NYSHFA
NYS HEALTH FACILITIES ASSOCIATION

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NYS CENTER FOR ASSISTED LIVING

Testimony of:

NEW YORK STATE
HEALTH FACILITIES ASSOCIATION

and the

NEW YORK STATE
CENTER FOR ASSISTED LIVING

on the

2020-21 New York State Executive Budget Proposal
Health & Mental Hygiene
Article VII Bill

February 25, 2021

Albany, New York

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Introduction

Good afternoon. My name is Stephen Hanse and I have the privilege of serving as the President and CEO of the New York State Health Facilities Association (NYSHFA) and the New York State Center for Assisted Living (NYSCAL). NYSHFA/NYSCAL members and their 60,000 employees provide essential long-term care services to over 60,000 elderly, frail, and physically challenged women, men, and children at over 425 skilled nursing and assisted living facilities throughout New York State.

Two critical issues must be addressed by the Legislature and the Executive in the 2021-22 State Budget to truly ensure the continued provision of long-term care throughout New York. First the State must reverse its history of continually cutting Medicaid funding to nursing homes and treat long term care as an investment and not an expense. Second, New York is in a long-term care workforce crisis and the State must implement initiative to recruit and retain workers to provide essential care to our most vulnerable population.

Historical Funding Cuts to Nursing Homes

Over the past 12+ years, funding cuts to New York's skilled nursing providers have amounted to approximately $2 Billion (the absence of a trend factor since 2007 alone accounts for approximately $1.4 Billion). Skilled nursing providers rely on an antiquated base year (2007) for their reimbursable Medicaid costs, and have not had their regional Wage Equalization Factor (WEF) adjusted since 2009.

With the average daily Medicaid operating payment of $211 per day divided by a 24-hour shift equating to $8.79 per hour reimbursement for all staff. This helps explain the $55 per resident per day Medicaid shortfall between reimbursement and cost of care (2nd highest in the Nation). This Medicaid shortfall annualizes to $1.2 Billion per year, as Medicaid represents an average of 78% of a facility's total revenue.

Recent Cuts

In addition to the historical and annual financial implications noted above, the following has incurred since 1/1/20 and throughout the COVID-19 pandemic:

- A 1% Medicaid payment cut (effective 1/1/20); ($70M/SS and $140M/FMAP)
- An additional 0.5% Medicaid payment cut (effective 4/2/20); ($35M/SS and $70M/FMAP)
- A 5% Capital reimbursement cut (effective 4/2/20); ($16M/SS and $32M FMAP)

- An elimination of Residual Equity payments to proprietary providers; ($14M/SS and $28M FMAP)

Cash Flow Constraints

In addition to the State's budget cuts, the following cash flow constraints are placed upon SNF's:

- A 2-week lag of the weekly Medicaid payment;
- A 5% cap on Case Mix (acuity index) related rate increases, pending OMIG MDS audit (which is now four years behind);
- Delay at many county levels with the timely processing of Medicaid applications resulting in a back log of payments to the facilities that provide care from the first day of admission; and
- An approximate one-year delay in updated Medicaid payment rates (January 1, 2020 rates were approved just a few weeks ago).

COVID-19 Implications

In addition to the above budget cuts and cash constraints, and despite the fact that New York has received $7.5 Billion to date from the Federal CARES Act, the following provider costs have not been reimbursed by the State's Medicaid Program:

- PPE acquisition and distribution;
- Mandated bi-weekly staff and resident testing;
- Revenue loss sustained during CY 2020, when average SNF occupancy rates plummeted from 91% to 76%. ($1.44 Billion);
- New costs related to visitor screening, cleaning and housekeeping supplies, drastic increases in paid sick leave utilization, and the costs of hiring replacement staff;
- Quarantining expenses;
- Payroll costs for healthcare employees dedicated to the pandemic response; and
- Emergency medical response expenses.

The financial state of New York's nursing homes are truly in a precarious position. Despite Federal Relief Funding to the State designed to reimburse affected healthcare providers, NYS has instead added additional Medicaid budget cuts to SNF providers who are simultaneously absorbing historic and never before seen pandemic costs.

Documented Workforce Shortages in Nursing Homes

The availability of trained and competent healthcare workers impacts the access to care and the ability to provide quality health care services.

According to the Center for Health Workforce Studies Report (CHWS, 2018-2020) historically, health care job growth in New York State has outpaced all other employment sectors since 2000. Nevertheless, New York State continues to face local provider shortages in multiple health care settings. Fluctuations in population, including declining rural populations as well as a diversifying patient population, changes in local opportunities for health care education, and the current COVID-19 pandemic have impacted the need for both our current and the future health care workforce.

Over the last two decades the health profession workforce has become more diverse, older, and, in most disciplines, made up of a larger fraction of women. New York State reported nearly 1.2 million healthcare jobs in 2018 — a 3% increase from 2017. Since 2000, jobs in healthcare in the state have increased by nearly 39%, compared with an 8% increase in jobs in other employment sectors.

New York State's nursing and residential care facilities have the most difficulties recruiting nurses and nursing assistants. The CHWS report shows the largest shortage at 44.9% is nursing assistant with nurse shortages at 38.9%. Regional fluctuations in health care employment may impact some communities', especially rural communities', ability to meet health care demands. The COVID-19 pandemic has created an atmosphere of uncertainty in terms of both supply and demand for existing health care workers, as well as the educational pipelines of many future health care workers.

The SUNY School of Public Health Center for Health Workforce Studies (CHWS) survey data indicated a shortage of qualified workers and non-competitive salaries among the reasons all health care settings have difficulty meeting demand. The vast majority of actively practicing RNs in New York are female and nearly two-thirds are age 50 or older. Nearly 70% of New York's RNs were age 45 or older, with 35% of them older than age 55. Active RNs in New York were, on average, eight years older than the state's civilian labor force (age 50 compared to age 42, respectively).

According to the National Association of Health Care Assistants (NAHCA) in order to "ensure vulnerable residents receive safe, quality care, there must be adequate numbers of exceptional CNAs in the nation's nursing homes. Poor image, recruitment issues, inadequate training, lack of support on the job, and a perceived lack of growth opportunities contribute to CNA shortages and CNA turnover, which currently is at about 120 percent."

The American Association of Colleges of Nursing forecasts that with a quarter of all nurses are nearing retirement, the current shortage in those entering the nursing profession will result in negative growth in the profession.

The number of residents in New York aged 65 and older grew 26% in the past 10 years; compared to the State's overall population that grew just 3% over the same period. New York's senior citizen population grew 8 times faster than the State's total population while the State continues to cut Medicaid reimbursement to healthcare facilities caring for this growing population.

Obstacles During COVID 19 Affecting LTC Staff

Lack of staffing for long-term care. New York State entered this pandemic with an inadequate workforce and a variety of other documented needs. Staffing shortages existed prior to the outbreak and with high restrictions posed on nursing homes on visitation and provision of support services to residents added to the burden to already stressed nursing home staff. Workforce shortages will continue to be a problem unless steps are taken to address both training and investment as well as scope of practice policies that can enhance health care careers.

- Continued restrictions of visitors and family has led to documented depression and regression of residents cognitive functioning.

- Continued restriction of providing beautician services despite the plans submitted to demonstrate low risk exposure for residents has been detrimental for residents.

- NYS Volunteer staffing portal was only open to hospitals not nursing homes.

- Staffing lists were not vetted for nursing home assignments.

- Access to trained, LTC staff was not forthcoming.

COVID-19 Testing

The first CMS COVID QSO Memo was received on March 4, 2020 followed by the NYS DOH DAL for Nursing Homes on March 6th. The following are the outcomes surrounding testing and visitation as it relates to COVID-19.

- On May 10th twice a week testing was required pursuant to Executive Order 202.30 for all employees, contract staff, medical staff, operators, and Administrators in NYS Nursing Homes.

- The cost of the tests was to be covered by the providers, testing was not covered by insurance coverage except is diagnostic cases, but the cost of mandatory, preventative testing for non-symptomatic staff, as required under the Executive Orders, is generally not covered by health insurance. The costs of tests are at $50-$100 per test. The cost to the providers was significant.

- There were several variations related to testing, starting with two times a week, reduced to once a week, then outbreak testing as CMS directed on August 26th every 3-7 days, back to twice a week testing in the red, orange, and yellow zones and then eventually resumed back to twice a week across the State. Twice a week testing remains in place currently.

- Early in the pandemic, testing supplies were unavailable and facilities were directed to stop testing and presume those with respiratory symptoms had COVID-19. Additionally, when testing was at twice a week, only small amounts of testing supplies was provided to facilities by the DOH when requested, most recently prior to issuing the twice a week testing again, the DOH gave some out some antigen testing supplies for the second test. Not only were facilities faced with the expense of having to obtain testing supplies and test their staff, but they were required to break away from resident care and report to the Department of Health daily, through a survey with numerous questions related to COVID. Failure to meet the strict 1:00 PM deadline subjected facilities to citations and additional fines.

- The facilities that wished to perform their own antigen testing were required to obtain a Limited Clinical Laboratory Improvement Amendment (CLIA). The CLIA application was an additional cost to Operators on top of obtaining testing supplies.

- Laboratories were feverishly trying to process the volumes of tests PCR tests that was required by the EO. It was difficult for the facilities to receive lab reports timely due to the sheer volume. The required turnaround time was 24 -48 hours.

- The time associated with swabbing the employees sometimes took the entire day to do this task and further time is spent reporting the results daily. Thus, taking staff away from caring for the residents.

Visitation Restrictions

Visitation was shut down in NYS Nursing Homes on March 13th, 2020. Many months went by until limited visitation was opened.

- On July 10th, the advisory was released allowing facilities in Phase 3 regions could begin limited visitation and activities 5 days after the advisory was released. Facilities needed to meet specified criteria such as the submission of the NYS Forward Safety Plan with no outbreaks of COVID within 28 days reported to HERDS or NHSN. Facilities could have up to 10 individuals visiting in a well-ventilated area.

- Guidance was again issued on September 17th, added to the guidance visitors must present a negative test result within 7 days of the visit.

- To have open visitation a facility must have 14 days without an outbreak as reported in the daily HERDS and NHSN. It was near impossible for facilities to sustain 14 days without a positive test for the residents or staff.
- Oct 9th as a part of the Cluster Initiative Governor Cuomo issued EO 202.68 a red, orange, and yellow zones which imposed restrictions in those zones.

- Resumption of Salon Services guidance was issued on November 4th, but only after a negative test result within a 24 period prior to initiating services and on each day, they

provide services. This further lead residents in a depressive state not being able to have their hair cut or styled was also affecting their overall quality of life.

- On November 10th Holiday guidance was issued strongly recommending the use of virtual visits versus in person.

- The prolonged restriction on visitation affected the residents and staff, the residents became withdrawn and depressed, staff accommodated the best they could by allowing for virtual visits via zoom, facetime, and phone calls. Additionally, residents were isolated to their rooms with little interaction with others and staff.

- End of life and compassionate care was allowed if certain criteria were met. Months passed by without the families seeing their loved ones, more frustration was had by the families, residents, and staff.

- There has been no change to the visitation guidance as of this date.

Personal Protective Equipment Requirements

Long-term care facilities have felt the brunt of the COVID-19 pandemic. In the beginning of the public health crisis, many facilities grappled with severe personal protective equipment (PPE) shortages.

- Prior to the pandemic, there were no regulations requiring providers to maintain a certain day's supply of PPE. In general, identifying appropriate PPE levels is based upon how an organism can be transmitted. In the beginning of the pandemic, the exact mode of transmission of COVID-19 was unknown.

- PPE requirements were constantly changing as the CDC acquired more knowledge regarding how the virus spread, making it difficult for providers to secure appropriate PPE stockpiles.
- On top of ever-changing guidance, state PPE supplies were prioritized for distribution to hospitals.

- Further attempts to secure adequate PPE was hampered by supply chain issues and price gauging by vendors.

- In addition to difficulty obtaining appropriate PPE stockpiles, the fluctuation in state guidance on preserving PPE caused much confusion among providers, in some cases forcing them to go through PPE much faster than anticipated.

- Guidance from the state regulatory and epidemiology staff differed from region to region and did not always align with current established federal guidelines.

- Any fluctuation in PPE guidance requires facilities to make extensive policy changes, conduct staff education and training to be in compliance with the new guidelines.

Completion of Daily HERDS Surveys

- Required, complex reporting of COVID-19 related data (staff and resident positive cases, deaths, vaccinations) 7 days a week on HERDS is burdensome with very little feedback from NYSDOH.

- Highly punitive penalties given to providers who submitted survey information late to NSDOH caused increased stress to providers who were faced with providing care to extremely ill residents or meeting the artificial deadline for submitting HERDS surveys on time.

General Operations

- Changing guidelines from NYSDOH with directions not to follow federal (CDC/CMS) recommendations for residents, staff and visitation were disruptive to the provision of care to residents and created much angst and confusion with families.

- The COVID-19 pandemic made clear that government licensing of health professionals contributes to obstacles blocking access to care:

    - By suspending licensing rules allowed access to out of state licensed staff to work thereby improving access to care for COVID-19 patients;
    - Reduction of federal requirements under the 1135 Waiver; and

    - These waivers were crucial steps forward in facilitating care delivery during the COVID-19 pandemic, with many of them becoming staples in new healthcare delivery models.

- Lack of core competencies that should be present in all professionals working in long-term care settings examine the geriatric competencies developed for the health care workforce and to what extent and how they need to be adapted and modified for licensed professionals employed in long-term care settings.

- Need for strategic plan for funding of the sustainability of elder care structure for capital improvements, wage increases (hiring RN with higher wage requests) and offering competitive benefit packages.

Proposed Recommended Actions

- **Alternative Training Programs:** Continue to recognize the value of creative program ideas to meet the needs of the residents with less than adequate number of available staff choosing long term care as their career choice.
    - Reinstate Nurse Aide Training Programs (CNA) – all SNF should be able to provide the full CNA training program, regardless of their survey outcomes (once

they are back in compliance) to meet the workforce needs in each community. BOCES and Community Colleges have not been able to meet full need.

- Allow the adoption of the Temporary Nurse Aide (TNA-Bridge Program)
  - ✓ Reduce the numbers of hours necessary to train certified nursing assistants.
  - ✓ Revise the current curriculum requirements.
  - ✓ Providing new skill development to give nursing assistants with skills necessary to engage them in a LTC careers for improved retention and reduced turnover.
- Waive regulations affecting the limitation of scope of work for staff currently hired as new nursing home staff. – Allow home health aides to utilize skills they have demonstrated to be competent in at the SNF.
- Continue to promote and allow the one hour on-line Paid Feeding Assistant program for non-clinical staff feeding and socializing with residents.
- Develop new models of Health Care Team Members such as scribes, patient navigators, and expanded care coordinators as key roles in LTC to add to the traditional jobs already in place in the health care arena.

- **Medication Tech Program**

  - Allow the ability to train med techs and test their competencies in SNF to assist with lower-level medication administration. All CNAs should be trained to apply creams, ointments and minor treatments under the supervision of a nurse.

  - Authorize nurse aides to be certified as medication aides and administer medications in residential health care facilities. Supervision by a registered nurse and completion of training program and clinical practice in dispensing medications is required. This is currently permitted for home health aides and would authorize similar care in nursing homes.

- **Promote specialized training for LTC workers including nursing, physicians and physician extenders**:

  - The relatively small number of existing healthcare professionals specialized in geriatrics and the unique challenges of caring for older adults with complex health issues mandates the need for a more robust and broader training on geriatrics skills across the health workforce.

  - The curriculum should address knowledge domain areas essential to providing quality and effective care to cover the unique needs and challenges related to older adults.
  - Geriatric interprofessional team training is also an important model of care that is collaborative and team based.

  - increasing specialized geriatrics training available to all healthcare students, professionals, and direct care workers throughout their careers.

- Promote greater use of telemedicine to improve access to specialty care, including psychiatry and a variety of consultative disciplines.

- Changes with NYSED Licensing Requirements

    - Expand the Executive Order currently in place to allow nurses from any other state in the US, or from Canada, whose license is in good standing, to practice in NYS.
    - Enter the NCSBN Compact which would require a legislative change.
    - Nurse Licensure Compact (NLC) allows nurses to have one multistate license, with the ability to practice in their home state and other compact states. The NLC increases access to care while maintaining public protection at the state level.

- The Public Health Emergency created by COVID-19 required CMS to adapt and issue waivers to address a growing health emergency. Removing unnecessary regulatory hurdles for APRNs and expanding opportunities for patients and providers to leverage telehealth are both stated goals of the Administration.

Additional Strategies to Increase Healthcare Workforce

Focus dedicated funding for increasing Healthcare Workforce Initiative

- Dedicate funding for a statewide campaign for recruitment and retention of healthcare workers in long term care.
- Engage and fund Colleges, Business leaders, Financial Institutions, Healthcare Providers including Nursing Homes and Assisted Living that focus on building gerontology programs in their nursing programs and provide a certification for care of the elderly in LTC.
- Focus workforce improvement on efforts for advancing long term care.
- Provide incentives to people entering healthcare: tuition reimbursement for nursing programs, additional incentives such as full scholarships, housing incentives and other rebates. People must provide a written commitment to LTC for scholarship and other funding.
- Provide a financial incentive to LTC facilities to develop and implement nursing internships with colleges.
- Establish regional/localized hotlines to specifically recruit for SNF and AL employment and enable community individuals and displaced workers to submit an online application to work at local nursing homes and assisted living facilities.
- Support the continued /enhanced Workforce Investment Organizations (WIO) initiatives of community outreach and offer incentives for training of new employees.
- Establish Regional Training Centers (could be shuttered colleges with large classrooms and clinical equipment) to teach displaced workers to take on healthcare jobs: use online programs or classroom learning with exposure and risk minimized. Training for health care workforce should be considered essential and not grouped in with other higher education closures and cancelations.

COVID-19 Pandemic and Adult Care Facilities

COVID-19 took a devastating toll on Adult Care Facilities financially, clinically, through workforce issues as well as restricting visitation to name a few.

Facilities are facing financial difficulties as well as an emotional toll through a decrease in census. They were faced with residents that they had provided years of care for either transferring to a hospital and not knowing whether they would return or passing due to COVID. Census decreased and facilities found it difficult to market vacancies because of the concerns individuals had about being in a congregate care setting during a pandemic. The lack of financial income due to that decrease made it increasingly difficult to meet operational expenses.

To add to the financial burden, Executive Order 202.30, signed by Governor Cuomo on May 10, 2020 required both nursing homes and adult care facilities to perform mandatory testing of all personnel, including employees, contract staff, medical staff, operators and administrators twice weekly and to certify compliance with the order and all guidance or face revocation of their license or heavy fines. Not only were facilities faced with the expense of having to obtain testing supplies and test their staff, but they were required to break away from resident care and report to the Department of Health on a daily basis, through a survey with numerous questions related to COVID. Failure to meet the strict 1:00 PM deadline (even by 1 minute) subjected facilities to citations and additional fines. In a later Executive Order, dated June 9, 2020, the facilities in regions that reached Phase 2 of reopening would be required to test or make arrangements for testing all personnel once per week. However, this would be modified at a later date to require facilities that are in orange or red cluster zones to revert back to testing twice per week.

While health insurers covered the testing costs for diagnosis and treatment of COVID-19, the cost of mandatory, preventative testing for non-symptomatic staff, as required under the Executive Orders, is not covered by health insurance. A single COVID-19 diagnostic test can cost between $50 to $100 per person, per test. For example, a large company that has several facilities could potentially have 2,000 employees, i.e., 2,000 X $100 = $200,000; for each employee to receive one test. Being required to test staff twice a week would double those costs.

ACF facilities that wished to perform their own testing were required to obtain a Limited Clinical Laboratory Improvement Amendment (CLIA). The CLIA application was an additional cost to Operators on top of obtaining testing supplies. Applications took time to process and Operators were faced with sending staff out to have testing done. Most facilities are unable to utilize the CLIA because they do not have Medical Directors, and therefore are still using laboratories and pay for once or twice a week testing. Operators expressed frustration because the free testing sites could not accommodate staff to be tested two times a week, nor would the results be available in time to report to the Department of Health for their daily report. For those employees who were able to secure appointments, facilities were required to pay the employee for time up to 4 hours from work to get the testing done.

Pre-COVID, if a resident had an infectious disease or condition, under ACF regulations, facilities were required to send the resident to the hospital. DOH guidance dated April 7, 2020,

allowed Hospitals to discharge COVID positive residents to ACFs. ACFs were then required to purchase PPE for staff and residents (masks, gloves, gowns, face shields, etc.) to attempt to prevent the spread of COVID. Originally, PPE was not provided to the ACFs and they had to secure their own. This was a huge expense and suppliers did not have the sufficient supplies needed due to demand which forced operators to look elsewhere and pay whatever was being asked.

Financial Relief from the CARES ACT Provider Relief Fund (PRF) allowed facilities that had Medicaid residents to apply for relief in the form of a 2% payment. While beneficial, this payment did little to offset the costs that ACF Operators had already expended. In addition, Assisted Living Programs (ALP) were notified that because the State had data discrepancies related to minimum wage costs from 2017 through 2019, facilities are now facing a recoupment of Medicaid funds. This in addition to the cost operators have already faced will have devastating financial implications. Residents in the ALP that received a stimulus payment and did not spend that stimulus within 12 months would have that counted as an asset and could affect their Medicaid eligibility, thereby costing the operator an additional financial burden.

In September, 2020, the U.S. Department of Health and Human Services (HHS) announced that private-pay assisted living/memory care providers would be eligible to apply for CARES Act Provider Relief Funds under the current Phase 2 General Distribution round of funding. This allowed eligible facilities to apply for 2% of their annual revenue for patient care. Again, while beneficial, this was insufficient to defray the costs expended by facilities.

In October 2020, the U.S. Department of Health and Human Services (HHS) announced a new distribution under Phase 3. This new distribution was available to Medicare, Medicaid, Child Health Plus, dental, Assisted Living facilities and behavioral health regardless of whether they previously received, accepted, or rejected General Distribution payments and was meant to ensure that all eligible providers receive at least 2% of net patient revenue and provide an add on payment to selected providers based on financial losses and changes in operating expenses caused by COVID-19. Some facilities that applied are still waiting for this financial relief. The change in the White House Administration has delayed payments to be issued due to staffing changes.

Facilities that have residents that receive Social Security Income (SSI) have in the past been able to apply for an Enhancing the Quality of Assisted Living (EQUAL) grant every year based on the number of residents receiving SSI in the facility. This money is used for various reasons and is counted on by these facilities to better the lives of their residents. However, in 2020, facilities are still awaiting EQUAL funding. The Governor's 2021/2022 Executive Budget proposes elimination of the EQUAL grant.

Recently, regulations regarding residents that receive SSP were changed and included items that affected Adult Care Facilities. The first change was that State Supplemental Program ("SSP") benefits of a deceased individual cannot be issued to or assigned on behalf of a deceased individual or anyone surviving that deceased individual (i.e., relatives, heirs, the decedent's estate, payees) or for the purpose of paying any debts that survive the deceased individual. This specifically includes debts that a deceased individual may owe to a congregate care facility, such as an Adult Care Facility, that provided care, room, and board to the individual. Similarly, no SSP retroactive benefits or underpayment adjustments will be paid to individuals who are not in "active

receipt" of SSI benefits. This will limit the use of the SSP benefits of a deceased Adult Care Facility resident in connection with the payment of debts owed to the Facility at the time of death. A similar provision regarding underpayments of a deceased individual cannot be issued to or assigned on behalf of a deceased individual or anyone surviving the deceased person or on behalf of any remaining debt of the deceased individual. This amendment specifically applies to the debt that a deceased individual may owe at the time of their death to a congregate care facility, such as an Adult Care Facility, that provided care, room, and board to the individual and affects the use of SSP underpayments to pay any unpaid debts of a deceased Adult Care Facility resident related to that resident's stay and care at the Facility.

Workforce issues suffered by the ACFs continue to be challenging. Staff was either out sick, were exposed and were required to quarantine or refused to come to work because of the fear they would get the virus. Operators were also required to pay employees for the time they were out for quarantine. Operators were faced with overtime wages due to increasing staffing or staff shortages to keep up with the needs of the facility. Some of the additional expenses incurred included increased housekeeping staff to maintain infection control as well as childcare and other staff benefit cost increases. Recently, the CDC revised their guidance on quarantining after exposure for staff members who have completed vaccination if they meet certain requirements. As our ACF facilities complete their vaccinations, we are having to continue to quarantine after exposure for 14 days, increasing cost for overtime, increasing burnout of staff, and possibly incurring agency cost to fill shifts.

Operators who had COVID positive residents in their facility were required to cease visitation. The New York State Department of Health provided guidance that seemed to be a "one size fits all" when it came to visitation. Facility staff spent more time with residents to try to deter the feelings of loneliness and isolation while fighting their own fears about the virus. Operators bore an additional expense to provide virtual activities and other ways to keep residents engaged in socialization. Residents were isolated to their rooms with little interaction with others and staff. This caused an increase in falls, dementia process, and depression. ACFs on campus settings were not allowed to have visitation with families, even though they did not have COVID in their facility but the SNF side did. Congregate dining was not allowed even for facilities that did not have any positive cases. They were made to eat in their room alone. This was also an additional cost to the facility, serving food with disposables, and increasing staffing to complete food passes for the residents. Residents in the ACF had many issues with major weight loss from dining alone. They could not socialize, which allows our residents to eat more. Dining alone also caused the residents an increased risk of falls due to not being able to move their table away to use the bathroom. Weight loss created weakness and increased falls and confusion. The majority of residents who had weight loss were sent to hospital or to a SNF rehab and were never able to return home. Many who had never suffered from dementia or depression became unsafe to stay independently in an ACF and had to move into a higher level of care.

ACF Operators incurred expenses far beyond the reimbursement received, and even though they continue to face financial distress, they continue to provide the quality services to their residents through this pandemic while following the continually changing guidance.

Conclusion

In conclusion, the New York State Health Facilities Association and the New York State Center for Assisted Living (NYSHFA/NYSCAL) is thankful for the New York State Legislature's time and attention on these critical issues to ensure the continued delivery of high-quality, cost effective long-term care to our most vulnerable individuals.

As stated above, the Legislature must reverse its history of continually cutting Medicaid funding to nursing homes and treat long term care as an investment and not an expense. New York is in a long-term care workforce crisis and the State must implement initiative to recruit and retain workers to provide essential care to our most vulnerable population. It is essential that these two issues be addressed in the 2021-22 enacted State Budget.

As always, NYSHFA/NYSCAL will continue to work together with the Governor, the Legislature and all affected constituencies to ensure the continued delivery of high quality, cost effective long-term care services throughout New York State.

Thank you.