

# Separate and Unconscionable

**A Report on Racial and Ethnic Disparities in Pennsylvania's  
Nursing Homes with Recommendations for Immediate Action**

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## EXECUTIVE SUMMARY

### A CRISIS WITHIN A CRISIS

The COVID-19 crisis has not only devastated the world, but it has also starkly illuminated the disparate inequalities in our society. One of the most egregious examples is the disparate harm and vulnerabilities suffered by Black and Hispanic residents in nursing homes, before and during the COVID-19 crisis.

Throughout the pandemic, Black and Hispanic people were getting sick and dying of COVID-19 at rates higher than White individuals and at rates higher than their share of the general population. A Kaiser Health Network study of CDC data found that “African Americans ages 65 to 74 died of COVID-19 five times as often as White individuals.”<sup>[1]</sup>

**Comparatively, Black and Hispanic residents, particularly those in nursing homes where they were the majority population, were more likely to have a COVID-19 outbreak, more likely to have a severe outbreak, and more likely to have deaths as a result of COVID-19.<sup>[2]</sup> Additionally, nursing homes with at least 7 in 10 Black and Hispanic residents saw a death rate that was about 40 percent higher than homes with majority-White populations.<sup>[3]</sup>**

This paper will center the unequal impact of the COVID-19 virus on Black and Hispanic nursing home residents, as well as the underlying quality of care crisis affecting the same populations. Though quality of care and COVID-19 impact all nursing home residents, systemic race-based inequity has created a crisis within a crisis for Black and Hispanic nursing home residents.

Evidence shows that, regardless of race, most nursing homes have been severely impacted by COVID-19. The mortality rate among all older residents with chronic conditions and/or medical complexities in nursing homes far exceeded their counterparts in the community. **“Nursing home residents account for less than half-of-1-percent of the U.S. population but roughly a quarter of the deaths related to COVID-19.”<sup>[4]</sup>** Simply put, the longstanding infection control failures, staffing shortages, and other quality of care issues that many nursing homes face has negatively affected most nursing home residents irrespective of racial make-up.

However, Black and Hispanic nursing home residents have been affected by COVID-19 most severely. Not only are Black and Hispanic nursing home residents enduring the crisis of a cross-national virus and the crisis of long-established quality of care problems in nursing homes, but they are also enduring the crisis of race-based systemic inequity

that is foundational in creating disparate and disproportionate outcomes alongside the other two crises.

Although systemic race-based inequities harm people of all non-white races, most of the available data centers on Black and Hispanic nursing home residents. We found comparatively less data on quality-of-care issues impacting Asian American and Indigenous nursing home residents. Because of this, this paper primarily focuses on the inequity facing Black and Hispanic nursing home residents. However, one of the paper's recommendations calls for significantly increased and sub-aggregated data on the experiences of Asian and Indigenous nursing home residents, in order to provide for more informed analysis and recommendations in the future.

It is important to explicitly acknowledge that race-based systemic inequity aids in formulating the egregious disparities discussed in this report, a disparity in harm that has existed since the creation of long-term care facilities for older adults and people with disabilities. This is evidenced by the longstanding history of racially segregated and poor performing nursing homes for Black and Hispanic nursing home residents.

The evidence of immense disparities in COVID-19 outcomes and mortality for Black and Hispanic people comes at a time when the country is reeling with a broader awareness of racial disparities and injustices across systems, services, communities, policing, policies, and more. We—as a country—must discuss and look to address not only the vast disparities that exist for Black and Hispanic people in nursing homes, but we must also address the systemic inequities that create the conditions for disparity across systems.

## RECOMMENDATIONS TO ADDRESS COMPLEX PROBLEMS

Pennsylvania must take immediate and meaningful action to address race-based systemic inequities and the disparities that arise from them. A statewide task force should be convened engaging stakeholders, including Black and Hispanic residents, to help catalyze change. The Report contains an extensive list of detailed recommendations. Among the Report's recommendations, specifically, the state must make changes to address racial and ethnic disparities by:

- Issuing regulations to address inadequate staffing levels, infection control requirements, and the numerous other deficiencies that COVID exposed.
  - During the research and writing of this paper, Pennsylvania proposed increasing staffing regulations to 4.1 hours per resident. As nursing homes with primarily Black and/or Hispanic residents are disproportionately understaffed, enacting this proposed regulation would address racial and ethnic disparities in addition to enhancing quality of care for nursing home residents.

- Developing policies to incentivize improved quality in majority Black and Hispanic serving nursing homes.
- Enforcing civil rights requirements to operationalize prohibitions on discriminatory practices.
- Changing admissions protocols to protect against discriminatory admissions practices which disproportionately direct Black and Hispanic residents to poor performing nursing homes.
- Evaluating Medicaid reimbursement policy to ensure it can support improved quality and staffing levels and reward improved outcomes for Black and Hispanic residents.
- Engaging in robust and expansive sub-aggregated data collection and transparency to identify all racial and ethnic disparities, including those affecting Asian and Indigenous nursing home residents.
- Vigorously monitoring and enforcing quality and compliance by nursing home operators, prioritizing reoccurring poor performing nursing homes, where Black and Hispanic residents disproportionately reside.
- Requiring Community HealthChoices managed care organizations to ensure that their members who reside in nursing homes receive quality care, free from racial disparities or inequities.
- Creating immediate short-term payments to increase staffing and improve quality in nursing homes that disproportionately serve Black and Hispanic residents.

<sup>[1]</sup> Why Black Aging Matters, Too, Kaiser Health News, September 3, 2020, <https://khn.org/news/why-black-aging-matters-too/>

<sup>[2]</sup> [Chidambaram](#), P., Neuman, T., [Garfield](#), R., Racial and Ethnic Disparities in COVID-19 Cases and Deaths in Nursing Homes, Kaiser Family Foundation, October 2020, <https://www.kff.org/coronavirus-covid-19/issue-brief/racial-and-ethnic-disparities-in-covid-19-cases-and-deaths-in-nursing-homes/>

<sup>[3]</sup> Near birthplace of Martin Luther King Jr., a predominantly Black nursing home tries to heal after outbreak, The Washington Post, September 9, 2020, <https://www.washingtonpost.com/business/2020/09/09/black-nursing-homes-coronavirus/>

<sup>[4]</sup> Covid awakened Americans to a nursing home crisis. Now comes the hard part., The Washington Post, April 28, 2021, <https://www.washingtonpost.com/outlook/2021/04/28/nursing-homes-covid-pandemic-reform-staffing/>

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## I. INTRODUCTION

There are no words for the tragic and devastating illness and death that COVID-19 has brought upon Pennsylvanians. The worst of COVID-19's impact has been on older adults who reside in the state's long-term care facilities. Evidence is mounting that amongst the older residents with chronic conditions and/or medical complexities, those who are Black and Hispanic have been disproportionately harmed by this brutal virus.\* A Washington Post analysis of data from more than two dozen states found that the death rate was more than 20% higher in nursing homes with majority-Black residents compared with nursing homes with majority-White residents.<sup>1</sup>

The evidence of immense disparities in COVID-19 outcomes and mortality for Black and Hispanic individuals comes at a time when the country is reeling with a broader awareness of racial inequities and injustices across systems, services, communities, policing, policies, and more. Finally, we as a country are discussing and looking to address the vast disparities that exist in the treatment of persons of color by systems at all levels of government. In this vein, the Governor's Task Force on Racial Equity published its report in August 2020.<sup>2</sup> The Department of Human Services published its Racial Equity Report in January 2021.<sup>3</sup> Likewise, on the national level, President Biden's National Strategy for the COVID-19 Response and Pandemic Preparedness centers the need to address racial and ethnic disparities.<sup>4</sup>

This Report is presented by a coalition of consumer advocacy organizations that formed in May 2020 to address COVID-19 issues related to residents of Pennsylvania's long-term care (LTC) Facilities. On August 17, 2020, the Center for Advocacy for the Rights and Interests of the Elderly (CARIE), Community Legal Services of Philadelphia (CLS), and several other organizations that advocate on behalf of LTC residents released a Position Paper with recommendations for immediate steps that Pennsylvania needed to take to prevent COVID-19 from claiming more lives and causing needless suffering in LTC facilities.<sup>5</sup>

In our [August 2020 Position Paper](#), we identified the need for the state to take action to address racial and ethnic disparities in COVID-19 outcomes for LTC facility residents. Data gathered by this point in the pandemic showed that Black and Hispanic residents

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\* Although systemic race-based inequities harm people of all non-white races, most of the available data centers on Black and Hispanic nursing home residents. We found comparatively less data addressing quality-of-care issues impacting Asian American and Indigenous nursing home residents. Because of this, this paper primarily focuses on the inequity facing Black and Hispanic nursing home residents. However, one of the paper's recommendations calls for significantly increased and sub-aggregated data on the experiences of Asian and Indigenous nursing home residents, in order to provide for more informed analysis and recommendations in the future.

were being disproportionately affected by COVID-19, but the incomplete data did not provide a clear understanding of the scope and severity of these disparities.<sup>6</sup> We flagged the urgency of taking action to address racial and ethnic disparities in COVID-19 outcomes for Pennsylvania’s LTC facility residents. We also recommended an intragovernmental workgroup specifically dedicated to this purpose. Since then, it has been confirmed that

throughout the pandemic, Black, Hispanic and Native American individuals get sick and die of COVID-19 at rates much higher than whites and at rates higher



*Black and Hispanic individuals get sick and die of COVID-19 at rates higher than whites and at rates much higher than their share of the population.*

than their share of the population.<sup>7</sup> And, as evidence began to mount that this was playing out quite measurably in nursing homes, our coalition of advocacy groups felt it imperative to do everything we could to stem the racial and ethnic disparities in nursing home resident COVID-19 trends. Beyond the context of COVID-19, it is also clear from many research studies that segregation exists in nursing facilities and that the quality of care received by Black and Hispanic residents is inferior to that received by White residents.

Accordingly, the Coalition decided to research and provide the state with discrete recommendations it can implement. This Report is the result of that work. It largely presents the national picture, a stark indictment of a too-long history of disparate care in nursing homes. The discussion is largely limited to nursing homes as the research on disparities in personal care homes and assisted living residences is incomplete.

***However, we encourage Pennsylvania to review data related to personal care homes and assisted living through an equity lens and determine what recommendations may also apply to these settings.*** The intragovernmental workgroup we recommend the state immediately form to implement our recommendations could be used to help in this regard. Additionally, research studies specifically about disparities in Pennsylvania’s nursing homes could not readily be found.

There is no question that there are racial and ethnic disparities in nursing home care generally, in COVID-19 outcomes *generally*, and in nursing home resident outcomes during COVID-19 *specifically*. The only question is: what will state agencies and legislators do about the disparities that exist?

## II. LONG-STANDING RACIAL AND ETHNIC DISPARITIES IN NURSING HOME CARE

Long before COVID-19, studies provided evidence of racial and ethnic inequities in the quality of care provided to nursing home residents.

### A. Disparities in Quality

It has long been established that there are racial disparities in the quality of nursing home care.<sup>8</sup> African Americans and Hispanics are more likely to reside in substandard nursing homes compared to White residents.<sup>9</sup> Relative to White individuals, Black and Hispanic residents are:

- **More likely to reside in substandard nursing homes:**<sup>10</sup> A 2004 study found that African American residents were found to be concentrated in facilities with low ratings of cleanliness, maintenance, and lighting.<sup>11</sup> A 2010 study similarly found that “elderly Hispanics are much more likely than elderly whites to reside in poor-performing facilities”.<sup>12</sup>
- **More likely to be admitted to facilities with a greater number of deficiencies:** A nationwide study of the required Minimum Data Set data that nursing homes must collect regularly on each of their residents showed that African Americans were admitted to nursing homes with forty-four percent more deficiencies than the nursing homes to which White people were admitted.<sup>13</sup>
- **More likely to reside in a nursing home with “actual harm” deficiencies:** A 2007 study determined that Black residents were 1.41 times as likely as White people to reside in a nursing home cited by surveyors with a deficiency that caused actual harm to one or more residents.<sup>14</sup>
- **More likely to reside in a nursing home that has been terminated from Medicare and Medicaid:** The same 2007 study showed that Black residents were 1.7 times as likely to remain as a resident in facilities that were terminated from the Medicare and Medicaid programs as were White residents.<sup>15</sup>
- **More likely to reside in nursing homes that were historically poor performing:** A 2004 study showed that residents of color were more than four times as likely to reside in a nursing home with historically poor performance than were White residents, as 9% of White residents were in lower-tiered nursing facilities compared to 40% of residents of color.<sup>16</sup> One 2007 study found that in 2000, Blacks were significantly more likely to be served by facilities in the bottom quartile of many structural and performance measures of quality.<sup>17</sup>

Disparities persist. Poor quality care is not rectified and, thus, continues. Compounding the injustice of Black and Hispanic residents residing disproportionately in poorer quality

facilities, we note that Pennsylvania has not taken all actions possible to cite deficiencies or improve quality. A 2015 study raised considerable concerns about the enforcement activities taken, or in this case not taken, by the Pennsylvania Department of Health (DOH).<sup>18</sup> Specifically, DOH:

- “Dismissed 92% of complaints filed by residents or other individuals as unfounded.”<sup>19</sup>
- “Routinely mischaracterized the severity and breadth of violations, which, in addition to harming nursing home residents, misinformed members of the general public who were looking for safe nursing homes.”<sup>20</sup>
- “Conducted 161 follow-up visits after finding a violation, and never once found that a violation persisted, despite the unlikelihood that every violation was remedied immediately.”<sup>21</sup>

Since research shows that Blacks and Hispanics disproportionately live in substandard nursing homes, it is imperative that DOH improve its oversight of all facilities and ensure that its response to complaints centers equity and assures cultural competency. DOH must consider and correct for any and all racial bias in its regulatory oversight role. There is no acceptable justification or rational basis for the racial and ethnic disparities seen in the overall quality of nursing home care. Accordingly, the state must take immediate action to correct for this inequity and injustice.

## **B. Disparities in Health Outcomes**

In addition to gross disparities in the overall quality of nursing home care that have been demonstrated by research studies, multiple studies demonstrate specific areas of disparities in health outcomes for Black and Hispanic residents as compared to White residents. Black and Hispanic residents receive a lower clinical quality of care than do White residents, with worse health outcomes being demonstrated across a variety of measures. In a 2020 study, Black, Hispanic, Native American and Asian-American residents also reported a lower quality of life than their White counterparts.<sup>22</sup>

Evidence of demonstrated disparities in nursing home outcomes include that resident of color are:

1. **More likely to have severe pressure ulcers/bed sores:** Research demonstrates that “late-stage pressure sores are more common to African Americans, while early-stage pressure sores are more common to Caucasians.”<sup>23</sup> Pressure ulcers generally develop due to a failure to clean, turn, and care for residents often enough or at all. They are often symptomatic of a lack of sufficient staff. The study further shows that higher rates of late-stage pressure sores in people of color are a result of delayed diagnosis and, thus, treatment.<sup>24</sup> “Caucasians received treatment before the pressure sores became too severe, while African Americans and other minorities suffered without treatment until the pressure sores became irreparable.”<sup>25</sup>

2. **Less likely to receive appropriate pain management:** One study found that Black nursing home residents were 1.19 times more likely to have untreated persistent pain and 1.23 times more likely to have undertreated persistent pain than White residents.<sup>26</sup> The same study suggests that non-White residents are less likely to receive the appropriate pharmacologic pain management they need than are White residents.
3. **Less likely to receive appropriate Physical Therapy following discharge from a nursing home:** A 2000 study of hospitalized hip fracture patients found that patients of color were less likely to receive appropriate physical therapy following hospital discharge to a nursing home.<sup>27</sup>
4. **More likely to be subject to physical restraints:** Findings of a 2013 study of National Nursing Home Survey data shows that Black residents were more likely than White residents to be restrained with bed rails, side rails, and trunk restraints.<sup>28</sup>
5. **Less likely to receive appropriate medication for their conditions:** Research shows that residents of color are less likely than White residents to be prescribed appropriate medications.<sup>29</sup> One 2003 study showed racial disparities in use of secondary stroke prevention medications.<sup>30</sup>
6. **More likely to be hospitalized while residing in a nursing home:** A 2011 study showed that Black residents had a “40% higher risk of being re-hospitalized within 30 days of admission and a 50% increased risk of being re-hospitalized within 90 days of admission” than did White residents. These disparities existed across all states and the District of Columbia even after the study authors adjusted for variations in “patient characteristics (demographic, socioeconomic, and clinical) and the type of admitting facilities” as well as “interstate differences in predicted re-hospitalization rates”.<sup>31</sup> An earlier study from 2008 had already found that “regardless of a resident's own race, risk of hospitalization increased as the percent of residents identified as Black in the NH increased.”<sup>32</sup> A 2019 study reconfirmed the increased likelihood of re-hospitalization.<sup>33</sup>
7. **More likely to be hospitalized for conditions associated with not receiving proper care:** A 2008 study found that African American residents were more likely than White residents to be hospitalized for “dehydration, poor nutrition, bedsores and other ailments because of a gap in the quality of in-house [nursing home] medical care.”<sup>34</sup> These are conditions that can easily be caused by residents not receiving proper care.

### C. Disparities Related to Payment Source

Over the years, studies have connected racial and ethnic disparities in nursing home care to the payment source for that care, specifically with Medicaid funding as compared to Medicare or private pay funding. Nursing homes that are more Medicaid-reliant and have fewer private pay residents are often disadvantaged since Medicaid rates are generally below private pay rates and sometimes below actual costs of care.<sup>35</sup> Facilities that are largely Medicaid-reliant are often found to be under-resourced to provide the care the residents require.

Medicaid rates have long been too low to pay for high quality care. Medicaid rates are lower than Medicare rates. Medicare pays for short-term, rehabilitative Skilled Nursing Facility stays. Medicaid pays for long-term care. These differences aside, the Medicaid rates remain too low in Pennsylvania.<sup>36</sup> The result is that facilities that are more reliant on Medicaid reimbursement are significantly under-resourced.

Research shows that nursing homes that are under-resourced disproportionately serve Black residents.<sup>37</sup> Long-lasting, systemic racism that has impacted the ability of people of color to obtain education, employment, housing, income, and access to justice has resulted in older adults of color experiencing greater poverty and having less wealth than their White counterparts.<sup>38</sup> As a result, older adults of color are more likely to be more reliant on Medicaid than are White residents.<sup>39</sup> One study showed that African American residents were nearly four times as likely to reside in a nursing home with "limited resources" than were White residents.<sup>40</sup> As of a 2004 study, 41% of African Americans in a nursing home relied on Medicaid as a primary payor where only 23% of White people who were admitted to nursing homes relied on Medicaid.<sup>41</sup>

Research has also found that the more a nursing home relies on Medicaid funding, the more likely it is that care is worse than in facilities with less reliance on Medicaid funding.<sup>42</sup> Since racial and ethnic minorities disproportionately rely on Medicaid to pay for their nursing home care as compared to White people<sup>43</sup>, the adequacy of Medicaid reimbursement is a racial justice issue.

Not only are African American nursing home residents more likely than White residents to rely on Medicaid for their nursing home care, they are 2.64 times more likely than White residents to live in homes that primarily serve individuals who rely on Medicaid.<sup>44</sup> This is significant since the proportion of residents whose care is paid for by Medicaid has been associated with between-facility (but not within-facility) differences in quality.<sup>45</sup> Residing in a nursing home disproportionately serving residents of color correlates to lower quality, just as residing in a facility that predominately serves residents on Medicaid is linked to lower quality and challenges with compliance.

One measure correlated with lower quality nursing home care is high rates of nursing home resident hospitalizations. Before COVID-19, researchers found "a persistent association between Medicaid reimbursement policies and hospitalization"<sup>46</sup>, with higher rates of hospitalizations for nursing homes residents primarily funded by Medicaid.<sup>47</sup> Another study showed that adjusting Medicaid nursing home rates by just \$10/day resulted in a 5–9% decrease in the risk of hospitalization.<sup>48</sup> Increased Medicaid nursing

home rates have also been associated with overall decreases in the number of care-related deficiencies.<sup>49</sup>

Questions about how much Medicaid reimbursement rates must be adjusted are compounded by the Medicaid program's failure to require nursing facilities to be fully transparent about how their costs are incurred and how Medicaid funds are used. Recent reports show a considerable number of nursing homes paying potentially inflated rates to "related" companies (owned by the same owner of the nursing home) for rent, staff, ancillary services, and administrative functions.<sup>50</sup> These concerns have been amplified recently as states, Congress, and researchers grapple with understanding the byzantine corporate ownership structure of many nursing homes.

Further escalating these concerns is the relatively recent practice of private equity firms buying and profiting from the purchase of nursing homes. (Private equity firm purchase of nursing homes has been strongly correlated with reduced quality of care.<sup>51</sup>) While we agree that Medicaid reimbursement rates are low and need to be increased, further investigation and ongoing full transparency into use of Medicaid dollars (as well as corporate structure and reliance on "related parties") is needed to determine adequate rates. Nursing homes should be required to complete fully auditable, consolidated reporting to facilitate adequate rate-setting.

#### **D. Disparities in staffing**

Long before COVID-19, research found that relative to White people, Black people are more likely to be admitted to nursing homes with lower nurse staffing ratios.<sup>52</sup> Lower staffing ratios and levels result in fewer trained people on duty to provide necessary care. When residents do not receive the care they need, they can experience bad outcomes.<sup>53</sup> Blacks were found to be .81 times as likely to be in a nursing home with the highest level of direct care providers, .77 times as likely to be in nursing homes with the highest ratio of RNs to all nursing staff, and 1.12 times more likely to be in a nursing home that was greatly understaffed relative to the needs of that nursing home's residents' needs/acuity.<sup>54</sup>

### **III. RACIAL AND ETHNIC DISPARITIES IN RELATIONSHIP TO COVID-16 IN NURSING HOMES**

**T**his section presents evidence of racial disparities in COVID-19 outcomes for nursing home residents, particularly in disproportionately non-White nursing homes.

Residents of LTC Facilities, including but not limited to nursing homes, make up 1% of the general population in the United States.<sup>55</sup> Nationally, as of March 1, 2021, 5% (1,401,984) of all COVID-19 cases occurred in LTC Facilities and 34% (178,980) of all deaths.<sup>56</sup> As of March 1, 2021, 82,353 cases and 12,765 deaths had occurred in

Pennsylvania's LTC facilities.<sup>57</sup> Above the national average, 9% of all Pennsylvania cases and 52% of all Pennsylvania deaths occurred in LTC facilities.<sup>58</sup> The percentage of deaths was significantly higher earlier in the pandemic in August 2020, topping out at 68% of COVID-19 deaths having occurred in LTC facilities.<sup>59</sup>

The Center for Medicare and Medicaid Services did not require nursing homes to report race and ethnicity data for COVID-19 cases and deaths. Neither did Pennsylvania require this. The absence of nursing COVID-19 case and death data stratified by race and ethnicity makes it challenging for researchers to document the full impact of COVID-19 on Black, Hispanic, Asian and Indigenous residents in nursing homes.<sup>60</sup> Researchers have relied on multiple state and federal data sources in reaching their conclusions. This paper reflects findings that are based on analyses of multiple related data sets.

## A. Racial and Ethnic Disparities in the Impact of COVID-19 Generally

COVID-19 has had a devastating impact on lives around the globe. More than half a million people have died of COVID-19 in the United States alone. With 80% of COVID-19 deaths occurring in adults aged 65 and over, it is apparent that older adults, as well as people with certain underlying medical conditions, have been more severely impacted by COVID-19. Put both being an older adult and being a person of color together and the disparities are increased.

COVID-19 data shows "higher contraction rates and worse outcomes, including mortality, among racial/ethnic minorities".<sup>61</sup> Black, Hispanic and Indigenous people are disproportionately affected by and dying from COVID-19 as

compared to White people. COVID-19 "has been infecting and killing people of color at disproportionately high rates in the United States, data has shown."<sup>62</sup> The coronavirus has taken a disproportionate toll on people of color, and this can be measured by the proportion of COVID-19 cases, deaths, **and** hospitalizations. "Black, Hispanic, and American Indian and Alaska Native (AIAN) populations have been shown to be at increased risk for cases, deaths, and hospitalizations."<sup>63</sup>

*The age-adjusted death rate from COVID-19 for Black people is 3.6 times higher than for White people; for Hispanic/Latino people, it is 2.5 times higher than for White people.*

The rates of COVID-19 hospitalizations (with African Americans being found to be 2.7 times as likely as non-Hispanic Whites to be hospitalized from COVID-19, even after adjustment for age, sex, comorbidities, and income)<sup>64</sup> and of COVID-19 deaths for Blacks and Hispanics far exceed their representation in the total population. According to researchers at the Brookings Institution, the age-adjusted death rate from COVID-19 for Black people is 3.6 times higher than for White people; for Hispanic people, it is 2.5

times higher than for White people. Pre-existing racial inequities in health, such as reduced access to healthcare and greater prevalence of comorbidities, mean that Black and Hispanic people are likely to be more vulnerable to the ravages of COVID-19.<sup>65</sup>

Similarly striking is the considerable difference in the likelihood of dying from COVID-19. A Kaiser Health Network study of CDC data found that **"African Americans ages 65 to 74 died of COVID-19 5 times as often as whites."**<sup>66</sup> This fact is worth repeating: being Black and age 65-74 was found to increase the likelihood of death five-fold over being White and age 65-74. These findings are appalling.

COVID Rate ratios compared to White, Non-Hispanic persons	American Indian or Alaska Native, Non-Hispanic persons	Asian, Non-Hispanic persons	Black or African American, Non-Hispanic persons	Hispanic or Latino persons
Cases	1.6x	0.7x	1.1x	2.0x
Hospitalization	3.3x	1.0x	2.9x	2.8
Death	2.4x	1.0x	2.0x	2.3x

Table 1: CDC data, June 17, 2021 (not stratified by age)

The disparity narrows somewhat with age. For older adults, age 75-84, Black people were 3.5 times as likely to die of COVID-19 than White people.<sup>67</sup> Black adults age 85 and older were two times as likely to die from COVID-19 than White people in the same age group.<sup>68</sup> Note that the disparity lessens with age because "advanced age, itself, becomes an increasingly important, shared risk."<sup>69</sup> Equally disturbing, Hispanic people over age 75 were two times as likely to die from COVID-19 than White people in the same age group (see Table 1).<sup>70</sup>

## B. Racial and Ethnic Disparities in COVID-19 Outcomes in Nursing Homes Serving a Disproportionate Share of Black and Hispanic Residents

Just as with the patterns observed outside of nursing homes, a September 2020 study found that, within nursing homes, racial and ethnic minority residents were more likely to become sick with or die of COVID-19 infections than White residents.<sup>71</sup> More notable, however, is the considerable evidence of a connection between the racial composition of a nursing home and the likelihood of coronavirus cases and deaths in that nursing home.<sup>72</sup> A March 2021 study showed, after controlling for interstate differences, facility-

level resident characteristics, resource availability, and organizational characteristics, that nursing homes with the highest percentage of non-White residents were more than twice as likely (61% more likely) to have coronavirus cases and deaths as nursing homes with only White residents.<sup>73</sup>

A 2020 study similarly shows that nursing homes caring for a disproportionate number of Black and Hispanic residents tended to have more new COVID-19 confirmed cases among their residents and staff, and more new COVID-19 related deaths among residents.<sup>74</sup> “These disparities across nursing homes persisted after adjustment for important nursing home, county, and state covariates, with predicted counts of cases and deaths per facility being two to four times as high in nursing homes with highest proportions of racial/ethnic minority residents as in nursing homes with low proportions.”<sup>75</sup>

The data below clearly shows that nursing homes with a disproportionate share of residents of color have had more cases, more severe outbreaks, and more deaths from COVID-19.

### *1. Nursing Homes with a Disproportionate Share of Black and Hispanic Residents are More Likely to Have an Outbreak*

Nursing homes in which African Americans and Hispanics make up a significant portion of the residents — no matter their location, no matter their size, no matter their past performance — have been twice as likely to have a COVID-19 outbreak as those where the population is overwhelmingly White.<sup>76</sup>

A New York Times analysis found that a racial disparity remained even after accounting for a variety of factors, including the size of a nursing home, the infection rate in the surrounding county, the population density of the neighborhood and how many residents had Medicaid or Medicare.<sup>77</sup> Large homes with few Black and Hispanic residents were less likely to have outbreaks than large ones with more Black and Hispanic residents. A home in an urban area was less likely to get hit by the virus if it had a small Black and Hispanic population.<sup>78</sup> Nursing homes with at least a quarter of residents who are Black or Hispanic are disproportionately impacted.<sup>79</sup> These nursing homes have been twice as likely to be hit by COVID-19 than those with less than five percent Black or Hispanic residents.<sup>80</sup>

## 2. Nursing Homes with a Disproportionate Share of Black or Hispanic Residents are More Likely to have an Outbreak that is Severe

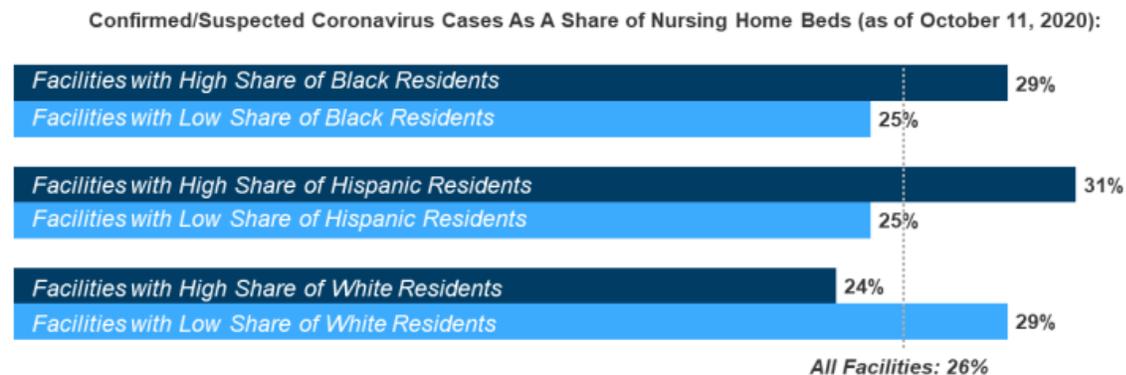
Not only are nursing homes that have a disproportionate share of Black or Hispanic residents more likely to have COVID-19, but they are more likely to have a severe outbreak than are nursing homes with a higher proportion of White residents (see figure 1). Among homes that had at least one case of COVID-19, those with relatively high shares of Black or Hispanic residents reported more severe case outbreaks than those with low shares of Black or Hispanic residents, as measured by confirmed or suspected cases as a share of nursing home beds.<sup>81</sup> In nursing homes with a relatively high share of Black residents, COVID-19 cases in residents account for 29% of beds, as compared to 25% of beds in nursing homes with a relatively low share of Black residents.<sup>82</sup> Similarly, among nursing homes with a relatively high share of Hispanic residents, positive cases among all residents account for 31% of beds, as compared to 25% of beds in nursing homes with a relatively low share of Hispanic residents.<sup>83</sup>

Figure 1

## 3. Nursing Homes with a Disproportionate Share of Black and Hispanic Residents are More Likely to have Deaths from COVID-19

Not only are nursing homes with a disproportionate share of Black and Hispanic residents more likely to have COVID-19 cases and to have them be more severe, but these homes are more likely to have deaths from COVID-19 than nursing homes without a disproportionate share of Black and Hispanic residents. A Washington Post analysis of data from more than two dozen states found that the death rate was more than 20% higher in nursing homes with majority-Black residents compared with nursing homes with majority-White residents.<sup>84</sup> “The analysis, which used demographic data

### Coronavirus Infection Outbreaks Were More Severe in Nursing Homes With A Relatively Large Share of Black or Hispanic Residents



NOTES: Includes 11,296 nursing homes with at least one coronavirus case and where resident cases were not > total number of beds. High share of Black residents or Hispanic residents refers to 20% or more. High share of White residents is 80% or more. Facilities may fall into more than one of these groups.

SOURCE: KFF analysis of Shaping Long Term Care in America Project at Brown University funded in part by the National Institute on Aging (1P01AG027296), CMS COVID-19 Nursing Home Data (as of October 11, 2020)

**KFF**

Figure 1

compiled by Brown University and included about 11,000 nursing homes — nearly three-quarters of all facilities in the United States — additionally found that death rates increased as the proportion of Black residents increased.”<sup>85</sup> Homes where at least 7 in 10 residents were Black saw a death rate that was about 40% higher than homes with majority-White populations.<sup>86</sup>

Another study found that nursing homes with the highest proportions of non-White residents experienced COVID-19 death counts that were 3.3-fold higher than those of facilities with the highest proportions of White residents.<sup>87</sup>

Nursing homes with a relatively large share of Black and Hispanic residents have conclusively been disproportionately impacted by COVID-19, as measured by the share of reported deaths and cases, and the severity of outbreak.<sup>88</sup> We cannot simply accept these differences in COVID-19 cases, severity, and deaths by nursing home racial composition. We must work to identify the potential reasons for these differences and actively endeavor to address the factors related to these differences.

#### IV. PRE-EXISTING RACIAL AND ETHNIC DISPARITIES CONTRIBUTED TO COVID-19 OUTCOMES

**A**s will be further discussed herein, the full relationship between racial disparities and other contributing factors is still being studied. Early studies, however, show that pre-existing factors such as poor quality, low staffing levels, and troubled performance history impacted COVID-19 outcomes.

##### A. Low Staffing Levels Contributed to Poor COVID-19 Outcomes

Research has found that nursing homes with one or more COVID-19 cases were likely to have fewer deaths and a lower probability of a severe outbreak if they had higher levels of staffing before the pandemic.<sup>89</sup> Staff shortages are thought to have contributed to the spread of COVID-19 in many homes and it is understood that nursing homes with a higher complement of staff were better able to adopt and implement best practices, such as regular testing of residents and staff, and separating residents by COVID-19 status.<sup>90</sup>

The Center for Medicare Advocacy’s analysis of COVID-19 staffing studies found that “nursing facilities that have more nurses are more successful in containing coronavirus cases and deaths among residents than facilities with lower nurse staffing levels.”<sup>91</sup>

A study on the first COVID-19 wave in California shows that: “nursing homes with total RN staffing levels under the recommended minimum standard (0.75 hours per resident day) had a two times greater probability of having COVID-19 resident infections. Nursing homes with lower Medicare five-star ratings on total nurse and RN staffing levels (adjusted for acuity), higher total health deficiencies, and more beds had a higher

probability of having COVID-19 residents. Nursing homes with low RN and total staffing levels appear to leave residents vulnerable to COVID-19 infections. Establishing minimum staffing standards at the federal and state levels could prevent this in the future.”<sup>92</sup>

Another study shows that staffing levels are a major factor in rising COVID-19 cases and death rates. In May 2020, nursing homes with total direct care staff levels “under 3.8 hours per resident day had about twice the case rates of homes with staffing levels greater than 4.4 hours per resident day”.<sup>93</sup> For context, Pennsylvania currently only requires 2.7 hours per resident per day.

In interviews with nearly 60 people, “Nursing home staff and administrators told Human Rights Watch that understaffing influenced their ability to provide sufficient and consistent support to residents, and that the absence of family visitors who previously assisted with care exacerbated this problem. Family members and independent monitors, who were restricted in their ability to visit facilities during the pandemic, raised concerns about inadequate care and limited transparency.”<sup>94</sup>

A May 2021 study used national, publicly reported data from CMS on nearly all of the over 15,000 nursing homes in the country to examine the association between nursing home quality of care and COVID-19 incidence, mortality, and persistent burden.<sup>95</sup> Researchers found a relationship between Medicare Star Ratings on staffing and COVID-19 incidence and mortality. “With respect to staffing, facilities with 1 to 3 stars for nurse staffing had 18%–22% more weeks with high COVID-19 incidence (all  $p < 0.0001$ ) than 5-star staffed nursing homes.”<sup>96</sup> Nursing homes that have higher staffing ratios, this study found, have a lower COVID incidence.<sup>97</sup>

## **B. Low Rated Nursing Homes Contributed to Poorer COVID-19 Outcomes**

COVID-19 entered nursing homes without regard for the nursing home’s performance history. Both the best and lowest performing nursing homes had COVID-19 cases and deaths. The quality of a nursing home, as measured by Medicare Star Ratings, did not impact whether COVID-19 entered the nursing home; however, the quality of a nursing home did influence what impact COVID-19 had on residents and staff once it entered. A July 2020 study of Connecticut nursing homes published in the *Journal of the American Geriatrics Society (JAGS)* found that “the acquisition of the virus was not associated with quality ratings” but that “the average number of cases was lower in facilities with higher quality ratings and higher nursing staffing”.<sup>98</sup> Higher quality nursing homes with higher levels of nursing staff appeared, early on, to be better prepared to contain the spread of the virus once it entered a nursing home.<sup>99</sup>

A May 2021 study used national, publicly reported data from CMS on nearly all of the over 15,000 nursing homes in the country to examine the association between nursing home quality of care and COVID-19 incidence, mortality, and persistent burden.<sup>100</sup> Researchers found “a consistent relationship between higher quality ratings for all

domains of the Five-Star Quality Rating System and lower COVID-19 incidence, mortality, and the number of high-incidence weeks.”<sup>101</sup> Specifically, they found that for the overall star ratings, “nursing homes rated at less than 5 stars had greater COVID-19 incidence, mortality, and high-incidence weeks. For example, nursing homes with a 1- to 3-star overall rating had about 10% more weeks with high COVID-19 incidence (all  $p < 0.001$ ) than 5-star homes, and nursing homes with an overall star rating of 1 to 3 stars also had about 13%–16% higher incidence ( $p < 0.0001$ ) and 8%–10% higher cumulative COVID-19 mortality than 5-star nursing homes ( $p = <0.01$ ).”<sup>102</sup>

The findings suggest that nursing homes can adopt practices associated with improved quality that are empirically associated with a lower COVID incidence. For example, nursing homes that better comply with state and federal regulations, or facilities that have higher staffing ratios, have a lower COVID incidence.

### C. Overcrowding in Nursing Homes Contributed to Poor COVID-19 Outcomes

Overcrowding is another problem that contributed to worse COVID-19 outcomes in nursing homes. Reports out of Illinois in April 2021 showed that “60% of COVID-related deaths of nursing home residents between March and July 2020 occurred in facilities where at least 10% of residents were in rooms with three or more people.”<sup>103</sup> In a hearing before lawmakers, the Director of the Illinois Department of Healthcare and Family Services indicated that “heavy reliance on crowding three or four people into one room was far more common in Medicaid-funded homes serving Black and Hispanic residents, and led to preventable deaths.”<sup>104</sup>

A Canadian study of 78,000 residents in 618 nursing homes likewise found that COVID-19 deaths were less than half in homes with less crowding than in homes with crowding, supporting the finding that “Shared bedrooms and bathrooms in nursing homes are associated with larger and deadlier COVID-19 outbreaks.”<sup>105</sup>

## V. NURSING HOMES ARE SEGREGATED NATIONALLY AND IN PENNSYLVANIA

### A. Segregation in Nursing Homes – a National Problem

**I**n the past several decades, research has concluded that nursing homes in the United States are racially segregated.<sup>106</sup> There is no gentler way to state it. “Blacks and whites ... are getting different care because they live in different nursing homes,” said Vincent Mor, Ph.D. who chairs the Department of Community Health at Brown University and participated in many of the studies cited in this paper.<sup>107</sup>

Racial segregation is the systematic separation of people into racial or other ethnic groups in daily life. Study after study confirms that nursing home racial segregation is a long-standing, pervasive problem that has yet to be tackled directly and intentionally. One study found that nursing home care was segregated in 2000, with two-thirds of all Black residents living in just 10 percent of all facilities.<sup>108</sup> A 2007 national study of nursing homes found that the facilities that are home to African Americans tend to be racially segregated.<sup>109</sup> An October 2020 study of COVID-19 and nursing homes reiterates this as a cause, and a contributory factor, in bad COVID-19 outcomes.<sup>110</sup>

A 2007 study found that nationally, 40% of Black residents, compared with 9% of White residents, resided in “lower-tier” nursing homes as determined across several metrics. These researchers concluded that fundamental inequalities inherent in the healthcare and non-healthcare sectors led to poorer health outcomes for residents of color.<sup>111</sup> Data from several states, including New York, North Carolina, and Illinois, show race as the greatest predictor of the receipt of poor-quality nursing home care.<sup>112</sup>

A 2019 study found that segregation had gotten worse. This study “found that African American post-acute patients are highly concentrated in a small number of institutions, with 28% of facilities accounting for 80% of all post-acute admissions for African American patients. Similarly, just 20% of facilities accounted for 80% of all admissions for Hispanics.”<sup>113</sup>

Researchers “observed a relatively high correlation between nursing home and residential segregation” in the broader community.<sup>114</sup> Theoretically, nursing homes may merely reflect the racial composition of the communities in which they are located.<sup>115</sup> However, research shows the racial segregation in nursing homes to be greater than in the surrounding neighborhood, and thus concluded that geographical segregation could not fully explain racial segregation in nursing homes in the states in the study.<sup>116</sup> Regardless of whether segregation reflects the racial composition of the surrounding community, individuals are being guided, urged, or, in some cases, admitted without having a say about the location, into nursing homes that provide substandard care and lower staffing levels. These practices warrant deeper evaluation of hospital discharge and nursing home admissions procedures and how they might be perpetuating segregation in nursing home care.<sup>117</sup>

A 2011 study found that “Black patients were more likely to be admitted to for-profit facilities (78% vs 72%), to facilities with higher concentrations of Black patients (37% vs 7%) and to facilities with higher percentages of long-term care residents receiving Medicaid benefits (59% vs 50%) than were White patients.”<sup>118</sup>

It is imperative that Pennsylvania explore what can be done prior to admission to prevent discrimination, including a closer look at hospital discharge planning, community referrals, managed care oversight and enforcement, leading to change in processes and policy.

Since disparities in care appear to be largely a function of where people receive care rather than differential treatment by staff members within the same facilities, segregation in nursing homes is a problem to be directly addressed.<sup>119</sup>

Fundamentally, high quality care should be provided at all facilities, regardless of location or racial/ethnic composition, and with no disparate health or quality of life outcomes based on race or ethnicity. In that scenario, all Pennsylvanians could be free to safely choose a facility in their neighborhood, that meets their individual requirements and provides good quality care. However, this is not the case. High quality care is not being uniformly provided or ensured. Additionally, recent findings of another soon-to-be-published study by Ashvin Ghandi show that 19% of residents are not in their first-choice nursing home, despite the availability of openings in their first-choice nursing home,<sup>120</sup> suggesting again that admissions processes require review.

## B. Segregation in Pennsylvania's Nursing Homes

In *Taylor v. White*, a 1990 class action lawsuit against the Pennsylvania Departments of Health and Human Services, plaintiffs alleged that Medicaid recipients and people of color were subjected to discrimination on the basis of payor source and that nursing homes in Pennsylvania were unlawfully segregated based on race. The lawsuit was informally settled and dismissed by the court without prejudice because of the informal nature of the settlement. Yet little has changed. In many areas of Pennsylvania, the

*19% of residents are not in their first-choice nursing home, despite the availability of openings in their first-choice nursing home.*

make-up of facilities is not representative of the communities in which facilities are located.

For example, nursing homes in Philadelphia are highly segregated. By race, the city's

population is 42% Black, 41% White and 7% Asian. 34.5% of Philadelphia residents identify as White alone, and 14.7% are Hispanic or Latino.<sup>121</sup> A review of data compiled by the Brown University School of Public Health shows that the demographics of Philadelphia's nursing homes look nothing like those of the city.<sup>122</sup> Of 41 nursing homes for which data was available, 19 had a predominantly White resident population, and 14 of these were more than 80% White.<sup>123</sup> Four nursing homes were 97% or more White and one had a resident population that was 100% White.<sup>124</sup> The other 22 nursing homes were predominantly Black and Hispanic, with 18 of these homes having a resident population that was 75% or more Black and Hispanic.<sup>125</sup> Not one nursing home had resident demographics that reflected those of the city.

Just as national studies have found, Black and Hispanic nursing home residents in Philadelphia tend to be segregated in lower quality facilities. Out of 11 Philadelphia nursing homes which have a one-star Medicare rating through the Centers for Medicare and Medicaid Services' Five-Star Quality Rating System or have been designated a Special Focus Facility by the Centers for Medicare and Medicaid Services, 8 were predominantly Black.<sup>126</sup> All but one of these nursing homes had a resident population that was at least 80% Black. Of the four five-star nursing homes in Philadelphia for

which demographic data was available, all were 80% or more White (and three of the four had a resident population that was between 97-100% White).<sup>127</sup>

The state's failure to collect and make public important data on the demographic make-up of nursing facilities and their resident outcomes or quality of care makes it hard to fully measure exactly how similar or different things are 31 years later. In the decades since the *Taylor* case was settled, plaintiffs' expert David Barton-Smith<sup>128</sup> continued to evaluate the extent of segregation up until a few years ago. He observed, in a conversation with the authors, that based on his ongoing analysis the extent of the segregation in Pennsylvania had continued to increase over time. Collection of relevant racial data by Pennsylvania abruptly stopped in 2017 and can no longer be found in the public domain.<sup>129</sup> Notwithstanding, we have no reason to believe that the continued increase in segregation observed by experts for decades suddenly stopped or reversed itself in the absence of data collection since 2017.

Failure to collect, analyze, and use data around racial and ethnic disparities of care has the effect of perpetuating the status quo. We strongly recommend that the state commit to robust data collection, analysis, and use data to address and mitigate the inequities and injustices caused and revealed by existing disparities.

## VI. BOTH SEGREGATION AND RACIAL AND ETHNIC DISPARITIES IN NURSING HOMES MUST BE ELIMINATED

### A. Discrimination is Unlawful

**D**iscrimination is defined and interpreted by law to include both differential and disadvantageous treatment of individuals or a group on the basis of race (the intentional act) as well as differential and disadvantageous treatment of individuals or a group on the basis of some other unjustifiable factor other than race but that has a disparate impact on those in a racial group (the disparate effect).

Discrimination is unlawful and unacceptable. The Pennsylvania Human Relations Act prohibits discrimination on the basis of race or ethnicity.<sup>130</sup> Title VI of the federal Civil Rights Act of 1964 prohibits nursing homes that receive Medicare and/or Medicaid from discrimination in admissions, from using race to deny admission or quality care to residents of color.

Research demonstrates that people of color are systematically denied equal access to quality nursing homes because of their race/ethnicity and that racial segregation continues. Racial segregation is the systematic separation of people into racial or other ethnic groups in daily life. The Pennsylvania Human Relations Act includes segregation in its definition of discrimination.

The Commonwealth must take all possible actions to mitigate the racial and ethnic inequities and injustices that this paper details. Study after study confirms that nursing

home racial segregation is a long-standing, pervasive problem that has yet to be tackled directly and intentionally. It is time to act. Failing to do so, thereby knowingly allowing racial and ethnic inequities in nursing home quality of care to continue, perpetuates structural racism.

## **B. Pennsylvania Must Take Immediate and Meaningful Action to Address Racial and Ethnic Disparities**

Pennsylvania must improve quality, raise staffing levels, increase Medicaid reimbursement, enforce civil rights requirements, modify admissions policies, enforce regulations, assess its policies for potential bias, provide training, and collect and share data – including racial and ethnic data – to identify issues and demonstrate change.

**Regardless of the causation or correlation amongst quality, staffing, etc., there are irrefutable disparities in outcomes that are clearly linked to both race and ethnicity as well as to the racial make-up of a facility. For this reason, we must take all actions possible to address racial inequities and injustices in outcomes.**

While there are published recommendations broadly related to addressing racial disparities and achieving health equity, our research has found little written with specific recommendations for expeditiously addressing racial disparities in COVID-19 outcomes for nursing home residents. Accordingly, our coalition has developed a significant number of actionable recommendations that we believe will address racial and ethnic disparities in Pennsylvania’s nursing homes.

## **VII. RECOMMENDATIONS TO ADDRESS RACIAL AND ETHNIC DISPARITIES IN PENNSYLVANIA’S NURSING HOMES**

**M**any recent national reports have been published demonstrating the existence of racial and ethnic disparities. Pennsylvania has begun to focus on these issues. The Governor’s COVID-19 Taskforce issued a report on health disparities in August 2020.<sup>131</sup> The Department of Human Services issued its own disparities report in January 2021. In it, DHS described health equity initiatives already underway and committed to a more “coordinated, department-wide approach”.<sup>132</sup> DHS described how it is “moving forward with analysis of data specifically looking for gaps, opportunities and trends by race” and doing this “across physical health, behavioral health, long-term services and supports, and programs serving people with intellectual disabilities and autism”.<sup>133</sup>

In another recent undertaking that began in February 2021, [the LTSS subcommittee of the Pennsylvania Medical Assistance Advisory Committee submitted recommendations to the Department of Human Services Office of Long-Term Living](#). Several of these recommendations relate to racial and ethnic disparities in nursing home care. The Office

of Long-Term Living is engaging stakeholders in impactful discussions of advancing the recommendations, has produced an initial detailed data analysis, and appears to be thoughtfully evaluating how to implement recommendations.

We are pleased to see that discussion has begun. However, we have seen few discrete proposals from our state agencies to address racial inequities in nursing home care. Our research into published reports yielded a dearth of comprehensive recommendations specifically around how to remediate and address racial and ethnic disparities in nursing homes. For this reason, our coalition has spent several months developing comprehensive recommendations, described below, and summarized in a [table](#).<sup>134</sup>

Our recommendations are a starting point. We strongly encourage the Wolf Administration and legislature to use our recommendations in the important work of addressing equity and eradicating racial and ethnic disparities in nursing homes and all LTC facilities. An intragovernmental workgroup should be created for the express purpose of operationalizing these and other recommendations. A broad and inclusive array of stakeholders, including residents and their families, should be consulted in a thoughtful dialogue around implementation.

## **A. Recommendations for Systemic Reforms to Address Racial and Ethnic Disparities in Pennsylvania’s Nursing Homes**

**Systemic Reforms Recommendation #1: Create a Governor’s Cabinet level Office of Civil Rights Enforcement and Racial Equity.** Eliminating disparities in quality and outcomes in publicly funded and state-licensed human services and healthcare programs across race, ethnicity, spoken language, sexual orientation, gender identity and payor source is a critically important undertaking which merits the creation of a cabinet level secretary who can take a cross-department enforcement approach. This office would oversee all agencies in their civil rights compliance and would be charged with enforcing civil rights, including language access. As relates to nursing home care, this office could either exercise oversight over DOH’s civil rights compliance and enforcement activities for nursing homes and hospitals (and DHS’ civil rights enforcement for personal care homes and assisted living facilities) or the office could be assigned responsibility itself for fulfilling the civil rights compliance activities related to long term care facilities.

**Systemic Reforms Recommendation #2: Convene an intragovernmental workgroup to immediately begin work to implement these recommendations.** The state should immediately convene a diverse and inclusive workgroup of stakeholders, trusted community members, residents, their representatives, advocates, and decision-makers across governmental agencies to implement these and other recommendations to address and mitigate the racial and ethnic inequities and injustices in long term care facilities. We recommend the Office of Advocacy and Reform serve as convener and lead for this workgroup.

**Systemic Reforms Recommendation #3: Engage the RAHCs in developing a plan to address racial and ethnic disparities in nursing homes.** The DHS established Regional Accountable Health Councils (RAHCs), which are regional collaborations of MCOs, large providers, health centers, and trusted community institutions and community-based providers tasked with promoting health equity and reducing disparities.<sup>135</sup> We urge DHS to engage the RAHCs in adding nursing home racial and ethnic health equity to their priorities.

## **B. Regulatory Reform Recommendations to Address Racial and Ethnic Disparities in Pennsylvania’s Nursing Homes**

The following are recommendations that we believe the Department of Health has the authority to make within its regulatory framework. Legislative action mandating these changes is another way of moving the ball and we support any legislative effort to implement these important reforms.

### **Regulatory Reform Recommendation #1: Revise Pennsylvania’s nursing facility regulations immediately to improve quality, conditions, and oversight.**

Without a doubt, revising Pennsylvania’s antiquated and inadequate nursing home regulations – which have not been updated since 1995 - to establish meaningful standards for quality, infection prevention, staffing levels, training, and more would have a tremendous impact on outcomes for Black and Hispanic residents who disproportionately reside in poorer-performing nursing homes. We simply cannot state in stronger terms the moral imperative to improve overall conditions through regulatory reform to adequately address racial and ethnic disparities. Improved regulations must be coupled with vigorous enforcement or adoption will be for naught.

**Regulatory Reform Recommendation #2: Mandate Pandemic Preparedness Plans for all nursing homes.** We know that nursing homes were not prepared for the COVID-19 pandemic. Current regulations do not require them to prepare for a public health emergency, as they are required to do for a fire emergency. The Department of Health’s nursing home licensing regulations should be amended to add language detailing a requirement that facilities develop, adopt, and implement Emergency, Pandemic, and Disaster Preparedness Plans specifically tailored to the facility and its residents. We have provided the state with [draft regulatory language demonstrating how it could implement this recommendation](#).

**Regulatory Reform Recommendation #3: Adopt nursing home change of ownership policy and process to prevent change of ownership to poor performing providers.** Considerable concerns have been raised by Congress, advocates, and academics about the risks to care associated with private equity firms buying up nursing homes without expertise to provide the care required. In recommendations provided to DOH in November 2020, our coalition articulated specific recommendations for how the state should exercise its oversight of applications for new

licenses when nursing homes change ownership, with requirements around what information should be evaluated and what scrutiny should be applied in determining whether a would-be owner should receive a license to operate a nursing home, based in part on strong Massachusetts regulations. These regulations can be found in Appendix 3 below. Since Black and Hispanic residents disproportionately end up in poorer-performing facilities, this regulatory change is needed to eliminate racial disparities and inequities in quality of care.

### **C. Data Recommendations to Address Racial and Ethnic Disparities in Pennsylvania's Nursing Homes**

One concern raised by many researchers is the incomplete data collection by states and the federal government to support a full understanding of racial disparities in care. The COVID Tracking Project assessed each state's data collection and reporting and found serious issues with Pennsylvania's collection of racial and ethnic data.<sup>136</sup> Pennsylvania is one of the states that does not collect the data needed to fully analyze the breadth of experience and outcomes for nursing home residents by racial and ethnic groups.<sup>137</sup> In fact, Pennsylvania stopped reporting racial data on nursing home residents a few years ago. It is unclear whether the state just stopped reporting this information publicly and is still collecting it or whether it has stopped collecting it, which would make civil rights compliance responsibilities by DOH and DHS almost impossible to execute.

To address racial, ethnic, and language disparities, Pennsylvania must collect accurate and meaningful data to show where disparities exist. This requires accurate collection of race, ethnicity, and language data concerning nursing home residents, along with the resources to provide for analysis and corrective actions. Our recommendations include improving racial, ethnic, and spoken language disparity data collection, analysis, and utilization related to COVID-19 and long-term care facilities.<sup>138</sup> As the state is analyzing how to use its American Recovery Plan dollars, we urge the state to improve and modernize the Department of Health's data systems with an eye to how it can better collect, analyze, and use this important data.

In its January 2021 Health Equity Report, DHS indicated it was "looking to improve our data infrastructure for continuous monitoring of racial disparities. This infrastructure will facilitate better coordination and help us refine and hold to benchmark data, goals, and progress of initiatives as they are implemented."<sup>139</sup> We support this endeavor.

**Data Recommendation #1: Improve and expand the state's data collection activities and requirements to collect a greater depth and breadth of data by race and ethnicity.** Generally, data collection must be broad and inclusive enough to capture the full extent of racial, ethnic, and language diversity in the Commonwealth.

Accordingly, we recommend that at a minimum the state collect race data by 1) African American or Black, 2) American Indian or Alaska Native, 3) Asian, 4) Native Hawaiian or Other Pacific Islander, 5) Other Race, 6) Multiple Race, and 7) White. We also recommend that the state further disaggregate ethnicity data. There are many different ethnic groups within "Asian" race and many subgroups within the "Hispanic" ethnicity.<sup>140</sup> Additionally, written and spoken language data should also be incorporated into routine data collection.

Not only does the state need a broader dataset of race and ethnicity groups, but for nursing homes during COVID-19, we recommended that the state have a more complete set of reported data points. During the height of the COVID-19 crisis, DOH was unable to identify the facility level demographic data and analyze that by number of COVID-19 tests, cases, hospitalizations, ICU beds used, or deaths. The state should also collect the data necessary to compare resident-level race and ethnicity experience and outcomes data across zip codes, against co-morbidities, by payor, across age group, and more.

**Data Recommendation #2: Leverage access to and utilize existing sources of demographic data.** We believe that the state could significantly streamline data collection in a way that would improve access to information while ensuring consistency across multiple state agencies. The state should complete a full inventory of data currently available across all state agencies to eliminate any duplication of reporting by providers. We believe the state could much better use multiple data sources, including public data, to compile and collect information that includes data derived from the federal nursing home resident Minimum Data Set, facility reporting, CHC-MCOs, Medicaid applications, and any other accessible source.

**Data Recommendation #3: Publish data collected on race and ethnicity of residents and the nursing home care provided to them.** Transparency is essential. All data on racial and ethnic disparities must be made public and readily available. To be useful, data must be reported in a format that is comprehensible or accessible. Reporting cumulative aggregates on COVID-19 data at nursing homes remains excessively opaque, for the public can never know whether a facility has current COVID-19 cases or only ones from months prior. The state must make and honor a commitment to full transparency and exceptional reporting. We specifically recommend a LTSS disparities dashboard that includes qualitative and quantitative data to ensure there is equitable access to quality LTSS. This dashboard should include details from regulatory, quality, and satisfaction surveys by race and ethnicity. Additionally, data from civil rights compliance questionnaires should be made public by facility.

**Data Recommendation #4: Analyze data on race and ethnicity of residents and the nursing home care provided to them and share that analysis publicly.** The purpose of data collection is to be able to use it to analyze where disparities exist and whether interventions are necessary. Accordingly, it is imperative that the state devote the resources to analyze data and share the analysis. The state should analyze racial, ethnic, and language data against existing data sources; compare nursing home

quality data, including Medicare star ratings, by racial, ethnic, and language characteristics of the resident populations, monitor health disparities on an on-going basis and produce annual reports on racial and ethnic health disparities in nursing homes; and share data analysis publicly through annual reports as well as monthly reports to stakeholders.

**Data Recommendation #5: Probe root causes of disparities in nursing home care as reflected in the data collected.** National studies are beginning to uncover the causation behind the disparate impact COVID-19 has had on Blacks and Hispanics. Pennsylvania must take a hard look at these studies and determine how it can directly and expeditiously conquer the factors causing disparate outcomes, developing both essential immediate steps to “plug the dam” and prevent inequity as well as long-term strategies for addressing systemic issues. Multiple layers of analysis are necessary to truly understand the disparities using various data sources. The Department of Health should work in partnership with the Governor’s Task Force on Racial Disparities and the Departments of Human Services and Aging as well as researchers, experts, and other stakeholders to probe the root causes of disparities identified in the data.

To do this, the state must: evaluate data across income levels, payment source, geographic location, by facility, across comorbidities; evaluate facility quality, staffing levels, and compliance data against racial, ethnic, and language disparity data; correlate disparate outcomes and performance problem areas; and determine causes and correlations for disparities identified.

**Data Recommendation #6: Use the data, analysis of the data, and root causes to develop and accomplish meaningful change in policy and practice related to racial and ethnic disparities in nursing homes.** Collecting and analyzing data is just a first step to achieve meaningful results including changes to policy and practice. Attention should be paid to the urgently needed interventions for COVID-19 first, with more lasting focus on broader systemic changes including:

1. Design interventions based on the data with the goal of improving outcomes and performance in the areas where the data demonstrated disparities.
2. Identify health disparity reduction target(s) and select an intervention(s).
3. Measure impact of interventions and modify or expand over time, using continued data collection.
4. Develop an ongoing process for evaluating data and adjusting policies and practices.
5. Develop long-term interventions to correct for identified racial and ethnic disparities.
6. Use performance reviews and performance measures to ensure that providers understand and are actively addressing disparities.
7. Engage community-based organizations and stakeholder groups to discuss data and gather input into strategies to address disparities.
8. Utilize focus groups with LTSS participants, including nursing home residents, that represent historically marginalized communities to understand what they

value, want, and see as barriers. Local LTC Ombudsman programs may be a good source to identify residents for this effort.

9. Utilize focus groups with LTSS providers: nursing home, home and community based, Area Agencies on Aging, advocates, and other CBOs as appropriate.
10. Survey and engage non-English speaking adults and LGBT communities of all ages and backgrounds to evaluate needs and identify goals.

**Data Recommendation #7: Assess policy and practice interventions implemented to address and mitigate racial and ethnic disparities to determine their impact and efficacy.** Evaluating how interventions have impacted disparities is the final step in the data cycle. We recommend that the state determine and implement a measurement approach that includes assessing performance, reassessment program design, and using data over time to assess impact and change in health disparities.

#### **D. Nursing Home Admissions Process Recommendations to Address Racial and Ethnic Disparities in Pennsylvania's Nursing Homes**

The Departments of Health and Human Services must take steps to eradicate implicit or explicit biases in the hospital discharge and nursing home admissions processes. The Departments should improve ongoing monitoring and implement more rigorous enforcement of Title VI of the Civil Rights Act of 1964 in admission practices.<sup>141</sup> In the 1990s, a class action lawsuit, *Taylor v. White*, took the Pennsylvania Departments of Health and Human Services (then Public Welfare) to court over discrimination in nursing home admissions practices. The case was informally settled with the state agreeing to work on preventing discrimination in admission practices, but it does not appear that significant changes resulted or that these efforts are ongoing.

**NH Admissions Recommendation #1: Conduct an evaluation of nursing home admissions and residency data across all Pennsylvania nursing homes by race and ethnicity.** We urge the Departments of Health and Human Services to jointly investigate where segregation is occurring in both admissions and residency by conducting a full evaluation of nursing home admissions and residency data. The Departments should conduct a thorough review of evaluation data from existing data sources and compare it with the Civil Rights Compliance Questionnaires each nursing home completes. The demographic characteristics of the residents in nursing homes across the Commonwealth reflect a level of racial disparity that is disturbing and requires further investigation and then corresponding action.

**NH Admissions Recommendation #2: Mandate that facilities document the demographic information of all individuals for whom a verbal or written inquiry and/or formal application for admission is made.** Each nursing home must meet Department of Health civil rights compliance requirements. They must annually complete and submit a Civil Rights Compliance Questionnaire. LTC Facilities licensed by the Pennsylvania Department of Human Services must also complete a Civil Rights Questionnaire, a sample of which can be found [here](#). The DOH form is not

available online. Once completed, these questionnaires must be submitted to the LTC Facility's regional office annually.

While these forms require facilities to submit aggregate racial and ethnic data on current residents and recent admissions (the last 25), the form does not require information about those who applied for admission by submitting a written application form and were denied admission or those who verbally inquired about and sought admission but were verbally turned away. Additionally, the form does not require the facility to report information about payment sources for those who applied, were admitted, and are residents.

We suggest the Departments collect the following data annually from nursing homes and all other LTC Facilities to aid in this analysis:

1. Daily census;
2. Number applied for admission by race, ethnicity, and spoken language;
3. Number admitted by referral/discharge source (hospital, community, other nursing home) and by race, ethnicity, and spoken language;
4. Number denied admission by race, ethnicity, and spoken language;
5. Reason for denied admission;
6. Payment source for each admitted resident and for individuals denied admission;
7. Number of Medicare Skilled Nursing Facility patients total by race, ethnicity, and spoken language;
8. Medicare SNF patients that convert to long term care residents by race, ethnicity and spoken language; and
9. Number of Medicare Skilled Nursing Facility patients that converted to Medicaid nursing home coverage by race, ethnicity, and spoken language.

**NH Admissions Recommendation #3: Publicly report data gathered from the annual Civil Rights Compliance Questionnaires completed by nursing homes.**

The Department of Health's Civil Rights Compliance Questionnaire requires the filer to answer questions about the demographic composition of the residents or people otherwise served by the nursing home. The Department of Health should compile and make public the considerable data that nursing homes are required to report on the Civil Rights Compliance Questionnaire, and this should be reported publicly on the DOH website.

**NH Admissions Recommendation #4: Require a standard admissions application form and process for all nursing homes.** Dozens of Pennsylvania nursing homes that we looked at have a form on their website that can be used by an interested applicant. The Departments should require facilities to accept and/or complete an application form for every inquiry about and/or formal application for admissions, regardless of whether it was received by the facility in verbal, in-person, electronic, or paper form. The Departments should either draft a standard form to be used or should articulate requirements facilities must use in their own form. Nursing homes should be required to retain these forms for at least 5 years, and demographic

and payment source data collected should be reported to the Departments, as further detailed in #2 above.

**NH Admissions Recommendation #5: Define requirements for hospital discharge planners that would further the goal of preventing intentional or implicit bias in discharge planning.** Recommendations for requirements include:

1. All nursing home referrals must be done in writing and documented by the discharge planner/hospital and by the nursing home. Hospitals and Nursing homes must retain the documentation for at least 5 years for the state to evaluate and cross-check for evidence of discrimination referral or admissions practices.
2. All referrals that are rejected must be in writing and include the basis for denial of admission. Hospitals and Nursing homes must retain the documentation of these denials for at least 5 years for the state to evaluate and cross-check for evidence of discrimination referral or admissions practices.
3. Hospitals must log final discharge placements and retain these logs for at least 5 years. Discharge data has long been used by many states to identify care needs or service gaps.<sup>142</sup> Pennsylvania should be using it to ensure compliance with civil rights requirements.
4. DOH must commit to reviewing and analyzing this collected data.

**NH Admissions Recommendation #6: Release Access Monitoring Review Plans that reflect DHS' evaluation of nursing home access for Pennsylvanians by race, ethnicity, spoken language, and payment source.** Federal Medicaid law requires states to issue to CMS their Medicaid Access Monitoring Review Plans at least every three (3) years.<sup>143</sup> CMS publishes these on the Medicaid.gov website. Pennsylvania has not submitted an AMRP since 2016. Pennsylvania's published 2016 report includes some discussion on Pennsylvanians' access to nursing homes.<sup>144</sup> Other states submitted and published their 2019 reports.<sup>145</sup> Pennsylvania did not. We recommend that DHS revise the AMRP to include race, ethnicity, and language spoken and that DHS resume compliance with the AMRP requirement.

**NH Admissions Recommendation #7: Adopt a first-come, first-served admissions policy for nursing homes as a Medicaid Condition of Participation.** Connecticut and New Jersey are two states that have first-come, first-served admissions approaches aimed at preventing discrimination in admissions based on payor source.<sup>146</sup> Residents must be accepted into facilities in the order in which they applied for admission. We recommend that Pennsylvania enforce this requirement with penalties for failure to comply as practiced in Connecticut. Since Black and Hispanic residents disproportionately rely on Medicaid as a funding source, such a policy would reduce the racial disparities and inequities described in this report.

**NH Admissions Recommendation #8: Consider capping private pay rates at the Medicaid rate to equalize access to care for nursing homes as a Medicaid Condition of Participation.** Implement a rate equalization approach as has been used in Minnesota for decades. Under this approach, private pay rates cannot exceed

Medicaid rates.<sup>147</sup> The intention behind this approach is to prevent discrimination based on payor source. We support the adoption of this requirement in concert with the establishment of adequate Medicaid rates and believe it will result in better quality care and reduce racial inequities across the nursing home system.

**NH Admissions Recommendation #9: Conduct annual “secret-shopping” for nursing home admission with the objective of measuring any processes that are contributing to segregation.** Annually, the Department of Health should conduct “secret shopping” of nursing homes admission processes to detect any discrimination on the basis of race, ethnicity, language spoken, payor, or other prohibited grounds.

**NH Admissions Recommendation #10: Develop mandatory hospital patient education on nursing home quality to help ensure informed consent in the nursing home selection process.** DOH should develop requirements around educating patients and/or their designated representatives during the hospital discharge planning process to ensure that they understand and have the opportunity to evaluate the quality of a nursing home. Hospital patients and their designated representatives must be fully informed about the past performance (quality, staffing levels, infection control violations, etc.) of a nursing home for their agreement to placement to be considered “informed consent”. Low literacy and the anticipated unlikelihood of the patient being able to research the quality of a nursing home using the Medicare Star Rating or any similar system should be directly addressed by education about facility choices, and patients should be informed that they have the right to make an informed decision including refusing a substandard placement. This patient education is needed to ameliorate the disproportionate admission of Black and Hispanic individuals to poorer-performing facilities.

## **E. Staffing Recommendations to Address Racial and Ethnic Disparities in Pennsylvania’s Nursing Homes**

**Staffing Recommendation #1: Increase direct care staffing levels in Pennsylvania’s nursing homes.** As the research demonstrates that nursing homes with fewer direct care staff hours had more serious outbreaks, harsher COVID-19 outcomes, and other poor outcomes for Black and Hispanic residents, we reiterate our November 2020 recommendation that the state increase the minimum staffing levels in the state’s nursing facility regulations. Our recommendation is multi-pronged: 4.1 hours of direct care staff per resident as the minimum, with actual staffing levels above the minimum being calculated based on the facility assessment (performed quarterly rather than annually) and each of the actual residents’ assessed needs as determined by their individualized assessment. This calculation would be made and employed by the nursing home but recorded and quality checked by DOH in its monitoring and oversight activities.

**Staffing Recommendation #2: Adopt a Medical Loss Ratio requirement for nursing homes to ensure Medicaid payments are directed toward care and staff pay to address racial and ethnic disparities in care that are attributed to**

**low levels of staffing.** A Medical Loss Ratio requires a provider to ensure that the lion's share of their Medicaid payment is actually used for the cost of care and staff compensation, as opposed to administrative expenses or profits. New Jersey recently adopted a medical loss ratio, which it calls a "direct care ratio" of at least 90% for its nursing homes.<sup>148</sup> Pennsylvania should follow suit and demonstrate its commitment to the care residents receive.

## **F. Quality Recommendations to Address Racial and Ethnic Disparities in Pennsylvania's Nursing Homes**

The National Quality Forum Roadmap for Promoting Health Equity and Eliminating Disparities outlines four essential actions for achieving equity and eliminating disparities. These include: "prioritizing measures that can help to identify and monitor disparities, implementing evidence-based interventions to reduce disparities, investing in the development and use of measures to assess interventions that reduce disparities, and providing incentives to reduce disparities."<sup>149</sup>

**Quality Recommendation #1: Invest in both regulatory enforcement and technical assistance for nursing homes.** With data demonstrating that Black and Hispanic residents are more likely to have poorer outcomes in Pennsylvania's nursing homes, we urge the Department of Health to infuse significant resources into an effort to improve enforcement and to provide technical assistance to bring providers into compliance. We believe that providers must be given any support they need to improve, as their improvement will, according to the research, save lives. Technical assistance should be provided in concert with, not in lieu of, strong enforcement. The state should develop a technical assistance taskforce that is firewalled from enforcement personnel. In such a model, non-compliance would be cited by enforcement personnel and would result in a detailed plan of correction with distinct activities to be undertaken with the support of the technical assistance personnel. Technical assistance that is in concert with enforcement activities should be time-limited so that nursing homes are given the tools/supports but also a reasonable timeframe within which to achieve high quality. Progressive enforcement actions that start with citation and technical assistance and advance in severity should be outlined and followed.

**Quality Recommendation #2: Measure nursing home improvement against each facility's past performance.** DOH should hold under-performing providers not to a static quality benchmark but to improvement on particular measures as compared to their prior performance.<sup>150</sup> Instead of measuring whether a provider achieves x% on a specific measure, the state can encourage improvement by making the measure unique and attainable to the facility.<sup>151</sup>

**Quality Recommendation #3: Evaluate rates of hospitalization and rehospitalization for racial and ethnic disparities.** "Skilled nursing facilities in the top decile ranked by proportion of African Americans had on average 4.05 percentage point higher 30-day rehospitalization rates compared to facilities that serve no African

Americans.”<sup>152</sup> With Black and Hispanic residents more likely to be hospitalized and re-hospitalized, we recommend that DOH evaluate hospitalization data by race and ethnicity to identify, address, and mitigate racial and ethnic disparities in hospitalization/rehospitalization rates.

**Quality Recommendation #4: Evaluate nursing homes’ actual total staffing hours and ratios to identify and address any disparities in staffing levels.**

Calculate the total numbers of care hours and the ratios of staff to residents provided to Black and Hispanic residents and in facilities that serve a disproportionate number of Black or Hispanic residents. Compare this data with the staffing data for White residents and with overall data from facilities that do not serve a disproportionate share of Black and Hispanic residents.

**G. Medicaid Reimbursement Recommendations to Address Racial and Ethnic Disparities in Pennsylvania’s Nursing Homes**

As described in section II.C., disparities have long been associated with Medicaid reimbursement. Addressing disparities through Medicaid reimbursement reforms can take several forms. Medicaid rates may need to be revised to support increased staffing levels; however, the current lack of transparency makes it impossible to evaluate the adequacy of rates. We urge targeting additional funds for under-performing facilities with racial disparities to bring them up to par, acknowledging that years of poor performance may be the result of under-resourcing and that such facilities may now require support to improve before being subject to enforcement penalties. We support improving quality to level up the quality playing field first, then once stable and level, penalizing nursing homes that fail to maintain quality, and continuing with progressive enforcement steps moving towards closure/loss of license for continual poor performance.

We believe that incentives are valuable but as a second step after technical assistance and support are provided to struggling nursing homes serving a disproportionate number of Black and Hispanic residents. One value-based payment program had results that showed “that majority-Black homes had a 14% lower chance of receiving a bonus and a 6% higher chance of being fined than those that were majority White; a clear example of structural racism because the policy advantaged majority-White homes and disadvantaged majority-Black homes, thereby exacerbating the underlying differences in resources.”<sup>153</sup> Additionally, when systemic improvement reflects that the timing is right for incentives, the incentives must be crafted in a way that supports overall quality and not just performing well in areas related to earning incentives.

As a majority of nursing home residents with Medicaid are enrolled in the Community HealthChoices program, the following recommendations for DHS are ones that should be applied to the Community HealthChoices (CHC) program. Each of the CHC Managed Care Organizations (MCOs) negotiate rates with nursing homes with rates prohibited from falling below the rate set prior to the start of CHC. Our recommendations for DHS should be incorporated into the CHC program by being added as requirements for the

CHC-MCO nursing home contracting process through an amendment to the CHC-MCO Agreement with DHS or other oversight mechanisms. Specifically, we recommend:

**Medicaid Reimbursement Recommendation #1: Evaluate Medicaid nursing home reimbursement rates to determine whether they support more appropriate staffing levels.** As stated above, nursing home direct care staffing levels need to be increased. They should be set based on the individualized needs of the residents in the facility with a floor of 4.1 hours per day and minimum ratios (as outlined in our recent recommendations to revise PA's nursing home regulations). We acknowledge that increased staffing levels may require an increase to Medicaid reimbursement rates. It is imperative that the change in staffing requirement be adopted first and that any increase in reimbursement, which follows, be crafted to directly support the increase in staffing levels.

**Medicaid Reimbursement Recommendation #2: Create a disparities reduction incentive payment.** DHS has recently implemented program-wide equity incentive payment structures within Medical Assistance.<sup>154</sup> The state has similarly created a health enterprise zone to address disparities in North Philadelphia.<sup>155</sup> None of these are specifically designed to address disparities in nursing home care. We urge DHS to create a Medicaid Disparities Reduction Incentive Payment available to nursing homes that reduce disparities over their own prior performance on select metrics. The metrics should be tied to measurable outcomes such as infection reduction, reduction in occurrence of pressure ulcers, etc.

**Medicaid Reimbursement Recommendation #3: Create short-term payments to increase staffing and improve quality for nursing homes that are disproportionately serving Black and Hispanic residents.** With documented negative outcomes arising from the low staffing levels in facilities that serve a disproportionate number of Black and Hispanic people, an immediate short-term payment should be created to directly support increased staffing levels until such time as Medicaid rates are adjusted to support improved staffing. These additional payments must be structured so that they can only be used for increasing direct care staffing and in a way that pays livable wages to reduce unnecessary staff turnover. Likewise for overall quality improvements, aside from increasing staffing levels, an immediate short-term payment should be created to directly support increasing quality until such time as Medicaid rates are adjusted to support improved quality performance. DHS would determine what qualifies as a disproportionate number of Black and/or Hispanic residents for purposes of qualifying for this short-term payment.

**Medicaid Reimbursement Recommendation #4: Evaluate the adequacy of the Medicaid Day-One Payment and whether it is sufficient to disrupt disparities in admissions processes and, ultimately, in nursing home care.** Pennsylvania has a Medicaid Day-One Payment that provides enhanced reimbursement to nursing homes that accept residents who are eligible for Medicaid on their first day of admission. This payment should be evaluated to determine whether it needs to be increased to have a meaningful impact on preventing or reducing ongoing disparities in admissions and care.

**Medicaid Reimbursement Recommendation #5: Ensure that Medicaid reimbursement rates are set in a way that accounts for acuity and comorbidities with sensitivity to ensuring that racial and ethnic disparities are not unintentionally exacerbated or perpetuated.** Black and Hispanic residents may be more likely to have higher acuity or increased comorbidities. If rates are not adequately adjusted for the actual patient population and don't properly account for the increased acuity and comorbidities, reimbursement may cause continued disparities.

**Medicaid Reimbursement Recommendation #6: Consider reinstating an updated version of a disproportionate share (DSH) payment specifically to address racial and ethnic disparities.** The DSH program provided an enhanced payment for facilities with a disproportionate share of Medicaid residents. The Department of Human Services should consider whether a DSH-type payment for facilities with a disproportionate share of Black and/or Hispanic residents is an appropriate approach for addressing and mitigating racial and ethnic disparities in nursing home care.

**Medicaid Reimbursement Recommendation #7: Institute a Value-Based Payment (VBP) system to support continued high-quality, equitable care, once that is achieved.** VBP ties payment to quality of care. PA has implemented a maternity health VBP payment bundle in the HealthChoices program.<sup>156</sup> Unlike other recommendations in this section that could be implemented simultaneously, this one is a second-round recommendation that needs to be implemented after the state has had success in achieving good quality care in all facilities. After facilities that serve a disproportionately high number of Black and/or Hispanic residents have been supported to provide an improved level of quality of care and positioned to maintain a high quality of care, DHS should institute a VBP system to support high-quality care and to continue to reward health equity in nursing home care.

**Medicaid Reimbursement Recommendation #8: Mandate transparency in Medicaid reimbursement and spending.** DHS should require full transparency in how nursing homes spend their Medicaid payments. This will address concerns about funds being siphoned away from care to create profits for the nursing home or related entities. We recommend a requirement that nursing homes make complete disclosure through auditable, consolidated financial statements of all monies transferred to related parties and the salaries, compensation, and distributions made to their owners, officers, directors and investors, and all loans made to and from any nursing home, and the repayment thereof.<sup>157</sup>

**Medicaid Reimbursement Recommendation #9: Adjust Medicaid reimbursement rates to provide single rooms and prevent overcrowding in nursing homes.** With recent studies demonstrating that shared rooms contributed to bad COVID-19 outcomes, and in support of respecting the human dignity of low-income Pennsylvanians, the state should consider increasing Medicaid reimbursement and/or providing a one-time capita expense to provide single rooms. Special funding, perhaps through federal COVID relief, should be considered to help facilities retrofit and/or convert to single occupancy rooms.

### **Medicaid Reimbursement Recommendation #10: Link a portion of Medicaid payment to complete and continuous data, financial, and quality reporting.**

We strongly recommend connecting at least a portion of Medicaid payment to the obligations (per our recommendations throughout this paper) to report comprehensive data, to provide auditable, consolidated financial statements, and to complete essential quality reporting.

## **H. CHC-HMO Medicaid Managed Care Recommendations to Address Racial and Ethnic Disparities in Pennsylvania's Nursing Homes**

As stated above, most Pennsylvania nursing home residents covered by Medicaid are members of a Community HealthChoices (CHC) managed care organization. Through written agreements, DHS sets requirements for the CHC-MCOs. One such requirement is that all CHC-MCOs must meet National Council on Quality Assurance Distinction in Multicultural Health Care certification requirements, and we applaud DHS for requiring this.<sup>158</sup> In addition to the CHC-MCO related changes outlined in the Medicaid Reimbursement Recommendations above, it is imperative that DHS assign CHC-MCOs responsibility for ensuring that their members receive quality care, free from racial disparities, from the nursing homes with which they contract.

**CHC-MCO/Medicaid Managed Care Recommendation #1: Detail CHC-MCOs' accountability for disparities in nursing home care.** CHC-MCO contracts and policies should be revised and adjusted to reflect both a commitment to ensuring nursing home quality and a service coordination obligation to ensure that nursing homes are meeting the needs of residents as outlined in their person-centered service plans. Low-quality care should not be tolerated, and CHC-MCOs should intervene to ensure that their Participants who are nursing home residents are provided with person-centered quality care. Medicaid Managed Care plans should be required to report on discrete metrics that will facilitate quality oversight, as well as tracking and helping to prevent disparities in quality and care.

**CHC-MCO/Medicaid Managed Care Recommendation #2: Require each CHC-MCO to adopt a Quality Improvement Plan (QIP) specifically related to addressing and mitigating racial and ethnic disparities in nursing home care.** CHC-MCOs are required to complete Quality Improvement Plans as determined or approved by the Department of Human Services. We recommend that the Department of Human Services require CHC-MCOs to complete at least one QIP specifically related to racial and ethnic disparities in nursing home care.

**CHC-MCO/Medicaid Managed Care Recommendation #3: CHC-MCO service coordinators should make monthly in-person visits to participants who reside in nursing homes.** CHC-MCOs are responsible for the nature, scope, and quality of care being provided to their members who reside in nursing homes. If there are racial disparities in the quality of care and the outcomes experienced by Black or Hispanic residents, CHC-MCOs must actively participate in disrupting these disparities.

Distressingly, CHC-MCO service coordinators did not enter nursing homes to see their members during the COVID-19 pandemic until very recently. The monitoring of the provision or quality of care occurred through paper review and/or conversations with staff. Only by placing eyes on their members and on the facilities in which they reside can the CHC-MCOs' accountability be effectuated.

**CHC-MCO/Medicaid Managed Care Recommendation #4: CHC-MCOs should be required to send out contracted, additional nursing staff to support facility staff and supplement the services provided by the facility for any members who reside in one-star or Special Focus Facilities.** CHC-MCOs have a role to play in helping their members avoid admission to poor-quality nursing homes. They also have a role to play in contracting with high-quality nursing homes and helping improve the quality of the nursing homes with which they contract. But where their members are residing in a 1-star rated or Special Focus Facility, they have an obligation to ensure that those residents receive the necessary services to meet their needs. We believe that CHC-MCOs should be required to send out contracted, additional staff to support residents in these facilities and supplement the care the facility is providing. This requirement will encourage CHC-MCOs to take seriously and to assume accountability for the quality of nursing home care their Participants are receiving. Since Black and Hispanic residents disproportionately reside in poorer-quality nursing homes, this requirement is essential to ameliorate racial disparities and inequities in quality of care.

**CHC-MCO/Medicaid Managed Care Recommendation #5: Require CHC-MCOs to center equity in their role in the nursing homes admissions process.** It is time for the CHC-MCOs to start assessing nursing home quality and requiring quality compliance of the nursing homes in their networks. Accordingly, service coordinators who may be involved in nursing home admissions/placement decisions must be trained and required to provide bias-free, quality-based guidance on evaluating and choosing a nursing home for Participants who require and choose to receive care in that setting, after being counselled on all options.

## **I. Education and Training Recommendations to Address Racial and Ethnic Disparities in Pennsylvania's Nursing Homes**

**Education and Training Recommendation #1: Broadly require a state-developed civil rights and implicit bias training for surveyors, discharge planners, nursing home admissions personnel, and nursing home administrative personnel.** The Governor's cabinet level Office of Civil Rights Enforcement and Racial Equity that we recommend in Systemic Recommendation #1 must work with DOH/DHS/PDA to develop and require civil rights and implicit bias training for:

1. Hospital Discharge Planners and Administrators
2. Nursing home admissions staff and Administrators
3. CHC-MCO service coordinators
4. DOH surveyors and Supervisors

#### 5. Long-Term Care Ombudsman Program Staff/Volunteers

DOH and DHS must commit to having these individuals understand the role of racism in racial health disparities in nursing home care and should sponsor and encourage diversity, anti-bias and anti-racism training developed by DOH/DHS/PDA with input from the community.

**Education and Training Recommendation #2: Revise Pennsylvania’s nursing home regulations to increase the minimum hours of training for all staff, and staff training must include mandatory training topics that help address racial and ethnic disparities in nursing home treatment and care.** We have previously recommended to the Department that direct care training hours be increased to 120 for initial training to ensure overall delivery of high-quality care. We do not support the grandfathering, without adequate training, of the 4,000 plus temporary nursing aides who were permitted to begin independent work during COVID-19 with only 8 hours of training due to a federal waiver of the required minimum of 75 hours. Adopting standards that ensure that staff are well and completely trained to address care needs, identify pressure ulcers early, manage pain, prevent dehydration, undertake proper infection control, be culturally competent to provide care and more will ensure better outcomes for Black and Hispanic residents. Administrative and direct care staff must be fully trained to identify and report disparities in care and to help achieve health equity.

**Education and Training Recommendation #3: Make educational resources, training materials, and templates available to facilitate broad access to helpful tools and information to help address racial and ethnic disparities.** DOH/DHS should provide hospitals and nursing homes with training and educational materials to facilitate provider understanding of bias, racial and ethnic disparities, data collection requirements, and more.

## **J. Other Recommendations to Address Racial and Ethnic Disparities in Pennsylvania’s Personal Care Homes (PCH) and Assisted Living Residences (ALR)**

**Related Provider Recommendation: Address racial and ethnic disparities in other sectors of the delivery system to help address racial and ethnic disparities in nursing home care.** The state should holistically consider all of the intersecting and overlapping health care providers and systems and how these can be leveraged to address and mitigate racial and ethnic disparities in nursing home care. For example, DOH is presently revising its hospital regulations. This presents an opportunity to outline requirements for hospital discharge processes and patient education to address and mitigate the perpetuation of racial and ethnic inequities in nursing home admissions and care.

**Personal Care Home and Assisted Living Residence Recommendation: Explore breadth and scope of racial and ethnic disparities in PCH and ALR settings and take action to address.** DHS should study whether there are racial and ethnic disparities in the care within personal care homes and assisted living residences, and whether policies such as room size or the low SSI personal care home supplement that has not been increased in years create disparities. National studies have not focused as much on these settings as they have on nursing homes. Some research shows racial and ethnic disparities in the likelihood of hospitalization for assisted living residents of color and another study shows increased risk of COVID-19 infection and

death for Black assisted living residents.<sup>159</sup> Data should be collected and evaluated, and action should be taken to identify, prevent and remediate racial disparities in care in all LTSS settings.

**Rebalancing Recommendation to Address Racial and Ethnic Disparities: Review the reliance on congregate settings and continue rebalancing efforts with an eye towards addressing racial and ethnic disparities.** DHS should review the use of nursing homes and other congregate settings to reduce unnecessary use and consider policy changes that allow people to receive the supports or treatment they need at home. DHS should center equity in its efforts to increase the availability of home and community-based alternatives to nursing home care.

**Community Engagement Recommendation to Address Racial and Ethnic Disparities in Pennsylvania’s Nursing Homes: Engage community-based organizations, experts, and stakeholder groups in outreach around strategies to address disparities.** Our recommendations are a starting point. We urge the state to develop and implement a thoughtful and strategic plan for meaningfully engaging with individuals and groups (including residents, advocates, providers, academic, and others) that are trusted by and members of Black, Hispanic and other communities of color.

**Medicare Managed Care Recommendation: Revise the state’s MIPPA Agreement with Medicare Advantage D-SNPs to address and mitigate racial and ethnic disparities in nursing home care.** A large number of Medicaid recipients participate in Medicare Dual Eligible Special Needs Plans (D-SNP). As each D-SNP is required by federal law to have a contract with the state Medicaid program, DHS sets requirements for the D-SNPs operating in Pennsylvania.<sup>160</sup> These requirements are set in what is called a MIPPA Agreement, named for the Medicare Improvements for Patients and Providers Act of 2008 that requires the agreement. Revisions to the state’s MIPPA Agreement should require D-SNPs to conduct diversity and inclusivity training, to implement non-discrimination policies related to hospital discharge and nursing home admission, and to require education about nursing home quality for patients before discharge.

**Vaccine Distribution Recommendations to Address Racial and Ethnic Disparities in Pennsylvania’s Nursing Homes.** In March 2021, our coalition submitted a [comprehensive set of vaccine distribution recommendations \(covering all long-term care facilities\) to the Departments of Health, Aging, and Human Services](#). These recommendations centered health equity. The state needs to ensure that nursing homes are continuing to offer/provide vaccines and to encourage staff to be vaccinated. The state should also evaluate lessons learned and develop plans for centering equity and ensuring quick implementation should booster shots need to be distributed or should another pandemic strike.

## CONCLUSION

Immediate action is imperative to address and eradicate long-standing racial and ethnic disparities in nursing home care in Pennsylvania. We have articulated dozens of recommendations the state can implement to begin this process.

These disparities were not created by COVID-19, but they did make COVID-19 outcomes measurably more deadly for Black and Hispanic nursing home residents than for White residents. COVID-19 laid these disparities bare, unearthed them, and raised them to the attention of the public as never before. Pennsylvania must act and it must act now. **To do nothing in the face of this injustice is immoral and unacceptable.**

## ENDNOTES

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- <sup>1</sup> King S, Jacobs J, Near birthplace of Martin Luther King Jr., a predominantly Black nursing home tries to heal after outbreak, *The Washington Post*, September 9, 2020, <https://www.washingtonpost.com/business/2020/09/09/black-nursing-homes-coronavirus/>
- <sup>2</sup> Pennsylvania COVID-19 Response Task Force: Health Disparity Policy Recommendation Report, July 22, 2020, <https://www.governor.pa.gov/wp-content/uploads/2020/08/20200813-COVID-19-Health-Disparity-Report.pdf>
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health care and continues to lecture widely on this topic.” <https://drexel.edu/dornsife/academics/faculty/David-Barton-Smith/>

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<sup>134</sup> A few of these have already been submitted to the Departments of Health, Aging, and Human Services or shared with legislators over the past several months as part of ongoing stakeholder dialogue.

<sup>135</sup> DHS Racial Equity Report, *supra* note 3. “The RAHCs will use state and community-based health assessments, regional social determinants of health needs assessments, as well as any other specific health indicators, as the basis to both advance population health planning and establish a long-term strategy for public health in the region. This strategy will have a special focus on areas of high burden of disease and on demographic groups impacted by health disparities, focused on addressing the root causes of the disparities. With all these organizations working together in regions across the commonwealth, we believe we can make meaningful headway in the elimination of health disparities.”

<sup>136</sup> <https://covidtracking.com/data/state/pennsylvania/assessment#race-ethnicity>

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<sup>138</sup> We believe the state should expand its data collection to capture sexual orientation and gender identity (SOGI) data, however, this is not the focus of this set of LTC Facility/COVID/Data recommendations.

<sup>139</sup> DHS Racial Equity Report, *supra* note 3

<sup>140</sup> We must further disaggregate Asian health data because disaggregated analyses typically identified differences in access to care for Asian American subgroups. State policies to collect disaggregated health data for Asian Americans may reveal heterogeneity in experiences of care and inform specific policies to reduce disparities in access to care. Nguyen KH, Trivedi AN, Asian American Access to Care in the Affordable Care Act Era: Findings from a Population-Based Survey in California. *Journal of General Internal Medicine*, 2019, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6848322/>. Additionally, this 2017 toolkit from the National Asian Pacific Center on Aging strongly supports the argument for disaggregating Asian ethnic disparities. A Toolkit for Outreach and Education For Asian American and Pacific Islander Medicare Beneficiaries, March 2017, <https://www.napca.org/wp-content/uploads/2017/10/AAPI-Toolkit-FINAL.pdf>. Another very helpful primer on the need to disaggregate Asian ethnic disparities data can be found at: <https://equitablegrowth.org/how-data-disaggregation-matters-for-asian-americans-and-pacific-islanders/>.

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<sup>142</sup> STATE USES OF HOSPITAL DISCHARGE DATABASES TO REDUCE RACIAL AND ETHNIC DISPARITIES, National Academy of State Health Programs, September 9, 2010, <https://www.nashp.org/wp-content/uploads/sites/default/files/fxtc58cwlxtvqbs%5b1%5d.pdf>

<sup>143</sup> Access Monitoring Review Plans, <https://www.medicaid.gov/medicaid/access-care/access-monitoring-review-plans/index.html> Federal regulations at 42 CFR 447.203 and 447.204, implementing section 1902(a)(30)(A) of the Social Security Act (the Act), describe procedures for states and territories to follow in order to document that Medicaid payment rates are sufficient to enlist enough providers so that care and services are available under the state plan at least to the extent that such care and services are available to the general population in the geographic area. Through Access Monitoring Review Plans (AMRPs), states are required to analyze data and supporting information to reach conclusions on sufficient access for covered services provided under fee-for-service. Every three years, states must conduct the analysis for: primary care services (including those provided by a physician, FQHC, clinic, or dental care); physician specialist services; behavioral health services, including mental health and substance use disorder; pre- and post-natal obstetric services, including labor and delivery; and home health services. States are required to include additional services within the AMRPs when proposing to reduce rates or restructure payments in ways that may harm access to care and describe procedures to monitor access over three years once the reductions are approved. The AMRPs, and subsequent additions to the AMRPs, are developed in consultation with a state's Medical Advisory Committee and subject to a 30 day public comment period prior to submission to the Centers for Medicare & Medicaid Services (CMS).

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- <sup>146</sup> Connecticut Nursing Home Waiting Lists Policy, August 16, 2010, <https://www.cga.ct.gov/2010/rpt/2010-R-0350.htm>; N.J. Admin. Code § 8:39-5.2, <https://casetext.com/regulation/new-jersey-administrative-code/title-8-health/chapter-39-standards-for-licensure-of-long-term-care-facilities/subchapter-5-mandatory-access-to-care/section-839-52-admissions>
- <sup>147</sup> 2020 Minnesota Statutes: 256R.06 PRIVATE PAY RESIDENTS; REQUIRED PRACTICES, <https://www.revisor.mn.gov/statutes/cite/256R.06>
- <sup>148</sup> NJ Assembly No. 4482 - P.L. 2020, CHAPTER 89 [https://legiscan.com/NJ/text/A4482/id/2212711/New\\_Jersey-2020-A4482-Chaptered.html](https://legiscan.com/NJ/text/A4482/id/2212711/New_Jersey-2020-A4482-Chaptered.html)
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- <sup>150</sup> Advancing Health Equity in Medicaid: Emerging Value-Based Payment Innovations, The Center for Health Care Strategies, March 26, 2019, <https://www.chcs.org/advancing-health-equity-in-medicaid-emerging-value-based-payment-innovations/>
- <sup>151</sup> Id. States like Colorado's "[Primary Care Alternative Payment Model](#) rewards primary care providers based on demonstrated improvement on selected performance measures relative to their own historical baseline rather than against performance of other primary care providers during the same period."
- <sup>152</sup> Rivera-Hernandez M, Rahman M, Mukamel DB, Mor V, Trivedi AN, *supra* note 33
- <sup>153</sup> Sloane PD, Yearby R, Konetzka RT, Li Y, Espinoza R, Zimmerman S, Addressing Systemic Racism in Nursing Homes: A Time for Action, JAMDA 22 (2021) at [https://www.jamda.com/article/S1525-8610\(21\)00243-7/fulltext](https://www.jamda.com/article/S1525-8610(21)00243-7/fulltext);
- <sup>154</sup> DHS Racial Equity Report, *supra* note 3
- <sup>155</sup> Id.
- <sup>156</sup> Id.
- <sup>157</sup> New York State Office of the Attorney General Letitia James: Nursing Home Response to COVID-19 Pandemic, January 30, 2021, <https://ag.ny.gov/sites/default/files/2021-nursinghomesreport.pdf>
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- <sup>160</sup> Pennsylvania Department of Human Services Medicare Improvements for Patients and Providers Act Contract, <https://www.dhs.pa.gov/HealthChoices/HC-Services/Documents/2020%20MIPPA%20Contract.pdf>