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McKnight's LONG-TERM CARE NEWS

Reports of COVID-19 False Positives Not Exceeding Expectations: HHS Official

According to HHS Assistant Secretary Admiral Brett Giroir, the rate of false positive results from COVID testing thus far is to be expected. The testing procedures for the COVID virus are so new that we have to expect some errors but as time goes by, the results should be more accurate.

Written by: Danielle Brown

9/28/2020

Reports of false positive results from COVID-19 antigen testing devices are not in "excess of expectation," according to a top official at the Department of Health and Human Services.

"We know with every test, including molecular tests and PCR tests, that there are false positives," HHS Assistant Secretary Admiral Brett Giroir told reporters Friday.

"The relative rate of false positives is going to depend on the population you test and the overall prevalence in that population, so we expect false positives on any test," he added.

Giroir's comments come after reports of the COVID-19 point-of-care testing equipment supplied by the federal government to nursing homes producing false positive reports. A joint survey by the American Health Care Association and LeadingAge revealed that about 20% to 25% of skilled nursing facilities received false positive results from their equipment.

Federal officials, along with Becton Dickson Veritor and Quidel, said they were investigating.

Giroir explained that point-of-care tests are going to be "relatively less sensitive" and "pretty specific" than others tests. He added the expectation is that there won't be many significant false positives.

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"I want everybody to understand that false positives and false negatives are true with any test. We have to understand how the test can be employed, how it should be employed, how to interpret the results and especially with the prevalence of the population, and that's really where we are," he explained.

"This is just part of testing no matter what kind of test you're going to have that," he added.

The federal government completed delivery of point-of-care testing devices to all eligible nursing homes in mid-September, Giroir reported Friday. Providers received a total of 13,985 instruments and more than 4.9 million tests.

McKnight's LONG-TERM CARE NEWS

Matros Gives 'Fantastic' CMS a B+ for Pandemic Response

With the response to the current pandemic, there have been varying viewpoints and levels of encouragement. Taking everything into consideration, Sabra Health Care REIT top executive Rick Matros believes that the nation should be looking at the CMS's contribution in a mostly positive light.

Written by: James M. Berklan

9/25/2020

In much of public policy discourse today, false dichotomies abound. One is either for or against, in the right or in the wrong. No middle ground.

Not so for Sabra Health Care REIT top executive Rick Matros. He at least sees glimmers of "grays" while others may see blacks and whites.

And while the coronavirus undeniably has ravaged the healthcare sector and much of the U.S. economy, Matros also sees bright spots here and there.

"I think 'cautious optimism' is fair only because of how well operators have adjusted, given all the barriers they've had," Matros told me Thursday. "Once those barriers are removed, like testing … I think cautious optimism is a fair way to put it."

It sure beats a typical skeptical outlook many operators have been conditioned to have.

Get Matros going, in fact, and he winds up finding more silver linings than even he might expect.

Other reasons for optimism? Geographic areas that have had big spikes in the greater community lately haven't translated into major outbreaks in facilities. Cases have been more easily isolated. "That's one thing that's been heartening," he said.

The other?

"The other big positive is CMS has been fantastic," he offered. Between it and the CARES Act "and all the assistance nursing homes have been given lately … they've basically stepped up. [CMS Administrator] Seema Verma has been great."

Numerous sources have noted that Verma has been in frequent contact with Mark Parkinson, the president and CEO of the American Health Care Association.

"They've really worked well together," said Matros, repeating an observation we've heard more than once. "There was good dialogue even before the pandemic."

They had to have had it. As the saying goes, you can't really build relationships during a crisis. The making-nice behind the scenes dates back several years actually, certainly into the build-up to the Patient Driven Payment Model (PDPM).

"You want to give a lot of credit to Seema Verma, but a lot of collaboration on reimbursement system proceed her," Matros noted, again turning to Parkinson's outsized effects on events. "You have to give credit to Mark Parkinson because we've never had an executive like him before, ever. He's just really, really been proactive, creating a relationship with a dialogue."

One theory goes that CMS partly softened after its disastrous encounter with RUGS-IV, which resulted in the federal government having to "claw back" billions of dollars from providers after just six months. And even then outcomes still didn't move the needle enough.

At least PDPM was in play long enough before the pandemic to start changing caregiving dynamics. True, group and concurrent therapy — planned to be bright spots in providers' PDPM machinery — have been put on hold during the public health emergency. But they will eventually come back, as will more talk about special needs plans and other alternative payment models that were starting to draw broader interest.

Overall, providers should be grateful for having had a sip of life with PDPM. It is, after all, one of CMS' bigger successes. Matros agrees but doesn't wear rose-colored glasses when giving grades. He would bestow high marks for CMS' prep work on PDPM, rating it far better than RUGs for pandemic conditions. He also pointed to other actions, such as CMS's recent withdrawal of its controversial proposed Medicaid Fiscal Accountability Rule (MFAR).

"You hardly give anybody an 'A' because there's always room for improvement," he explained. "On a scale of 1 to 10, I give 9's. I'll give CMS a B-plus on this."

Both sides have worked for it. About six weeks ago, Verma mentioned into an open microphone that the industry has been a "good partner." That might be tough to swallow for some who have felt the sting of added CMS regulatory threats lately. And many providers hope that CMS will recognize the gravitas of the situation and focus collaboratively on, say, infection control practices rather than writing up F-tags for dustballs in the corners.

But … the CMS administrator *had* paid a pretty broad compliment to providers.

“That hasn’t happened historically,” Matros pointed out, “so, yeah, I think they’ve been really great.”

Now if only that sentiment can hold for about, oh, five or 10 years. That’s one extreme providers might be able to live with.

Skilled Nursing News

Genesis, Signature Raise ‘Going Concern’ Doubts with Omega, Prompting $140M Write-Down

The loss of occupancy in skilled facilities due to the COVID pandemic is a huge issue for just about everyone across the country. Genesis Healthcare Investors and Signature HealthCARE are sharing some of their mounting concerns with the rest of the industry.

Written by: Alex Spanko

9/24/2020

Omega Healthcare Investors (NYSE: OHI) on Thursday announced that it will begin recording revenues associated with tenants Genesis HealthCare (NYSE: GEN) and Agemo Holdings LLC — the legal name for its portfolio of buildings operated by Signature HealthCARE — on a cash basis, citing concerns about the nursing home operators’ future.

As a result, the real estate investment trust (REIT) expects a write-down of $140 million in straight-line receivables and lease inducements during the fourth quarter of 2020, or $65 million for Genesis and $75 million for Agemo, respectively. Omega intends to also record an impairment of $28 million, which represents an non-collateralized portion of a loan to Agemo.

The two companies in August and September “informed the Company of doubt regarding their ability to continue as a going concern,” according to the REIT.

As part of a 2018 restructuring, Signature consolidated its leases with Omega into Agemo, a holding company, alongside separate entities for facilities owned by its two other primary landlords.

“Throughout this pandemic, we have continued to collect all contractual rents due from both Genesis and Agemo,” Omega CEO Taylor Pickett said in a statement. “Our conservative accounting treatment going forward for these operators is triggered by their pandemic-influenced accounting disclosures. Based on our continuing dialogue with both companies, we are hopeful that ongoing government support and a return to pre-pandemic resident occupancies will provide them with the liquidity needed to meet all of their future Omega financial obligations.”

The Hunt Valley, MD-based REIT framed the move as advance warning of a significant revenue hit ahead of public earnings disclosures.

"We expect our reported revenues during the third quarter will be meaningfully lower than in the second quarter, even though our cash rents, funds available for distribution and cash flows will not be impacted by this change," chief financial officer Bob Stephenson said. "We are disclosing this revenue recognition change today so investors can better understand the accounting impact of this change prior to the release of our third quarter earnings next month."

Executives from both Genesis and Signature have sounded alarms about their futures in the wake of the COVID-19 pandemic, which has brought significant expense increases and revenue reductions to operators across the sector.

Genesis in August announced "substantial doubt" about its ability to survive the subsequent 12 months, even if the federal government provides more than the $228 million in aid that Genesis had received through various stimulus programs.

"Without giving effect to the prospect, timing and adequacy of future governmental funding support and other mitigating plans, many of which are beyond the Company's control, it is unlikely that the Company will be able to generate sufficient cash flows to meet its required financial obligations, including its rent obligations, its debt service obligations and other obligations due to third parties," the Kennett Square, Pa.-based operator announced in its second-quarter earnings release.

Genesis CEO George Hager specifically pointed to the dual effects of occupancy drops and expense spikes associated with early COVID-19 outbreaks in the company's home territory of the Northeast.

"Financially speaking, the key performance drivers in this business have always been and will continue to be overall occupancy levels and the ability to effectively control labor costs," Hager said on the company's second-quarter earnings call. "Even a 1% change in occupancy or labor costs in this business is a big deal. All other drivers, quite frankly, pale in comparison."

The Louisville, Ky.-based Signature laid off 100 corporate employees in June, citing a lack of Medicaid assistance.

"We are at a point where difficult decisions have to be made on how to survive," CEO Joseph Steier said in a statement provided to SNN. "We know that COVID-19 will not be over in our business any time soon, and even as it may be overcome in the future, our sector and how we do business will never be the same again."

Later that month, Steier told Louisville Business First that the company was spending $5 million per week on testing, personal protective equipment, and hazard pay, indicating that operators across the sector would need to undergo "restructuring" in order to weather the storm.

"We think we did it right, that we cut deep enough to withstand the next 12 to 18 months as we rebuild," Steier told the publication. "We feel good, but there's no guarantee. We all think we will survive long-term. But it's our going to be our toughest period in our company history."

Omega COO Dan Booth expressed optimism that both operators could pull out of the COVID-related stress, as well as hope that the government will continue to financially support the space.

"Our portfolios with both Genesis and Agemo were performing well prior to the pandemic as both operators were benefitting from a favorable rate environment and moderately increased occupancy, and we anticipate they will perform well once the pandemic is behind us," Booth said in a statement. "To date, we believe the financial support provided by the federal and state governments has meaningfully assisted these two operators, as well as all of our operators, in offsetting lost revenues and incremental costs related to COVID-19."

Skilled Nursing News

LTC Pharmacies Crucial for Nursing Home Vaccine Distribution, But Financial and Logistical Hurdles Loom

The hopes of pretty much everyone in the country now rest on the distribution of a safe and effective COVID-19 vaccine, and for nursing home residents and their families, the stakes are even higher: With significantly elevated risk of fatalities from the novel coronavirus among the frail and elderly, the race for a vaccine is a life-or-death proposition for millions of Americans and their loved ones.

Written by: Alex Spanko

9/23/2020

Long-term care pharmacies, which will likely serve as the primary vector for coronavirus vaccine distribution in the setting, haven't been immune to the financial turmoil that the rest of the health care industry has weathered — and a top advocate for the sector says the government needs to provide significantly more relief for LTC pharmacies if it expects a smooth vaccine rollout.

"We need the resources in order to be capable of handling the vaccines," Alan Rosenbloom, president and CEO of the Senior Care Pharmacy Coalition, said during an interview conducted earlier this month.

With so much on the line, Rosenbloom expects the challenges of safely sending out millions of COVID-19 vaccines will be significantly greater than LTC pharmacies have faced in the past, with specialized storage requirements and strict rules around tracking exactly who has received the vaccine, and in how many doses.

SNN called Rosenbloom to learn more about logistics of vaccine distribution, and what he believes Washington must do in order to meet the demand of long-term care facilities and their staffs.

Where are we right now — what have some of the biggest challenges been for LTC pharmacies, and what problems still remain, in your view?

In the first month to six weeks after the national emergency was declared, most of the focus for long-term care pharmacies was on regulatory relief — primarily regulatory relief from certain things that CMS allows under the Medicare Part D portion of the Medicare program, which is the most significant payer for patients who get medications from long-term care pharmacies.

The Part D program is basically an insurance model: HHS contracts with plans, plans contract with pharmacy benefit managers, and the pharmacies provide the drugs to patients and facilities. Through the PBM, they bill the patient's insurer under Part D. There are a variety of [things] that are allowed under the regulation, but they often really translate into the way that PBMs manage their spend, essentially — things like prior authorization requirements before drugs can be dispensed, preventing prescriptions from being refilled too soon, those kinds of administrative problems.

Normally they may be headaches for long-term care pharmacies, but they aren't real obstacles to getting medications to patients in a timely way. At the outset of the pandemic, of course, they became obstacles, so we devoted a lot of attention to trying to get some relief from CMS, which they provided probably around the end of April.

At about that point, we started to hear from the long term-care pharmacy community that the financial impact that was hitting facilities was also hitting pharmacies. What's happened to pharmacies in terms of revenue loss pretty much mirrors what happened to both nursing homes and assisted living facilities in terms of patient loss.

That fits into two timetables. The first, which was pretty immediate, was the short-stay rehab population — the Medicare Part A and Medicare Part C patient populations — because those patients essentially disappeared from nursing homes for a while. So, too, did their need for medications, and those patients take about 13 prescription drugs a day.

Over the course weeks after the pandemic — even until now, depending on the market — there was an almost immediate 25% loss of revenues for that percentage of patients, and that's pretty much still at around 20% across the country. Obviously, some markets have rebounded better than others. Some are worse than that, some are better than that. But overall, that kind of decline in revenues is continuing.

The second phase of revenue loss pertains to the longer-stay patients, and this would be the Medicaid-based population in nursing homes, and essentially the entire population in the assisted living world, which primarily is paid for by private pay or private insurance — although the drugs continue to be paid for primarily by Part D for the long-stay population, regardless of where people reside.

There's about a 4% attrition rate, on average [under normal circumstances], across both kinds of settings for that patient population — people die, people are transferred, whether it be to the hospital or back home, those kinds of things.

Not surprisingly, given all of the uncertainties around COVID, there wasn't the usual repopulation of new patients coming in. That 4%-a-month attrition has gotten to somewhere between 16% and 20%. Again, on a market-by-market basis, it may differ, but there really hasn't been the significant bounce-back yet. I think there are some open questions about what will happen post-pandemic with respect to where those patients might end up.

That's translated to a significant economic hit, coupled with probably about a 10% increase in costs to manage the pandemic. It ranges from things that everybody else in the health care space and, frankly, in the business community had to face: PPE, social distancing, hard costs and soft costs.

But in the long-term care pharmacy context, it also changed the nature of deliveries. The handoff at facilities became much more complicated and time-consuming, which of course translates into costs — entirely appropriate to protect patients and employees at facilities, but it did add both time and cost.

Generally speaking, the drugs for the patients in the facility are delivered at least once a day, sometimes more, and they're generally delivered in hard plastic totes. You have prescriptions for 100 patients, and they're delivered in these totes, which make it easy to take the drugs out of the totes, and put them into the med carts for administration.

However, when you can't reuse the totes, suddenly you've got a new expense, because those totes are kind of indestructible — you buy them once every 10 years, as opposed to buying for every individual day, one-day use. Those are the kinds of things that increase the expenses, and that's a pretty bleak economic picture.

On average, how would you quantify the financial hit?

The revenue hit's been around 20%, plus about a 10% increase in cost - the overall bottom-line is about 30%.

What about the various CARES Act relief levers?

LTC pharmacies have been eligible to apply for some of the general relief that has been available. But HHS in June amended the frequently asked questions that are used to interpret what the various distributions really mean, and how you apply for things. They came to the conclusion that prescription sales are not patient care.

Why is this important? It's important because the CARES Act, that $175 billion fund, says that to be eligible, providers have to provide diagnosis, testing, or care for patients with or who are suspected of having COVID-19. That isn't a long-term care pharmacy decision. Frankly, it's a pharmacy decision driven by perceptions about retail pharmacy. Pharmacies don't provide diagnosis for disease; therefore, they don't provide diagnosis for patients with COVID. They don't generally test for disease. Even though subsequently, there's been some capacity for pharmacies to do testing, it really isn't relevant to a pre-pandemic, during-pandemic kind of world, which is the intent of the CARES Act.

The department came to the conclusion, rightly or wrongly, that the stuff that a retail pharmacy does not include patient care. Now, we're not commenting on whether that's a reasonable interpretation or not, but what we do know is that long-term care pharmacies are required by the Medicare and Medicaid statutes to provide patient care. It's clear in statute, it's clear in the regulations, it's clear in the sub-regulatory guidance. Even the State Operations Manual for facilities specifically says that the pharmacy services, that are part of the requirements of participation, are, quote, integral, close quote to patient care.

So our argument has been: We understand you have this limitation, but it doesn't take into account the reality of the long-term care pharmacy world. But as of right now, that interpretation is still applicable. The pharmacies that have applied for relief have gotten far less than the goal that HHS has set. This is true for nursing homes, and others who've applied for money under general distributions, not just targeted distributions — that their goal is to try to give providers roughly 2% of their annual patient-care revenues to offset the economic consequences of COVID.

Generally speaking, that's what hospitals got, doctors got, others have got — separate and apart from any targeted distributions, like the $4.9 billion in addition that nursing homes got. Nursing homes were able to get money under the general distributions to the extent that an individual home qualified. They've also been able to get an allocated amount from that $4.9 billion, and now there's going to be a dedicated, separate distribution to be announced — in terms of the details — for assisted living facilities that only accept private-pay patients.

For long-term care pharmacies, they largely — not entirely, but largely — were eligible for distributions through the general distribution so far, but their relief was limited such that it is well below the 2% goal because of this prescription sales limitation.

What kind of support do you believe LTC pharmacies need to continue smooth operations during the pandemic?

Let me start with this. It's not necessarily what we need, but another dimension to the set of issues. It starts with the business partners, the nursing homes, because the nursing homes make payments directly for Part A and Part C patients — just for Part A, in some degree Part C, because the plans or the Medicare program, respectively, pay a kind of combined payment to the facilities, which include pharmacy services.

What ends up happening, of course, when a sector is significantly stressed economically, is that the time it takes to collect lengthens, and the risk of bad debt goes up. That's par for the course, whenever there's a significant negative economic effect — in any business, really, but that includes long-term care.

Having said that, the most important thing that can happen right now is for HHS to determine that because long-term care pharmacies do provide patient care, and federal law requires it, somehow there needs to be a workaround for long-term care pharmacies under this prescription sales limitation.

From our perspective, the good news is that [in early September], HHS issued a new FAQ — which doesn't change the FAQ that already exists about this limitation, but adds language that HHS continues to consider … a workaround. That was a pretty clear indication that our efforts to create, if you will, an exemption from this prescription sales limitation if you provide patient care, continues to be in play.

We know that there's going to be a phase three distribution, because the HHS has already said so publicly with respect to private-pay assisted living. It seems to me that it's quite possible there will be other elements to that next distribution.

We are really hoping that that will include long-term care pharmacies, and that is the most important thing that we could accomplish right now — especially given that as Operation Warp Speed is unfolding, the vaccine program, they are looking to long-term care pharmacies to be responsible for delivering vaccines to patients and possibly to staff, employees at long-term care facilities. Not only to deliver them, but to track them, which is likely to add substantial costs.

On the one hand, you're saying: Please take on two other responsibilities. They're urgent, and we're not sure how you're going to get paid for them. On the other hand, [you're] saying: We're not sure you deserve any financial relief for the losses that you've suffered. That, to us, is a very important dynamic. We need the resources in order to be capable of handling the vaccines.

The vaccine that seems on the fastest track to authorization, at least at this point, is the Pfizer vaccine, and the Pfizer vaccine has to be kept at a constant minus 94 degrees [Fahrenheit] — so super cold. That has very significant ramifications for the distribution chain, which includes long-term care pharmacies, in terms of costs, because there are not a lot of places that are currently equipped — including distribution centers for wholesalers, major shippers to the commercial markets like FedEx or the postal service.

It certainly extends to long-term care pharmacies. The tracking is going to be very complicated because all of the vaccines that are currently in third-stage testing in the United States are two-stage vaccines. So you can't simply send 100 doses to a nursing home [in one] box, that everybody's been administered the same drug in the same dose. They're going to require booster shots. That's going to be specific to the particular kind of vaccine.

There's a hell of a lot of patient tracking that's going to have to happen, and employee tracking is going to have to happen — and obviously, that adds costs, especially since it appears that some of the data points that will have to be collected are not things that are currently part of electronic health records in long-term care facilities.

That's the world right now. The first thing is: Get additional relief to help long-term care pharmacies in response to the pandemic and in preparation for vaccine distribution. Then the second thing is: Make sure that you are appropriately recognizing the costs that long-term care pharmacies are going to incur to get the vaccines delivered safely and effectively — particularly since, in nursing homes in particular, it is probably going to be the nursing home staff that administers the vaccine.

Generally speaking, the idea is that you pay for the drug and the administration of the drug as one lump sum to whoever is doing the administration, in this case staff at the nursing homes. You assume that all of the related

expenses, whoever's incurring them, are wrapped up in that payment, and that's not a model that's going to work here.

That's where I think the real focus ought to be right now, not only for long-term care pharmacies, but for the patients and staff at facilities.

What are some of the other hurdles you're seeing with vaccine distribution? A lot of people — from resident to their families to leaders in the industry — are really pinning all of their hopes on it.

The first problem here is that unlike the retail world, where you might be able to turn to a couple of the national chains to handle most of the vaccines in the community — that will not work in a long-term care pharmacy context. You couldn't simply go to the largest, or the handful of the largest companies and say, "You take care of it," because it's too diffuse a world, number one.

And number two, there are actual requirements imposed on which pharmacies can provide medications to people in nursing homes and other kinds of long-term care facilities. That would make it very difficult to simply pick a pharmacy company, and it would be almost impossible to pick a retail pharmacy. A Walgreens or a Rite Aid or any of those folks, it would be very difficult to simply say to them: Take care of it.

There's also the information-gathering problem, which is: How many vaccines do you need? How many patients are there? Where are they? The same set of questions for employees. How many doses does the CDC have to allocate to long-term care facilities? All of that information-gathering is very challenging. It's going to be important to figure out how we get that information assembled.

There's some efforts already ongoing, through the Operation Warp Speed effort, but there are lots of potential data obstacles there — and data problems both to get the upfront information you need to make sure that you have a smooth distribution chain, and then to track once you got the drugs distributed.

The second set of concerns is the priority. Some vaccines are apparently proving more effective in younger adults than in older adults. If you looked at the recommendations that the National Academy of Sciences, Engineering, and Medicine issued [earlier this month], they have two priority categories: Priority 1A, which is health care workers, and priority 1B, which includes older adults living in congregate settings like nursing homes.

That Pfizer drug that seems to be likely the first in the pipeline, apparently seems to be proving out more effective in younger than older adults. It may not be the vaccine of choice for people in nursing homes. However, the employees in nursing homes would be on the priority list — 1A priority, and then when another vaccine that's more effective in the older population is developed, then that's when 1B would kick in.

You're seeing these kinds of concerns reflected, but there's no guarantee that the Pfizer drug is the first drug out of the box, right? If it's not the Pfizer drug, are these standards going to have to change? What if the first one is really effective for old people, and not so great for younger people. All of those are open questions.