequacy of current staffing practices. In a recent policy proposal, for example, the American Health Care Association (for-profit facilities) and LeadingAge (non-profit facilities) recognized the need for around-the-clock registered nurses.¹² Likewise, LeadingAge published a report arguing in favor of paying a living wage to direct care workers.¹³ In each of these instances, however, provider associations declined to commit to actually taking these positive steps, which they claim must be contingent upon increased Medicaid reimbursement rates.

Nursing Homes Create Complicated Corporate Structures to Hide Profits.

[Nursing Home Staffing to Quality of Care?](#), Health Serv. Res., vol. 39, no. 2, at 225 (April 2004) (higher staffing linked to better performance by nurse aides).

⁶ 42 U.S.C. §§ 1395i-3(b)(4)(C)(i), 1396r(b)(4)(C)(i); 42 C.F.R. § 483.35(b).

⁷ See, e.g., Mary Ellen Dellefield et al., [The Relationship Between Registered Nurses and Nursing Home Quality: An Integrative Review \(2008-2014\)](#), *Nurs. Econ.*, vol. 33, no. 2, at 95 (March-April 2015) (literature review).

¹⁴ Yue Li et al., [COVID-19 Infections and Deaths Among Connecticut Nursing Home Resident: Facility Correlates](#), *J. Am. Geriatrics Soc’y*, vol. 68, no. 9, at 1899 (Sept. 2020); Charlene Harrington et al., [Nursing Staffing and Coronavirus Infections in California Nursing Homes](#), *Policy, Politics, & Nursing Practice*, vol. 21, no. 3, at 174 (2020).

⁹ Yue Li et al., [COVID-19 Infections and Deaths Among Connecticut Nursing Home Resident: Facility Correlates](#), at 1903.

¹⁰ Yue Li et al., [Racial and Ethnic Disparities in COVID-19 Infections and Deaths Across U.S. Nursing Homes](#), *J. Am. Geriatrics Soc’y*, vol. 68, no. 11 (Nov. 2020).

¹¹ Robert Gebeloff et al., [Striking Racial Divide: How COVID-19 Has Hit Nursing Homes](#), *N.Y. Times*, Sept. 10, 2020.

¹² American Health Care Ass’n and LeadingAge, [Care for our Seniors Act](#), *Improving America’s Nursing Homes by Learning from Tragedy & Implementing Bold Solutions for the Future*, at 4 (2021).

¹³ Christian Weller et al., LeadingAge, [Making Care Work Pay](#): How Paying at Least a Living Wage to Direct Care Workers Could Benefit Care Recipients, Workers, and Communities, at 30 (2020).

The recent congressional hearings shone a light into common nursing home business practices that frustrate sane public policy. In particular, testimony submitted to the Oversight Subcommittee of the House Ways and Means Committee showed how nursing homes use corporate organizational structures to hide profits.¹⁴ Similarly, a recent academic paper demonstrated how private equity investment in nursing homes has led to a deteriorating quality of care, including unnecessary deaths, increased use of dangerous psychotropic medications, declining mobility, and increased expense.¹⁵

In testimony submitted to the Oversight Subcommittee, Ernest Tosh clearly explained the gaping holes exploited by the nursing home industry. First, nursing home business practices have corrupted the cost reporting required by CMS. As Mr. Tosh reports, “[o]n the surface the financial information appears to be useful, until one realizes the financial picture of a single facility can be highly manipulated if it is within a chain of nursing homes that also contains multiple related corporations.”¹⁶

These cost reports may show, for example, that a nursing home has annual revenues approaching ten million dollars, but nonetheless is losing money and has relatively few assets. At first glance, such a nursing home may appear to be in precarious financial shape, but that first glance does not take into account the nursing home’s many “related party” transactions. The “related parties” are other corporations owned by the same persons or entities that own the nursing home. By contracting with the related parties to provide various aspects of the nursing home’s operation — the building itself, for example, or management services, nursing services, or therapy services — the nursing home can claim expenses even though it is essentially paying itself. This allows a nursing home with few assets and purported annual losses to continue operating successfully: the overall corporate structure is profitable, even though the entity holding the nursing home license consistently claims losses.¹⁷

The written testimony of David Kingsley highlighted a related problem: nursing homes’ frequent use of real estate investment trusts (REITs). REITs are used in a common type of related party transaction — the nursing home operator transfers the real property into a REIT, and then leases back the property from the REIT, claiming rent payments as expenses. Like all related

¹⁴ See Written Testimony of Ernest C. Tosh, Statement of Sabrina T. Howell, PhD, and Written Testimony of David E. Kingsley, PhD. Mr. Tosh and Prof. Howell also testified in person at the hearing.

¹⁵ Atul Gupta et al., Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes, at 3 (Feb. 2021). The findings of this study constitute much of the material presented by Prof. Sabrina Howell (one of the study’s co-authors) during the recent hearing in front of the Oversight Subcommittee of the House Ways and Means Committee.

¹⁶ Tosh Written Testimony at 2.

¹⁷ Tosh Written Testimony at 2-6.

party structures, the REITs create false expenses that are actually just transfers within a single corporate structure.¹⁸

Mr. Kingsley aptly characterizes the nursing home business as “a financial engineering industry engaged in trading property as a commodity and tax arbitrage as a core technique.”¹⁹ The web of related party transactions has no justification from a *health care* perspective. Indeed, to a significant extent, the provision of care — and the quality of such care — is a secondary concern in such business models.

Congress Should Provide Better Access to Medicaid-Funded At-Home Care, and Limit Nursing Homes’ Use of Deceptive Corporate Structures.

We make two recommendations to improve care for older Americans in need of daily care. First, Congress should improve access to Medicaid-funded home and community-based services, so that no one is forced to live in a nursing home if they would rather receive necessary services at home. Under current federal law, a state Medicaid program must offer nursing home care to every qualifying person, but home and community-based services can be subject to a waiting list or other limit on enrollment.²⁰ Congress should make home and community-based services available to all persons qualifying under Medicaid rules. Such equal access to home and community-based services would provide the dual benefit of enabling persons to receive necessary services at home, and give nursing homes a greater incentive to offer quality care and a good quality of life, in order to compete with home and community-based services.

Second, as set forth in this statement, Congress should take steps to prohibit the financial machinations that distort the business of providing nursing home care. Under current business structures, many nursing homes are focused not on providing high quality care, but rather on funneling profit out of a nursing home to related parties. These practices penalize both residents and staff members, and inevitably lead to deterioration, injuries and deaths.

Also, as addressed above, these financial structures prevent honest evaluation of the adequacy of Medicare and Medicaid reimbursement rates. From our perspective, an increase in Medicaid rates could almost never be justified under current practices, because nursing home operators are not being forthcoming about their true financial status.

On a closely related matter, we support calls for greater transparency in nursing home finances, but are skeptical as to whether transparency alone can address the current problems. It is not

¹⁸ Kingsley Written Testimony at 2-4.

¹⁹ Kingsley Written Testimony at 5.

²⁰ 42 U.S.C. §§ 1396d(a)(4)(A) (obligation to provide nursing home services), 1396n(c) (home and community-based services waivers).

realistic to expect CMS to perform forensic accounting on the incredibly intricate corporate structures in use today.

And, finally, we assert that it is entirely fair to prohibit certain corporate structures as a condition of Medicare or Medicaid certification. Nursing homes rely on public funding for the bulk of their revenue.²¹ Given that relationship, along with the importance of setting appropriate Medicare and Medicaid reimbursement rates, it would be eminently reasonable for Congress to prohibit the corporate structures that currently hamper our ability to make meaningful reforms.

²¹ See, e.g., [Medicaid's Share of Nursing Home Revenue, Resident Days Hits Record High as Medicare Drops to Historic Low](#), Skilled Nursing News (Dec. 11, 2019) (Medicaid and Medicare funding constituting over 72% of overall nursing home revenue).