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INCAL**

INDIANA HEALTH CARE ASSOCIATION
INDIANA CENTER FOR ASSISTED LIVING

Sustainable COVID-19 Planning for Long-Term Care Facilities in Indiana

*A Report to the Office of Governor Holcomb,
the Indiana State Department of Health,
the Indiana Family and Social Services Administration, and
the Indiana Economic Recovery and Relief Team*

June 16, 2020

Introduction

The Indiana Health Care Association / Indiana Center for Assisted Living (IHCA/INCAL) is the state's largest membership organization representing long-term care facilities in Indiana. IHCA/INCAL represents 450 long-term care facilities and has been an active partner with state and local officials to support long-term care facilities in their work to mitigate the spread of COVID-19.

IHCA/INCAL appreciates the quick action Indiana took at the outset of the public health emergency to limit visitors and activities within long-term care communities, while also providing flexibility and enhanced reimbursement to providers, to respond to COVID-19. As the state moves past its initial response and allows for a rolling reopening of the economy, though, long-term care facilities must also look at allowing expanded activities and interactions that are vital to residents' wellbeing.

With families looking ahead to July 4, 2020, when guidance regarding long-term care facilities is to be reevaluated, IHCA/INCAL desires to proactively partner with the Indiana State Department of Health (ISDH) and other state and local officials to put in place clear guidelines that protect residents, staff, and visitors, while also allowing increased socialization and visitation for the health and wellbeing of residents.

This Sustainable COVID-19 Planning for Long-Term Care Facilities in Indiana document builds upon IHCA/INCAL's [recommendations to increase socialization](#) in long-term care communities and the state's [Back on Track Plan for Long-Term Facilities](#), both of which were issued on May 11, 2020. This document also recognizes the recommendations included in the federal Centers for Medicare and Medicare Services' (CMS) memo on [Nursing Home Reopening Recommendations for State and Local Officials](#) issued on May 18, 2020, and the state's outdoor visitation guidance issued on June 3, 2020. However, it is important to note that the guidelines outlined below provide a baseline only. Facilities may always adhere to additional precautions and are encouraged to do so if community spread increases in a particular facility's area.

This document also looks at the sustainability of the long-term care industry moving forward, from recent financials and reimbursement, to growing the sector's valuable workforce. Prior to the federal Health and Human Services Department allocating dedicated CARES Act funding to nursing facilities, it was estimated 20% of nursing facilities nationwide would not be able to meet payroll. Maintaining increased reimbursement through available state and federal funding will therefore be essential to ensure nursing facilities remain viable operations in the state. Further, Aged and Disabled (A&D) Waiver assisted living providers have not received any increased reimbursement during this time, from state or federal resources, despite serving Hoosiers with nursing home level of care and adhering to the same COVID-related precautions and requirements. As the state continues its rebalancing efforts, with an eye towards the next decade and more sustainable Medicaid spending, ensuring A&D Waiver assisted living providers remain in the continuum of care is vital.

Finally, a key component to reopening for long-term care facilities is the coordination of reopening strategies with existing waivers to licensure regulations and other laws. The guidelines outlined below are dependent on the flexibilities provided by ISDH through the various waivers issued throughout the public health emergency. For example, comprehensive care communities have received a waiver from 410 IAC 16.2-3.1-8, which would otherwise require comprehensive care communities to provide reasonable visiting hours at least nine (9) hours a day. Similarly, residential care facilities have received a waiver from 410 IAC 16.2-5-1.2(cc), which would otherwise require residential care facilities to provide reasonable visiting hours at least twelve (12) hours a day. With the precautions and restrictions that will accompany visitation in the near future, it would be extremely difficult for long-term care facilities to accommodate visitation nine (9) to twelve (12) hours a day, while also conducting testing, screening, increased infection prevention and control practices, and more. The waivers issued to date for comprehensive and residential care facilities also help facilitate the cohorting of residents when a COVID-19 case is confirmed. IHCA/INCAL therefore urges ISDH to consider maintaining the waivers while the guidelines outlined here are in place.

Thank you for your consideration and feedback so that residents, families, providers, public health officials, and regulators are all on the same page.

Infection Control in the New Normal

As long-term care facilities move to a reopened phase in resident care, it is expected that their COVID-19 infection prevention and control measures should remain in place as long as the virus is present in epidemic levels and until a vaccine is available and can be widely administered. The following measures would be maintained until guidance is otherwise issued by ISDH:

- Long-term care facilities would maintain their [COVID-19 Preparedness Checklist](#) and update it as needed.
- Continued universal mask use by all staff and visitors.
- Residents to wear mask when they leave their room, as tolerated, unless otherwise outlined below.
- Continue to maintain social distancing of at least six (6) feet between residents and staff as much as possible.
- Continue staff screening and temperature checks at the start of each shift and do not permit entry if symptoms are present. All staff should adhere to the federal Centers for Disease Control and Prevention's (CDC) [Return to Work Criteria](#) if symptoms are present or they are confirmed COVID-19 positive. However, those facilities with active COVID-19 cases can continue to employ COVID-positive staff who are asymptomatic in the COVID-dedicated areas of the facility.
- Continue visitor screening and temperature checks and do not permit entry if symptoms are present.
- Continue monitoring residents for signs and symptoms daily and increase monitoring if a resident becomes symptomatic.
- Cohort residents within a facility if COVID-19 cases are confirmed, as outlined in ISDH's [Red/Yellow/Green cohorting strategy](#), and utilize dedicated staff. Facilities should then adhere to the CDC's [Discontinuation of Transmission-Based Precautions](#) guidance prior to moving a resident off of a Red unit.
- Adherence to strict hand hygiene should continue for all, particularly staff, including when entering the facility and before and after resident care.
- Staff should continue to wear appropriate personal protective equipment (PPE), beyond universal mask use, as needed.
 - Gloves: Use non-sterile gloves upon entry into a resident's room for direct care and change gloves if they become torn or when visibly soiled while in the resident's room. Remove and discard gloves when leaving the resident's room and immediately perform hand hygiene after removal of gloves.
 - Gowns: Gowns should be prioritized for aerosol-generating procedures, care activities where splashes and sprays are anticipated, and high-contact resident care activities that provide opportunities for transfer of pathogens to the hands and clothing of the staff, including dressing, changing linens, bathing, wound care, changing briefs or assisting with toileting, and device care or use.
- Continue focused and frequent environmental cleaning on all high touch surfaces with [approved disinfectants according to the manufacturer's instructions and recommendations](#).
- Limit performance of aerosol-generating procedures on confirmed or presumed COVID-19 positive residents unless medically necessary. [CDC guidance](#) for aerosol-generating procedures should be followed for infection control measures and the appropriate PPE, including keeping the door closed throughout the procedure and disinfecting all surfaces following the procedure.
- Maintain communication and collaboration with hospital partners, particularly regarding transfers and capacity to care for confirmed or presumed COVID-19 patients, including resource availability.
- Long-term care facilities are strongly encouraged to have a comprehensive flu vaccination program in place.

New Facility-Onset COVID-19 Cases

Many features of this guidance depends on the definition of “new facility-onset COVID-19 cases” as this term came in more use with the issuance of CMS’s recommendations to reopen nursing homes via QSO-20-30-NH on May 18, 2020. We recommend the following definition and understanding of new facility-onset COVID-19 cases to be as follows:

- The term “new facility-onset COVID-19 case” should apply to COVID-19 cases in resident only and not staff given that staff enter and exit facilities daily. Facilities must practice effective infection control, as discussed above, to prevent transmission of COVID-19. Confirmed COVID-19 cases among staff before any new facility-onset COVID-19 resident cases are confirmed will still impact timelines with regard to activities, communal dining, and visitation as set forth in the below recommendations but are not included in this term.
- “New facility-onset COVID-19 resident case” is defined as a resident who contracts COVID-19 within the facility without prior hospitalization or other outpatient/external-facility based health service within the last 14 days. New Facility-onset cases in residents do not include any new admission with a known COVID-19 positive status or unknown COVID-19 status but who became positive within 14 days after admission.
- Facilities that place new admissions in and practice effective Transmission-Based Precautions to prevent transmission of COVID-19 for 14 days after admission are not required to test residents upon admission or within a specified period of time upon admission in order to continue internal activities or visitation from family/the community. Facilities may follow the CDC’s test-based strategy for the end of Transmission-Based Precautions in order to end Transmission-Based Precautions prior to 14 days after admission.
- If a new admission develops signs and symptoms of COVID-19 the facility should test the resident for COVID-19 and, as stated above, the timeframe after admission will determine whether a COVID-19 positive result is either new facility-onset or not.

Activities and Dining

Long-term care facilities may begin activities and communal dining if:

- There have been no new facility-onset COVID-19 resident cases in the past fourteen (14) days.
- All activities and communal dining are limited to COVID-negative, or “Green,” residents, although COVID-positive residents may conduct communal dining within the Red unit as space and staffing allow. If a resident was previously positive, the resident must meet the CDC’s guidance for discontinuation of transmission-based precautions.
- The facility has proper PPE for residents and staff.
- The facility notifies residents and their representatives of its intention to resume activities and communal dining, with participation by residents being solely voluntary.

The facility ceases all expanded activities and communal dining if a new facility-onset COVID-19 resident case is confirmed in the facility. Fourteen (14) days must pass without a new facility-onset of a COVID-19 resident case occurring prior to activities and communal dining beginning once again. If a staff member is confirmed COVID-19 positive before any confirmed new facility-onset COVID-19 resident cases are confirmed, then the facility may resume expanded activities and communal dining after either of the following: (1) it has been fourteen (14) days since the last new facility-onset COVID-19 cases; or (2) the facility has completed contact tracing related to the confirmed positive staff member and has obtained two negative COVID-19 test results taken within 24 hours for any resident identified as having had contact with the confirmed positive staff member.

Activities

Activities are important to residents and are critical to their quality of life. To safely reincorporate activity program, the following guiding principles should be utilized:

- Activity programming should be limited to groups of ten (10) individuals or less at first. Once there have been no new facility-onset COVID-19 resident cases for twenty-eight (28) days in the facility, activities may include greater numbers of residents. However, COVID-naïve facilities are encouraged to phase in activities, even if they have not had a case of COVID-19 in the past twenty-eight (28) days. COVID-naïve facilities should wait at least seven (7) days to increase group sizes beyond ten (10) residents.
- All activity programming should prioritize social distancing with residents at least six (6) apart.
- All activity programming areas and materials should be thoroughly cleaned before and after each use. Materials that cannot be thoroughly cleaned between each use are discouraged.
- Residents should wear masks at all times, to the extent feasible, unless they are eating or drinking.

Examples of permitted activity programming include:

- Resident use of a facility’s gym and/or outdoor group exercise. A mask would not be required when an individual is in the gym by themselves. Facilities should set a policy regarding how many residents may use the facility’s gym at one time to ensure residents can maintain social distancing of at least six (6) feet based on the size of the facility’s gym.
- Hallway exercise or activities to allow group participation from each resident’s doorway.
- Indoor group activities, such as bingo, karaoke, religious services, or expressive arts.

Hair Salons / Personal Services

Hair Salons / Personal Services are also an important part of residents’ quality of life and mental wellbeing. They can resume with the following precautions in place:

- The stylist is screened for symptoms and receives a temperature check prior to entering the facility. The stylist would also need to comply with any COVID-19 testing protocol required of facility staff.

- A meeting occurs with the facility administrator and infection control lead prior to opening to ensure timing between appointments is adequate.
- Educate stylist on hand hygiene, proper PPE use, cough etiquette, and disinfectant use.
- Deep clean of work area before beginning service for the day.
- Ensure adequate PPE and other supplies are available, including masks, soap, paper towels, regular towels, hand sanitizer, tissues, and gloves.
- The stylist would wash hands prior to each appointment and sanitize the workstation, chair, and all equipment (i.e., combs, bobby pins, curlers, bottles, capes) used between each appointment. If the capes cannot be fully sanitized, they should be changed between residents.
- Both the stylist and resident would wear a mask during the appointment, and only one resident would be permitted in the salon area at one time.
- Remove all resident-accessible products from the salon area.

Dining

Communal dining is permitted per the state's [Back on Track Plan for Long-Term Care Facilities](#), although long-term care facilities that have not already commenced communal dining are encouraged to start with one meal service per day for at least the first week to assess any operational challenges before expanding the dining schedule. Other guidelines include:

- Arrange dining room tables and chairs six (6) feet apart, which may necessitate utilizing other portions of a facility for dining service.
- Create separate, staggered dining times to accommodate the required physical distancing and to minimize traffic flow before and after mealtimes, as needed.
- Residents at risk of aspiration or choking should not participate in the mealtime but may congregate with other residents during mealtime if they have already been served or are to be served after.
- Sanitize tables, chairs, and any other high touch surfaces before and after dining service.
- Assign tables and seats to residents to minimize risk and help with contact tracing.
- Remove all extra chairs from the dining area to avoid residents joining other tables.
- Remove all sharable or decorative table-top items.
- Sanitize residents' hands before and after dining service.
- Servers would wear masks during dining service, masks and gloves when sanitizing following dining service, and follow all hand-washing guidelines.
- Buffets are prohibited.
- Pre-rolled silverware or plasticware, individual condiments, and single-use menus should be utilized.

Visitors

Visitation is certainly the most requested activity among long-term care facilities throughout the state. While restricting visitors was an important part of the initial response to the COVID-19 outbreak, resident protections should be balanced with their need to visit with family and friends.

Outdoor Visitation

Outdoor visitation may begin immediately if there have been no new facility-onset COVID-19 cases in the past fourteen (14) days among residents or staff in accordance with [state guidelines](#) issued on June 3, 2020. We encourage the state to revise its outdoor visitation guidance to adopt this document's definition of new facility-onset COVID-19 resident cases that focuses on residents and permits outdoor visitation if a staff member tests positive before any new facility-onset COVID-19 resident case is detected.

If a staff member is confirmed COVID-19 positive before any confirmed new facility-onset COVID-19 resident cases are confirmed, then the facility may resume outdoor visitation after either of the following: (1) it has been fourteen (14) days since the last new facility-onset COVID-19 cases; or (2) the facility has completed contact tracing related to the confirmed positive staff member and has obtained two negative COVID-19 test results taken within 24 hours for any resident identified as having had contact with the confirmed positive staff member.

Indoor Visitation

Based on the experience following the release of the outdoor visitation guidelines, several weeks' notice for facilities before indoor visitation begins will be helpful to ensure a smooth rollout for residents and their loved ones. Accordingly, we ask that indoor visitation guidelines be finalized and communicated with long-term care facilities by June 26, 2020, but that they not be publicly announced until after the July 4th weekend. Residential care facilities would be permitted to allow indoor visitation starting July 20, 2020, and comprehensive care facilities would be permitted to allow indoor visitation starting July 27, 2020, according to the following:

- **The decision to permit indoor visitation is subject to the facility's policy on the frequency (how often), duration (length of time), and volume (total number of visitors for all residents at any one time) of visitors.** A facility can therefore create a policy limiting the amount and length of visits, the number of visitors per resident, and the number of visitors at any one time. Consideration to staffing availability, PPE stocks, resident clinical needs, and community transmission of COVID-19 are the minimum factors to be considered in creation of facility policies permitting indoor visitation. Facilities are also strongly encouraged to engage their local health department to further survey local conditions prior to allowing indoor visitation.
- There have been no new facility-onset COVID-19 resident cases in the past twenty-eight (28) days.
- Visitation is limited to COVID-negative or COVID-recovered, or "Green," residents. Visitation for "Green" residents includes residents that have recovered from COVID-19, as defined by the resident meeting the CDC's guidance for discontinuation of transmission-based precautions.
- The facility has proper PPE for residents, staff, and visitors, although visitors are encouraged to bring their own masks to help conserve facility supplies.
- The facility notifies residents and their representatives of its intention to resume visitation, outlining the guidelines below.
- The facility ceases indoor visitation if a new facility-onset COVID-19 resident case is confirmed in the facility. Twenty-eight (28) days must pass without a new facility-onset of a COVID-19 case occurring among residents prior to visitation beginning once again.
- If a staff member is confirmed COVID-19 positive before any confirmed new facility-onset COVID-19 resident cases are confirmed, then the facility may resume indoor visitation after either of the following: (1) it has been fourteen (14) days since the last new facility-onset COVID-19 cases; or (2) the facility has completed contact tracing related to the confirmed positive staff member and has obtained two negative COVID-19 test results taken within 24 hours for any resident identified as having had contact with the confirmed positive staff member.
- Facilities are also strongly encouraged to cease visitation if it is highly likely there has been COVID-19 exposure in the facility, even if testing has not been conducted or completed yet, and facilities may cease visitation if

circumstances require, including low levels of PPE, insufficient staffing, and/or local community spread.

Visitors shall:

- Participate in and pass a symptom screening and temperature check. Facilities shall also require visitors to attest to their current COVID-status and may require, at the option of the facility, that visitors receive a COVID-19 test prior to visiting the facility.
- Wash their hands or utilize an alcohol-based hand rub upon arriving at the facility.
- Sign-in and provide their contact information.
- Wear a mask at all times while visiting.
- Maintain at least six (6) feet distance from all residents in the facility.
- Utilize the routes indicated by the facility to travel to and from the visitation area.
- Children under twelve (12) years of age are permitted to visit. Visitors with children must be able to manage them, and children must be able to wear a face mask during the entire visitation. Special family circumstances warranting children under the age of twelve (12) to visit can be approved by individual facilities.
- Visitors that do not follow these criteria may have the privilege of visitation revoked.

Staff shall:

- Monitor that PPE use and visitation policies are followed.
- Ensure residents wear a mask when visitors are present.
- Designate certain areas inside and outside the facility that will be utilized for visitation and determine proper space considerations. Visits in a private resident room may only occur for bedbound residents or those who, for health reasons, cannot leave their room. Visitation in outdoor spaces should continue to be prioritized. If indoor spaces are utilized, increased social distancing and other protective measures such as physical barriers should be considered.
- Create a route for visitors to travel to and from the visitation areas.
- Disinfect visitation areas after each use.
- Facilities should require that visits are scheduled by appointment to ensure proper PPE and staffing are available.

Testing

Rapid testing of staff and potentially visitors is a long-term solution that will be helpful to prevent the spread of COVID-19 in long-term care facilities once testing machines and kits become widely available, affordable, and capable of providing rapid and accurate results.

Currently, there is concern about the accuracy rates for these tests. The federal Food and Drug Administration issued a cautionary report on the reliability of rapid tests utilizing a portable testing instrument by Abbott Laboratories. Reports have indicated false negative rates can be anywhere from 20% to as high as 48%, which makes this tool currently ineffective for long-term care use.

Once available and accurate, rapid testing systems should be placed in long-term care facilities. In preparation for this preventative tool, we encourage ISDH to work with the CMS regional office to prepare an approval process that long-term facilities can use to request Civil Money Penalty (CMP) funds to purchase these systems, similar the recent CMP grant initiative for tablets and other technology supplies to allow residents to communicate with family members. While facilities would not purchase these devices prior to improvements in accuracy and availability, ISDH securing the necessary waivers would place Indiana facilities at the front of the line when the market and technology improve.

In the absence of rapid testing, IHCA/INCAL supports ISDH's goal to increase availability of testing for long-term care residents and staff. IHCA/INCAL submitted a [letter](#) to ISDH on May 29, 2020, detailing considerations should regular testing of nursing facility staff be required.

Initial testing of all nursing facility staff is expected in June, with the development of a plan for regular, ongoing testing thereafter. State support for the initial testing of all nursing facility staff is expected to be available through the distribution of testing kits and/or testing conducted by ISDH at nursing facilities. The external Optum sites are available as well, but the reliance on distant testing sites is disruptive to patient care, costly for facilities (i.e., having to pay for travel time, and likely overtime, to and from testing), and presents liability concerns. External testing sites also only report to the individual tested, presenting logistical difficulties to determine who is confirmed positive. IHCA/INCAL therefore greatly appreciates the support provided by the state to distribute testing kits and/or conduct testing at nursing facility locations during the initial testing phase in June.

Should regular, ongoing testing be required beyond June, continued state-supported onsite facility-based specimen collection with direct reporting of results to the facility so immediate action can be taken to protect residents and staff is key. Any regular testing must be accompanied by sustainable funding and/or regular distribution of test kits and processing assistance. Insurance coverage of testing is not a complete solution given the high rate of self-insured health plans and employees that do not elect coverage. Twice-monthly testing equates to \$10 million per month at a cost of \$100 per test on a statewide basis. Decreased patient revenues alone are far outpacing the assistance from federal and state government, and while the recent federal CARES Act monies for nursing facilities was helpful, it will not cover these costs beyond a month or two.

Sample financials from a mid-sized, high-quality provider further illustrate this point. Comparing March - April 2019 revenue against March - April 2020 revenue, the provider is down \$6,086,019, even with increased reimbursement, due to decreased censuses and increased costs. More specifically, additional COVID-related reimbursement to this provider for the month of April 2020 equated to \$4,601,797, while additional COVID-related expenses to this provider for the month of April 2020, including supplies, increase payroll, and hazard and overtime pay was \$6,482,533, with testing of staff every-two weeks factored in.

Medical Appointments

Facilities should continue to restrict residents from leaving the facility except for medically necessary services. Residents, resident representatives, and the facility's interdisciplinary team should work together to determine what appointments are medically necessary and what options are available. Use of telemedicine services should continue to be prioritized. For those residents leaving for medically necessary appointments, facilities should take the following precautions to minimize the risk of transmission of COVID-19:

- Ensure the resident is wearing a mask to and during the appointment, including when leaving and returning to their room
- The need to place the resident in contact-droplet transmission-based precautions upon return for a fourteen (14) day period to monitor signs and symptoms of respiratory infection should be made by the facility with consideration for the type of appointment (i.e., close contact), the availability and use of appropriate PPE by resident and provider, and the frequency of leaving the facility (i.e., a single dermatology appointment vs. several times a week for dialysis).
- The vehicle should be disinfected before and after each use, and the driver should wear a mask throughout the trip as well. The Indiana Family and Social Services Administration should instruct any nonemergency medical transportation conducted by Southeastans to follow these same guidelines.

Personal Protective Equipment (PPE)

Indiana's long-term care facilities are competing in a global market for PPE that is seeing demand outstrip the supply by 300%. Materials that once cost less than a dollar to procure are now being purchased anywhere from \$6 to \$10.

Shortages remain in long-term care facilities across the state, and we anticipate that demand will only continue to increase with doctor's offices, ambulatory surgical centers, and other healthcare facilities reopening and as the general population needs more PPE. Shortages of cleaning supplies are expected to exacerbate as reopening the economy increases demand as well.

IHCA/INCAL greatly appreciates the steps Indiana has taken to create a Small Business PPE Marketplace to ensure health care providers and small businesses are not competing for the same PPE materials. We would ask that Indiana also consider long-term care facilities being able to partner with the state's bulk buying efforts. Adding long-term care facilities would only increase the buying power of the overall effort, and IHCA/INCAL could help determine which long-term care facilities are interested in participating.

Long-Term Care Workforce

A stable and trained workforce is essential to the continued quality of care for residents in long-term care facilities. Prior to the pandemic, long-term care providers were already facing critical workforce shortages due to competition among a limited workforce. While many facilities have provided increased pay throughout the public health emergency, initial fears of the virus and increased regulations and staff responsibilities have only exacerbated the shortages.

Two programs approved and implemented by ISDH have assisted providers with these staffing challenges: 1) The Personal Care Attendant (PCA) program, and 2) the Temporary Nurse Aide (TNA) program. Both programs have been utilized throughout the public health emergency and have helped attract interested individuals to the long-term care industry during this critical time. IHCA/INCAL recommends that the PCA program be continued indefinitely and a clear pathway be provided for those who completed the PCA or TNA program during the public health emergency to become permanent Certified Nurse Aides (CNA), as follows:

- The PCA program be made permanent as a temporary 120-day position for those ages sixteen (16) and older that are enrolled in a CNA or CNA test prep program. The [PCA training](#) would continue as an eight (8) hour program, with five (5) hours of classroom time and three (3) hours of simulation and competency checkoff. Registered nurses and the CNA Program Director both would be available to sign-off on the three (3) hours of simulation and competency checkoff. This will allow students to receive greater hands-on training and can serve as a method to quickly increase the health care workforce in the event of another emergency. The program also allows interested youth to determine if they would like to pursue a career in the long-term care industry, thereby providing continuity in their training.
- Those who completed either the PCA or [TNA program](#) during the public health emergency would be eligible to become a permanent CNA if they complete an additional twenty-five (25) hours of classroom time, an additional sixteen (16) clinical hours, and sit for the written test. The regular CNA training requirements would otherwise be waived.
- For those CNA students who completed the classroom portion of the regular CNA training prior to the public health emergency but were unable to complete their clinical hours, IHCA/INCAL recommends they be able to complete three (3) hours of clinical competency checkoff and then be eligible to sit for the written test.

Reimbursement

Indiana long-term care providers are required and continue to take significant actions to prevent and mitigate the spread of COVID-19 in their facilities. These necessary decisions come at a great financial cost to an industry already operating on narrow margins. This section discussed existing and needed reimbursement mechanisms for nursing facilities and Medicaid waiver Assisted Living providers.

In response to COVID-19, long-term care providers have hired additional staff and increased existing staff hours for screening and disinfecting purpose, to manage COVID-19 symptoms and any required cohorting, and to accomplish communication and reporting needs. Providers are also paying overtime and incentive pay, particularly in COVID-dedicated units; supplementing with agency staff when regular staff test positive; purchasing additional PPE at increased costs, in addition to other supplies such as physical barriers and disposable materials; and are offering additional benefits like meals and child care coverage so staff can continue to work.

These cost overruns have been compounded due to a decrease in resident census, which has in part been derived from elective surgeries being put on hold for a period of time, resulting in the loss of Medicare payers. Short-term rehabilitation, which is covered by Medicare, plays an important role in reimbursement and cash flow due to long-term care facilities' unique Medicaid/Medicare payer mix. One large Indiana provider has recorded a 50% decrease in admissions alone.

IHCA/INCAL appreciates the financial support provided by Indiana to date to help cover these increases in cost, including the 4.2% rate increase for all nursing facilities, the 2% rate increase for [COVID-ready nursing facilities](#), and the \$115 add-on for COVID-positive residents for 21-days in COVID-ready nursing facilities. The assistance from our federal partners through dedicated CARES Act funding for skilled nursing facilities has also been of assistance to cover increased costs. IHCA/INCAL asks that the federal CARES Act funding that Indiana has received to date be utilized in part to continue the 4.2% rate increase for all nursing facilities and additional rate enhancements for COVID-ready nursing facilities through at least the end of quarter in which the enhanced Federal Medical Assistance Percentage is available. These enhanced rates go directly toward the state's COVID-19 response as required by the federal allocation—caring for those Hoosiers most vulnerable to the virus. Even if the overarching public health emergency is ended at an earlier date, long-term care facilities will not likely return to pre-COVID operations at that time and are expected to conduct increased screening and infection prevention and control practices for the foreseeable future.

Further, any testing of staff that is required in regular intervals that is not supported by the state will be an immense burden on providers. An estimate of expenses to cover testing is as follows:

Statewide Nursing Facility Employee Testing

50,000 employees x \$100/test x 2 tests monthly = \$10 million per month

- Approximately 1 employee, all types and employed or contracted, per bed

Individual Facility Level

90 employees x \$100/test x 2 tests monthly = \$18,000

- Approximately 1 employee, all types and employed or contracted, per bed
- 50,000 beds (a lower number based on licensure data) / 537 facilities = 93 (Rounded down to 90)

Medicaid Rate Increases

60 Medicaid residents x 13.33 x 30.4 days = \$24,313

- Medicaid is approximately 60-65% of average census (a percentage that is now higher because of rapidly declining Medicare census)
- \$13.33 is the average amount a facility would receive from the increased Medicaid rate of 6.2%, assuming a facility elects to obtain the COVID Ready increase of 2% that is added to the base increase for all of 4.2%. This rate is time limited as you know.
- There are 30.4 days in an average month.

Based on these estimates, testing of nursing facility staff would consume two-thirds of the COVID-specific Medicaid reimbursement from the 4.2% increase, not considering the other increases in costs facilities are already experiencing.

If a COVID-ready nursing facility also has COVID-19 positive residents, the facility would be eligible for the enhanced reimbursement. A facility with 20 COVID-19 positive residents, for example, would receive \$48,300 for the \$115 add-on (20 x \$115 for a 21-day period). The \$115 add-on is only available for a 21-day period, though, so this additional funding would not continue month to month, despite some residents showing symptoms for periods of up to 30 days. Much of the enhanced reimbursement would be directed toward PPE, supplies, incentive pay for staff, and most likely additional staff as well. Further, approximately 70% of nursing facilities in Indiana are taking all precautions and incurring additional costs with no COVID-19 residents, thereby not receiving the add-on. Maintaining the increased reimbursement for nursing facilities will therefore be crucial to ensure providers can continue to cover the increases in costs, and state support for any regular, ongoing testing will be vital.

In addition to maintaining the increased reimbursement to assist with decreased censuses and increased costs, temporary changes to the Case-Mix Index (CMI) and Quality Assessment Fee (QAF) should also be considered. CMI measures nursing facility residents' acuity and drives the Medicaid nursing facility reimbursement system. Due to a variety of factors related to the current pandemic, including the waiver of physician visitation requirements and the reduction of elective surgeries and group therapy, the CMI is likely to decrease and negatively impact the reimbursement rate. To mitigate this impact, the CMI for the quarter ending March 31, 2020 should be used to calculate the July 1, 2020 through June 30, 2021 rates. The QAF should also be deferred temporarily to increase nursing facility cash flow. Based on the most recent Myers and Stauffer data, a QAF deferral will improve the average facility's cash flow by \$26,000 per month.

Finally, it is also important to note that Aged and Disabled (A&D) assisted living providers have not received any temporary rate increases throughout the public health emergency, despite incurring similar costs and being subject to the same requirements as nursing facilities as a result of the pandemic.

By implementing the ISDH and CDC guidelines, one A&D Waiver assisted living provider estimates an increase of \$10,000 in expenses in each of its assisted living communities in March, and an increase of up to \$20,000 in expenses in each of its assisted living communities in April related to the public health emergency. Another A&D Waiver assisted living provider estimates an increase of almost \$18,000 for just one of its communities related to the public health emergency, including an increase of over \$9,000 for extra supplies and equipment and an increase of almost \$9,000 for additional staffing costs. A third A&D Waiver assisted living provider estimates an additional \$8.65 per resident per day related to the public health emergency, which covers additional staffing, childcare needs of staff, additional housekeeping supplies, additional PPE, and room meal delivery. With one community of that A&D Waiver assisted living provider being home to almost 120 residents, the additional cost equates to over \$30,000 a month. Other communities owned and operated by that A&D assisted living provider have census counts closer to 100 residents, equating to approximately \$25,000 per month per facility in additional costs.

As a partial offset of increased COVID-19 expenses, while serving a population that is the same level of care as the nursing facility population, IHCA/INCAL submitted a letter on April 22, 2020, requesting a temporary 6.2% rate increase for A&D Waiver assisted living providers retroactive to March 1, 2020, which could also be accomplished through the federal CARES Act funding allocated to the state in its response to COVID-19. IHCA/INCAL continues to advocate for this temporary rate increase to ensure A&D Waiver assisted living providers remain viable operations in the overall continuum of care and as a part of the state's rebalancing efforts.