Chairman Doggett and Ranking Member Nunes, thank you for inviting me to testify before you and this distinguished subcommittee. A special thanks to Congressman Thompson, a representative for our community, and Congressman Horsford, from my beloved home State of Nevada.

My goal today is to help you understand the landscape of long-term care in this country and how COVID-19 exploited its weaknesses and left residents without protection or oversight. If it were normal times, I would invite you to come along for a ride-along, but these are not normal times so I pray that my words are enough to help you understand the plight of 1.7 million seniors and disabled adults in the United States live in skilled nursing facilities.

I am Nicole Howell, the Executive Director for Ombudsman Services of Contra Costa, Solano, and Alameda (Officially Ombudsman Services of Contra Costa Inc.). I lead a team of staff and volunteers that are charged with resolving issues for residents living in licensed long-term care facilities. We are often the only place for residents and families to turn to when they need advice, guidance, and assistance with serious issues such as bedsores, isolation, evictions/discharges, as well as abuse and neglect.

Long-term care ombudsmen are charged with protecting the rights of residents who live in licensed long-term care facilities, including skilled nursing facilities as well as other congregate settings, including what is commonly referred to as assisted living. We are charged with making unannounced facility visits and investigating complaints related to quality of life and quality of care. In the last federal fiscal year in California, we investigated 36,000 complaints, 20% relating to abuse and neglect. LTC Ombudsman are not regulators, we are expressed wish resident advocates.

COVID-19 is an opportunistic disease that continues to prey on our most vulnerable citizens and exploit the foundational weaknesses within a web of regulation and safety net services. Here in the United States, long-term care is paid for in two primary ways: privately (income/savings or with long-term care insurance), and more likely government dollars. Assisted living costs at least $5,000 per month, pricing many out of access and leaving our most vulnerable hard-working adults reliant on the Medicaid system as they age. Forced to seek care and housing within a skilled nursing facility that was not designed to meet their long-term care needs, many Medicaid patients were placed directly in the path of COVID-19 and its deadly impacts.

These residents are often in stark contrast to Medicare patients who are only at a skilled nursing facility for a short stay following a hospitalization and require therapy and care along with a healthy dose of visits from concerned family and friends. Medicare patients receive the lion's share of attention and draw in a reimbursement rate in excess of $600 per day. Whereas recipients of Medicaid are billed at less than $200 per day, the lowest payor source for skilled

nursing properties. Even the layperson can see the strong disparity in payment and understand the perverse incentive for skilled nursing providers to seek out short-term Medicare patients versus long-term Medicaid residents. This discrepancy in pay is the result of both state and federal reimbursement strategies that often conflict with each other and create unnecessary competition.

It is important to underscore that skilled nursing facilities can chose to be exclusively private pay or just certified for Medicare shorter term residents, but if they chose to be certified to do both then we should ensure they are providing the highest level of care for those who need it most. A particularly callous Administrator remarked recently that they could make more running a "doggy day care" than they can with Medicaid residents.

For those individuals who are able to pay in excess of $5,000 per month for care, they are more likely to choose what is commonly referred to as an assisted living facility that does not provide medical care, but these residents often have the same impairments as those individuals who live in skilled nursing facilities. The only difference is some are able to pay privately, whereas others are not. Meaning, the social determinants of health outcomes, particularly income disparity, are more evident now than ever, and in this case, may be deadly.

It is important to note that facilities that have significant numbers of African Americans and Latino residents, irrespective of facility size, rating, or location, are twice as likely to have Coronavirus infection as those facilities whose residents are white. Due to longstanding inequalities in this country, these residents often have had poorer quality health care throughout their lives and rely on Medicaid to pay for long-term care. The New York Times reports that "More than 60 percent of nursing homes where at least a quarter of the residents are black or Latino have reported at least one coronavirus case. That is double the rate of homes where black and Latino people make up less than 5 percent of the population." However, because reporting from facilities is not consistent, we cannot see the full picture of the disparate risk.

Today's skilled nursing residents are a mix of individuals who experience dementia, physical impairments, mental health issues, and homelessness. They live together in aging buildings without appropriate isolation capabilities and under the management of companies unable to adapt to the rapidly changing care conditions created by this pandemic.

The issues that COVID-19 exploited are not highly technical or complex; they are basic issues of training and adequate staffing. California facilities with one or more patients with a COVID-19 case had, on average, 25% fewer registered nurses per resident in the final three months of 2019. In addition, 91% of nursing homes reporting at least one case of COVID-19 had a prior violation related to infection control prior to the pandemic, when they knew a surveyor was in the building. These violations are not egregious errors; they are failures to ensure basic hand

washing or wearing protective clothing. Even in the best of times, these facilities have a documented history of poor infection control and low staffing.

Poor staffing in long-term care facilities was the gasoline to COVID-19's match. Within the long-term care industry, direct care workers, on average, earn only one to two dollars more per hour over the state minimum wage, forcing these dedicated people to work 60-80 hours per week, at multiple locations, to pay the most modest of rent/expenses. Meaning, you could have a caregiver that works at one facility where there are active COVID-19 infections, yet, is forced to work at a second location and may transmit the virus to residents.

Though facilities did not cause this disaster, their response has been sub-standard, and they did it with the people's money. A facility can choose to be private pay, and some do, but largely they do not because the lucrative and reliable stream of Medicare dollars is highly attractive. In exchange, they care for a few Medicaid residents along the way, but they will take every chance to not admit a "Medicaid resident" regardless of if they can provide the care, and all too often seek to discharge these residents at their first opportunity. Sadly, some facilities have exploited the pandemic and the lack of oversight to evict residents without notice, sending them to homeless shelters that cannot provide proper care. This is not a new practice, but with facilities locked down, it is difficult for ombudsmen like me to assure proper accountability and intervene on behalf of residents.

This crisis is the direct result of inadequate resources, staffing, and regulation to protect these precious lives. In order to address these critical issues, I respectfully request that you consider the following recommendations:

- Require long-term care facilities to substantially increase wages for all frontline caregivers, paying them an adequate salary in line with their professional skills and talents. Consideration should be made to connecting the compensation of frontline staff to the Medicare "star" rating system.
- Direct CMS to improve transparency and oversight in all skilled nursing facilities by establishing national protocols and standards for reporting COVID-19 infections, recoveries, and deaths, as well as other applicable information.
- Direct CMS and local licensing and certification entities to strengthen the preparedness requirements for skilled nursing facilities, including the ability to effectively isolate residents and maintain adequate PPE supply. Increase the "citation value" of violations related to infection control on annual surveys and complaint investigations.

- Direct CMS to develop protocols to reinstate regular annual surveys and inspections of all long-term care facilities. Create a national taskforce to develop protocols for the return of regular activities and investigations by the Long-Term Care Ombudsman.
- Direct CMS, in partnership with other appropriate partners, to review the reimbursement rate for Medicare vs Medicaid and provide a report to this committee outlining strategies to reduce incentives to discriminate against Medicaid recipients.
- Direct CMS to review and, where possible, reinstate the regulations capriciously thrown out during COVID-19 that provided a modicum of safety for residents, particularly the requirement to notify the resident, responsible party, and Long-Term Care Ombudsman of pending discharges and limit discharges to "alternative care settings." For those regulations not able to be reinstated immediately, CMS should provide an explanation as to why they cannot and an estimated timeline of when they will be reinstated.
- Fund federal home and community-based waiver programs, thereby creating a broader range of care options for older and disabled adults to live in community where they will be less at risk for COVID-19 and other opportunistic infections.
- Direct the state units on aging to contract directly with the local Long-Term Care Ombudsman programs to expedite the contract and access to the 20 million dollars authorized under the CARES Act. Congress approved these funds to allow Ombudsman programs to expand their virtual presence to residents and their families, and continue to promote the health, safety welfare, and rights of residents in the context of COVID-19. This funding will give Ombudsman programs the flexibility to hire additional staff and purchase additional technology, associated hardware, and personal protective equipment once in-person visits resume. Unfortunately, some local counties and Area Agencies on Aging are placing undue restrictions on these funds, making it difficult to respond to the needs of residents.

Thank you for allowing me to testify before you and for your sincere attention to this issue.