
IMPACT OF COVID-19 ON LONG-TERM CARE IN NEW YORK

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Acknowledgements:

This project is part of a larger unfunded project in Duke-Margolis Center for Health Policy on state long-term care responses to Covid-19 led by Courtney H Van Houtven, managed by Hilary Campbell. We thank Alice Chun for her research assistance.

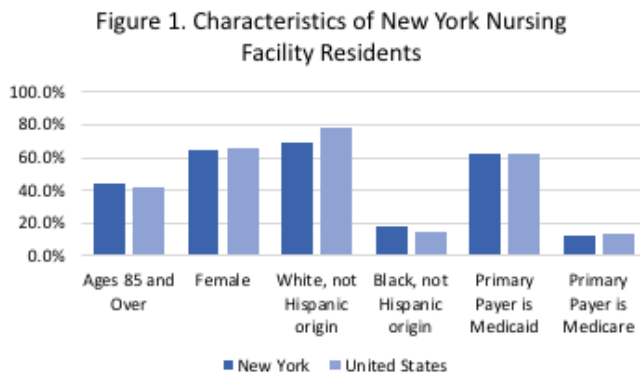
STATE LONG-TERM CARE SETTING

GENERAL (PRE-COVID) SETTING AND CONTEXT

There are 19.5 million people living in New York, with approximately 13.4% over the age of 65. The percentage of the New York population identifying as Black (14.7%) and Hispanic (16.8%) is slightly higher than the national average, 12.3% and 15.8% respectively. The 11.8% poverty rate for residents 65+ is higher than the national median of 8.7% and is the 5th highest in the country. It is estimated that 0.53% of the population resides in nursing homes, slightly higher than the 0.45% national median.

New York contains over 600 nursing homes that provide long-term services and supports to roughly [100,000](#) residents. Sixty-one percent of these homes are for-profit facilities. Nursing homes in New York are highly dependent on Medicaid as a source of revenue – approximately 61.2% of nursing home residents are covered by Medicaid and only 12.8% are covered by Medicare. Approximately 15.6% of nursing homes are part of a chain and 8.6% are hospital-based. The average age of nursing home residents in New York is 79.9, with 43.7% aged 85 and older, 64.2% of residents are female, 18.5% are Black and 9.9% are Hispanic. (Figure 1)

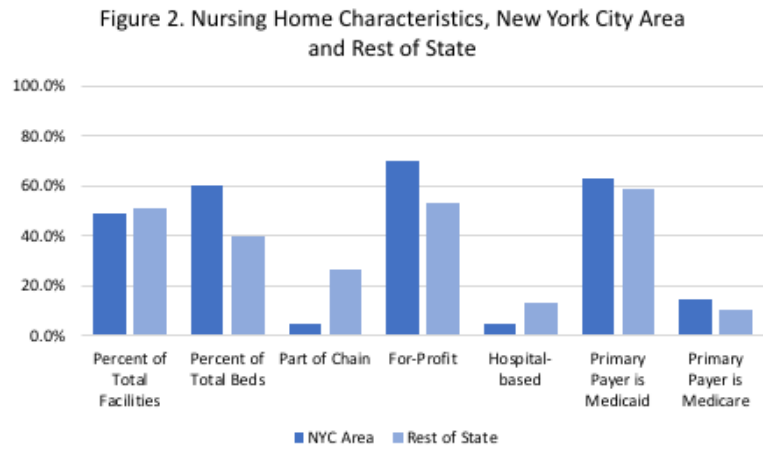
Long-term care spending also constitutes a large portion of New York Medicaid spending, though exact numbers are difficult to obtain due to widespread use of Medicaid managed long-term care throughout the state. Despite the importance of state financing in this sector, New York does not require minimum direct care staffing levels in nursing homes like a number of neighboring states.



Heterogeneity between New York City area and rest of state. In New York City and the surrounding counties (NYC Area)¹, there are significant differences in the overall population, nursing home population and in the nursing home facility characteristics. The NYC Area accounts for 63.3% of the total state population. The NYC Area is slightly younger, 12.8% of the population over 65 as compared to 14.5% in the rest of the state, and is much more diverse, 18.9% Black and 23.4% Hispanic. Residents in the nursing homes in the NYC Area are also slightly younger (average age 77.5) and more diverse (30.8% Black and 17.9% Hispanic).

¹ For purposes of this report, the NYC area is defined as the 5 counties of NYC (Bronx, Kings, New York, Queens and Richmond), the 2 counties of Long Island (Nassau, Suffolk), and the 2 counties immediately north of the city limits (Westchester, Rockland).

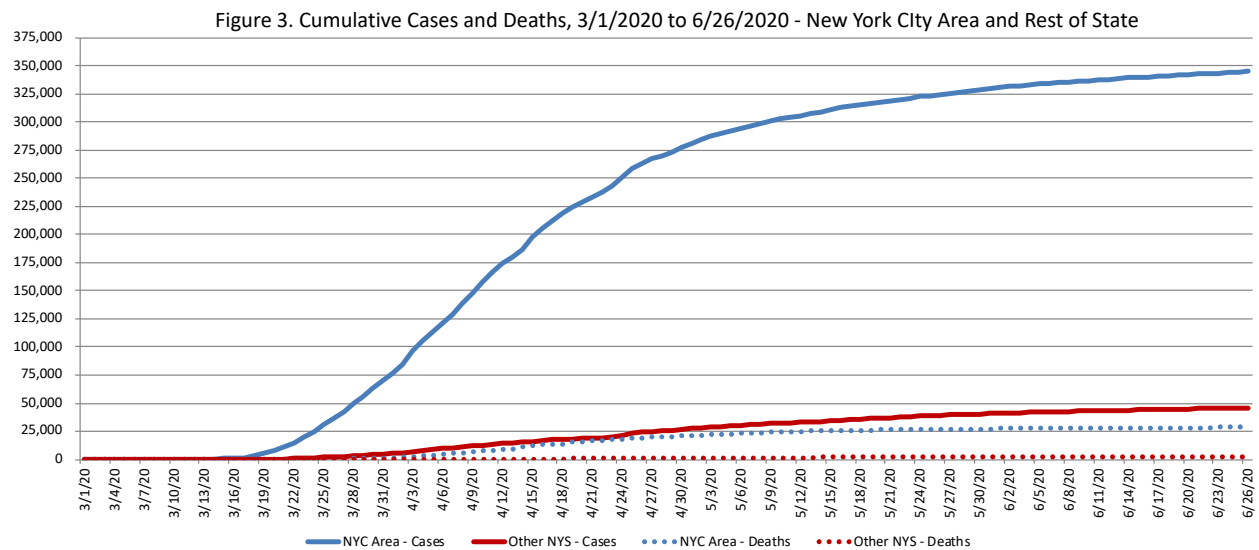
Nursing home facility characteristics are also different in the NYC Area as compared to the rest of the state. While 48.7% of nursing home facilities are in the NYC Area, 60.0% of total beds statewide are in those facilities, for an NYC Area average of 230.5 beds per facility as compared to 145.8 in the rest of the state. NYC Area nursing homes are less likely to be part of a chain (4.7%) and hospital-based (4.3%) and are more likely to be for-profit (69.9%). The NYC Area nursing home residents are also more likely to be covered by Medicaid (62.8%) or Medicare (14.6%). (Figure 2)



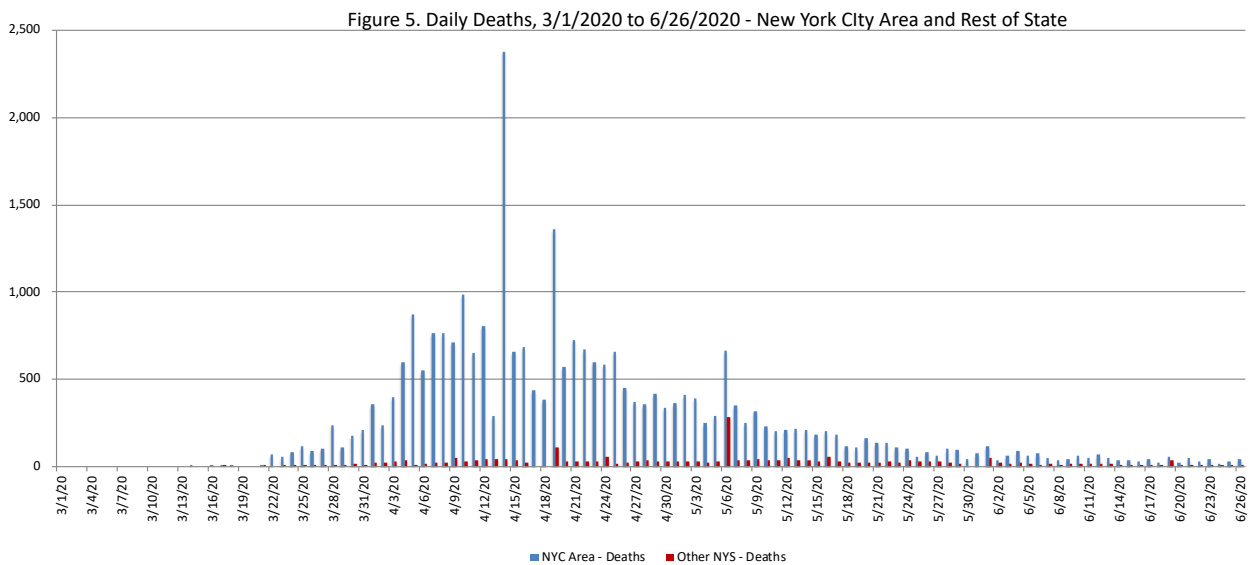
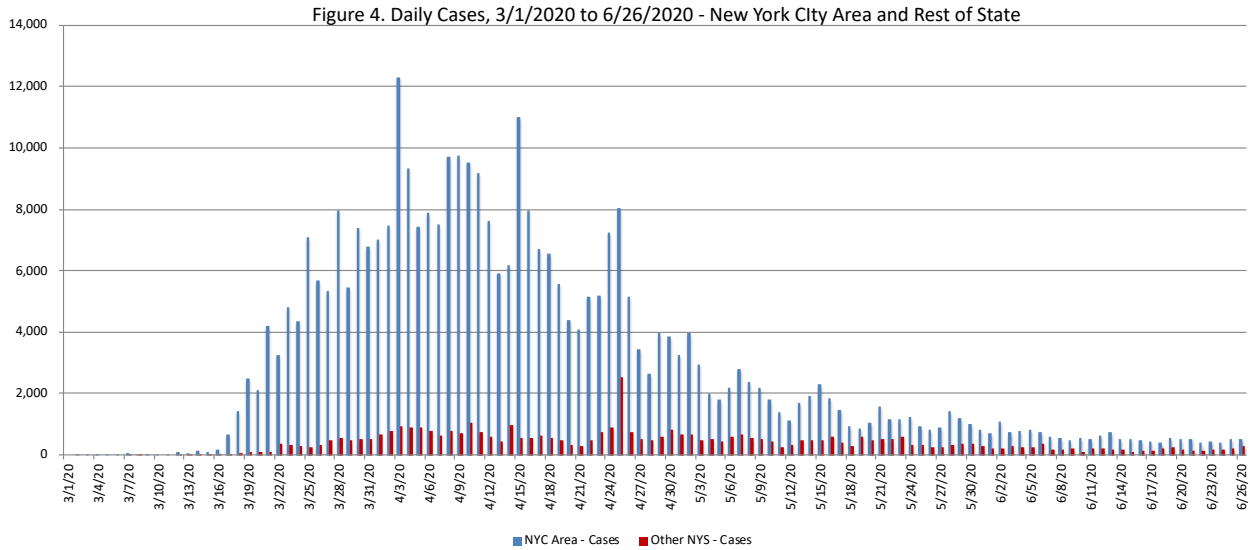
STATE COVID-19 OUTBREAK AND POPULATION LEVEL MEASURES

STATE COVID-19 CONTEXT

New York, and more specifically, the NYC Area was an early epicenter of the COVID-19 outbreak. The first case was confirmed on March 1, 2020 and as of June 26, 2020, New York had a cumulative total of



391,220 cases (16.0% of the United States total), of which 88.2% were in the NYC Area. (Figure 3 and 4) The 30,924 individuals that died as a result of COVID-19 in the state accounted for 25.4% of the national total. (Figure 3 and 5) The NYC Area alone accounted for 23.4% of the total national deaths and 92.0% of the state total as of June 26, 2020.

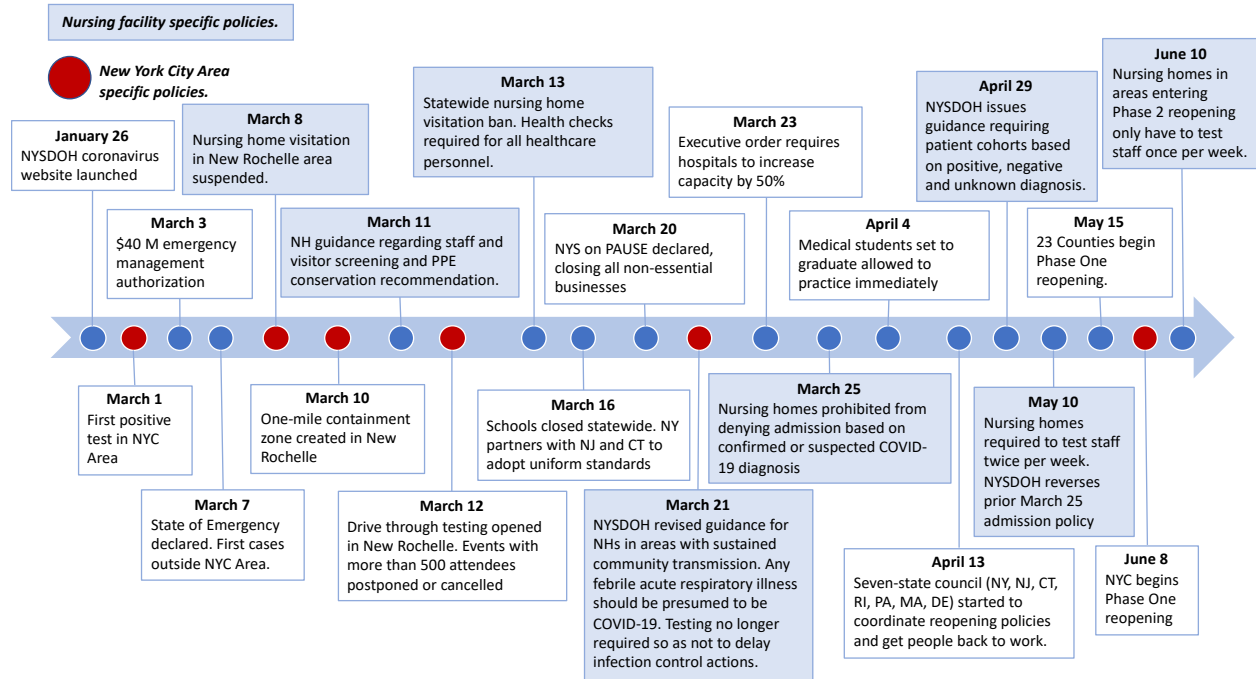


State intervention evolved rapidly. New York began COVID-19 preparations prior to the first confirmed case in the state. On January 17, 2020, the State Health Department issued guidance regarding coronavirus and the Port Authority and NYC began working with the CDC to [screen passengers](#) arriving from Wuhan, China. Unfortunately, [as has been reported](#), the emergence of cases in New York mostly originated from Europe. On March 3rd, two days after the first case, Governor Cuomo signed a \$40 million emergency management authorization and then, on March 7, 2020, he declared a [State of Emergency](#). On March 10, with only 173 cases in New York, a [one-mile containment zone](#) was created to attempt to control a hot spot in New Rochelle, NY – it was the largest cluster in the country at the time. [Schools were closed](#) statewide on March 16, and then, on March 20, 2020, as the total statewide cases had risen to over 7,000, Governor Cuomo signed the [New York State on PAUSE](#) executive order that closed non-essential businesses statewide and instituted social distancing requirements.

New York joined neighboring states to adopt more uniform approaches. On March 16, 2020, New York worked with Connecticut and New Jersey to implement [uniform standards](#) that included limiting gatherings to 50 or fewer people and closing restaurants, bars, movie theaters, gyms and casinos. On

April 13, 2020, the partnership expanded to address reopening plans. Governor Cuomo and his team joined leadership from New Jersey, Connecticut, Pennsylvania, Delaware, Massachusetts and Rhode Island to adopt a [regional approach](#) to lifting stay-at-home orders and reopening the economy. New York adopted a four-phased approach, [NY Forward](#), to reopening and implemented it based on seven metrics related to hospitalizations, covid-19 related deaths, testing and health system capacity, and tracing capabilities. On May 15, 2020, three regions (23 counties) in New York began Phase One reopening. As of [June 26, 2020](#), thirty-five counties had entered phase four, twenty-two counties had entered phase three, and five counties (NYC) had entered phase two.

Figure 6. New York State COVID-19 Response.



Governor Cuomo holds daily briefings to keep New York informed. Starting on March 2, the day after the first case was identified in New York, Governor Cuomo held a [daily press briefing](#) to keep the public informed about the state of the pandemic in New York. Governor Cuomo went on to hold 111 straight daily briefings until they were transitioned to an “as needed” basis. The last of the daily briefings was on June 19. During the briefings, Governor Cuomo would discuss the current state of the pandemic, present simple data and messaging slides, and then answer questions from reporters. The daily briefings were often aired nationally and viewed by many outside the New York region. The transparency in these briefings was important to set the tone for the state despite the rising case and mortality numbers. According to a [March poll](#), 87% of New Yorkers approved of his handling of the pandemic.

RISK MITIGATION STRATEGIES

Testing

Testing policies evolved over time. The New York State Department of Health (NYSDOH) issued guidance to nursing homes on [March 11, 2020](#). The initial guidance did not include language regarding diagnostic testing, but rather included requirements for staff to screen visitors for symptoms or

potential exposure and for staff to be screened for respiratory symptoms upon arrival to work. Further, the guidance outlined quarantine procedures for staff exposure and reinforcement of infection control policies. On March 13, 2020, the NYSDOH expanded the [staff testing requirement](#) to include all healthcare personnel and other facility staff to be screened at the outset of each shift. As more data emerged regarding community spread, NYSDOH revised its testing requirements on March 21, 2020 where there was sustained community transmission. This included New York City, Long Island, Westchester and Rockland counties (the NYC Area). Facilities in these areas, and anywhere else in the state with sustained community transmission, were advised to implement strict infection control actions regardless of confirmed test results, since “[ANY febrile acute respiratory illness or clusters of acute respiratory illness... should be presumed to be COVID-19.](#)”

Testing requirements were altered again on May 10, 2020 via executive order 202.30 signed by Governor Cuomo. The new mandate required facilities to test all nursing home personnel twice per week and carried significant penalties (up to \$10,000 per day) and threat of license revocation. The order was [met with resistance](#) as it was not clear whether testing capacity in NYS could handle the increase. On June 10, 2020, the New York State Health Commissioner, Dr. Howard Zucker, [released a statement](#) scaling back the requirements to weekly testing for regions that had met criteria to enter Phase Two. Dr. Zucker noted that more than 425,000 nursing home staff tests had been processed from May 10, 2020 to June 10, 2020, identifying an additional 6,500 positive cases, and, for facilities in regions entering Phase Two, just 0.76% of tests came back positive. In addition to the staff testing, Dr. Zucker noted that the NYSDOH had also completed testing for nearly all nursing home residents across the state.

According to the Centers for Medicare and Medicaid (CMS) Nursing Home COVID-19 [database](#), as of the week ending 6/15/2020, less than 1% of New York nursing homes outside the NYC Area reported not having access to COVID-19 testing within the facility. Within the NYC Area, about 1% of nursing homes reported an inability to administer tests at the nursing home (with samples being sent off-site for analyses). However, anecdotal reports indicate that the turnaround time for laboratory results remain an issue, with results taking anywhere from 1 to 15 days to obtain.

Supply and use of Personal Protective Equipment (PPE) presented early challenges. PPE shortages [hampered](#) many nursing homes throughout the state in preventing the spread of COVID-19. Reports indicate that supplies have improved, yet as demonstrated in Table 1, shortages persist. In the NYC Area, nearly a [quarter](#) of nursing homes reported less than a one-week supply of at least one type of PPE, while about 13% of nursing homes in the rest of the state had such a shortage. In both regions, shortages of N95 masks and gowns were the most common shortage types.

Table 1. Reported Personal Protectives Equipment Shortages in New York State

	Percent of Nursing Homes Reporting Less than a 1-week Supply	
	NYC Area	Rest of State
Any PPE Shortage	24.4	12.6
N95 Masks	15.8	7.6
Surgical Masks	4.9	0.4
Eye Protection	5.3	0.4
Gowns	10.5	9.0

Gloves	8.3	0.7
Hand Sanitizer	8.3	1.1

Source: CMS Nursing Home COVID-19 Data for the week ending 6/14/2018

Beyond obtaining sufficient PPE supplies, another concern was whether staff were trained on how to properly use, don, and doff PPE. To help ensure proper PPE use, NYSDOH [modified](#) their annual nursing home survey framework to emphasize the monitoring of staff training and use of PPE, in addition to other infection control surveillance.

Facility direct care changes

New York adopted cohorting model. In one of the [initial guidance letters](#) to administrators, the NYSDOH suggested that nursing homes “cohort residents with COVID-19” and use “dedicated health and direct care personnel” that do not move between units. Further, all residents on affected units were directed to be “placed on droplet and contact precautions.” Residents suspected of infection were required to wear masks and had to be isolated in a room with the door closed. HCP were able to use eye protection and facemasks to see multiple patients, but NYSDOH suggested changing gloves and gowns and hand washing between patients. The [cohort model was updated](#) in guidance distributed to nursing home administrators on April 29, 2020. The new guidance required nursing homes to have protocols in place to cohort residents as positive, negative, and unknown and to have separate staffing teams to care for the positive and non-positive residents. Nursing homes were directed to transfer patients “within a facility, to another long-term care facility, or to another non-certified location” if separation was not feasible.

New York developed on-line volunteer health worker portal. New York announced an on-line portal to help hospitals and other healthcare providers address staffing shortages stemming from the COVID-19 pandemic. In a [letter sent April 29, 2020](#) to nursing home administrators outlining stricter standards for positive tested staff to return to work after 14 days rather than the CDC guidance suggesting 7 days after symptoms first appeared. Given the stricter standards and the potential effect on staffing, the letter reminded nursing homes that the portal contained access to more than 95,000 health workers and that nearly one-third of statewide nursing homes had accessed and used the portal. Further, New York provided two-thirds of nursing homes in the state with free access to the Indeed.com recruiting website.

Telehealth was leveraged to provide medical care to nursing home residents across New York. New York was well positioned to leverage telehealth to conduct remote medical visits with nursing home residents and limit physician visits to multiple facilities. In 2014, the state passed the [Telehealth Parity Law](#), which required commercial insurers and Medicaid to reimburse services provided through telehealth if those services would have been covered during an in-person visit. As such, much of the infrastructure needed to increase telehealth use, as well as the mechanisms to provider reimbursement, were already in place. Furthermore, New York [relaxed](#) many of the restrictions related to Medicaid reimbursement for telehealth services on March 1, 2020. For instance, the state expanded the definition of Medicaid-eligible telehealth to include phone calls, consistent with federal changes to Medicare policies.

LTC facility worker policy changes

Should a staff member become infected with COVID-19, the NYSDOH [mandates](#) that “nursing home employees who test positive for COVID-19 but remain asymptomatic are not eligible to return to work for 14 days from first positive test date in any situation and will no longer adhere to the shorter CDC timeframe.” Similarly, the NYSDOH mandates that “symptomatic nursing home employees may not return to work until 14 days after the onset of symptoms, provided at least 3 days (72 hours) have passed since resolution of fever without the use of fever-reducing medications and respiratory symptoms are improving.”

Staff shortages remain a challenge in New York, particularly among nursing homes outside of the NYC Area. (Table 2) As of the week ending 6/14/2020, 35.5% of nursing homes outside of the NYC Area [reported](#) some type of staff shortage, the most frequent of which were nurses and nursing aides. One-in-five homes outside of the NYC Area reported a shortage of other staff, which included environmental service works and food staff. In the NYC Area, 18.0% of nursing homes reported a shortage of any staff, with 15.4%, 12.8%, and 8.0% reporting shortages of nurses, nursing aides, and other staff, respectively. The volunteer online health portal (described above) and the national media attention on the NYC Area may help explain the relatively lower staff shortage rates as compared to the rest of New York.

Table 2. Reported Staff Shortages in New York State

	Percent of Nursing Homes Reporting a Shortage	
	NYC Area	Rest of State
Any Staff Shortage	18.0	35.5
Nurses	15.4	31.5
Clinical staff	3.4	7.2
Nursing Aides	12.8	31.5
Other	7.9	18.3

Source: CMS Nursing Home COVID-19 Data for the week ending 6/14/2018

Resident life changes

Visitation restrictions escalated quickly. New York halted visitation to nursing homes in New Rochelle, NY as early as March 8, 2020 when there was known community spread in the area. Nursing homes in the area were directed to provide telephone and electronic means of communicating and the ban was scheduled to extend until March 22, 2020. Three days later, though, the NYSDOH announced statewide screening criteria for nursing home visitors but had not yet adopted a statewide visitation ban. The full statewide ban would come two days later, on March 13, 2020. The ban on nursing home visitation across the state was accompanied by cancellation of group activities and communal dining.

FINANCIAL SHOCKS AND STRATEGIES FOR RESILIENCE / REPORTING

Financing changes

Lost Revenue Due to COVID-19. A major fallout of the pandemic has been a decline in the short-stay rehabilitation patient census (and revenue). Across the state, nursing home [occupancy rates](#) dropped

from an average of 92.1% on 2/12/2020 to 78.2% on 6/24/2020. A recent [study](#) examining 65 nursing homes in the NYC area found the March-May average daily census was roughly 17.0% lower compared with the same months in the prior year. In accordance with the state [suspension](#) of elective surgical procedures in late March, much of the decline in resident census was due to loss of short-stay rehabilitation patients. Nursing homes typically rely heavily on these more profitable short-stay patients to offset long-term care losses, meaning that New York nursing homes lost substantial revenue at a time when financial resources were desperately needed to ensure resident and staff safety.

Additional Costs Due to COVID-19. In addition to reductions in average daily census, an additional financial concern was the [need](#) to test staff for COVID-19 on a weekly basis. The average cost of a lab test for COVID-19 is about \$100. With an estimated 195,000 healthcare workers in the nursing home setting in New York, the weekly state-wide cost is about \$195 million. The state [requires](#) that nursing homes pay for the cost of testing if a staff member's insurance does not cover for it. Furthermore, on March 13, 2020 New York [prohibited](#) insurers from charging cost sharing (i.e., copays, deductibles, coinsurance) for COVID-19 testing. Yet, it is [estimated](#) that 20% of nursing home certified nursing assistants are uninsured. Combined with uncertain availability of federal reimbursement testing costs incurred by nursing homes, testing at this scale presents a significant financial liability for facilities.

Medicaid Reimbursement. The Medicaid payment model for did not change during the pandemic. Additional financial support for nursing homes was secured through federal [funding](#) mechanisms available to facilities nation-wide.

Transparency

New York Became More Transparent with COVID-19 Reporting Over Time. The NYSDOH began reporting online COVID-19 deaths among residents of nursing homes and adult care facilities, which include assisted living, by county, in mid-April. Over time, the reporting expanded; as of June 26, 2020, the state made [available](#) COVID-19 deaths (confirmed and presumed) by individual facility as well. The reporting is updated almost daily.

New York was less forthcoming with suspected and confirmed COVID-19 case reporting in nursing homes. In the early days of the pandemic, [many media reports](#) captured residents' frustration with the difficulty of getting COVID-19 information from their loved one's nursing homes and the lack of intervention on the part of the state in this area. In late March, the state advised nursing homes to inform residents' family members when a COVID-19 case was confirmed in the facility. Many facilities [interpreted](#) this guidance to mean they only needed to communicate about the *first* COVID-19 case in the facility and not subsequent ones. On [April 4](#), the state clarified their guidance and required facilities to inform families of all new cases and deaths within 24 hours.

New York was still not reporting facility-level information (for nursing homes or adult care facilities) regarding COVID-19 cases as of completion of this report. Federal data collection has filled this gap for nursing homes, but case counts for assisted living are not publicly available. With respect to nursing homes, the main barrier to transparency is facility compliance with data reporting. For the reporting week ending 6/14/2020, 11.5% of homes in the NYC Area and 9.3% of homes outside of it did not report data to the CMS COVID-19 nursing home website.

CHANGES, NEEDS, AND CALLS FOR ACTION

Issues being addressed

The majority of nursing homes are severely under-resourced. The frantic push to procure supplies to address the rapid rise in cases in New York highlighted the limited resources in nursing homes. As hospitals with sophisticated supply chain departments, board members with extensive networks, or access to other network facilities were able to adopt novel and unique strategies to build PPE inventory, nursing homes were often left off the priority list. According to a recent [article](#), median nursing home operating margins ranged from -1.6% to 0.7% depending on the facilities star-rating. Margins such as those do not give facilities the financial reserves to fund the necessary staffing, testing, inventory needs to survive a pandemic. Further, much of the early focus was on hospital operations and did not prioritize the high-risk nursing home populations. Focusing on the high-risk nursing home residents and ensuring adequate resources were directed to under-resourced facilities would have saved lives.

The coronavirus pandemic also highlighted the blurring lines between the public health system and care provided via private institutions. For instance, in New York, the DOH mandated nursing home's accept patients regardless of suspected or confirmed COVID-19 diagnosis. However, given the limited resources in many nursing homes, many facilities were not well equipped to accept patients. Failure to recognize the resource limitations when adopting policies can lead to [unnecessary deaths](#).

Cross-subsidization model fails the pandemic test. Nursing homes balance their budgets by offsetting long-term care losses with short-stay rehabilitation cases in skilled beds (SNF). This type of cross-subsidization is common in health care delivery, as evidenced by declining hospital margins resulting from reduced hospital census and halting high-profit elective surgeries. The pause on elective surgeries, though, also had a trickle-down effect on nursing homes, as the short-stay rehabilitation patients that generate significant facility revenue fell precipitously. Nursing homes were not well positioned to weather the loss of these profitable cases, further eroding their already fragile financial position.

Strengthen communication and coordination between hospitals and nursing homes. Examples such as the Hebrew Home at Riverdale that coordinated with New York-Presbyterian to ease hospital capacity by opening a 22-bed isolated wing to accept COVID-19 patients are the exception. More often, though, communication between hospitals and nursing homes is inadequate. Careful coordination and strong communication between facilities, including communicating the inability to adequately care for COVID-19 patients, can aid in preparing for and providing the necessary care for each patient. One mechanism to facilitate enhanced coordination and communication is by developing preferred relationships between hospitals and nursing homes.

OTHER

New York reversed unpopular policy requiring nursing homes to accept patients. On March 25, 2020, the NYSDOH mandated that nursing homes cannot deny patients based on "[confirmed or suspected COVID-19 diagnosis](#)." The policy was enacted to relieve pressure on hospitals, especially those in the NYC Area, that were experiencing rapid increases in occupancy rates as a result of COVID-19 patients. At the time, though, nursing homes were still struggling with acquiring PPE and therefore were not in a position to adequately care for incoming COVID-19 patients, with few exceptions, like the Hebrew Home at Riverdale. As hospital capacity opened up, the state removed the mandate and issued a new

“requirement for hospital patients to test negative for the coronavirus before they could be discharged to nursing homes.”