BRAD R. WENSTRUP, D.P.M.
CHAIRMAN

ONE HUNDRED EIGHTEENTH CONGRESS

RAUL RUIZ, M.D.
RANKING MEMBER

Congress of the United States
House of Representatives

SELECT SUBCOMMITTEE ON THE CORONAVIRUS PANDEMIC
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October 30, 2024

The Honorable Merrick B. Garland
Attorney General
Department of Justice
950 Pennsylvania Avenue, NW
Washington, D.C. 20530

Dear Attorney General Garland:

The Select Subcommittee on the Coronavirus Pandemic (Select Subcommittee) is examining the United States' response to the COVID-19 pandemic.[1] As part of this broader investigation, the Select Subcommittee is investigating how the State of New York implemented federal guidance from the U.S. Centers for Medicare and Medicaid Services and U.S. Centers for Disease Control and Prevention to protect residents in nursing homes and other long term care facilities.[2] This includes investigating the State of New York's decision to issue the March 25, 2020 New York State Department of Health (NYSDOH) directive entitled, "Advisory: Hospital Discharges and Admissions to Nursing Homes" (hereinafter "March 25 Directive"). The March 25 Directive mandated nursing homes admit or re-admit potentially COVID-19 positive patients while simultaneously prohibiting nursing homes from testing these patients before admission or re-admission.[3]

In furtherance of this investigation, the Select Subcommittee interviewed multiple witnesses regarding these topics, including their knowledge of the drafting, editing, and issuance of the July 6, 2020 NYSDOH report entitled, "Factors Associated with Nursing Home Infections and Fatalities in New York State During the COVID-19 Global Health Crisis" (hereinafter "July 6 Report").[4]

On June 11, 2024, the Select Subcommittee conducted a transcribed interview with the former Governor of the State of New York, Andrew M. Cuomo, who was accompanied by counsel.[5] During the transcribed interview, the Select Subcommittee believes that Mr. Cuomo

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[1] *See generally* H. Res. 5 § 4(a)(2)(A), 118th Cong. (2023).
[2] *See* Letter from Hon. Brad Wenstrup, *et al*., Chairman, Select Subcomm. on the Coronavirus Pandemic, H. Comm. on Oversight & Accountability, to Hon. Kathy Hochul, Gov., N.Y. at 1 (May 19, 2023).
[3] Mem. from the N.Y. State Dep't of Health to Nursing Home Adm'rs, *et al*., *Advisory: Hospital Discharges and Admissions to Nursing Homes* (Mar. 25, 2020) (on file with Subcomm. Staff).
[4] FACTORS ASSOCIATED WITH NURSING HOME INFECTIONS AND FATALITIES IN NEW YORK STATE DURING THE COVID-19 GLOBAL HEALTH CRISIS, NEW YORK STATE DEPARTMENT OF HEALTH (July 6, 2020; Revised Feb. 11, 2021).
[5] Transcribed Interview of Andrew M. Cuomo (June 11, 2024) (hereinafter "Cuomo TI").

made false statements about his involvement in and knowledge of the drafting of the July 6 Report.

Accordingly, the Select Subcommittee attaches to this letter a detailed referral for criminal charges against Mr. Cuomo pursuant to 18 U.S.C. § 1001. As explained in the attached referral, Mr. Cuomo made multiple criminally false statements, including that he was neither involved in the drafting nor the review of the July 6 Report.[6] Documents establish that statement to be false.[7] Mr. Cuomo also testified that he did not have any discussions about the July 6 Report being peer reviewed.[8] Documents show that statement to be false.[9] And Mr. Cuomo testified that he did not know whether the July 6 Report was reviewed by persons outside of the NYSDOH.[10] Documents again demonstrate that statement to be false.[11]

Mr. Cuomo provided false statements to the Select Subcommittee in what appears to be a conscious, calculated effort to insulate himself from accountability. The Department of Justice should consider Mr. Cuomo's prior allegedly wrongful conduct when evaluating whether to charge him for the false statements described in the attached.[12]

Thank you for your prompt attention to this important matter.

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[6] Cuomo TI at 173, 177.

[7] Referral of Andrew M. Cuomo, Select Subcomm. on the Coronavirus Pandemic, at 11-94 (Oct. 30, 2024) (hereinafter "Referral").

[8] Cuomo TI at 287-88.

[9] Referral at 94-98

[10] Cuomo TI at 173.

[11] Referral at 94-98.

[12] *See* DOJ Manual, 9-27.230, Initiating and Declining Charges – Substantial Federal Interest, The Person's Criminal History ("If a person is known to have a prior conviction or **is reasonably believed to have engaged in criminal activity at an earlier time, this should be considered in determining whether to commence or recommend federal prosecution**,") (emphasis added); IMPEACHMENT INVESTIGATION REPORT TO JUDICIARY COMMITTEE CHAIR CHARLES LAVINE AND THE NEW YORK STATE ASSEMBLY JUDICIARY COMMITTEE *at* 2, 25, DAVIS POLK & WARDWELL LLP (Nov. 22, 2021) ("We conclude that **there is overwhelming evidence that the former Governor engaged in sexual harassment**,") ("We have carefully reviewed the former Governor's submissions, all of the arguments therein, and have independently reviewed the multitude of evidence – documentary and testimonial, including the former Governor's own statements – and **find overwhelming support that the former Governor engaged in multiple instances of misconduct**,") (emphasis added); REPORT OF INVESTIGATION INTO ALLEGATIONS OF SEXUAL HARASSMENT BY GOVERNOR ANDREW M. CUOMO *at* 1, OFFICE OF THE ATTORNEY GENERAL, N.Y. (Aug. 3, 2021) ("We … **conclude that the Governor engaged in conduct constituting sexual harassment under federal and New York State law.** Specifically, **we find that the Governor sexually harassed a number of current and former New York State employees** by, among other things, engaging in unwelcome and nonconsensual touching, as well as making numerous offensive comments of a suggestive and sexual nature that created a hostile work environment for women.") (emphasis added); AGREEMENT BETWEEN THE UNITED STATES AND THE STATE OF NEW YORK EXECUTIVE CHAMBER REGARDING WORKPLACE REFORM *at* 1, U.S. DEP'T OF JUSTICE (Jan. 26, 2024) ("At the conclusion of the investigation, **the United States found that former Governor Cuomo subjected at least thirteen female employees of New York State, including Executive Chamber employees, to a sexually hostile work environment**,") (emphasis added).

Sincerely,

Brad Wenstrup, D.P.M.
Chairman

cc: The Honorable Raul Ruiz, M.D., Ranking Member
Select Subcommittee on the Coronavirus Pandemic

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A. SUMMARY

1. The Select Subcommittee on the Coronavirus Pandemic (hereinafter "Select Subcommittee") is authorized to investigate the origins of, response to, and impacts of the COVID-19 pandemic.[1]

2. Since May 19, 2023, the Select Subcommittee has been investigating the State of New York's response to the COVID-19 pandemic. This investigation includes the State's decision under the leadership of Andrew M. Cuomo, then-Governor of the State of New York, to issue the March 25, 2020 New York State Department of Health (hereinafter "NYSDOH") directive entitled, "Advisory: Hospital Discharges and Admissions to Nursing Homes" (hereinafter "March 25 Directive")[2] and the July 6, 2020 NYSDOH report entitled, "Factors Associated with Nursing Home Infections and Fatalities in New York State During the COVID-19 Global Health Crisis" (hereinafter "July 6 Report").[3]

3. As part of this investigation, the Select Subcommittee conducted a transcribed interview with Mr. Cuomo.[4] During this interview, Mr. Cuomo made criminally false statements to the Select Subcommittee in violation of 18 U.S.C. § 1001.

4. First, Select Subcommittee counsel asked Mr. Cuomo if he was "involved in the drafting of [the July 6 Report] in any capacity."[5] Mr. Cuomo testified, "[n]o."[6] Select

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[1] *See* H. Res. 5 § 4(a)(2)(A), 118th Cong. (2023); Throughout this referral, "COVID-19 pandemic" will be used to identify the global pandemic caused by the virus SARS-CoV-2.
[2] Mem. from the N.Y. State Dep't of Health to Nursing Home Adm'rs, *et al*., *Advisory: Hospital Discharges and Admissions to Nursing Homes* (Mar. 25, 2020) (on file with Subcomm. Staff).
[3] FACTORS ASSOCIATED WITH NURSING HOME INFECTIONS AND FATALITIES IN NEW YORK STATE DURING THE COVID-19 GLOBAL HEALTH CRISIS, NEW YORK STATE DEPARTMENT OF HEALTH (July 6, 2020; Revised Feb. 11, 2021); Letter from Hon. Brad Wenstrup, *et al.,* Chairman, Select Subcomm. on the Coronavirus Pandemic, H. Comm. on Oversight & Accountability, to Hon. Kathy Hochul, Gov., N.Y. (May 19, 2023).
[4] Transcribed Interview of Andrew M. Cuomo (June 11, 2024) (hereinafter "Cuomo TI"). Throughout this referral, the Select Subcommittee will reference individuals by their titles and positions during the applicable time period.
[5] *Id.* at 173.
[6] *Id.*

Subcommittee counsel informed Mr. Cuomo that another witness testified that Mr. Cuomo was involved in reviewing the July 6 Report and asked if he "review[ed] a draft of [the July 6 Report] prior to its release."[7] Mr. Cuomo testified, "I did not."[8] Documents prove Mr. Cuomo's testimony to be false.[9]

5. Second, Select Subcommittee counsel asked Mr. Cuomo if he had "any discussions regarding the [July 6 Report] being peer reviewed."[10] Mr. Cuomo testified, "[n]o."[11] A document proves Mr. Cuomo's statement to be false.[12]

6. Third, Select Subcommittee counsel asked Mr. Cuomo if he knew "if people outside of [NYSDOH] were involved with drafting or editing [the July 6 Report]."[13] Mr. Cuomo testified, "[n]o."[14] The Select Subcommittee later asked if Mr. Cuomo "recall[s] anyone outside of the New York government being involved in the report,"[15] and Mr. Cuomo responded, "[n]o."[16] Documents prove Mr. Cuomo's testimony to be false.[17]

7. Mr. Cuomo knowingly and willfully made false statements to the Select Subcommittee, and these false statements were material to its investigation.

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[7] *Id.* at 177.
[8] *Id.*
[9] *See* E-mail from Farrah Kennedy, Executive Assistant, Executive Chamber, N.Y., to Executive Chamber Staff (June 23, 2020 2:42 p.m.) (attaching Mr. Cuomo's typed edits to July 6 Report); E-mail from Executive Chamber Staff to Executive Chamber Staff (June 24, 2020 11:13 a.m.) (attaching Mr. Cuomo's handwritten edits to July 6 Report); E-mail from Executive Chamber Staff to Executive Chamber Staff (June 28, 2020 3:20 p.m.) (attaching Mr. Cuomo's handwritten comments on July 6 Report).
[10] Cuomo TI at 287.
[11] *Id.*
[12] *See* E-mail from Stephanie Benton, Executive Assistant, Executive Chamber, N.Y., to Executive Chamber Staff (June 30, 2020, 10:59 a.m.).
[13] Cuomo TI at 173.
[14] *Id.*
[15] *Id.* at 287.
[16] *Id.*
[17] *See* E-mail from Michael Dowling, Chief Exec. Office, Northwell Health, to Executive Chamber Staff (June 30, 2020, 4:31 p.m.); E-mail from Kenneth Raske, Pres. & Chief Exec. Officer, Greater N.Y. Hospital Ass'n, to Michael Dowling, Chief Exec. Office, Northwell Health (June 30, 2020, 6:00 p.m.).

8. For these reasons, the Select Subcommittee makes this referral to the Department of Justice (hereinafter "DOJ") for further action.

B. THE INVESTIGATION INTO NEW YORK'S MANAGEMENT OF COVID-19 IN NURSING HOMES

9. On January 9, 2023, the United States House of Representatives voted to establish and authorize the Select Subcommittee and "directed [it] to conduct a full and complete investigation and study" regarding nine distinct jurisdictional areas with a nexus to the COVID-19 pandemic.[18]

10. On May 19, 2023, the Select Subcommittee began its investigation into the State of New York's response to the COVID-19 pandemic, specifically how it implemented federal guidance from the U.S. Centers for Medicare and Medicaid Services and U.S. Centers for Disease Control and Prevention to protect residents in nursing homes and other long term care facilities.[19]

11. The Select Subcommittee has jurisdiction to conduct this investigation. Specifically, it is authorized to investigate: (1) "the efficiency, effectiveness, and transparency of the use of taxpayer funds and relief programs to address the coronavirus pandemic, including any reports of waste, fraud, or abuse"; (2) "the implementation or effectiveness of any Federal law or regulation applied, enacted, or under consideration to address the coronavirus pandemic and prepare for future pandemics"; (3) "executive branch policies, deliberations, decisions, activities, and internal and external communications related to the coronavirus pandemic"; and (4) "cooperation by the executive branch and others with Congress, the Inspectors General, the

[18] *See* H. Res. 5 § 4(a)(2)(A) (i)-(ix), 118th Cong. (2023).
[19] Letter from Hon. Brad Wenstrup, *et al.,* Chairman, Select Subcomm. on the Coronavirus Pandemic, H. Comm. on Oversight & Accountability, to Hon. Kathy Hochul, Gov., N.Y. *at* 1 (May 19, 2023).

Government Accountability Office, and others in connection with oversight of the preparedness for and response to the coronavirus pandemic."[20]

12. The Select Subcommittee is investigating the State of New York's decision to issue the March 25 Directive and the drafting, editing, and issuance of the July 6 Report that "vastly undercounted" the number of nursing home patient deaths because of COVID-19 by 50 percent.[21]

13. As part of this investigation, the Select Subcommittee requested and received more than 300,000 pages of documents from the New York State Executive Chamber (hereinafter "Executive Chamber") and the NYSDOH. But the Executive Chamber is continuing to withhold responsive documents, even after being served with a duly authorized subpoena for documents on September 10, 2024.[22] Despite this, the Select Subcommittee was able to obtain, via other sources, documents deliberately withheld by the Executive Chamber that establish Mr. Cuomo made criminally false statements to the Select Subcommittee.

14. As part of this investigation, the Select Subcommittee sought and conducted interviews with many people with direct knowledge of and involvement in the March 25 Directive and July 6 Report. These witnesses included: (1) Melissa DeRosa, Secretary to the Governor, (2) Jim Malatras, Advisor to the Governor, (3) Howard Zucker, Commissioner of the NYSDOH, (4) Gareth Rhodes, Deputy Superintendent of the New York Department of Financial Services (NYDOFS), (5) Eleanor Adams, Special Advisor to the Commissioner of NYSDOH,

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[20] H. Res. 5 § 4(a)(ii), (iii), (vii), (ix).

[21] *See, e.g.*, NURSING HOME RESPONSE TO COVID-19 PANDEMIC, OFFICE OF THE ATTORNEY GENERAL, N.Y. at 12, 48 (Jan. 28, 2021; Revised Jan. 30, 2021) ("Data obtained by OAG shows that **DOH publicized data vastly undercounted these deaths**,") ("…COVID-19 resident deaths associated with nursing homes in N.Y. state appear to be **undercounted by DOH by approximately 50 percent**") (emphasis added).

[22] Letter from Hon. Brad Wenstrup, Chairman, Select Subcomm. on the Coronavirus Pandemic, to Hon. Kathy Hochul, Gov., N.Y. (Sept. 10, 2024).

and (6) Farrah Kennedy, Executive Assistant to the Governor.[23] Each witness was directly involved in the State of New York's response to the broader COVID-19 pandemic, including issues surrounding COVID-19 in New York nursing homes.

15. Additionally, as part of this investigation, Mr. Cuomo testified before the Select Subcommittee at a transcribed interview.

16. The evidence demonstrates that Mr. Cuomo made criminally false statements during his transcribed interview. The basis and evidence supporting this criminal referral are laid out in detail below.

C. MAKING FALSE STATEMENTS TO CONGRESS IS A FEDERAL CRIME

17. It is a federal crime to make materially false statements or representations to Select Subcommittee staff and Members of Congress during a Congressional investigation "conducted pursuant to the authority of any … subcommittee, … consistent with applicable rules of the House or Senate."[24] The Select Subcommittee sets forth overwhelming evidence below establishing that Mr. Cuomo made criminally false statements during a duly authorized Congressional investigation in violation of 18 U.S.C. § 1001.

18. DOJ has prosecuted witnesses for making false statements to Congressional committees. For instance, in 2019, DOJ Special Counsel Robert Mueller prosecuted Roger Stone for obstruction of a proceeding and making false statements to the U.S. House of Representatives Permanent Select Committee on Intelligence.[25] Prior to trial, DOJ filed its proposed jury instructions describing the purpose of the statute and addressed the importance of protecting the

[23] Transcribed Interview of Melissa DeRosa (June 21, 2024) (hereinafter "DeRosa TI"); Transcribed Interview of Jim Malatras (May 20, 2024) (hereinafter "Malatras TI"); Transcribed Interview of Howard A. Zucker (Dec. 18, 2023) (hereinafter "Zucker TI); Transcribed Interview of Gareth Rhodes (May 3, 2024) (hereinafter "Rhodes TI"); Transcribed Interview of Eleanor Adams (Apr. 8, 2024) (hereinafter "Adams TI"); Transcribed Interview of Farrah Kennedy (Oct. 8, 2024) (hereinafter "Kennedy TI").
[24] *See* 18 U.S.C. § 1001.
[25] *See United States v. Stone*, No. 1:19-cr-00018-ABJ-1 (D.D.C. Jan. 24, 2019), Doc. 1.

authorized functions of Congressional committees from "deceptive practices."[26] DOJ submitted the following to the court:

> The purpose of § 1001 is to protect the authorized functions of the various governmental departments from any type of misleading or deceptive practice and from the adverse consequences that might result from such deceptive practices.
>
> To establish a violation of § 1001, it is necessary for the government to prove certain essential elements . . . beyond a reasonable doubt. However, I want to point out now that it is not necessary for the government to prove that the House committee was, in fact, misled as a result of the defendant's actions. It does not matter whether the House committee was in fact misled, or even whether it knew of the misleading or deceptive act, should you find that the act occurred. These circumstances would not excuse or justify a concealment undertaken, or a false, fictitious or fraudulent statement made, or a false writing or document submitted, willfully and knowingly about a matter within the jurisdiction of the government of the United States.[27]

19. DOJ must follow the same reasoning and rationale when evaluating this criminal referral. As discussed below, Mr. Cuomo's responses to questions from the Select Subcommittee about his involvement in and knowledge of the drafting of the July 6 Report were false and warrant criminal prosecution.

D. MR. CUOMO KNEW THAT MAKING FALSE STATEMENTS TO CONGRESS IS A CRIME WHEN HE TESTIFIED TO THE SELECT SUBCOMMITTEE

20. On June 11, 2024, Mr. Cuomo testified at a transcribed interview before the Select Subcommittee in Washington, D.C.[28] Counsel accompanied Mr. Cuomo during the transcribed interview.[29] Prior to testifying, Select Subcommittee counsel warned Mr. Cuomo that, although he was participating in the transcribed interview voluntarily and was not sworn under oath, he was "required pursuant to Title 18, Section 1001 of the United States Code to answer questions

[26] *See* Proposed Jury Instructions, *United States v. Stone*, No. 1:19-cr-00018-ABJ (D.D.C. Sept. 6, 2019), Doc. No. 199-2 at 11.
[27] *Id.*
[28] Cuomo TI at 1.
[29] *Id.* at 2.

from Congress truthfully."[30] Select Subcommittee counsel informed Mr. Cuomo that this obligation to answer truthfully "also applie[d] to questions posed by congressional staff…."[31] Mr. Cuomo was asked if he understood, and he responded in the affirmative.[32] Additionally, Select Subcommittee counsel warned Mr. Cuomo that "[i]f at any time [he] knowingly ma[d]e false statements, [he] could be subject to criminal prosecution."[33] Mr. Cuomo was asked if he understood, and he said yes.[34] Finally, Select Subcommittee counsel asked Mr. Cuomo if there was "any reason [he was] unable to provide truthful testimony in today's interview."[35] Mr. Cuomo said no.[36]

21. The transcript establishes Mr. Cuomo knew he was required to tell the truth to Congress and that knowingly making false statements constituted a crime. Mr. Cuomo provided no reason why he could not be truthful during his transcribed interview.

E. MR. CUOMO KNOWINGLY AND WILLFULLY MADE MATERIALLY FALSE STATEMENTS TO THE SELECT SUBCOMMITTEE DURING ITS COVID-19 INVESTIGATION

22. The July 6 Report evaluated the effects of, and factors associated with, the spread of COVID-19 in New York's nursing homes. It concluded that "[d]ata suggest nursing home quality is not a factor in mortality from COVID," "[a]dmission policies were not a significant factor in nursing home fatalities," and "[e]mployee infections were related to the larger community spread and employee transmission has the strongest correlation to nursing home fatalities."[37]

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[30] *Id.* at 16-17.
[31] *Id.* at 17.
[32] *Id.*
[33] *Id.*
[34] *Id.*
[35] *Id.*
[36] *Id.*
[37] July 6 Report, *supra* note 3, at 25.

23. Witnesses testified that Mr. Cuomo initiated the July 6 Report to create a basis to claim the March 25 Directive was not a factor in COVID-19-related New York nursing home fatalities.

24. On June 7, 2020, Stephanie Benton, Executive Assistant to the Governor, emailed Executive Chamber staff about initiating a report that would become the July 6 Report.[38]

From: Stephanie Benton <[redacted]>
Sent: Sunday, June 07, 2020 9:51 AM
To: Jim Malatras <[redacted]>; Gareth Rhodes (dfs.ny.gov) <[redacted]>; Howard A Zucker (health.ny.gov) <[redacted]>
Cc: Melissa DeRosa <[redacted]>
Subject:

This is going to be the great debacle in the history books. The longer it lasts the harder to correct. We have a better argument than we made. Get a report on the facts because this legacy will overwhelm any positive accomplishment. Also how many covid people were returned to nursing homes in that period? How many nursing homes? Don't u see how bad this is? Or do we admit error and give up?

25. The recipients of this e-mail understood it to be from Mr. Cuomo.

26. Select Subcommittee counsel asked Secretary to the Governor, Ms. DeRosa, about the e-mail:

> Q. Numerous witnesses have testified that they believed, or at the very least appeared to them that this email was actually from the former governor. What do you think?
>
> A. I think that's correct.
>
> Q. Was that common?
>
> A. He didn't have an email, and so he would often dictate emails to Stephanie to send from [sic] us. And we were aware based on tone who it was coming to [sic].[39]

27. When Select Subcommittee counsel asked a key former advisor to Mr. Cuomo, Dr. Malatras, about Ms. Benton's involvement, he responded:

[38] E-mail from Stephanie Benton, Executive Assistant, Executive Chamber, N.Y., to Executive Chamber Staff (June 7, 2020, 09:51 a.m.).
[39] DeRosa TI at 199.

> Q. Was Ms. Benton involved in the report?
>
> A. She was involved in submitting back comments from the governor at times in establishing meetings, and we took this e-mail as not coming from Ms. Benton. This was a message from the governor.[40]

28. Select Subcommittee counsel asked Mr. Rhodes, NYDOFS Deputy Superintendent, a similar set of questions about the e-mail and e-mailing practices of the former governor's office:

> Q. Have you ever known Ms. Benton to write e-mails on behalf of the former governor?
>
> A. Yes.
>
> Q. Do you believe this e-mail was written on behalf of the former governor?
>
> A. It appears that way, yes.
>
> …
>
> Q. In what situations would Ms. Benton write those e-mails?
>
> A. To the best of my recollection, the governor himself didn't have e-mail, so when there was a message that he wanted to communicate to other staff members, sometimes Stephanie or another person who kind of worked directly with him would send out on his behalf.
>
> Q. The governor didn't have an official e-mail account?
>
> A. If he did, I never received an e-mail from him. Not that I'm aware.[41]

29. Recipients of this e-mail also believed the direction to "[g]et a report on the facts"[42] was in reference to the July 6 Report. For example, Dr. Malatras testified:

> Q. Then, she writes: "Give a report on the facts." Do you think she's referring to the July 6 Report?

[40] Malatras TI at 130.
[41] Rhodes TI at 104.
[42] E-mail from Stephanie Benton, *supra* note 40.

A.	Yes.[43]

30. Dr. Malatras' testimony is confirmed by the November 22, 2021 report prepared by Davis Polk & Wardwell LLP entitled, "Impeachment Investigation Report to Judiciary Committee Chair Charles Lavine and the New York State Assembly Judiciary Committee" (hereinafter "Impeachment Report").[44] The Impeachment Report states, "the evidence obtained in our investigation demonstrates that former Governor Cuomo directed officials from the Executive Chamber, Task Force, and DOH to prepare a report from DOH in order to combat criticism of the March 25 Directive."[45]

a. Mr. Cuomo Edited and Drafted the July 6 Report on Multiple Occasions

31. Between early June 2020 and July 6, 2020, evidence shows that personnel from both the NYSDOH and Executive Chamber, including Mr. Cuomo, drafted the July 6 Report.

32. However, Mr. Cuomo testified that he was not involved with drafting the July 6 Report:

Q.	Were you involved in the drafting of this report in any capacity?
A.	No.[46]

Select Subcommittee counsel informed Mr. Cuomo that another witness testified that Mr. Cuomo was involved in reviewing the July 6 Report, but he again denied involvement:

Q.	Dr. Malatras also told us in his testimony that you did review a draft of this report prior to its release. Is that true?
A.	I did not. Maybe it was in the inbox, but I did not.[47]

[43] Malatras TI at 130.
[44] *See* IMPEACHMENT INVESTIGATION REPORT TO JUDICIARY COMMITTEE CHAIR CHARLES LAVINE AND THE NEW YORK STATE ASSEMBLY JUDICIARY COMMITTEE, DAVIS POLK & WARDWELL LLP (Nov. 22, 2021).
[45] *Id.* at 40.
[46] Cuomo TI at 173.
[47] *Id.* at 177.

33. Multiple witnesses testified that Mr. Cuomo was involved in the drafting of the July 6 Report. For example, Dr. Malatras testified:

> Q. Who worked on editing the report?
>
> A. I did, Beth Garvey, **Governor Cuomo**…
>
> ***
>
> Q. … [The Impeachment Report] says that the governor reviewed and edited the draft on multiple occasions. I believe you testified to this in the previous hour, but is that true?
>
> A. Yes.[48]

34. Similarly, Ms. Kennedy, the then-Governor's executive assistant, testified:

> Q. So, based on the documents that we reviewed today, was former Governor Cuomo involved in the drafting of the July 6th report in any capacity?
>
> A. Yes.[49]

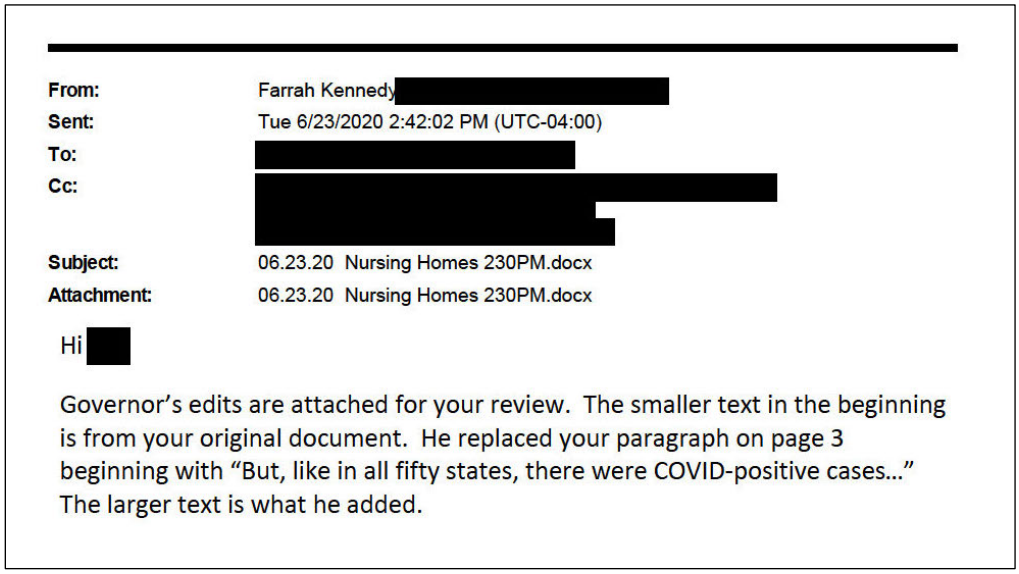
35. The Impeachment Report supports Dr. Malatras' and Ms. Kennedy's testimony:

> ... [T]he evidence obtained in our investigation demonstrates that former Governor Cuomo directed officials from the Executive Chamber, Task Force and DOH to prepare a report from DOH in order to combat criticism of the March 25 Directive. The report was initiated by the then-Governor and influenced by members of the Executive Chamber and Task Force, then released under the auspices of DOH. Throughout the drafting process, the former Governor reviewed and edited the draft DOH Report on multiple occasions, and made edits to strengthen the defense of the March 25 Directive.[50]

36. In addition to witness testimony and the Impeachment Report, the Select Subcommittee possesses documents that prove Mr. Cuomo was involved in the drafting of the July 6 Report.

[48] Malatras TI at 159-60, 208.
[49] Kennedy TI at 26.
[50] Impeachment Report, *supra* note 46, at 40.

37. On June 23, 2020, Ms. Kennedy emailed Executive Chamber staff stating:[51]



From: Farrah Kennedy [redacted]
Sent: Tue 6/23/2020 2:42:02 PM (UTC-04:00)
To: [redacted]
Cc: [redacted]
Subject: 06.23.20 Nursing Homes 230PM.docx
Attachment: 06.23.20 Nursing Homes 230PM.docx

Hi [redacted]

Governor's edits are attached for your review. The smaller text in the beginning is from your original document. He replaced your paragraph on page 3 beginning with "But, like in all fifty states, there were COVID-positive cases…" The larger text is what he added.

38. As for this email, Ms. Kennedy testified:[52]

> Q. The email writes, "Governor's edits are attached for your review." Reviewing this email, would it be your opinion that, when you write the "governor's" edits, you are referring to former Governor Andrew Cuomo?
>
> A. Yes.
>
> Q. So here you are communicating that the governor had drafted language for the report. Is that right?
>
> A. Yes.
>
> Q. … So, I want to direct your attention to the document itself. On page 3 - - starting on page 3, the rest of the document is in larger text. Would it be your impression that you were saying pages 3 through 16 are the governor's edits?
>
> …
>
> A. That is how I would interpret it.

[51] E-mail from Farrah Kennedy, Executive Assistant, Executive Chamber, N.Y., to Executive Chamber Staff (June 23, 2020, 2:42 p.m.).
[52] Kennedy TI at 20-21.

From: Farrah Kennedy [redacted]
Sent: Tue 6/23/2020 2:42:02 PM (UTC-04:00)
To: [redacted]
Cc: [redacted]
Subject: 06.23.20 Nursing Homes 230PM.docx
Attachment: 06.23.20 Nursing Homes 230PM.docx

Hi [redacted]

Governor's edits are attached for your review. The smaller text in the beginning is from your original document. He replaced your paragraph on page 3 beginning with "But, like in all fifty states, there were COVID-positive cases…" The larger text is what he added.

DRAFT
PRIVILEGED AND CONFIDENTIAL

Factors Correlating with Nursing Home Fatalities in New York State During the COVID-19 Global Health Crisis

New York State Department of Health
June 22, 2020

[redacted]

Executive Summary

ADD HERE

Background[1]

Nations all across the globe have been significantly impacted by COVID-19. The situation rapidly and dramatically altered everyday life—requiring social distancing, closing of schools and businesses, and restricting access to hospitals and other congregate facilities.

New York State was one of the earliest states affected by COVID-19, in large part, from inbound travel from Europe.[2] On March 1, 2020, NYS identified its first case of COVID-19 in an international traveler. On March 3, 2020, the first COVID-19 case with no travel-related risk factors was identified in Westchester, NY; contact tracing revealed additional ill contacts.

Congregate settings, like nursing home, are particularly susceptible to infectious diseases like COVID-19 and many states in the nation had to grapple with this difficult situation. The first known positive COVID-19 nursing home resident was in Washington State, in Kirkland, who was transferred to a hospital on February 24, 2020 and later tested positive. In New York, the first exposure of the virus to nursing home residents followed on March 7, 2020, with the first known transmission of COVID-19 to a nursing home resident occurring on March 11, 2020, after a staff member first tested positive for COVID-19.

The New York State Department of Health (NYSDOH) undertook took aggressive steps to prepare healthcare facilities for COVID-19 in order to prevent control the spread of COVID-19 in nursing homes. Prior to, and early in the outbreak, NYS issued orders, directives and guidance to nursing homes on a variety of topics, including, but not limited to, anticipating

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[redacted]

personal protective equipment shortages (February 2, 2020), infection control in healthcare facilities (February 26, 2020) (give an example), specific nursing home infection control and health & safety guidance (give an example) (March 6, 2020, March 11, 2020, & March 13, 2020), and discharge and admissions guidance (March 25, 2020). In addition, on March 7, 2020, Governor Cuomo banned visitors from nursing homes in New Rochelle, NY, and visitors were banned statewide on March 13, 2020—a dramatic step to protect residents. Enhanced infection prevention measures were directed to be implemented such as symptom and temperature checks for staff, facemasks for staff, and cancellation of congregate activities (March 13, 2020). NYSDOH surveyors and epidemiologists conducted thousands of calls, video assessments, and in-person assessments to support nursing homes and assess deficiencies.

But, like in all 50 states, there were COVID-positive cases in nursing homes in New York State. Below is an analysis of possible factors to determine whether they were the cause of increasing the infection rate or mortality rate in nursing homes.

We analyzed:

I. New York State's rate of mortality in nursing homes compared to the rate of mortality in other states.

II. The geographic location of the nursing home facility and community spread in that geographic location.

III. Staff illness infection rate in the community of the nursing home's location as a possible cause of exposure.

IV. Transmission from residents with COVID-19 who were admitted or readmitted to the nursing homes.

V. Nursing home quality of care contributing to COVID-19 resident exposures.

VI. The age of the nursing home residents as a factor for mortality.

[redacted]

INSERT B Analysis of COVID-19 Nursing Home Fatalities

I. Analysis of the New York State Nursing Home Rate of Mortality vs. Other State's Nursing Home Rate of Mortality

Through June 10, 2020, New York State is one of the lowest rates of nursing home fatalities among states with at least 1000 confirmed statewide fatalities. As of May 24, 2020, 38% of COVID-19 fatalities in New York State were among nursing home residents. In a rank ordering of COVID-19 related nursing home deaths in states with more than 1000 confirmed statewide fatalities, New York State placed 21 out of 23 states, meaning that New York State had fewer nursing home deaths than all but 2 of the states analyzed. See chart below.

(CHART)

An examination by the *New York Times* found that New York State ranked 35th in the nation – meaning 34 states had greater number of fatalities (even with some states being ranked only for confirmed fatalities and some being ranked for confirmed and presumed fatalities) FN5

(CHART)

II. The Geographic Location of the Nursing Home Facility and Community Spread in that Location.

Within New York State there has been significant geographic variation in overall positive tests within the community (Figure 1) and nursing home cases and fatalities. Regions most highly affected be COVID-19 also had the highest nursing home fatality rates. There is a correlation between the overall community spread in a geographic location and the number of nursing home cases in that geographic location. We explore these issues below.

(Figure 1)

III. Staff Illness Contributing to Nursing Home Infection Exposures

New York State had its first case of coronavirus on March 1, 2020. The date of the first known suspected or confirmed employee illness in nursing homes was March 16, 2020. This is approximately three weeks before the peak of nursing home residents' deaths, about April 1, 2020. This was also before the March 25th CDC provision and state alignment concerning non-discrimination against a COVID-positive resident. In March there was a general acceptance by the national healthcare professionals that asymptomatic people

were not likely to spread the infection. Therefore, asymptomatic nursing home employees may not have been detected. In early March the nation's testing capacity was still being developed and was not widely available for nursing home employees.

The peak of nursing home fatalities was at the beginning of April. Given the incubation period for COVID-19 as a median time of 4-5 days from exposure to symptoms onset, and can extend to 14 days, it is likely that employees infected in mid-March could have appeared in the nursing home for work, transmitted the virus which then manifested in the residents approximately 7-14 days later. It should be noted that once national testing capacity increased the CDC on May 3, 2020 changed its guidance to require people such as nursing home employees to utilize a test-based strategy and a 10-day isolation period before employees could return to work in a nursing home. Prior to May 3rd CDC was recommending that a positive but asymptomatic healthcare worker could return to work immediately with precautions such as a mask.

As figure 5 illustrates, nursing home fatalities were increasing in mid-March. New York State banned family

and friends' visitation on March 13, 2020. Given this timing, and given the COVID incubation period, it is possible that visitation by family and friends up to March 13th was a contributing factor. The only other possible factor to explain the mid-March increase was employee transmission. There is no data on the infection rate of family and friends. However, data does show that beginning mid-March the number of nursing homes with staff testing positive for COVID-19 more than doubled from 106-257. All of this activity well pre-dated the March 25th readmission policy for COVID-positive residents (see point 5.)

IV. Transmission from Residents with COVID-19 Who Were Admitted or Readmitted to the Nursing Homes

One of the factors that has been suggested to contribute to nursing home fatalities is the admission or readmission of COVID-positive residents.

Initially, there is no data to suggest that New York nursing home fatalities were disproportionate to any other state's nursing home fatalities. In fact, data shows the opposite to be true as New York was 35th by percentage in the number of nursing home deaths. (see Factor 1.)

Second, New York State followed CDC guidance which stated that a nursing home should not DISCRIMINATE against a COVID-positive person. However, neither CDC guidance nor the state directive mandated that a nursing home accept a COVID-positive person. In fact, the opposite is true. By state law a nursing home could not accept a COVID-positive person unless the nursing home could provide "proper isolation and protective procedures." Therefore, a nursing home could not accept a COVID-positive person unless they could isolate that person in a way that did not affect the other residents. The State Department of Health and Attorney General's office are doing an investigation to determine, among other things if nursing homes violated this law.

Statewide nursing home admission and readmission data from March 1 through May 8, 2020 show that 9,690 residents with confirmed or presumed COVID-19 were admitted or re-admitted from a hospital to a total of 371 unique nursing homes. This is one total nursing home population of 600,000. The data does not demonstrate a subsequent intra-facility transmission or increased mortality. For example, as Figure 4 illustrates, many nursing homes that did not admit any COVID-positive patients still had a high number of

COVID related deaths. In fact, 57 nursing homes that had 0 readmissions, had significant COVID-19 fatalities.

Following the timeline, data invalidates a cause and effect between a March 25th timeline and rate of mortality. Nursing home resident fatalities peaked on April 7, 2020. The peak of nursing home admissions or readmissions was not until April 14, 2020.

As the nursing home death peak occurred 7 days before the peak of readmissions of COVID-positive residents, it suggests no causation. Also a directive issued March 25th is highly unlikely, given the incubation period, to cause death by April 7, 2020.

Further, admissions and readmissions of residents with COVID-19 were still increasing when the number of nursing home deaths was already declining. If the March 25, 2020 guidance was a major causative factor in nursing home deaths, the peak in deaths should have occurred after the peak in admissions, not before.

The data suggests that people readmitted to nursing homes were most likely not contagious. Per CDC data, COVID-positive individuals are likely not capable of transmitting the

virus after 9 days from the onset of the illness. The CDC stated "the statistically estimated likelihood of recovering replication competent virus approaches 0 by 10 days." This comports with the CDC policies related to return to work and removal from isolation precautions after a positive COVID test. Viral shedding after this date, it is widely noted, is unlikely to transmit the virus. Length of stay data showed that for nursing home admissions and readmissions average length of stay for hospital visits were about 8-10 days. This is beyond the period of viral transmission. According to the CDC people are most infectious in the pre-symptomatic stage or 1-4 days after symptom onset. Therefore, patients admitted or readmitted to nursing homes were likely not infectious.

An additional complication is that health experts will opine that keeping a senior citizen in a hospital bed for multiple days longer than necessary poses a serious risk to the patient of being subject to a secondary infection such as sepsis or staph infection. What policy would justify posing a high risk to the patient.

V. Nursing Home Quality Contributing to COVID-19 Resident Exposure

We analyzed whether nursing homes that had a prior performance record of lower quality over the past several years had a higher death rate than nursing homes with a record of higher quality performance. In fact, the data shows the opposite is true. Using the Quality rating system developed by CMS, 5-Star Quality Rating System, nursing homes with higher CMS quality ratings were found to have higher mortality rates than those with lower quality ratings.

(See CHART)

From the data, the apparent explanation for this phenomenon is that the location of the nursing home facility had a greater causal connection than the performance of the nursing home facility.

Data shows the predominance of nursing home deaths were in downstate New York and unrelated to the performance of the particular nursing home. This supports the theory that community spread among employees or possibly visitation by family and friends were relevant factors rather than readmissions or facility quality.

VI. Age of the Nursing Home Resident as a Factor for Mortality

Another factor was reviewed on impact of mortality – age of the resident. As data show, older individuals are more susceptible to death from COVID-19 infection. The analysis between resident age and mortality suggests a relationship between a higher median resident age and an increase in the mortality rate. This is more pronounced in geographic areas where there were more nursing homes deaths. Downstate New York, which had a higher mortality rate, demonstrates this point. Upstate New York, with few nursing home residents, has less of a causal connection.

CONCLUSION

Several factors are clear from our analysis and research. Older people are more susceptible to the risk of mortality by COVID-19 in congregate settings pose a risk.

New York State has a lower percentage of deaths in nursing homes than most states, ranking 35th in comparison to other states.

Data shows a greater risk for older residents.

Data shows nursing home quality is not a factor in mortality from COVID.

Data shows community spread is the greatest causal factor.

[redacted]

Timeline data comparing nursing home policies and mortality rate timelines suggests COVID-19 transmission was most likely caused by employees entering the facility. Early in the COVID crisis health experts suggested a-systematic people did not spread the disease. Later in the crisis health care experts changed their opinion and found asymptomatic people could transmit the disease, and therefore no specific information to assess whether or not they transmitted the disease. Also there was a limited national testing early in the disease. Both factors may be relevant to employee spread.

Nursing home deaths spiked proximately April 1-7. CDC guidance did not provide for employee testing or isolation until May 3rd.

Family and friend visitation was ended on March 13th. There was no testing of family and friends visiting the facility prior to March 13th. There is no data on the infection rate among family and friends.

The March 25th CDC guidance and state directive against prohibiting discrimination of COVID-positive people is not supported by the data to be a significant factor. The peak mortality rate was early April, before COVID-positive people

could have reentered the nursing home, infected other people, incubating in other people, and caused death. Residents readmitted were on average 8-9 days past infection. Health experts believe the virus is not transmitted after 9 days and is mostly transmitted in pre-symptomatic stages to 1-4 days post infection.

The directive against discrimination did not mandate nursing homes to accept COVID-positive residents. In fact, the opposite is true. By law, a nursing home was prohibited from accepting a COVID-positive person unless they could isolate the person in a manner protecting other people in the nursing home. It is an open question and currently a matter of investigation where the nursing homes did violate this provision of law. However even if they did, it is highly unlikely a COVID-positive readmission was a significant factor given the factors outlined above e.g. timeline, little likelihood of transmission post 9 days. Health experts widely agree that they would advise against leaving an older patient in a hospital for a longer period than necessary as the risk to the patient increases dramatically. The longer the hospital stay, the more likely a patient could contract a secondary infection such as sepsis or staph infection.

Given these circumstances, a policy to leave a recovering COVID patient in a hospital rather than returning them to a nursing home that can safely treat them is problematic. There is no justification to justify the health risk of a recovering COVID patient IF the nursing home can effectively treat them in a protective environment, as required by law. As a matter of policy, the Department of Health has two options; either insure the nursing home comply with the law requiring isolation and protective care or create new facilities for senior residents to convalesce with populations that are recovering from similar disease or infections, if such a situation arises in the future. However, in any event, the data does not show that admissions or re-admissions of COVID-positive individuals was a significant factor in the mortality rate in nursing homes.

39. On June 24, 2020, a scanned version of the July 6 Report was sent to Executive Chamber staff.[53] The scanned version of the July 6 Report included handwritten edits and comments.

40. Dr. Malatras testified that Mr. Cuomo would communicate his edits to the July 6 Report via handwritten notes:

> Q. …You said that … Ms. Benton would also in the report … send comments back from the governor.
>
> A. Correct.
>
> Q. In track changes in the report, or was it kind of general "change this?"
>
> A. He didn't … use a computer for those purposes. So it would be either handwritten notes, or they would – he would have been handing changes to Ms. Benton.[54]

41. Ms. Kennedy testified that part of her responsibilities as Executive Assistant to the Governor were to transcribe Mr. Cuomo's handwritten notes:

> Q. You testified earlier that you would communicate or transcribe the governor's handwritten notes. Is that right?
>
> A. Correct.
>
> Q. Would you recognize his handwriting?
>
> A. Probably.[55]

> Q. Were you ever asked to decipher the governor's handwritten notes or what he was writing?
>
> A. Often.[56]

[53] E-mail from Executive Chamber Staff to Executive Chamber Staff (June 24, 2020, 10:55 a.m.).
[54] Malatras TI at 132.
[55] Kennedy TI at 24.
[56] *Id.* at 25.

42. When asked to review the handwritten notes of this draft of the July 6 Report, Ms. Kennedy testified:

Q.	Do the handwritten notes throughout this draft report appear to be former Governor Andrew Cuomo's handwriting?
A.	It does.[57]

[REMAINDER OF PAGE INTENTIONALLY BLANK]

[57] *Id.*

Subject: Fwd: Message from "RNP58387911B637"
Date: Wednesday, June 24, 2020 at 11:13:44 AM Eastern Daylight Time
From: [redacted]
To: [redacted]
Attachments: 20200624105333189.pdf, ATT00001.htm

Privileged
Can you read this?

Sent from my iPhone

Begin forwarded message:

From: [redacted]
Date: June 24, 2020 at 10:55:15 AM EDT
To: [redacted]
Subject: FW: Message from "RNP58387911B637"

-----Original Message-----
From: Ricoh39Copier1@exec.ny.gov [mailto:Ricoh39Copier1@exec.ny.gov]
Sent: Wednesday, June 24, 2020 10:54 AM
To: [redacted]
Subject: Message from "RNP58387911B637"

This E-mail was sent from "RNP58387911B637" (MP C6004ex).

Scan Date: 06.24.2020 10:53:33 (-0400)
Queries to: Ricoh39Copier1@exec.ny.gov

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Factors Correlating with Nursing Home Fatalities in New York State During the COVID-19 Global Health Crisis

New York State Department of Health
June 22, 2020

Background[1]

Nations all across the globe have been significantly impacted by COVID-19. The situation rapidly and dramatically altered everyday life—requiring social distancing, closing of schools and businesses, and restricting access to hospitals and other congregate facilities.

New York State was one of the earliest states affected by COVID-19, in large part, from inbound travel from Europe.[2] On March 1, 2020, NYS identified its first case of COVID-19 in an international traveler. On March 3, 2020, the first COVID-19 case with no travel-related risk factors was identified in Westchester, NY; contact tracing revealed additional ill contacts.

Congregate settings, like nursing home, are particularly susceptible to infectious diseases like COVID-19 and many states in the nation had to grapple with this difficult situation. The first known positive COVID-19 nursing home resident was in Washington State, in Kirkland, who was transferred to a hospital on February 24, 2020 and later tested positive. In New York, the first exposure of the virus to nursing home residents followed on March 7, 2020, with the first known transmission of COVID-19 to a nursing home resident occurring on March 11, 2020, after a staff member first tested positive for COVID-19.

The New York State Department of Health (NYSDOH) undertook took aggressive steps to prepare healthcare facilities for COVID-19 in order to prevent control the spread of COVID-19 in nursing homes, including requiring temperature checks every 12-hours; mandating PPE; that all nursing homes test residents and staff; DOH inspections of facilities that have not

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[1] The New York State Department of Health staff was supported by analysis provided by McKinsey & Company.

[2] *Introduction and Early Spread of SARS-CoV-2 in New York City,* Gonzalez-Reiche, et. Al. Pre-print https://doi.org/10.1101/2020.04.08.20056929 (Finding majority of 87 samples taken from Mount Sinai Hospital in March from diverse origins within New York City were genotypes to European variants of SARS-CoV-2.

complied with these all federal and state directives. Moreover, the state created strict penalities for non-compliance, including losing their operating license.

These activities began prior to, and early in the outbreak, and NYS issued orders, directives and guidance to nursing homes on a variety of topics, including, but not limited to, anticipating personal protective equipment shortages (February 2, 2020), infection control in healthcare facilities (February 26, 2020), specific nursing home infection control and health and safety guidance (March 6, 2020, March 11, 2020, & March 13, 2020), and discharge and admissions guidance (March 25, 2020). In addition, on March 7, 2020, Governor Cuomo banned visitors from nursing homes in New Rochelle, NY, and visitors were banned statewide on March 13, 2020—a dramatic step to protect residents. Enhanced infection prevention measures were directed to be implemented such as symptom and temperature checks for staff, facemasks for staff, and cancellation of congregate activities (March 13, 2020). NYSDOH surveyors and epidemiologists conducted thousands of calls, video assessments, and in-person assessments to support nursing homes and assess deficiencies.

But, like in all 50 states, there were COVID-positive cases in nursing homes in New York State. Below is an analysis of possible factors to determine whether they were the cause of increasing the infection rate or mortality rate in nursing homes.

We analyzed:

I. New York State's rate of mortality in nursing homes compared to the rate of mortality in other states.

II. The geographic location of the nursing home facility and community spread in that geographic location.

III. Staff illness infection rate in the community of the nursing home's location as a possible cause of exposure.

IV. Transmission from residents with COVID-19 who were admitted or readmitted to the nursing homes.

V. Nursing home quality of care contributing to COVID-19 resident exposures.

VI. The age of the nursing home residents as a factor for mortality.**Analysis of COVID-19 Nursing Home Fatalities**

I. Analysis of the New York State Nursing Home Rate of Mortality vs. Other State's Nursing Home Rate of Mortality

Through June 10, 2020, New York State is one of the lowest rates of nursing home fatalities among states with at least 1,000 confirmed statewide fatalities. As of May 24, 2020, 38% of COVID-19 fatalities in New York State were among nursing home residents. In a rank ordering of COVID-19 related nursing home deaths of the 21 states with more than 1, 000 confirmed statewide fatalities, New York ranked lower than 15 of the other states when examining fatalities among nursing home residents as a share of total fatalities. See Table 1 below.

Table 1. Percentage of Nursing Home Fatalities of Overall COVID-19 Fatalities for States With >1,000 Fatalities, by State

State	Nursing Home Fatalities as a Percentage of Total Confirmed Deaths
Minnesota	77.33%
Pennsylvania	68.10%
Massachusetts	63.05%
Connecticut	62.64%
Maryland	60.68%
Virginia	59.58%
Ohio	56.63%
North Carolina	51.74%
Illinois	51.10%
New Jersey	49.58%
Florida	49.07%

Georgia	44.82%
Indiana	43.44%
Louisiana	42.77%
California	41.13%
New York	40.41%
Texas	39.67%
Michigan	32.60%
Colorado	31.38%
Arizona	10.15%
Washington	2.73%

Source: New York State Department of Health Analysis

An examination by the *New York Times* found that New York State ranked 35th in the nation – meaning 34 states had greater number of fatalities (even with some states being ranked only for confirmed fatalities and some being ranked for confirmed and presumed fatalities).[3] A 50 state analysis of confirmed fatalities finds that New York is 37th in the nation as a percentage of total COVID-19 fatalities—meaning 36th states had higher percentages of nursing home fatalities compared to overall COVID fatalities (Table 2).

Table 2. Nursing Home Fatalities as a Percentage of Total COVID-19 Fatalities, by State

Rank	State	Confirmed deaths	Statewide Deaths	NH/LTC deaths as a percentage of total deaths
1	New Hampshire	273	331	82%
2	Minnesota	1,064	1,376	77%
3	North Dakota	56	75	75%
4	Rhode Island	629	885	71%
5	Pennsylvania	4,332	6,361	68%
6	Massachusetts	4,899	7,770	63%
7	Kentucky	327	520	63%
8	Delaware	263	431	61%
9	Maryland	1,830	3,016	61%
10	Virginia	945	1,586	60%
11	Ohio	1,491	2,633	57%

[3] See the chart "Cases and deaths in long-term care facilities, by state" from Karen Yourish, K.K. Rebecca Lai, Danielle Ivory and Mitch Smith, "One-Third of All U.S. Coronavirus Deaths Are Nursing Home Residents or Workers," *New York Times* (May 11, 2020).

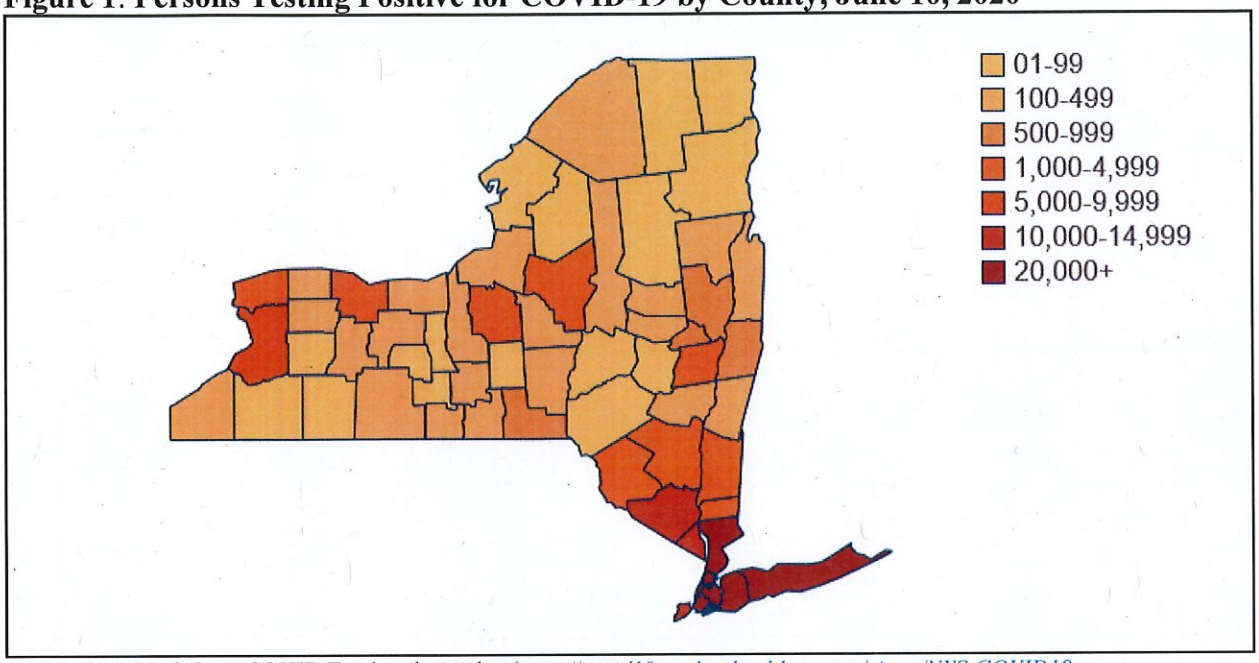
12	Kansas	134	247	54%
13	Oregon	97	187	52%
14	North Carolina	608	1,175	52%
15	Oklahoma	189	366	52%
16	Iowa	351	680	52%
17	Illinois	3,433	6,718	51%
18	Connecticut	2,106	4,226	50%
19	New Jersey	6,346	12,800	50%
20	Florida	1,502	3,061	49%
21	West Virginia	43	88	49%
22	Mississippi	477	983	49%
23	South Carolina	291	621	47%
24	Georgia	1,168	2,606	45%
25	Indiana	1,082	2,491	43%
26	Utah	66	152	43%
27	Louisiana	1,289	3,014	43%
28	Wisconsin	305	719	42%
29	California	2,176	5,290	41%
30	Texas	835	2,105	40%
31	Arkansas	72	208	35%
32	Michigan	1,976	6,061	33%
33	District of Columbia	153	527	29%
34	Tennessee	132	509	26%
35	Colorado	397	1,638	24%
36	Nevada	98	475	21%
37	New York	3,506	24,661	14%

Source: New York State Department of Health Analysis of Publicly Available Nursing Home Data, by State.

I. The Geographic Location of the Nursing Home Facility and Community Spread in that Location.

Within New York State there has been significant geographic variation in overall positive tests within the community (Figure 1) and nursing home cases and fatalities. Regions most highly affected be COVID-19 also had the highest nursing home fatality rates. There is a correlation between the overall community spread in a geographic location and the number of nursing home cases in that geographic location. We explore these issues below.

Figure 1: Persons Testing Positive for COVID-19 by County, June 10, 2020



Source: New York State COVID Tracker, located at *https://covid19tracker.health.ny.gov/views/NYS-COVID19-Tracker/NYSDOHCOVID-19Tracker-Map?%3Aembed=yes&%3Atoolbar=no&%3Atabs=n*, Accessed June 11, 2020.

II. Staff Illness Contributing to Nursing Home Infection Exposures

New York State had its first case of coronavirus on March 1, 2020. The date of the first known suspected or confirmed employee illness in nursing homes was March 16, 2020. This is approximately three weeks before the peak of fatalities of nursing home residents, about April 1, 2020. This was also before the March 25th CDC provision and state alignment concerning non-discrimination against a COVID-positive resident. In March there was a general acceptance by the national healthcare professionals that asymptomatic people were not likely to spread the infection. This was memorialized in March 7, 2020 federal CDC guidance which stated, "Asymptomatic HCP [healthcare personnel] in this category are not restricted from work."[4] And

[4] "Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease (COVID-19)" Centers for Disease

the March 7, 2020 federal CDC guidance further stated, "Facilities could consider allowing asymptomatic HCP who have had an exposure to a COVID-19 patient to continue to work after options to improve staffing have been exhausted and in consultation with their occupational health program."[5] Therefore, asymptomatic nursing home employees may not have been detected.

In early March the nation's testing capacity was still being developed and was not widely available for nursing home employees. Yet, for nursing home employees that were symptomatic, but not tested, CDC recommended that they wait only three days after the symptoms had passed to return to work and only seven days after the COVID-19-like symptoms first appeared, much less time than the 14 days required under certain circumstances.[6] It is likely that a percentage of these symptomatic employees could have spread the disease within the facility.

The peak of nursing home fatalities was at the beginning of April. Given the incubation period for COVID-19 as a median time of 4-5 days from exposure to symptoms onset, and can extend to 14 days, it is likely that employees infected in mid-March could have appeared in the nursing home for work, transmitted the virus which then manifested in the residents approximately 7-14 days later. As Figure 2 illustrates, peak in COVID-symptomatic nursing homes employees was in mid-March is potentially correlated to peak nursing home deaths in the first week in April.

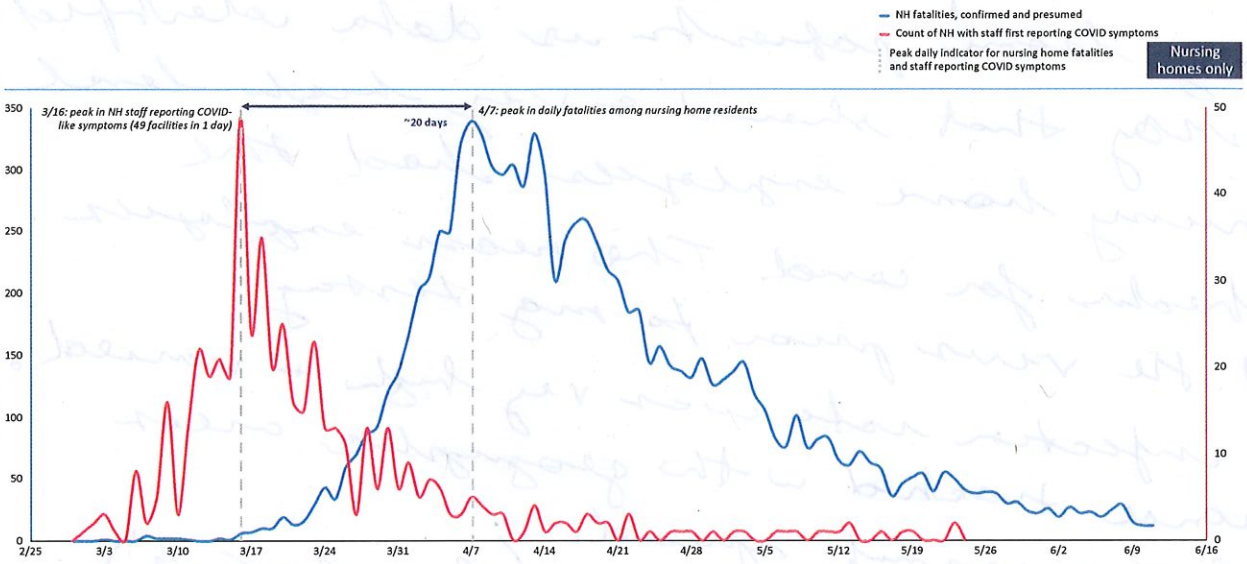
Control and Prevention (March 7, 2020) located at https://web.archive.org/web/20200404194131/https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html.

[5] Id.

[6] "Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19 (Interim Guidance)" Centers for Disease Control and Prevention located at: https://web.archive.org/web/20200404023742/https:/www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fhcp-return-work.html.

It should be noted that once national testing capacity increased the CDC on May 3, 2020 changed its guidance to require people such as nursing home employees to utilize a test-based strategy and a 10-day isolation period before employees could return to work in a nursing home. Prior to May 3rd CDC was recommending that a positive but asymptomatic healthcare worker could return to work immediately with precautions such as a mask.

Figure 2. Nursing Home Staff Symptoms and Nursing Home Resident Fatalities Timeline



Source: Facility Survey on staff sickness as 6/9

As Figure 2 also illustrates, nursing home fatalities were increasing in mid-March. New York State banned family and friends' visitation on March 13, 2020. Given this timing, and given the COVID incubation period, it is possible that visitation by family and friends up to March 13th was a contributing factor. The only other possible factor to explain the mid-March increase was employee transmission. There is no data on the infection rate of family and friends. However, data does show that beginning mid-March the number of nursing homes with staff testing positive for COVID-19 more than doubled from 106-257 [NEED TO CONFIRM #]. All

A significant factor highlighting the likelihood of employee transmission to nursing home patients is data identified in May that showed a very high level of nursing home employees had the antibodies for covid. This means employees had the virus prior to mg testing. The infection rate was very high + varied. Variance tracked with geographic areas of higher community spread. For example - - - - (Bio Ref #)

This data suggests the primary spread was due to employee transmission to patients.

A secondary factor may be spread by family + visitors.

of this activity well pre-dated the March 25th readmission policy for COVID-positive residents (see point 5)

III. Transmission from Residents with COVID-19 Who Were Admitted or Readmitted to the Nursing Homes

One of the factors that has been suggested by some observers to contribute to nursing home fatalities is the admission or readmission of COVID-positive residents. However, data do not broadly support this suggestion. Initially, there is no data to suggest that New York nursing home fatalities were disproportionate to any other state's nursing home fatalities. In fact, data shows the opposite to be true as New York was 35th by percentage in the number of nursing home deaths. (see Factor 1.)

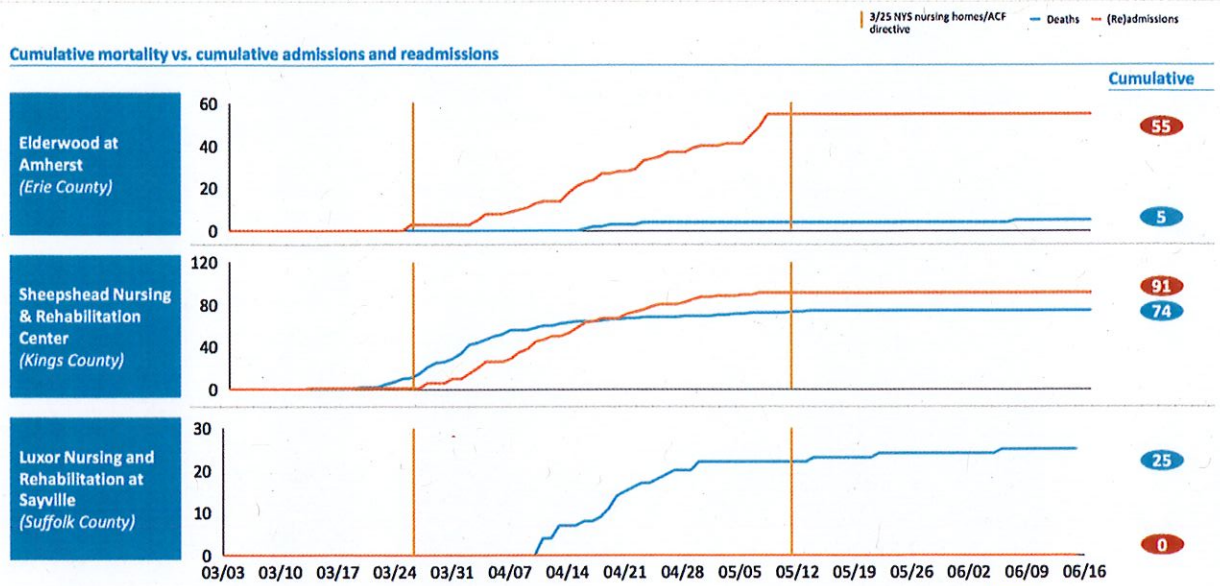
Second, New York State followed CDC guidance which stated that a nursing home should not DISCRIMINATE against a COVID-positive person (EMPHASIS ADDED). However, neither CDC guidance nor the state directive mandated that a nursing home accept a COVID-positive person. In fact, the opposite is true. By state law a nursing home could not accept a COVID-positive person unless the nursing home could provide "proper isolation and protective procedures." Therefore, a nursing home could not accept a COVID-positive person unless they could isolate that person in a way that did not effect the other residents. The State Department of Health and Attorney General's office are doing an investigation to determine, among other things if nursing homes violated this law.

Statewide nursing home admission and readmission data from March 1 through May 8, 2020 show that 9,690 residents with confirmed or presumed COVID-19 were admitted or re-admitted from a hospital to a total of 371 unique nursing homes. This is on a total nursing home population of 600,000. The data do not demonstrate or correlate to a subsequent intra-facility transmission or increased mortality. For example, as Figure 4 illustrates, many nursing homes that did not admit any COVID-positive patients still had a high number of COVID related deaths. In fact, 57 nursing homes that had 0 readmissions, had significant COVID-19 fatalities and178 facilities had their first COVID-19 fatality before or on the day of their first readmission suggesting that readmissions did not introduce COVID in the facility.

→ Importantly, the state had various alternative facilities for covid positive nursing home patients if any nursing home declined to accept them. The state had secured ~~[illegible]~~ thousands of additional health care beds suitable for covid positive nursing home patients. The state even constructed nursing home covid positive exclusive facilities across the state. In NYC MAJOR ~~[illegible]~~ ~~[illegible]~~ ~~[illegible]~~ capital ~~[illegible]~~ In addition surplus capacity ~~[illegible]~~ Therefore there was no reason for nursing homes to accept covid positive if they were not confident or state had many available alternatives.

For clarity, Federal guidance + state regulations stated that nursing homes could not DISCRIMINATE AGAINST COVID POSITIVE PATIENTS ~~BUT~~ but also could ~~not accept~~ NOT ACCEPT them ~~unless~~ UNLESS they could provide adequate-care by isolation and protection of other residents + staff. It was in the nursing homes sole discretion to determine if they would accept the covid positive person and if they could provide adequate care.

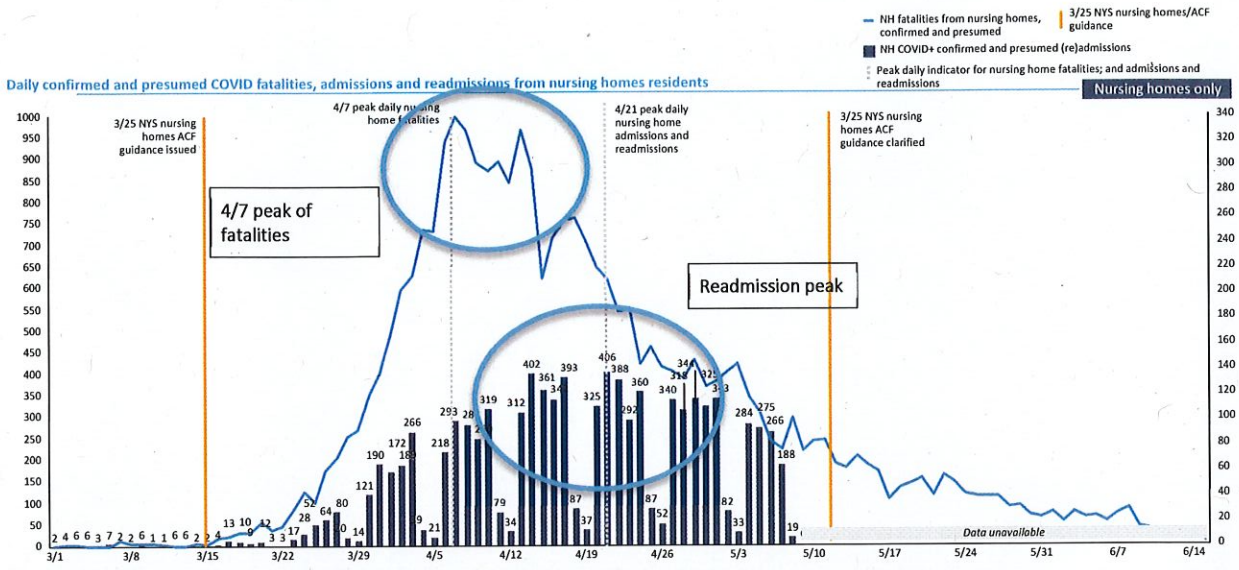
Figure 4. Example of No Causation Between Cumulative Mortality Versus Admissions/Readmissions, Select Facilities



Note: For a facility-by-facility examination of admissions versus fatalities see Appendix XX.

Following the timeline under Figure 5 below, data invalidates a cause and effect between a March 25th timeline and rate of mortality. Nursing home resident fatalities peaked on the week of April 1-7, 2020. The peak of nursing home admissions or readmissions was not until April 14, 2020.

Figure 5: Nursing Home Fatality Curve and Admission Readmissions Over Time



Source: Facility Survey as of 5/27/2020 for COVID+ readmissions and admissions 3/1-5/8

As the nursing home death peak occurred 7 days before the peak of readmissions of COVID-positive residents, it suggests no causation. Also, a directive issued March 25th is highly unlikely, given the incubation period, to cause death by April 7, 2020.

Further, admissions and readmissions of residents with COVID-19 were still increasing when the number of nursing home deaths was already declining. If the March 25, 2020 guidance was a major causative factor in nursing home deaths, the peak in deaths should have occurred after the peak in admissions, not before.

The data suggests that people readmitted to nursing homes were most likely not contagious. Per CDC data, COVID-positive individuals are likely not capable of transmitting the virus after 9 days from the onset of the illness. The CDC stated "the statistically estimated likelihood of recovering replication competent virus approaches 0 by 10 days." This comports with the CDC policies related to return to work and removal from isolation precautions after a positive COVID test. Viral shedding after this date, it is widely noted, is unlikely to transmit the virus. Length of stay data showed that for nursing home admissions and readmissions average

length of stay for hospital visits were about 8-10 days. This is beyond the period of viral transmission. According to the CDC people are most infectious in the pre-symptomatic stage or 1-4 days after symptom onset. Therefore, patients admitted or readmitted to nursing homes were likely not infectious.

An additional complication is that health experts will opine that keeping a senior citizen in a hospital bed for multiple days longer than necessary poses a serious risk to the patient by being subject to a secondary infection such as sepsis or staph infection. What policy would justify posing a high risk to the patient if there were not likely contagious and the nursing home certified by law they would isolate them and protect the residents? OR send them to one of the alternative facilities state had opened in event nursing home could not accept them.

IV. Nursing Home Quality Contributing to COVID-19 Resident Exposure

We analyzed whether nursing homes that had a prior performance record of lower quality over the past several years had a higher death rate than nursing homes with a record of higher quality performance. In fact, the data shows the opposite is true. Using the Quality rating system developed by CMS, 5-Star Quality Rating System, nursing homes with higher CMS quality ratings were found to have higher mortality rates than those with lower quality ratings (Figure 6).

Figure 6: CMS Quality Rating vs. Fatality Rate by Region

STATEWIDE | Nursing homes only

		Facility rating				
		1	2	3	4	5
Statistics (including mortality rate) by facility rating segment[1]	Number of NH	97	104	108	129	159
	Average Population	142	171	192	162	171
	Total capacity	15,509	19,548	22,357	22,961	30,066
	Total population	13,746	17,818	20,730	20,958	27,138
	Occupancy	89%	91%	93%	91%	90%
	Confirmed and presumed COVID deaths	937	1,391	2,272	1,912	3,292
	Mortality rate	7%	8%	11%	9%	12%

		% rated by group		
		# of facilities	Rated 1 to 2	Rated 4 to 5
Breakdown of county facilities by rating	New York City	167	19%	59%
	Long Isand	74	19%	62%
	Mid-Hudson	87	24%	53%
	Rest of State	264	50%	37%

Source: Facility Survey as of 5/27/2020 for readmissions and admissions 3/1-5/8, nursing homes Detail as of 5/26/2020. Facility ratings come from https://data.medicare.gov/Nursing-Home-Compare/Provider-Info/4pq5-n9py

From the data, the apparent explanation for this phenomenon is that the location of the nursing home facility had a greater causal connection than the performance of the nursing home facility.

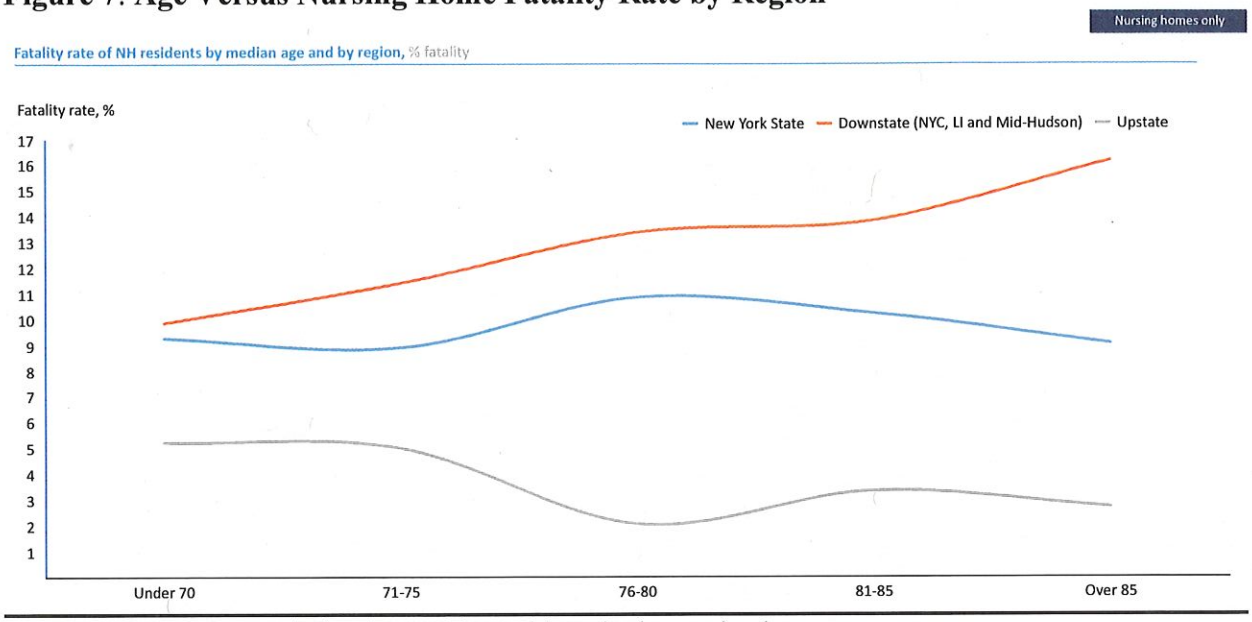
Data show the predominance of nursing home deaths were in downstate New York and unrelated to the performance of the particular nursing home. This supports the theory that community spread among employees or possibly visitation by family and friends were relevant factors rather than readmissions or facility quality.

V. Age of the Nursing Home Resident as a Factor for Mortality

Another factor was reviewed on impact of mortality – age of the resident. As data show, older individuals are more susceptible to death from COVID-19 infection. The analysis between resident age and mortality suggests a relationship between a higher median resident age and an increase in the mortality rate. This is more pronounced in geographic areas where there were more nursing homes deaths. Downstate New York, which had a higher mortality rate,

demonstrates this point. Upstate New York, with few nursing home residents, has less of a causal connection.

Figure 7: Age Versus Nursing Home Fatality Rate by Region



Source: MDS 2019 - Analysis of age of the residents in the nursing homes

CONCLUSION

Several factors are clear from our analysis and research.

Older people are more susceptible to the risk of mortality by COVID-19 and congregate settings pose a risk.

New York State has a lower percentage of deaths in nursing homes than most states, ranking 35th in comparison to other states.

-
- Data shows nursing home quality is not a factor in mortality from COVID.
- Data show community spread has the strongest correlation to nursing home fatalities.

Timeline data comparing nursing home policies and mortality rate timelines suggests COVID-19 transmission was most likely caused by employees entering the facility. Early in the COVID crisis health experts suggested a-systematic people did not spread the disease and

asymptomatic employees were allowed to work. Later in the crisis, health care experts changed their opinion and found asymptomatic people could transmit the disease. There is no specific information to assess how many asymptomatic employeestransmitted the disease. Nursing home deaths spiked approximately April 1-7. CDC guidance did not provide for employee testing or isolation until May 3rd.

Also, there was a limited national testing early in the disease. Both factors are likely relevant to employee spread.

Family and friend visitation was ended on March 13th. There was no testing of family and friends visiting the facility prior to March 13th. Again, asymptomatic visitors were allowed access. There is no data on the infection rate among family and friends.

The March 25th CDC guidance and state directive against prohibiting discrimination of COVID-positive people is not supported by the data to be a significant factor. The peak mortality rate was early April, before COVID-positive people could have reentered the nursing home, infected other people, incubating in other people, and caused death. Residents readmitted were on average 8-9 days past infection. Health experts believe the virus is not transmitted after 9 days and is mostly transmitted in pre-symptomatic stages to 1-4 days post infection.

The directive against discrimination did not mandate nursing homes to accept COVID-positive residents. In fact, the opposite is true. By law, a nursing home was prohibited from accepting a COVID-positive person unless they could isolate the person in a manner protecting other people in the nursing home. It is an open question and currently a matter of investigation whether nursing homes did violate this provision of law. However even if they did, it is highly unlikely a COVID-positive readmission was a significant factor given the factors outlined above e.g. timeline, little likelihood of transmission post 9 days. Health experts widely agree that they

Testing done by the state in May showed a very high percentage of nursing home employees had covid antibodies. In some facilities as high as 70 percent. By definition, with that high a percentage of employee positive it is a causal ~~consequence~~ factor for spread to patients.

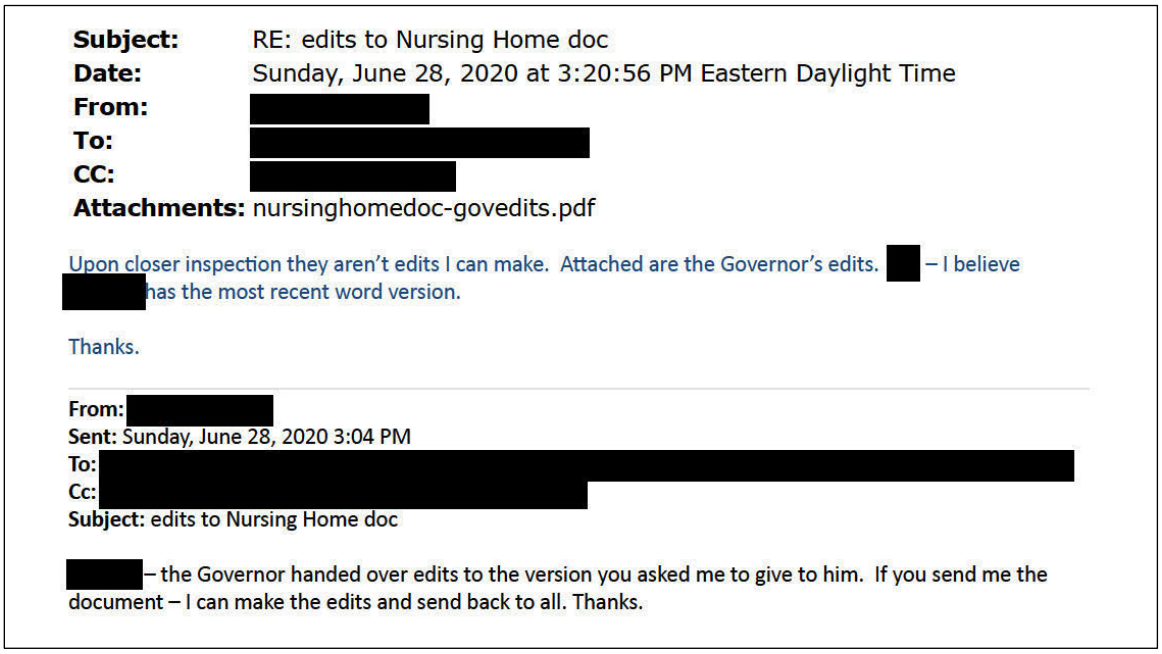
There was no necessity that the nursing home accept covid positive readmissions as the State had numerous available facilities + beds available as viable alternatives for any patients the nursing homes chose not to accept.

would advise against leaving an older patient in a hospital for a longer period than necessary as the risk to the patient increases dramatically. The longer the hospital stay, the more likely a patient could contract a secondary infection such as sepsis or staph infection.

Given these circumstances, a policy to leave a recovering COVID patient in a hospital rather than returning them to a nursing home that can safely treat them is problematic. There is no justification to increase the health risk of a recovering COVID patient IF the nursing home can effectively treat them in a protective environment, as required by law. To significantly endanger the health of 9,600 COVID-positive patients there must be a rationale. Total fatalities were approximately 8,000. As a matter of policy, the Department of Health has two options; either insure the nursing home comply with the law requiring isolation and protective care or create new facilities for senior residents to convalesce with populations that are recovering from similar disease or infections, if such a situation as COVID arises in the future. However, in any event, the data does not show that admissions or re-admissions of COVID-positive individuals was a significant factor in the mortality rate in nursing homes.

Or provide them one of the thousands of alternative beds available to the state.

43. On June 28, 2020, Executive Chamber staff communicated about Mr. Cuomo's edits to the July 6 Report.[58]



Subject: RE: edits to Nursing Home doc
Date: Sunday, June 28, 2020 at 3:20:56 PM Eastern Daylight Time
From: [redacted]
To: [redacted]
CC: [redacted]
Attachments: nursinghomedoc-govedits.pdf

Upon closer inspection they aren't edits I can make. Attached are the Governor's edits. [redacted] – I believe [redacted] has the most recent word version.

Thanks.

From: [redacted]
Sent: Sunday, June 28, 2020 3:04 PM
To: [redacted]
Cc: [redacted]
Subject: edits to Nursing Home doc

[redacted] – the Governor handed over edits to the version you asked me to give to him. If you send me the document – I can make the edits and send back to all. Thanks.

44. The version of the July 6 Report attached to this e-mail also included handwritten edits and comments. When asked about the source of the handwriting, Ms. Kennedy testified:

Q.	Do the handwritten notes appear to be Mr. Andrew Cuomo's handwriting?
A.	They appear to be.[59]

[REMAINDER OF PAGE INTENTIONALLY BLANK]

[58] E-mail from Executive Chamber Staff to Executive Chamber Staff (June 28, 2020, 3:20 p.m.).
[59] Kennedy TI at 26.

Subject: RE: edits to Nursing Home doc
Date: Sunday, June 28, 2020 at 3:20:56 PM Eastern Daylight Time
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DRAFT
PRIVILEGED AND CONFIDENTIAL

Factors Correlating with Nursing Home Fatalities in New York State During the COVID-19 Global Health Crisis

New York State Department of Health
June 2x, 2020

Executive Summary

An in-depth analysis of nursing home data finds that the transmission of the COVID-19 virus into nursing home and adult care facilities in New York is directly correlated to wider community spread in the nursing home's immediate community—more specifically, the transmission into nursing homes is directly correlated to infected nursing home staff.

According to data compiled by the New York State Department of Health (NYSDOH), submitted to NYSDOH by the nursing home facilities themselves, in many cases under the penalty of perjury, 37,800 nursing home staff members—one in four of the state's approximately 158,000 nursing home workforce — was infected with COVID-19 between March and early June. Of them, nearly 7,000 infected nursing home staff were working in facilities in the month of March; during the same period, more than half of the state's nursing home facilities (344 nursing homes) had residents who became infected with the virus. More than 20,000 infected nursing home workers were known to be COVID positive by the end of the month of April. These workforce infections are reflective of the larger community spread of the virus across the state.

NYSDOH further analyzed the timing of the COVID positive staff cases and the timing of nursing home deaths. The average length of time between infections to death is between 18-25 days. Therefore, the timing of staff infection directly correlating to nursing home mortality is supported by the fact that the peak number of nursing home staff reporting COVID-19 symptoms occurred on March 16th – 21 days prior to the date of the peak nursing home fatalities, which occurred on April 8th.

NYSDOH also examined the potential impact of the NYSDOH's March 25th admission policy. A preliminary survey conducted by NYSDOH in May shows that approximately 5,505 COVID-positive residents were admitted to facilities between March 25th and May 10th; this

finding is supported by an independent analysis done by the *Associated Press* on May 22nd.[1] However, an analysis of the timing of admissions versus fatalities shows that it could be not the driver of nursing home fatalities. An individual nursing_home-by-nursing_home analysis of admissions versus fatalities further supports this finding.

A causal link between the admission policy and fatalities would be demonstrable through a direct link in timing between the two –meaning that if admission of patients into nursing homes caused infection – and by extension mortality – there would be a direct causal link between the peak date of admission and the peak date of mortality. However, the peak date COVID-positive residents entered nursing homes occurred on April 13, a week *after* peak mortality in New York's nursing homes occurred on April 6.

NYSDOH further analyzed the period of time patients stayed in hospitals prior to admission to nursing home facilities. Preliminary data show that residents were on average admitted to nursing homes after 8-9 days of hospitalization. Health experts believe that individuals infected with the virus are most infectious 2 days before symptoms appear and that they are likely no longer infectious 9 days after symptom onset – thus, by the time these patients were admitted to a nursing home after their hospital stay, they were no longer contagious.[2]

NYSDOH also considered the impact of visitation into nursing homes as a cause of infections. A review shows that prior to nursing home visitation being suspended completely on March 13th, there was no tracking or testing of family and friends who were present in the facility, and any asymptomatic visitor would have been granted access. Given what we now know about how widespread the virus was in New York prior to testing availability in February and

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[1] Bernard Condon, Jennifer Peltz, and Jim Mustain, Over 4,500 virus patients sent to NY nursing homes" *Associated Press* (May 22, 2020) located at https://apnews.com/5ebc0ad45b73a899efa81f098330204c.

[2] He, Xi et al, Temporal dynamics in viral shedding and transmissibility of COVID-19, *Nature* (April 15, 2020) located at https://www.nature.com/articles/s41591-020-0869-5.

early March, there is a high likelihood that COVID positive visitors entered nursing homes, although there is no specific data to support this assumption, and so ultimately, this is inconclusive.

Background[3]

Nations all across the globe have been significantly impacted by COVID-19. The situation rapidly and dramatically altered everyday life—requiring social distancing, closing of schools and businesses, and restricting access to hospitals and other congregate facilities.

New York State was one of the earliest states affected by COVID-19 resulting from inbound travel from Europe.[4] On March 1, 2020, NYS identified its first case of COVID-19 in an international traveler. On March 3, 2020, the first COVID-19 case with no travel-related risk factors was identified in Westchester, NY; contact tracing revealed additional infected contacts.

Congregate settings, like nursing homes, are particularly vulnerable to infectious diseases like COVID-19[5], and many states in the nation and nations around the world have had to grapple with this difficult situation. The first known positive COVID-19 nursing home case in the United States was discovered when a Kirkland, Washington resident was transferred to a hospital on February 24, 2020 and later tested positive. In New York, the first known introduction of COVID-19 into nursing homes occurred on March 5, 2020 when a nursing home staff member tested positive; the first confirmed case of COVID-19 in a nursing home resident occurred on March 11, 2020.

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[3] The New York State Department of Health staff was supported by McKinsey & Company.
[4] Gonzalez-Reiche AS, Hernandez MM, Sullivan M, et al. Introduction and Early Spread of SARS-CoV-2 in New York City. Science. 29 May 2020; doi: 10.1126/science.abc1917. Online ahead of print.
[5] Centers for Disease Control and Prevention (2020). Nursing Homes and Assisted Living (Long Term Care Facilities [LTCFs]). Retrieved from https://www.cdc.gov/longtermcare/index.html. 26 June 2020.

The New York State Department of Health (NYSDOH) undertook aggressive steps to prepare healthcare facilities for COVID-19 to prevent and control the spread of COVID-19 in the state's 613 nursing homes, issuing orders, directives and guidance to nursing homes on a variety of topics, including, but not limited to: anticipating personal protective equipment shortages (February 2, 2020), infection control in healthcare facilities (February 25, 2020), specific nursing home infection control and health and safety guidance (March 6, 2020, March 11, 2020, & March 13, 2020).

On March 13 the NYSDOH mandated staff temperature checks every 12 hours, mandated use of face masks and PPE by all staff, and cancelled congregate activities within nursing homes. The same day, Governor Cuomo issued an executive order banning all nursing home visitation statewide; expanding an order issued days earlier in New York's first known 'hot spot' New Rochelle on March 7. Moreover, the state created strict penalties for non-compliance, including the potential for a nursing home to lose its operating license.

On May 10, New York State mandated twice weekly testing of staff for nursing homes in regions of the state operating in phases 1 and 2 of reopening, and once weekly testing for all nursing homes in phase 3 and beyond. NYSDOH surveyors and epidemiologists conducted over 2,000 of calls, video assessments, and in-person assessments to support nursing homes and assess deficiencies through April 2020 and, over the course of the crisis, provided nursing homes with 8,510,729 pieces of PPE.

Analysis of COVID-19 Nursing Home Fatalities

Below is an analysis of possible factors correlating to infection rates or mortality rates in nursing homes.

We analyzed the following factors—many of which have been suggested as potential causes of nursing home infections —to determine correlation, including:

I. New York nursing home fatalities vs the rest of the country

II. COVID-19 staff illness in the nursing home as a possible source of exposure

III. Transmission from residents with COVID-19 who were admitted or readmitted to the nursing homes

IV. Nursing home quality of care ratings contributing to COVID-19 resident exposures

V. The age of the nursing home residents as a factor for mortality

I. New York State Nursing Home Fatalities vs the Rest of the Country

First, NYSDOH considered whether fatalities occurring in New York's nursing homes were anomalous or disproportionate to the rest of the country. Data, however, demonstrates that COVID-19 has been a challenge for nursing home and adult care facilities nationwide.

New York State has approximately 100,000 nursing home residents housed in 613 nursing home facilities statewide. An analysis conducted by the Kaiser Family Foundation in 2017 indicates that New York State has more nursing home residents than any state in the nation, despite being the fourth most populous state:

State	Number of Nursing Facilities	Number of Residents
Alabama	228	22,482
Alaska	18	608
Arizona	145	11,343
Arkansas	231	17,439
California	1,198	101,030
Colorado	221	16,078
Connecticut	223	22,653
Delaware	45	4,181

District of Columbia	18	2,380
Florida	690	72,741
Georgia	359	33,043
Hawaii	42	3,474
Idaho	71	3,319
Illinois	731	66,643
Indiana	552	38,682
Iowa	437	23,638
Kansas	276	14,657
Kentucky	285	22,760
Louisiana	277	26,169
Maine	100	5,947
Maryland	226	24,414
Massachusetts	399	38,673
Michigan	443	38,062
Minnesota	375	24,755
Mississippi	204	15,950
Missouri	518	37,874
Montana	72	4,153
Nebraska	214	11,394
Nevada	61	5,336
New Hampshire	74	6,442
New Jersey	364	44,033
New Mexico	74	5,693
New York	609	101,518
North Carolina	429	35,763
North Dakota	80	5,531
Ohio	966	73,826
Oklahoma	303	18,361
Oregon	136	7,317
Pennsylvania	693	76,652
Rhode Island	83	7,817
South Carolina	191	16,993
South Dakota	108	5,984
Tennessee	314	26,481
Texas	1,227	92,250
Utah	99	5,178
Vermont	36	2,440
Virginia	286	27,595
Washington	217	15,993

West Virginia	123	9,251
Wisconsin	374	24,239
Wyoming	38	2,428
TOTAL USA	15,483	1,321,663

According to an analysis done by the *New York Times* on June 26, 2020, "at least 54,000 residents and workers have died from the coronavirus at nursing homes and other long-term care facilities for older adults in the United States, and as of June 26, the virus has infected more than 282,000 people at some 12,000 facilities". The same *New York Times* analysis found that in terms of percentage of total deaths in nursing homes, New York State ranked 46th in the nation – meaning 45 states had greater percentage of fatalities (even with some states being ranked only for confirmed fatalities and some—including New York—being ranked based on confirmed *and presumed* fatalities) (Table 1).[6]

Table 1. Cases and deaths in long-term care facilities, by state

		Facilities	Cases	Deaths	Share of COVID Deaths
	United States	12,000	282,000	54,000	43%
1	New Hampshire	26	1,967	293	80%
2	Rhode Island	64	2,745	715	77%
3	Minnesota	853	5,777	1,107	77%
4	Connecticut	289	9,888	3,124	73%
5	Pennsylvania	678	20,689	4,518	68%
6	North Dakota	65	569	56	64%
7	Massachusetts	565	23,321	5,115	64%
8	Idaho	30	323	56	62%
9	Maryland	289	12,641	1,924	61%
10	Virginia	236	6,714	1,039	61%
11	Kentucky	172	2,626	350	61%

[6] "43% of U.S. Coronavirus Deaths Are Linked to Nursing Homes", *New York Times* (June 27, 2020) located at https://www.nytimes.com/interactive/2020/us/coronavirus-nursing-homes.html?action=click&module=Spotlight&pgtype=Homepage.

12	Washington	389	4,376	779	60%
13	Vermont	6	172	32	57%
14	Ohio	530	9,928	1,580	57%
15	North Carolina	170	5,445	746	57%
16	Maine	16	485	58	56%
17	Kansas	100	927	149	56%
18	Oregon	49	821	112	55%
19	Colorado	166	5,660	910	54%
20	Oklahoma	134	1,647	201	53%
21	Florida	1,011	11,472	1,748	52%
22	Delaware	31	687	263	52%
23	Illinois	593	21,390	3,649	52%
24	Iowa	54	2,030	360	51%
25	Mississippi	137	2,787	507	50%
26	West Virginia	37	394	45	49%
27	California	923	23,646	2,832	48%
28	South Carolina	171	2,541	317	46%
29	Georgia	533	9,939	1,237	45%
30	New Jersey	562	36,316	6,617	44%
31	Indiana	268	5,147	1,140	44%
32	Texas	863	6,641	1,031	44%
33	South Dakota	58	384	38	43%
34	Utah	191	906	70	42%
35	Louisiana	400	7,833	1,315	41%
36	New Mexico	55	250	180	37%
37	Arizona	289	3,902	541	—
38	Tennessee	85	1,513	195	34%
39	Nebraska	119	519	92	34%
40	Arkansas	113	978	83	33%
41	Michigan	240	10,630	2,031	33%
42	Montana	3	35	7	32%

43	District of Columbia	20	1,072	173	32%
44	Wyoming	4	54	6	30%
45	Nevada	75	1,289	135	27%
46	New York	509	7,177	6,432	21%
47	Alabama	131	3,746	112	—
48	Hawaii	15	89	1	—
49	Missouri	118	1,394	15	—
50	Alaska	10	93	0	—
51	Wisconsin	318	1,242	0	—

SOURCE: *New York Times;* States with insufficient data to calculate a share of Covid-19 deaths are shaded gray.

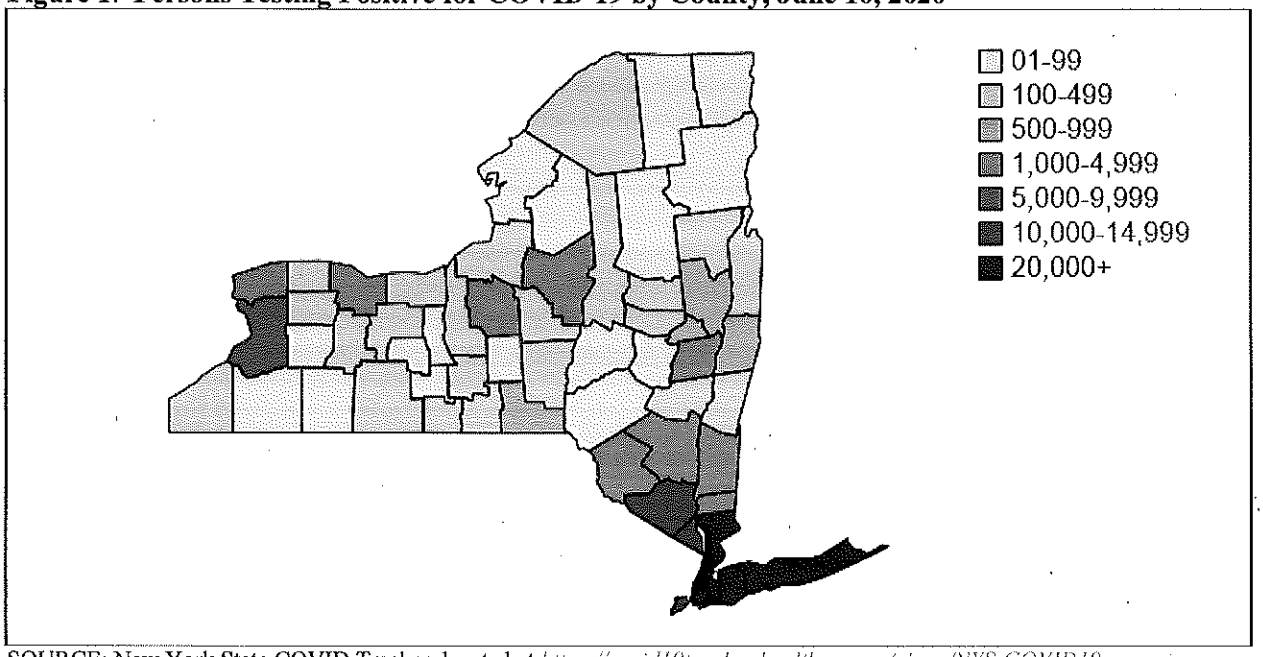
Further, an examination of fatalities in our neighboring states – despite having populations much smaller than New York's –illustrates clearly that nursing home fatalities were not a New York specific phenomenon: New Jersey reports 6,617 nursing home deaths, Massachusetts reports 5,115 nursing home deaths, Pennsylvania reports 4,518 nursing home deaths and Connecticut reports 3,124, compared to New York's XX

II. COVID-19 Staff Illness Contributed to Infections of Nursing Home Residents

Within New York State, there has been significant geographic variation in overall positive tests within the community (Figure 1) and nursing home cases and fatalities. The most impacted regions in New York State were in the downstate region (Mid-Hudson Valley, New York City, and Long Island) and those regions had the highest nursing home fatality rates.

This is a higher need area

Figure 1. Persons Testing Positive for COVID-19 by County, June 10, 2020



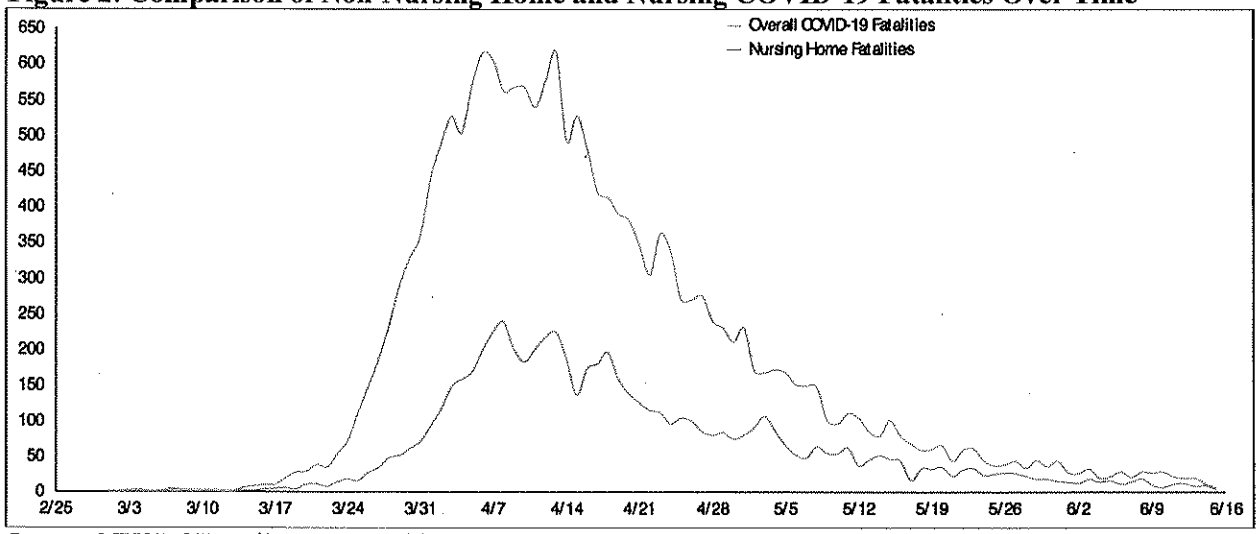
SOURCE: New York State COVID Tracker, located at *https://covid19tracker.health.ny.gov/views/NYS-COVID19-Tracker/NYSDOHCOVID-19Tracker-Map?%3Aembed=yes&%3Atoolbar=no&%3Atabs=n*, Accessed June 11, 2020.

Did Broader Community Infections Impact Nursing Home Infections?

As Figure 2 demonstrates, the mortality curve for nursing home residents closely follows the mortality curve for non-nursing home residents, with the peaks occurring at similar dates. This suggests a correlation between general geographic community spread and infections and fatalities in nursing homes.

BY geographic location.

Figure 2: Comparison of Non-Nursing Home and Nursing COVID-19 Fatalities Over Time



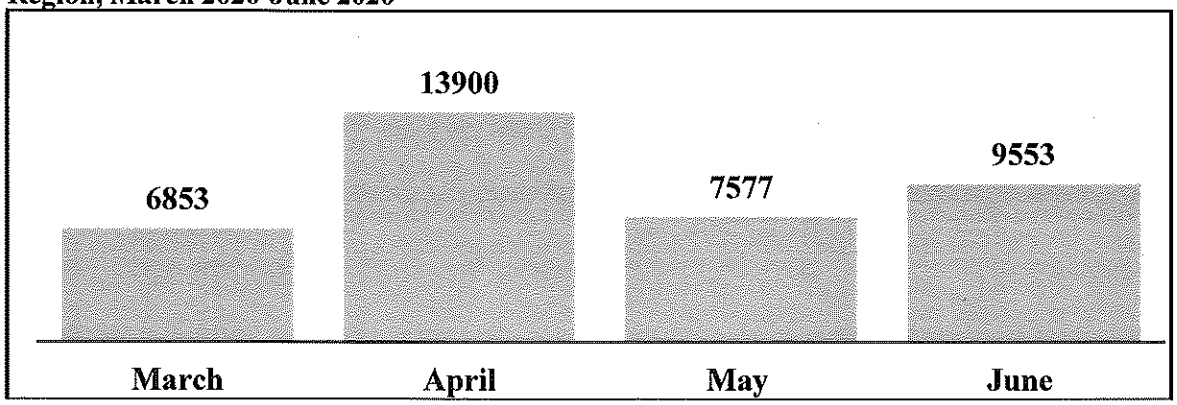
Source: NYSDOH Daily DOH Health Emergency Response Data System (HERDS) as of 6/16 1pm.

Why Does Broader Community Spread Impact Nursing Homes?

But why does the data show that nursing home fatalities mirror the overall curve and timing of COVID-19 in New York State writ large? Evidence suggests that nursing home residents were infected with COVID-19 as a result of transmission by the workforce.

Based on NYSDOH nursing home supplemental survey conducted on June 9, 2020 for the months of March, April, and mid-May found that 28,330 nursing home staff were confirmed or suspected COVID-positive cases across New York State. An additional staff testing initiative through from May 20, 2020 to June 16, 2020 found that 9,077 additional staff tested positive. That means in out of approximately 158,000 nursing home employees in the state 37,880, nursing home staff presumed or confirmed positive for COVID-19—or one out of every four workers were infected.

Figure 3. Number of Nursing Home Employees Confirmed or Suspected to be COVID-Positive, By Region, March 2020-June 2020



SOURCE: NYSDOH Nursing Home Staff Testing Survey, 6/9, data reported by NYS nursing homes to NYSDOH

Additional studies support this finding. In a May 2020 serological study conducted by the lab BioReference of 4,900 nursing home employees in New York State found that 31% of the nursing home staff tested positive for having the COVID-19 antibodies. Extrapolating that number nearly up to 47,000 nursing home staff were infected by May.

Moreover, many of the nursing home residents were in those areas most impacted in New York State, including in the outer boroughs of New York City, Long Island, and the Mid-Hudson Valley. For example, 80% of all infected nursing home staff were from the most impacted areas of the state: New York City (48%), Long Island (17%), and the Mid-Hudson Valley (15%) with only 20% coming from the rest of the state. Not only was the number of nursing home staff significant, they were found in the most impacted regions, correlating to the overall community spread in the most impacted areas.

Why were infected nursing home staff able to likely infect residents in the nursing homes? In March, the federal government's Centers for Disease Control and Prevention (CDC) did not suspect that asymptomatic people were likely to spread the infection. Therefore, the CDC guidance issued on March 7, 2020 stated that "Asymptomatic HCP [healthcare personnel]

in this category are not restricted from work."[7] This early, and ultimately, erroneous, understanding of viral spread allowed many nursing home COVID-positive employees to continue working. It was not until much later that as the true number of asymptomatic cases became clear, evidence based upon contact tracing established definitively that asymptomatic people were in fact capable of spreading the virus.

To compound the situation, on March 13th the CDC issued guidance that nursing home employees that were symptomatic, but not tested, should wait only three days after the symptoms had passed to return to work and only seven days after the COVID-19-like symptoms first appeared.[8] As more was learned about COVID-19, CDC issued updated guidance on April 30 increasing isolation to 10 days.[9] However, by that point, as data show, the disease was already in the nursing homes. It is likely that a significant percentage of both symptomatic and asymptomatic employees were advised to continue working and thus spread the disease within the facility.

As Figure 4 illustrates below, the peak of nursing home fatalities was in early April. In order to address possible correlation, you must consider COVID-19's incubation period. According to the CDC (DROP IN FOOTNOTE CITATION), the incubation period for COVID-19 is as follows:

> Infection to symptoms: Avg. 5 days (range 2-14)
> Symptoms to hospital: Avg. 8 – 12 days
> Infection to hospital: Avg. 13 – 17 days

---

[7] "Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease (COVID-19)" Centers for Disease Control and Prevention (March 7, 2020) located at https://web.archive.org/web/20200404194131/https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html. CDC did not recommend changing the beginning of the exposure period from the onset of symptoms to "48 hours before symptom onset" until April 2020.

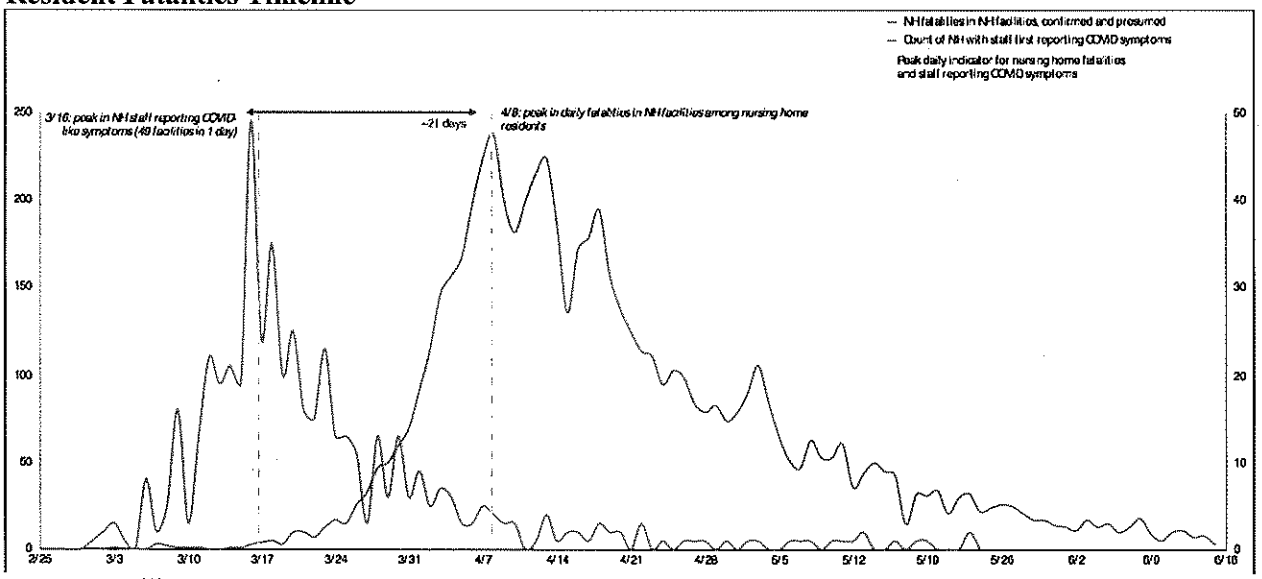
[8] "Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19 (Interim Guidance)" Centers for Disease Control and Prevention located at: https://web.archive.org/web/20200404023742/https:/www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fhcp-return-work.html.

[9] CDC Guidance updated on April 30, 2020.

Symptoms to death: Avg. 13 – 20 days
Infection to death: Avg. 18 – 25 days

Given this incubation period, it is likely that thousands of employees infected in mid-March could have unknowingly transmitted the virus while working, which then led to resident infection and subsequently deaths 3-4 weeks later, something that Figure 4 demonstrates. The average length of time between infections to death is between 18-25 days. Therefore, the theory that staff infection directly correlates to nursing home mortality is supported by the fact that the peak number of nursing home staff reporting COVID-19 symptoms occurred 21 days prior to the date of the peak nursing home fatalities.

Figure 4. Number of Nursing Homes Reporting First Symptomatic Staff and Nursing Home Resident Fatalities Timeline



Source: Facility Survey on staff illness as 6/9 and NYSDOH Daily DOH Health Emergency Response Data System (HERDS) survey6/9

However, other factors that cannot be ruled out include spread from family and visitors. As Figure 4 illustrates, nursing home fatalities were increasing in mid-March. New York State, acted early in its outbreak to ban any non-medical, including family and friends, visitation on March 13, 2020. The nursing home fatality peak was April 8, 2020. Given this timing, and given

the COVID-19 incubation period, it is possible that with visitation by family and friends prior to March 13, the potential for positive COVID-19 cases being among those visitors and spreading it within the facility was a contributing factor. There is no data on the infection rate of nursing home visitors, so this is inconclusive. All of this activity well pre-dated the March 25 admission policy for COVID-positive residents (see point 2, *Infra*).

III. Transmission from Residents with COVID-19 Who Were Admitted to the Nursing Homes

One of the factors that has been suggested by some observers to contribute to nursing home fatalities are the admission of COVID-positive residents. However, data does not support this assertion.

If the March 25 NYSDOH policy on admissions uniquely impacted nursing home fatalities, New York's nursing home fatalities would be disproportionate to the rest of the country. However, data shows the opposite to be true as, according to the *New York Times,* New York was 46th by percentage in the number of nursing home deaths. (*See,* Background, *Supra.*) Further, an examination of fatalities in our neighboring states – despite having populations much lower than New York's –illustrates clearly that nursing home fatalities were not disproportionate in New York: New Jersey reports 6,617 nursing home deaths, Massachusetts reports 5,115 nursing home deaths, Pennsylvania reports 4,518 nursing home deaths and Connecticut reports 3,124.

What Was the Specific State and Federal Policy on Admission?

New York State followed federal Centers for Medicare & Medicaid Services (CMS) guidance which stated that nursing homes **should** accept residents with COVID-19 as long as

they can use transmission-based precautions.[10] NYSDOH's March 25 admission guidance stated that a patient could not be rejected *solely on the basis of being suspected or confirmed COVID-19 positive (*DROP IN SPECIFIC LANGUAGE W CITATION). However, contrary to some press reports, neither CMS guidance nor the state directed that a nursing home must accept a COVID-positive person. In fact, the opposite is true. By state law, a nursing home could not accept a COVID-positive person unless the nursing home could provide "proper isolation and protective procedures."[11] It was in the nursing homes sole discretion to determine if they would accept the COVID-positive person and if they could provide adequate care. Furthermore, Title 10 of New York State Codes, Rules and Regulations clearly states, "a nursing home shall accept and retain *only* those nursing home residents for whom it can provide adequate care". Thus, it would be against the law for any nursing home operating in New York State to accept a patient it could not care for – in this instance that specifically meant a nursing home's ability to properly isolate patients and follow protective procedures.

Admission of COVID-19 Patients

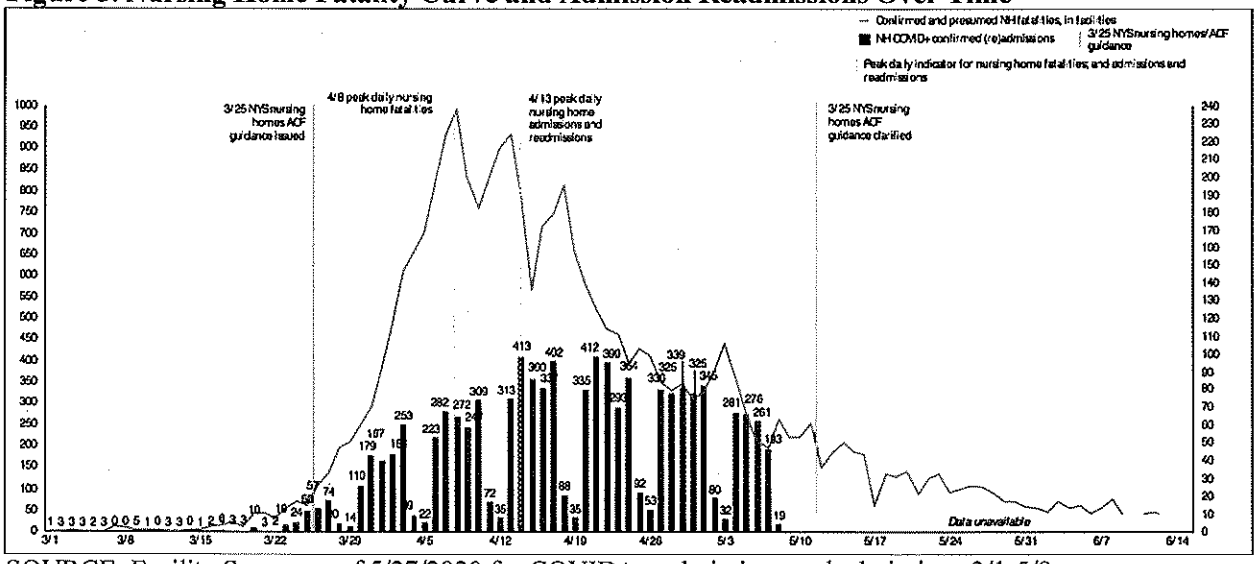
A preliminary statewide nursing home survey conducted in May for admission data from March 25th through May 9th, 2020 show that approximately 5,505 COVID-19 patients were admitted from a hospital to a total of 371 (CONFIRM THIS NUMBER) unique nursing homes with a total statewide nursing home population of nearly 100,000. However, by the point NYSDOH issued admission guidance on March 25, nearly 350 (WHAT IS THE SPECIFIC NUMBER) nursing homes already had residents that were infected.

---

[10] U.S. Centers for Medicare and Medicaid Services (13 March 2020). Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (Revised). (Report Ref: QSO-20-14-NH) Baltimore MD: US Centers for Medicare and Medicaid Services.

[11] *See* 10 NYCRR 415.26, establishing mandatory criteria for admission in nursing homes; see, also, CMS Guidance Related to COVID-19 in Nursing Homes.

Figure 5. Nursing Home Fatality Curve and Admission Readmissions Over Time



SOURCE: Facility Survey as of 5/27/2020 for COVID+ readmissions and admissions 3/1-5/8

Figure 5 above, shows the timeline of nursing home resident fatalities and COIVD-19 admissions. Nursing home resident fatalities peaked on April 8, 2020. The peak of nursing home admissions from hospitals did not occur until April 13, 2020, a week ***after*** peak nursing home fatalities —suggesting no correlation or causation.

Further, as Figure 5 shows, admissions of residents with COVID-19 were still increasing when the number of nursing home deaths was already *declining*. If the March 25, 2020 guidance was a causative or correlative factor in nursing home deaths, the peak in deaths should have occurred after the peak in admissions, not before.

In addition, the data suggests that people admitted to nursing homes were most likely not contagious. Per CDC data, COVID-positive individuals are likely not capable of transmitting the virus after 9 days from the onset of the illness. The CDC stated, "The statistically estimated likelihood of recovering replication competent virus approaches 0 by 10 days." This comports with the CDC policies related to return to work and removal from isolation precautions after a positive COVID test. CDC isolation period has been currently established to be 10 days. In April, the

CDC suggested an even more reduced isolation period of 7 days after testing positive as long as 72 hours had been with symptoms reducing and no fever.[12] Any viral shedding after this date, it is widely noted, is unlikely to transmit the virus, although it may still result in a positive PCR test. Length of stay data shows that for nursing home admissions average length of hospital had a median of 7-9 days. This is beyond the period of viral transmission. According to the CDC, people are most infectious in the pre-symptomatic stage or 1-4 days after symptom onset.

Approximately one-third of the total readmissions and admissions were readmissions, which means many of these residents were pre-symptomatic or in the early stages of illness at the nursing home when they would have been infectious but before COVID-19 might have been recognized and the resident put on transmission-based precautions. Therefore, based on the most cautious current provisions any patients admitted or readmitted to nursing homes were likely not infectious, which at the time they were being readmitted would have far exceeded the CDC standard.

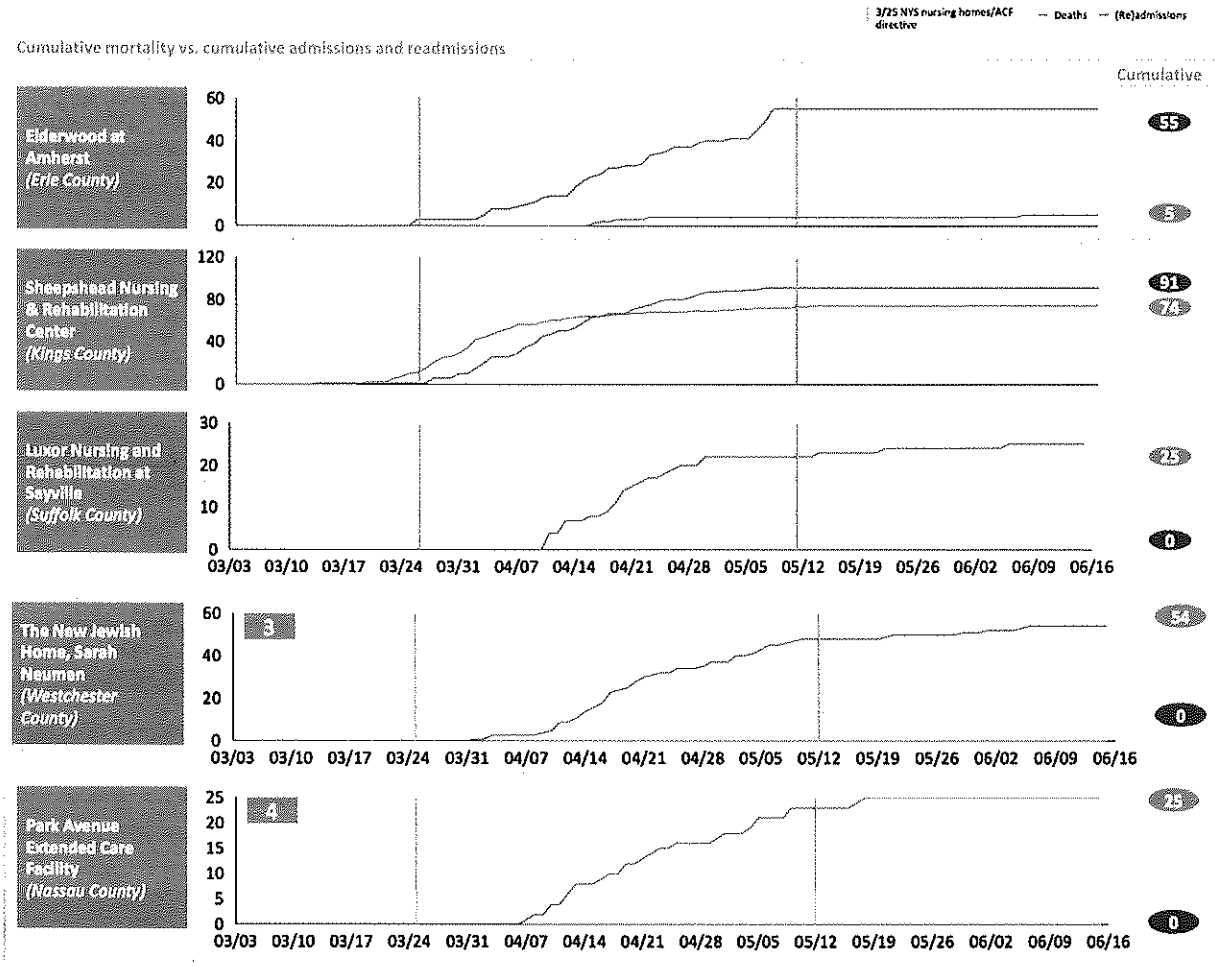
Does Intra-Facility Transmission Increase Nursing Home Fatalities?

The data do not demonstrate or correlate to a subsequent intra-facility transmission or increased mortality. As exemplified in Figure 6, many nursing homes that did not admit any COVID-positive patients, yet still had a high number of COVID related deaths. As the chart demonstrates in three cases, one facility with zero readmissions or admissions still had 54 deaths. In fact, 55 nursing homes that had 0 admissions from hospitals, nonetheless had one or more

[12] Centers for Disease Control and Prevention https://web.archive.org/web/20200417211515/https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fhcp-return-work.html.

COVID-19 fatalities. A total of 183 facilities had their first COVID-19 fatality before or on the day of their first readmission.

Figure 6. Cumulative Mortality Versus Admissions/Readmissions, Select Facilities



SOURCE: Daily HERDS and DOH Supplemental admission readmission survey submitted, as reported by NYS nursing homes

Were There Alternative COVID-Only Sites Established?

The State had secured various alternative facilities for COVID-positive nursing home patients had any nursing home declined to accept them. The state had secured thousands of additional healthcare beds suitable for COVID-positive nursing home patients. During the

outbreak, the state even created COVID-positive exclusive facilities for nursing home residents across the state. In New York City, the state created the Brooklyn Center in Brooklyn with 281 beds run by Maimonides and South Beach in Staten Island with 259 beds operational. In Upstate, Catholic Health's St. Joseph Post-Acute Center (operating under the license of Father Baker Manor Home) was made a COVID-only facility with 80 beds. In addition, surplus capacity was made available at SUNY Downstate Hospital in Brooklyn and SUNY Upstate Hospital in Syracuse. Therefore, there was no need for nursing homes to accept COVID-positive patients if they did not believe they could provide adequate care, as required by law, as the state had available alternatives. The State Department of Health and Attorney General's office are doing an investigation to determine, among other things if nursing homes violated this law.

IV. Nursing Home Quality Contributing to COVID-19 Resident Exposure

We analyzed whether nursing homes that had a lower quality rating over the past several years had a higher death rate than nursing homes with a record of higher rating. In fact, this hypothesis is not substantiated. Using the Quality rating system developed by CMS, 5-Star Quality Rating System, nursing homes with higher CMS quality ratings were found to have higher mortality rates than those with lower quality ratings (Figure 7).

Figure 7. CMS Quality Rating vs. Fatality Rate, by Region

		STATEWIDE	Nursing homes only			
		Facility rating				
		1	2	3	4	5
Statistics (including mortality rate) by facility rating segment[1]	Number of NH	97	104	108	129	159
	Average Population	142	171	192	162	171
	Total capacity	15,509	19,548	22,357	22,961	30,066
	Total population	13,746	17,818	20,730	20,958	27,138
	Occupancy	89%	91%	93%	91%	90%
	Confirmed and presumed COVID deaths	937	1,391	2,272	1,912	3,292
	Mortality rate	7%	8%	11%	9%	12%
		% rated by group				
Breakdown of county facilities by rating		# of facilities		Rated 1 to 2		Rated 4 to 5
	New York City	167		19%		59%
	Long Island	74		19%		62%
	Mid-Hudson	87		24%		53%
	Rest of State	264		50%		37%

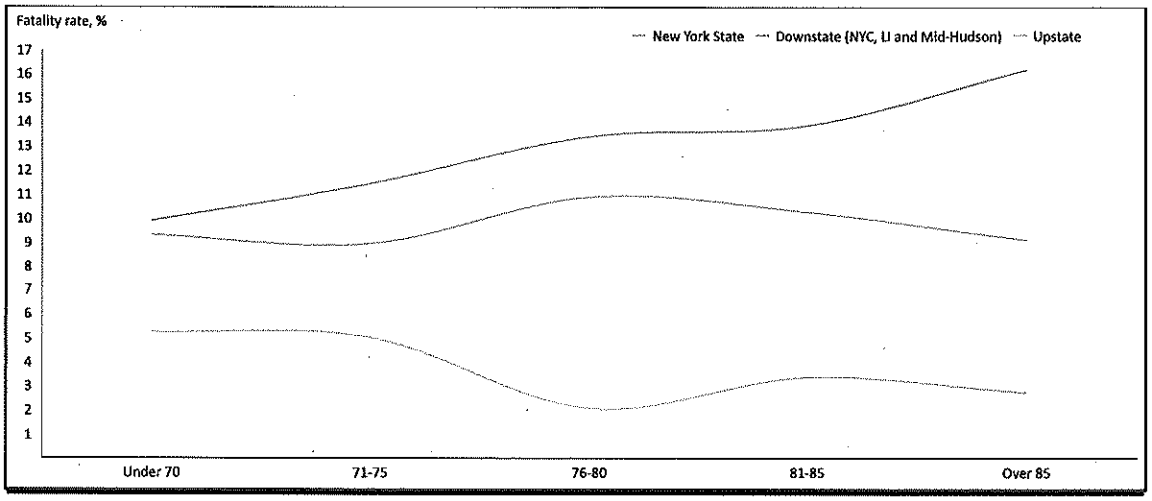
SOURCE: Facility Survey as of 5/27/2020 for readmissions and admissions 3/1-5/8, nursing homes detail as of 5/26/2020. Facility ratings come from https://data.medicare.gov/Nursing-Home-Compare/Provider-Info/4pq5-n9py.

From the data, the apparent explanation for this phenomenon is that the geographic location of the nursing home facility, and its corresponding rate of community infection had a greater connection than the performance of the nursing home facility. Data show the predominance of nursing home deaths were in downstate New York and unrelated to the performance of the particular nursing home.

V. Age of the Nursing Home Resident as a Factor for Mortality

Another factor was reviewed in relation to nursing home fatalities – age of the resident. As data show, older individuals are more susceptible to death from COVID-19 infection. The analysis between resident age and mortality suggests a relationship between a higher median resident age and an increase in the mortality rate. This is more pronounced in geographic areas where there were more nursing homes deaths.

Figure 8. Age Versus Nursing Home Fatality Rate by Region



SOURCE: MDS Q4 2019 - Analysis of age of the residents in the nursing homes

Conclusion

When examining the data, several factors are clear from our analysis and research:

- New York State has a lower percentage of deaths in nursing homes than most states, ranking 46th in comparison to other states.
- Data suggest nursing home quality is not a factor in mortality from COVID.
- Readmission policies were not the primary factor in nursing home fatalities.
- Data illustrate employee infections was related to community spread and employee transmission has the strongest correlation to nursing home fatalities.

Timeline data comparing nursing home policies and mortality rate timelines suggests COVID-19 transmission is strongly correlated by employees entering the facility. Early in the COVID-19 pandemic, the consensus among public health experts suggested asymptomatic people did not spread the disease and asymptomatic positive or presumed positive employees were allowed to continue to work. Later in the crisis, public health experts were forced to reverse this position as it became clear from the data that asymptomatic people could transmit the disease. Independent testing done by Bioreference in May showed 31% of nursing home

employees had COVID antibodies. By definition, with such a high a percentage of employees having at one time been positive for COVID-19 it suggests a strong correlation to contributing to the spread to patients.

Our analysis brings to the forefront the possibility of transmission from staff as an important mode of transmission. If we had accurate information about COVID transmission at an earlier time and had the testing capacity to detect asymptomatic but infected individuals, other procedures might have been taken. For example, asymptomatic employees should have been barred from facilities as if they were symptomatic, which is the current policy (*See,* Directive April 29, 2020 to Nursing Home Administrators). If widespread testing was available earlier, all employees could have been tested earlier (*See,* Executive Order 202.30, as amended). These are national issues that must be addressed as nursing homes as congregate settings will pose a continued risk for the Coronavirus or another public health threat in the future that attacks senior citizens.

45. These documents and testimony establish that Mr. Cuomo was involved in the drafting and review of the July 6 Report, despite him testifying otherwise.

b. Mr. Cuomo Directed the External "Peer Review" of the July 6 Report

46. The Select Subcommittee questioned Mr. Cuomo about whether he discussed the "peer review" process of the July 6 Report:

> Q. Did you have any discussions regarding the report being peer reviewed?
>
> A. No.[60]

47. Further, the Select Subcommittee questioned Mr. Cuomo regarding his knowledge of the involvement of persons outside of the NYSDOH in the review process of the July 6 Report:

> Q. Do you know if people outside of DOH were involved with drafting or editing this report?
>
> A. No.[61]

48. The Select Subcommittee questioned Dr. Malatras about the involvement of individuals outside of the NYSDOH, including Michael Dowling, Chief Executive Officer of Northwell Health, and Kenneth Raske, President and Chief Executive Officer of the Greater New York Hospital Association. Dr. Malatras testified:

> Q. While the July 6 report was being drafted, do you recall Raske having any input or involvement?
>
> A. Yes, I was on - - Ms. DeRosa was the one communicating with Mr. Raske on that report, and I believe she forwarded me. I mean, this is my recollection from four years ago. She forwarded me some comments. I do not remember the sum or substance of what those comments were.[62]

[60] Cuomo TI at 287.
[61] *Id.* at 173.
[62] Malatras TI at 29.

Q.	Are you aware of [Northwell Health] making any edits to the report, or just reviewing stuff and providing comments?
A.	They did. I remember there were e-mails that came back, where they did make recommendations for changes, of which I do believe some of them make it. Let me give you an example. I don't remember everything. Mr. Dowling from Northwell had not [sic] substantive to the facts or data, but he thought the executive summary should be clearer and rewritten, and I believe some of that was incorporated.[63]

49. Documents in the Select Subcommittee's possession corroborate Dr. Malatras' testimony about the involvement of Mr. Dowling and Mr. Raske.

50. Further, documents establish that it was Mr. Cuomo, himself, that directed the July 6 Report be peer reviewed by Mr. Dowling and Mr. Raske. On June 30, 2020, Ms. Benton emailed Executive Chamber staff.[64] A former Executive Chamber staffer told the Select Subcommittee that this e-mail was from Mr. Cuomo, consistent with his practice of dictating e-mails Ms. Benton sent.[65] The e-mail stated, "[g]et the Harvard guy[,] **dowling**[,] and **ken** Davis [sic] to be the **'peer review' experts** of the report. **Get them the draft now to study**."[66]

Subject: Ok?
Date: Tuesday, June 30, 2020 at 10:59:30 AM Eastern Daylight Time
From: Stephanie Benton
To: [redacted], [redacted] (health.ny.gov), [redacted], [redacted]

."we need to get the nursing home report out tomm morn at a 9 30 briefing in the city. Get the Harvard guy dowling and ken Davis to be the "peer review" experts of the report. Get them the draft now to study. They need to know the facts. Melissa do a briefing session with them tonite and walk thru report. Dr zucker has to know the report cold an be an aggressive advocate. The others will key off him. No one will be more aggressive than u Dr zucker. If they see u defer they will too. U have to set the tone. The facts are powerful. Giving these guys one day notice is unfair so get them the draft asap and walk them thru it.
Sent from my BlackBerry 10 smartphone on the Verizon Wireless 4G LTE network.

51. The e-mail does not specify who "dowling" and "ken" are, but subsequent e-mails establish that Mr. Cuomo meant Mr. Dowling and Mr. Raske.

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[63] *Id.* at 197-98.
[64] E-mail from Stephanie Benton, Executive Assistant, Executive Chamber, N.Y., to Executive Chamber Staff (June 30, 2020, 10:59 a.m.).
[65] Statement by Whistleblower to Select Subcomm. on the Coronavirus Pandemic Staff.
[66] E-mail from Stephanie Benton, *supra* note 66.

52. Later that same day, Mr. Dowling sent back edits and suggestions to an Executive Chamber staffer.[67] Mr. Dowling even stated, "Ken Raske's staff and mine can do a complete rewrite [of the Executive Summary] if you wish."[68]

Subject: Fw: CONFIDENTIAL
Date: Tuesday, June 30, 2020 at 4:32:24 PM Eastern Daylight Time
From: [redacted]
To: [redacted]

From: Dowling, Michael [redacted]
Sent: Tuesday, June 30, 2020 4:31 PM
To: [redacted]
Subject: CONFIDENTIAL

[redacted]

Overall – a good document. A few suggestions, however:

1. The Exec Summary needs to be redone with a clear statement of the problem/issue and the conclusion. That is, in effect, your press release. I would suggest something like the following.

   There has been much discussion of the number of nursing home patient deaths in NY and the causal relationship between nursing home admission policy and resident mortality. The DOH completed an independent analysis etc. and concluded:

   - NY State has a lower percentage of deaths in nursing homes than most states – ranking 46th.
   - Admission policies were not the factor in nursing home fatalities.
   - Mortality rate transmission is strongly correlated to employees entering the facilities.

   Ken Raske's staff and mine can do a complete rewrite if you wish.

2. Don't overly rush to get this out – not until there is a rewrite. It will get criticized and opponents will argue – even if they buy the argument – that we should have done more earlier to test the staff. This is political.

3. I am working with Ken to line up some physicians to be available to support the Commissioner – this will take a day or so.

I am waiting for my physician to get back to me. She is reviewing the report. Once I do, I will follow up with you.

Michael

[67] E-mail from Michael Dowling, Chief Exec. Office, Northwell Health, to Executive Chamber Staff (June 30, 2020, 4:31 p.m.).
[68] *Id.*

53. That evening, Mr. Raske sent his edits to Mr. Dowling, who then forwarded them to an Executive Chamber staffer.[69]

Subject: Fw: [EXTERNAL] Fwd: Revised Executive Summary
Date: Wednesday, July 1, 2020 at 8:18:33 AM Eastern Daylight Time
From: [redacted]
To: [redacted]
Attachments: 06302020 Nursing Home Report V14 Tuesday.docx, ATT00001.htm

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From: Dowling, Michael [redacted]
Sent: Tuesday, June 30, 2020 8:42 PM
To: [redacted]
Subject: Fwd: [EXTERNAL] Fwd: Revised Executive Summary

Sent from my iPhone

Begin forwarded message:

> **From:** "Raske, Ken" [redacted]
> **Date:** June 30, 2020 at 6:00:02 PM EDT
> **To:** "Dowling, Michael" [redacted]
> **Subject: [EXTERNAL] Fwd: Revised Executive Summary**
>
> ***External Email. Use Caution.***
> Per our discussion. Ken
>
> Sent from my iPad
>
> Begin forwarded message:
>
> > **From:** "Conway, Brian" [redacted]
> > **To:** "Raske, Ken" [redacted]
> > **Subject: Revised Executive Summary**
> >
> > Ken, a revised draft Executive Summary is below.
> >
> > The entire draft paper, including the original Executive Summary, is attached.

[69] E-mail from Kenneth Raske, Pres. & Chief Exec. Officer, Greater N.Y. Hospital Ass'n, to Michael Dowling, Chief Exec. Office, Northwell Health (June 30, 2020, 6:00 p.m.)

54. These documents and testimony establish that Mr. Cuomo had conversations regarding the "peer review" of the July 6 Report and directed and knew that people outside of the NYSDOH were involved in the July 6 Report.

F. MR. CUOMO'S STATEMENTS SATISFY THE ELEMENTS OF 18 U.S.C. § 1001

55. The testimony and evidence set forth in this referral establish that Mr. Cuomo made materially false statements to the Select Subcommittee about his involvement in and knowledge of the drafting of the July 6 Report.

56. As established, for a statement to be criminally false pursuant to § 1001, it must satisfy the following elements:

a. The defendant made the statement charged;

b. The statement was false, fictitious, or fraudulent;

c. The statement was material;

d. The defendant acted knowingly and willfully; and

e. The false statement pertained to a matter within the jurisdiction of the legislative branch of the government of the United States.[70]

57. *First*, Mr. Cuomo made voluntary, unsworn, oral statements during his transcribed interview with the Select Subcommittee.[71]

58. *Second*, Mr. Cuomo's statements were false.[72] As established in this referral, Mr. Cuomo made demonstrably false statements several times. Mr. Cuomo testified to have neither been involved in the drafting nor the review of the July 6 Report.[73] Documents prove that to be

[70] *See* 18 U.S.C. § 1001; *United States v. Bowser*, 318 F. Supp. 3d 154, 171 (D.D.C. July 17, 2018) (setting forth the elements of the statute).
[71] *See generally* Cuomo TI.
[72] *See United States v. Milton*, 8 F.3d 39, 45 (D.C. Cir. 1993) ("Falsity is an element of the section 1001 offense"); *United States v. Dale*, 991 F.2d 819, 832-33 (D.C. Cir. 1993), *cert. denied*, 510 U.S. 906 (1993) (affirming convictions because statements "were not literally true").
[73] Cuomo TI at 173, 177.

false.[74] Mr. Cuomo testified that he did not have any discussions about the July 6 Report being peer reviewed.[75] Documents prove that to be false.[76] Mr. Cuomo testified not to know about the July 6 Report being reviewed by people outside of the NYSDOH.[77] Documents prove that to be false.[78]

59. *Third*, Mr. Cuomo's false statements were material to the Select Subcommittee's investigation. A false statement is material if it has "a natural tendency to influence, or [be] capable of influencing, the decision of the decision-making body to which it was addressed."[79] Materiality of the false statement does not rest on the decision-making body being influenced; a statement that "had a tendency to influence" suffices.[80] Further, a false statement may still be material even if the decision-making body knows or thinks it knows the answer to the question.[81] In this case, Mr. Cuomo's false statements about his and others' involvement in the drafting of the July 6 Report had a "tendency" to influence the Select Subcommittee's investigation and indeed influenced the investigation. On September 10, 2024, the Select Subcommittee issued a subpoena to New York Governor Kathy Hochul for documents—many related to the drafting of the July 6 Report.[82] The cover letter to the subpoena specifically noted, "[t]he Executive Chamber is also improperly withholding documents needed to evaluate the veracity of witness

[74] Referral of Andrew M. Cuomo, Select Subcomm. on the Coronavirus Pandemic, at 11-94 (Oct. 30, 2024).
[75] Cuomo TI at 287.
[76] Referral of Andrew M. Cuomo, *supra* note 76, at 94-98.
[77] Cuomo TI at 173.
[78] Referral of Andrew M. Cuomo, *supra* note 76, at 94-98.
[79] *See Kungys v. United States*, 485 U.S. 759, 770 (1988) (citing *Weinstock v. United States*, 231 F.2d 699, 701-02 (D.C. Cir. 1956)) (internal quotation marks omitted).
[80] *United States v. Kim*, 808 F. Supp. 2d 44, 59-60 (D.D.C. 2011) ("[T]he Government need not prove that it actually relied on [defendant]'s statement, only that [defendant]'s statement had a tendency to influence a reasonable investigator."); *see also United States v. Abrahem*, 678 F.3d 370, 373 (5th Cir. 2012) (citation omitted) ("Actual influence is not required—a statement can be ignored or never read and still be material—and the statement need not be believed.").
[81] *United States v. Burke*, 425 F.3d 400, 409 (7th Cir. 2005) ("That the prosecutors knew (or thought they knew) the answers to the questions they asked [defendant] does not make the information less material.").
[82] Letter from Hon. Brad Wenstrup, *supra* note 23.

testimony already received by the Select Subcommittee. For example, former Governor Andrew Cuomo testified to Select Subcommittee staff that he did not have any role in the drafting of the NYDOH Report."[83] The decision to issue the subpoena was, in part, made to evaluate conflicting witness testimony on the drafting of the July 6 Report, including Mr. Cuomo's. The subpoena resulted in a whistleblower providing these documents to the Select Subcommittee.

60. *Fourth*, Mr. Cuomo's false statements were made knowingly and willfully. For the purposes of 18 U.S.C. § 1001, "knowingly" means only that the defendant acted with knowledge of the falsity.[84] It also encompasses reckless disregard of whether a statement is true or a conscious effort to avoid learning the truth.[85] Further, willfulness means nothing more in this context than that the forbidden act was done deliberately and with knowledge and does not require proof of evil intent.[86] As shown in this referral, Mr. Cuomo consciously disregarded the potential falsity of his statements. Indeed, the Select Subcommittee informed Mr. Cuomo that his former employee testified to Mr. Cuomo's involvement in the drafting of the July 6 Report. Even after being presented with that information, Mr. Cuomo still falsely testified that he was not involved in the drafting.[87] Further, the Impeachment Report confirms that Mr. Cuomo was involved in the drafting of the July 6 Report. The Impeachment Report was made public before Mr. Cuomo's transcribed interview, and based on Mr. Cuomo's own testimony, he was aware of the Impeachment Report:

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[83] *Id.*
[84] *See United States v. Lange*, 528 F.2d 1280, 1288 (5th Cir. 1976) (citations omitted).
[85] *Id.* (citations omitted); *See United States v. Evans*, 559 F.2d 244, 246 (5th Cir. 1977) (per curiam), *cert. denied*, 434 U.S. 1015 (1978).
[86] *See McClanahan v. United States*, 230 F.2d 919, 924 (5th Cir. 1955), *cert. denied*, 352 U.S. 824 (1956) (citation omitted)"kn.
[87] *See generally United States v. Zhen Zhen Wu*, 711 F.3d 1, 28 (1st Cir. 2013) ("So even if Wei had misinterpreted the SED requirements in the first instance, the jury could conclude that her misimpression had been corrected by her employee").

Q.	The impeachment report also says a [task] force member also assisted in the drafting and editing of Chapter 6 of the book. You don't recall someone assisting you in the drafting and editing?
A.	First of all, **I don't think that report is worth the paper it's written on**. We asked for the evidence, the underlying evidence, they wouldn't produce it.[88]

Even with the knowledge that his statements may be false, Mr. Cuomo disregarded that possibility and continued to make false statements.

61. *Fifth*, Mr. Cuomo's false statements are on a matter within the Select Subcommittee's jurisdiction. The plain text of the statute applies to matters within the jurisdiction of the "legislative" branch.[89] Further, the statute specifically includes "any investigation or review, conducted pursuant to the authority of any committee, subcommittee, commission or office of the Congress, consistent with the applicable rules of the House or Senate."[90] As clearly outlined in this referral, the Select Subcommittee's investigation was duly authorized by the U.S. House of Representatives and specifically falls within its jurisdiction pursuant to House Resolution 5.

G. MR. CUOMO HAS NO VALID DEFENSE FOR HIS FALSE STATEMENTS

62. None of the recognized defenses to § 1001 apply to Mr. Cuomo.

63. Further, Mr. Cuomo did not correct his false statement. On October 18, 2024, Mr. Cuomo's counsel notified the Select Subcommittee that "[i]t ha[s] come to [her] attention that subsequent to Governor Cuomo's June 11, 2024 transcribed interview, the Select Subcommittee … identified document(s) reflecting that Governor Cuomo reviewed and/or provided proposed edits or comments to a draft [July 6 Report]."[91] Mr. Cuomo's counsel requested "that the Select

[88] Cuomo TI at 306.
[89] *See* 18 U.S.C. § 1001(a).
[90] *See id.* § 1001(c)(2).
[91] Letter from Rita Glavin, Counsel for Andrew Cuomo, to Hon. Brad Wenstrup, D.P.M., Chairman, Select Subcomm. on the Coronavirus Pandemic, H. Comm. on Oversight & Accountability, at 1 (Oct. 18, 2024).

Subcommittee provide Governor Cuomo with the documents in question and afford him the opportunity to refresh his recollection."[92] The letter also conveyed that Mr. Cuomo stands by his June 11 testimony "that he did not recall (and still does not to this day) seeing or reviewing" the July 6 Report.[93]

64. To support this claim, Mr. Cuomo's counsel cites the following section of Mr. Cuomo's transcript:

> Q. And just to clarify your testimony, you did not recall reviewing the [July 6 Report]?
>
> A. I do not recall reviewing.
>
> Q. Did you edit the report?
>
> A. I do not recall seeing it.[94]

65. First, this testimony does not directly retract Mr. Cuomo's previous false statements. As outlined in this referral, Mr. Cuomo was asked directly if he was "involved in the drafting of this report in any capacity," and he testified, "[n]o."[95] As Mr. Cuomo's counsel noted, when Select Subcommittee counsel asked, "[d]id you edit the report?," Mr. Cuomo testified, "I do not recall seeing it." This did not answer the question posed and does not refute his previous unambiguous "no."[96]

66. Second, Mr. Cuomo's spurious lack of memory about his involvement in and knowledge of the July 6 Report is questionable, particularly in light of his memory on other topics. For example, when the Select Subcommittee asked Mr. Cuomo what information he used to draft his book, "American Crisis: Leadership Lessons from the COVID-19 Pandemic," and

[92] *Id.* at 2.
[93] *Id.* at 1.
[94] *Id.* at 2 (quoting Cuomo TI at 285-86).
[95] Cuomo TI at 173.
[96] *Id.* at 286.

whether he took notes, Mr. Cuomo did not answer but instead pointed to his head, insinuating that he wrote a 320-page book solely from his memory.[97]

Q.	What information did you use to write the book?
A.	(Indicating).
Q.	You didn't take notes to draft the book?
A.	(Indicating).
Q.	Can you answer the question?
Counsel for Witness.	Let the record reflect that he's pointing to his head.

67. Third, even if Mr. Cuomo were to make the argument that he did act to correct his false statement, it is irrelevant. The law states that even if Mr. Cuomo attempted to recant or correct the alleged false statement, it is not a defense.[98] An attempted recantation or correction does not make the original statement any less false.[99]

68. Although "immediately correcting" the original false statement can, in some circumstances, render the statement not materially false, Mr. Cuomo's months-late offer to provide new testimony in an attempt to undo his June 11 testimony does not provide any such defense.[100] Mr. Cuomo's offer to "clarify the record" arose more than four months after his transcribed interview. Additionally, on September 10, 2024, Mr. Cuomo had the opportunity to

[97] *Id.* at 301-02.

[98] *United States v. Kim*, 808 F. Supp. 2d at 60 ("The Court sees no reasons to impute a recantation defense under § 1001, where …, Congress has chosen not to do so. **Accordingly, the Court declines to impute a recantation defense under § 1001**") (emphasis added); *see also United States v. Sebaggala*, 256 F.3d 59, 64 (1st Cir. 2001) ("**[W]e see no basis for writing into section 1001 a recantation defense that Congress chose to omit.** After all, '[c]ourts may not create their own limitations on legislation, no matter how alluring the policy arguments for doing so'" (emphasis added) (quoting *Brogan v. United States*, 522 U.S. 398, 408 (1998)).

[99] *See United States v. Kishk*, 63 F. App'x 11, 13 (2d Cir. 2003) ("**The fact that [defendant] eventually recanted his false statement in no way renders it any less false**") (emphasis added) (citation omitted).

[100] *See United States v. Cowden*, 677 F.2d 417, 420 (8th Cir. 1982) (holding statement was not materially false when defendant immediately corrected the record with a true statement).

correct the record at a public hearing and chose not to.[101] Further, the new offer to correct his testimony comes after the Select Subcommittee already relied on his previous false statements.

69. Because of Mr. Cuomo's false statements, the Select Subcommittee issued a subpoena to the Executive Chamber for potentially corroborating documents, sent a follow-up letter to a witness, pursued gathering documents from sources other than the Executive Chamber, and sought and conducted another transcribed interview. Because Mr. Cuomo's testimony directly contradicted testimony from other witnesses and the Impeachment Report, these actions were required to find the facts, maintain the integrity of the Select Subcommittee's investigation, and properly inform legislative reforms. Further, these actions harmed the Select Subcommittee via using finite time and resources that would not have needed to be expended if Mr. Cuomo had testified truthfully.

70. Mr. Cuomo has no valid legal defense. Mr. Cuomo did not recant or correct his false statements during his June 11 transcribed interview, despite being given the opportunity to do so, or during the Select Subcommittee's September 10 hearing. Mr. Cuomo's belated request to "clarify the record" arose after the Select Subcommittee had already relied on his previous false statements.

71. For these reasons, Mr. Cuomo does not have any defense that negates his false statements.

72. The facts, evidence, and precedent suggest DOJ should proceed with criminal charges against Mr. Cuomo pursuant to 18 U.S.C. § 1001 for false statements.

73. For these reasons, the Select Subcommittee makes this referral to DOJ for further action.

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[101] *See generally A Hearing with Former New York Governor Andrew Cuomo: Hearing Before Select Subcomm. on the Coronavirus Pandemic, H. Comm. on Oversight & Accountability*, 118th Cong. (Sept. 10, 2024).