Public Comments on Report #464

Joint Commission on Health Care
Nursing Facility Workforce Workgroup
Friday, October 22, 2021 – 10 a.m.
House Committee Room

ANNE MCDONNELL, EXECUTIVE DIRECTOR, BRAIN INJURY ASSOCIATION OF VIRGINIA

On behalf of the Brain Injury Association of Virginia, we support:

- JCHC Policy Option 2&3: Virginia could require all nursing homes and certified nursing facilities to meet a staffing standard. Whatever it is, we need to have some sort of standard for staffing and direct care hours.

- JCHC Policy Option 4: JCHC Members could direct DMAS to develop a proposal for a nursing home provider assessment.

  If there's something that could help fund care that we are not tapping into, that needs to change.

- JCHC Policy Option 8: JCHC Members could direct DMAS to develop a plan for enhanced reimbursement for residents with behavioral health diagnoses.

  This is huge problem for persons with brain injury, and we have been pursuing some version of a bill or budget amendment to do this for more than 15 years. Virginia has been sending people with neurobehavioral problems subsequent to brain injury to a nursing home in Massachusetts for more than 15 years, because no NH in Virginia will take them at the current reimbursement rate. We are paying the Massachusetts facility 4 times what we would pay a Virginia nursing home to provide the same level of care. Two residents have been up there more than 10 years; they have been separated from their families, who find is difficult if not impossible to be involved in their care and their lives. This last year has been particularly difficult for families with loved ones out-of state in a nursing facility. And based on past experience, if any of them were to die in Massachusetts, the state would not pay to bring them, after having paid to get them there. From our perspective, fracturing families in this way is wrong on a number of levels, and Virginia needs to fix that problem

Please let me know if you have any questions or require any clarification.

LAST NAME: BERGMAN

LOCALITY: RICHMOND

Dear JCHC members,

Thank you for allowing me to submit comments on this study. I am a medical director and physician practicing exclusively in skilled nursing and long-term care medicine. Also, while I am employed by VCU and MCVP, the opinions listed in this letter are my own and do not reflect the beliefs of my employers or the Commonwealth of Virginia.

The current staffing shortage and issues around workforce supply in Virginia for nursing homes did not start with COVID-19. Being a frontline nurse (whether a nurse aide, an LPN, or an RN) in nursing homes is physically, intellectually, and emotionally challenging. It is important to separate the effect of COVID-19 on this long-standing clinical issue.

AMDA – The Society of Post-Acute and Long-Term Care Medicine is a national professional association that represents and supports clinicians and related professionals who work in nursing homes, long-term care, assisted living, home care, hospice, and other settings. AMDA recognizes that while having a sufficient number of staff is critical, staffing levels based only on resident-to-worker ratios will not adequately assess or meet resident needs.

Any decisions about staffing need to consider the broader issues, including:

- the complexity and acuity of a facility's population;
- the functional level of residents and services required;
- defining and including other categories of caregivers, such as medication aides, feeding assistants, restorative aides, family members, and activities professionals;
- the quality, competence, and engagement of staff leadership and supervision;
- addressing adequacy of training and skills development, and
- the career and educational development of staff

It is with this background in mind that I wish to comment on 3 potential options outlined in the study resolution document prepared by the JCHC.

- Option 3 – I am in favor of linking staffing to resident acuity but practically, how would this be carried out inside the facility?
- Option 6 – I like the idea of considering funding a pilot program to look at workforce issues and sense of community. In making this decision, please make sure that whatever project is funded that key stakeholders are present. Ideally, such a program would have oversight from a steering committee composed of nursing home clinicians, nurses, and administrators.
- Option 8 – This is perhaps my favorite option. Dementia, Depression, and Delirium and 3 key diagnoses that impact the lives of frontline staff, residents, and families. These are challenging conditions to manage non-pharmacologically and require extra staff on hand. If we could review and support the care and staff training requirements in homes that have a high proportion of these conditions, it would be very valuable to all involved.

Lastly, in closing, I just want to congratulate the JCHC staff including Jeff Lunardi and Kyu Kang, the JCHC members, as well as the Virginia General Assembly for working through this study and highlighting this important issue. I hope that my comments are helpful and I recognize that you have difficult decisions to make. We appreciate your public service and know you will ultimately make the right decision.

Think progressively. Be bold. Be compassionate.

Thank you,
Christian

Carl J. "Christian" Bergman, MD, CMD
Assistant Professor, Division of Geriatric Medicine, Virginia Commonwealth University
Email: Carl.Bergman@vcuhealth.org

References:

https://paltc.org/amda-white-papers-and-resolution-position-statements/position-statement-appropriate-staffing

https://paltc.org/newsroom/amda-statement-shines-spotlight-paltc-staffing

EMILY HARDY, ELDER LAW ATTORNEY, VIRGINIA POVERTY LAW CENTER ON BEHALF OF THE VIRGINIA ELDER RIGHTS COALITION.

The Virginia Elder Rights Coalition is writing in support of the Joint Commission on Health Care's (Commission) study which laid out valuable benchmarks for Virginia's nursing home industry. We appreciate the careful attention given to the various ways to help protect some of Virginia's most vulnerable residents. We thank the Commission for its work on this urgent issue.

In particular, we commend the Commission for its attention to inequities in care of black residents -- highlighting data showing that a facility with at least 60-80% black residents averages 2.96 hours per day of direct care versus a facility with less than 20% black residents which averages 3.88 hours per day. This is a shocking difference, especially where the dangers of understaffing have been known since the 1980s.[1] Systemic change is desperately needed to address this dramatic racial inequity in Virginia's care system and this study has laid out clearly some of the necessary steps before the Commonwealth.

We applaud the Commission for recommending mandatory staffing standards, bringing Virginia in line with the other 35 states which have already implemented this protection. The standard of 3.25 hours per day of care is a solid starting benchmark; and we suggest that progressively the standard could be raised toward the recommended 4.1 hours from the 2000 CMS Congressionally mandated report which has been a long recognized measure. We would recommend that a gradual increase from 3.25 to 4.1 hours per year be mandated in law as facilities are able to increase and retain their existing staff and then move towards staffing that is person-centered to promote health and longevity of life.

Although, we do not have a strong preference for which staffing standards are put in place, the hours per day method is used in the majority of states and may allow more clarity and an easier baseline for facilities and inspectors to use. Regardless of which method is chosen, facilities are still required to meet the actual needs of their residents and if a resident has higher than the minimum needs, the facility would be required to provide additional care.

We support funding to Medicaid facilities where it is tied to a pass through to support staff wages and growth of the workforce and mandatory staffing standards. Although Virginia needs to support the nursing home workforce, facilities must also not be allowed to divert money meant to support that force to other costs. Creating a pass-through makes sure that money is used for its intended purpose, supporting a work staff that can adequately provide care for nursing home residents.

We urge that as changes in nursing home staffing are implemented, there is a structured evaluation in place to measure the outcome looking at multiple factors. We need to know how well the multiple options described in the report are working to improve the lives of nursing home residents.

Finally, we appreciate JCHC's support of expanding home and community based services programs so that more individuals can age at home. The Covid-19 pandemic has shown the inadequacies of nursing homes in prevention of infections and disease. Decreasing the number of large facilities and investing in home based care will help Virginia avoid unnecessary loss of life such as occurred in facilities during the pandemic.

We appreciate the opportunity to comment on this important work and look forward to Virginia implementing these needed protections.

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7328494/#bibr2-1178632920934785

LAST NAME: WRIGHT
ORGANIZATION: SNF/LTC PARTNERS OF VIRGINIA
LOCALITY: MANAKIN SABOT

To the members of the JCHC Nursing Facility Workforce work group;

Thank you for the opportunity to contribute towards this worthwhile discussion. I am a physician who works full time in long term care and skilled rehab and feel truly honored to work with elders all day, every day. I am fortunate to be medical director for 2 excellent facilities in Richmond – Our Lady of Hope and Westminster Canterbury. I hold a PhD from VCU Medical Center and a Masters of Arts in Theological Studies from Union Presbyterian Seminary. You may know me as the former medical director of Canterbury Rehabilitation and Healthcare Center (not to be confused with Westminster Canterbury).

Canterbury is one of the many Virginia nursing homes with staffing ratings of 2 stars or less. During my tenure at Canterbury, its overall quality rating remained around 1-2 stars. Projects I initiated to improve quality and protocols I established to ensure safety foundered in the face of not only low staffing but staffing turnover rates that reached over 100%. In March of 2020, Canterbury became the first facility in Virginia with an outbreak of COVID-19, an outbreak that eventually took the lives of 51 of my patients. As you point out on page 7, lower staffing has long been linked to lower quality of care. During the pandemic, studies also showed that facilities with a history of lower staffing were also linked to higher mortality from COVID-19. I certainly saw this at Canterbury.

The Nursing Facility Workforce work group is meeting at a critical time in the history of long term care in Virginia. As you point out, residents of publicly-funded nursing homes have long suffered from staffing shortages, and much of this suffering has been borne by our poorer residents and residents of color – those supported by Medicaid. Prior to COVID-19, that suffering was manifested in such things as higher frequencies of bed sores, infections, and anti-psychotic use. After the COVID pandemic, however, we know that understaffing is not just a matter of quality, it's a matter of life and death.

In recognition of the urgency of this matter, and in hopes that lessons learned during the COVID pandemic will result in safer, better staffed nursing homes, I firmly support the following Options:

Option 1: Increase Medicaid funding: this is the bedrock of any improvement in staffing. We can see this in how staffing ratios improve as a facility has lower rates of Medicaid patients

Option 2: Set minimum staffing ratios for all nursing homes: although there are arguments to be made in favor of tying staffing to acuity levels (Option 3), many states – see New York's recent Safe Staffing bill – realize that the complexities and costs of determining acuity levels further eat into the scarce resources available to nursing homes. In such an urgent situation, setting minimum staffing ratios for all nursing homes will do the most good for the most at risk residents.

Option 8: increasing reimbursement rates for resident with behavioral problems: Nursing homes serve as the homes of last resort for poor people with mental health problems. Caring for these people takes more staffing time, sometimes requiring one-on-one care. If appropriate staff is not available, many providers are forced to use medications to sedate people who really just need something to do. Increasing reimbursement could not only increase staffing, but could improve activities and enhance the physical space in which we confine them.

LAST NAME: KUKICH

ORGANIZATION: DIGNITY FOR THE AGED

LOCALITY: POQUOSON

The Joint Commission on Health Care reported on Oct 5th, 2021 that about one-fifth of Virginia's nursing homes do not meet CMS expectations for staff hours. The actual numbers are unfortunately much higher. There are currently 108 Virginia Nursing Homes listed on the Nursing Home Abuse Watch list. These homes provide less than 2 hours of care per resident per day when more than 90% of the residents need assistance with incontinent care, transferring to a wheelchair or bed and have dementia. They also have very high revenues in spite of this poor care.

NHAA Hotline https://nursinghomesabuseadvocate.com/WATCHLIST/

NHAA (Nursing Homes Abuse Advocates) is a 501(c)(3) non-profit that gathers information about nursing home abuse, neglect, and unsafe practices. NHAA collects and makes available investigations conducted by state and federal nursing home inspectors. In addition, NHAA receives and processes complaints made about nursing homes across the United States from families of residents. Information is compiled on every nursing home with a reported problem and is made available to the public. Our interview process allows the community to participate without fear and allows callers to volunteer information anonymously. Our research and services are free. Our mission is to provide the public with updated information about abuse, neglect, and unsafe practices so that you can make educated decisions about: choosing a facility, remaining in a facility where there are unresolved complaints, and/or what actions can be taken on behalf of neglected or deceased nursing home residents.

Nursing Home Watchlist

What gets a nursing home on the list? In order to be on the Watchlist a facility must have one or more of the following.

- Actual Harm: The facility caused serious harm or injury, impairment or in the worst case, death of a resident. – found by State investigators in published inspections
- History of Actual Harm: The facility has a history of at least 5 actual harm findings.
- Special Focus Facility: The facility has a history of serious quality issues. – as determined by the Center for Medicare and Medicaid Services
- Unsafe Staffing: The facility's staffing levels are consistently below those levels necessary to avoid patient harm and ensure delivery of care. – as determined by the Center for Medicare and Medicaid Services, Institute of Medicine, and American Nurses Association
- Worst Ratings: The facility repeatedly received the worst possible rating for one or more of the following: Overall Rating, Health Inspection Rating, Quality Rating, Staffing Rating, RN Staffing Rating – as determined by the Centers for Medicare and Medicaid Services

Here is a sample of the 108 Nursing Homes on the Abuse Watch and the revenue they take in.

- Bayside of Poquoson Health and Rehab – Poquoson, VA $ 8,166,177.00
- Hampton Health & Rehab Center, Llc - Hampton $ 17,677,001.00

- Coliseum Convalescent and Rehab Center - Hampton $ 18,113,305.00
- Regency Health and Rehab Center – Yorktown $ 8,314,337.00
- Waterview Health and Rehab Center – Hampton $ 22,701,859.00
- Newport News Nursing and Rehab -NN $ 11,604,047.00
- Pelican Health Norfolk – Norfolk $ 6,540,275.00
- Signature Healthcare of Norfolk – Norfolk $18,697,951.00
- Norfolk Health and Rehab Center – Norfolk $18,957,443.00
- Portsmouth Health and Rehab – Portsmouth $ 13,616,894.00
- Pelican Health Virginia Beach – Virginia Beach $ 9,047,156.00
- Bayside Health and Rehab Center – VB $ 9,807,607.00
- Portside Health and Rehab – Portsmouth $ 4,612,219.00
- Accordius Health at River Pointe Llc – VB $ 6,618,990.00
- Envoy of Williamsburg, Llc – Williamsburg $12,082,580.00
- The Citadel Virginia Beach – Virginia Beach $4,616,078.00
- Greenbrier Regional Medical Ct – Chesapeake $8,268,625.00
- Kempsville Health & Rehab Center – VB $10,261,874.00
- Rosemont Health & Rehab Center, Llc – VB $16,456,175.00
- Consulate Healthcare of Williamsburg – $10,910,271.00
- Virginia Beach Healthcare and Rehab Center – Virginia Beach $ 24,351,036.00
- Colonial Health & Rehab Center Llc – VB $17,004,872.00
- Chesapeake Health and Rehab Center – Chesapeake $22,104,190.00
- Autumn Care of Suffolk – Suffolk $10,336,944.00
- Consulate Health Care of Windsor – Windsor $ 11,975,691.00
- Dockside Health & Rehab Center – Locust Hill $ 5,081,796.00
- Riverside Conval Center – Saluda Three Rivers Health & Rehab Center – West Point $ 11,189,512.00
- Lancashire Convalescent and Rehab Center – Kilmarnock $ 8,280,359.00
- Accordius Health at Courtland – Courtland $ 8,703,172.00
- River View On The Appomattox Health & Rehab Center – Hopewell $ 16,128,641.00
- Wonder City Rehabilitation and Nursing Center – Hopewell $ 11,290,873.00
- Battlefield Park Healthcare Center – Petersburg $ 12,200,971.00
- Petersburg Healthcare Center – Petersburg $ 11,804,224.00

- Colonial Heights Rehab and Nursing Center – Chesterfield $ 21,103,000.00
- Henrico Health and Rehab Center – Highland Springs $ 17,476,151.00 C
- arrington Place of Tappahannock – Tappahannock $ 6,252,241.00
- Dinwiddie Health and Rehab – Petersburg $ 9,011,656.00
- Hanover Health and Rehab Center – Mechanicsville $ 19,165,246.00
- Autumn Care of Mechanicsville – Mechanicsville $ 22,938,075.00
- Envoy of Westover Hills – Richmond $ 15,458,233.00
- Manorcare Health Services Imperial – Richmond 31-May-19 $ 16,292,794.00 Total $ 1,085,735,970.00

October 21, 2021

To: Joint Commission on Health Care – Nursing Facility Workforce Workgroup

From: Dana Parsons, Vice President & Legislative Counsel

Re: Comments - *Workforce Challenges in Virginia's Nursing Homes*

Thank you for the opportunity to provide comments on the policy options included in the Joint Commission on Health Care's recent study report, *Workforce Challenges in Virginia's Nursing Homes*. LeadingAge Virginia is an association of not-for-profit aging services organizations representing the entire continuum of aging services, including nursing homes, assisted living, adult day centers, life plan/continuing care communities, senior affordable housing, and home and community-based services.

The dialogue surrounding nursing homes not having adequate staff is predicated on the assumption that nursing homes do not want to increase staffing. This is a false assumption. We agree that there is a positive correlation between nursing home quality and appropriate staffing levels. As an association that represents not-for-profit providers, our members believe that proper staffing is the key to high quality care.

According to the Joint Commission's report, a fifth of Virginia's nursing homes are not meeting CMS expectations for total direct care hours per resident. Specifically, 21% of Virginia's nursing homes reported total nursing hours that fell short of the expected hours calculated by the Centers for Medicare and Medicaid Services (CMS). This means that 79% of nursing homes are meeting CMS expected direct care hours. Therefore, we assert that a mandated staffing ratio is not the solution.

Rather, Virginia lawmakers need to focus on the 21% of nursing homes that are identified as underperforming by not meeting CMS expected staffing levels for total direct care hours per resident. We believe that allocating time and resources for these nursing homes would positively benefit residents and staff and is the right investment to make to ensure quality of care. A framework could be developed for the understaffed nursing homes that includes:

1) Establishing a timeframe for these nursing homes to comply with the CMS federal minimum standard.
2) Reviewing ownership changes to determine if there are any negative trends that may be impacting quality and transparency.
3) Providing targeted funding to increase staffing and training.
4) Reassessing at the end of the established timeframe to determine compliance with the CMS standard. If the nursing home continues to fail to meet the CMS expectations for total direct care hours per resident,

the Office of Licensure and Certification could determine if there should be a limit placed on the nursing home's new admissions or if the license should be revoked.

We are tremendously grateful that the Joint Commission on Health Care is making aging a priority by examining workforce challenges in nursing homes, but the issue needs to be comprehensively reviewed. This study along with the recent *Strategies to Support Aging Virginians in their Communities* report needs to be considered together to determine the best approach to providing long-term care services. Therefore, in addition to providing focused support to the understaffed nursing homes, we also request that the General Assembly take the following steps to raise the quality standard for all aging Virginians:

Attract Prospective Employees to the Aging Services Field

Workforce shortages are not a new issue for aging services but have been exacerbated by the pandemic. Nursing-home staff have quit because of low pay, burnout, vaccine concerns, and/or fear of contracting COVID-19. Potential employees perceive that nursing homes are undesirable places to work, leaving these communities with minimal staff to care for residents with complex needs.

We also know that competition in aging services is not only from other healthcare settings, but also other industries that can pay more and do not require direct caregiving, such as retail and food services. At times, our members feel like they are fighting a losing battle with recruiting and retaining a robust workforce to provide for our most vulnerable adults. LeadingAge Virginia would welcome the opportunity to assist the Commission with a study to develop policy recommendations on ways to attract individuals to work in the aging services field.

Support Adult Day and Assisted Living

Older Virginians deserve the right to age in the most appropriate and cost-effective setting. There are nursing home residents that may be better suited to receive care in an adult day or assisted living setting. Therefore, these care options need to be adequately funded.

Adult Day, which provides for Medicaid savings, serves nursing home eligible individuals, and allows people who want to remain in their homes to do so. But with the current daily Medicaid reimbursement rate at $57.04, the adult day model cannot be sustained. Moreover, many residents in nursing homes may be better suited to reside in assisted living settings, but because we do not have a way to fund this option, these residents move to a nursing home where they can rely upon Medicaid as a payment source. Sadly, we know that the auxiliary grant program is not enough to cover the cost of care, so providers do not participate (currently $1,562 per month).

It is time for Virginia to strongly consider these care options and make the necessary financial investments. LeadingAge Virginia represents approximately half of the 65 licensed adult day providers in Virginia. Our members report that it costs approximately $125 to $150 per day to care for an adult day participant. According to Genworth's *2020 Cost of Care Survey*, the average monthly cost of assisted living in Virginia is $4,850.[1] This information demonstrates the need to increase these rates. Doubling the adult day daily rate would increase it to $114.08 and monthly auxiliary grant to $3,124.00 and would enable providers to be closer to the funding needed to care for the individuals in these settings.

Provide Funding for Direct Care Staffing

We suggest implementing a restricted Medicaid rate increase for nursing homes to provide enhanced wages for direct care staff. For example, nursing homes could be required to spend at least 70% to boost wages, while the remaining 30% could be used in other areas, such as enhancing infection control. A funding mechanism also needs to be created for the private pay nursing homes that have also experienced lost revenues attributable to the pandemic. Our membership is extremely grateful for the funds provided through the Provider Relief Fund; however, the loss in revenue is continuing. Therefore, a funding pathway needs to be established to provide support to the private pay nursing homes.

Pay a Living Wage

The pandemic has made it clear that direct caregivers are critical to aging services, but in many cases, they are not valued accordingly. These caregivers provide life-sustaining support to people with complex medical needs and should be adequately compensated.

A new LeadingAge study offers a glimpse into a different world in which direct caregivers earn at least a living wage.[2] Using publicly available data and standard economic simulation techniques, LeadingAge researchers found that higher wages would bring myriad benefits to direct caregivers, the direct care field, care recipients, and local communities. Specifically, higher wages would:

- Increase the financial well-being of direct caregivers;
- Reduce turnover and staffing shortages within care settings;
- Boost caregiver productivity;
- Enhance quality of care; and
- Increase overall economic growth in communities where direct caregivers live.

[1] Genworth *2020 Cost of Care Survey,* genworth.com/aging-and-you/finances/cost-of-care.html
[2] LeadingAge Study, *Making Care Work Pay,* leadingage.org/making-care-work-pay

In closing, LeadingAge Virginia recommends a focused approach for the 21% of nursing homes identified by the report findings as underperforming for existing CMS expectations for expected direct care hours. Furthermore, taking the above-mentioned steps to attract employees to the aging services field, to support adult day and assisted living through enhanced funding, and to provide funding for a paid living wage to direct caregivers, will raise the quality standard for all of Virginia's aging population.

Date: October 21, 2021

To: The Honorable Patrick Hope
Chairman, Joint Commission on Health Care

Members of the Joint Commission on Health Care

From: Keith Hare
President and CEO

Subject: Comments on the ***Workforce Challenges in Virginia's Nursing Homes***

On behalf of our over 250 nursing facility members serving the Commonwealth's most vulnerable citizens throughout the Commonwealth, I want to thank you and your staff for the effort to examine workforce issues impacting their ability to provide this much needed care. As you are aware, the multiple issues identified in the Commission report, *Workforce Challenges in Virginia's Nursing Homes*, are the same issues VHCA-VCAL and other advocates have been bringing to your attention for many years. We applaud the report in its clear confirmation that the issues are historic and complex and that addressing the issues will be multi-faceted and require a long-term, sustained effort.

Our members view this report as another step in the ongoing effort to improve the Medicaid program's approach to nursing facility care that the General Assembly has incrementally been addressing for several years now through additional funding and innovative approaches such as the value based payment program currently in development. While strides have been made, more work and resources are required to get the program to the level desired by all involved and our members stand ready to move forward to that goal with the appropriate resources.

We appreciate the confirmation of the issues impacting that goal and would like to provide insight into the policy options and some of the potential approaches outlined in the report. First, we have prepared a two-page document outlining our comments in brief, including our position on the policy options included in the report. Second, we have prepared comments which highlight areas of the report (in the order in which they are found) on which VHCA-VCAL believes clarification is necessary, as well as alternative ideas to advance our collective goals to enhance care for nursing home patients. Third, we have provided the results of a member survey conducted in September which reveals more details about the staffing crisis.

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Comments In-Brief on the JCHC Report: Workforce Challenges in Virginia's Nursing Homes

We applaud the General Assembly and the Joint Commission on Health Care (JCHC) for this substantial conversation about the state of nursing facility care in Virginia and **the challenges facing both the providers and the Commonwealth on improving that care for our most frail and vulnerable citizens**

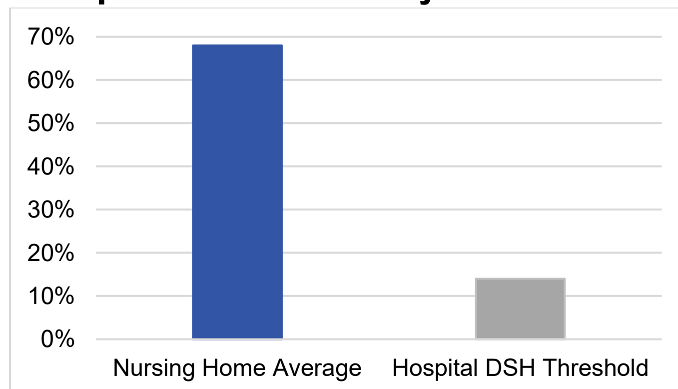
We are encouraged by the formal recognition in the report that **a staffing ratio is not a quick fix for nursing home staffing issues. A better first step is identifying how to address the lack of qualified workers and how to pay for them**. Calling for staffing ratios fails to acknowledge the reality of the current shortages in the nursing workforce and the steps nursing homes are taking to grow their staff and yet are still unable to fill vacancies.

Addressing nursing home staffing will take long-range efforts to increase the pipeline of nurses and nurse aids. The situation today is especially dire as **96 percent** of facilities in Virginia have vacancies for CNAs, **92 percent** have vacancies for LPNs, and **75 percent** have vacancies for RNs. Solutions must also recognize the increased costs of staff, which are not currently reflected in the Medicaid rates.

The report states that Medicaid rates cover the current costs of nursing care. In fact, the rate methodology as set in Virginia regulations specifies that approximately **50 percent** of the days for which the Medicaid program is responsible for payment are to be underfunded relative to the current Medicaid-calculated cost of care and staffing levels. Said a different way, the program is designed to only cover the cost for half of the days in the program. This underfunding is a longstanding policy and is largely responsible for many of the concerns listed in this report.

The only option the report presents for reimbursement increases for the typical nursing facility is an additional payment to facilities serving a "disproportionate share" of Medicaid residents. While a "disproportionate share" supplemental payment makes sense in concept, **Medicaid must first cover a higher percentage of current costs across all Medicaid-participating nursing homes.** Nursing homes already care for an overwhelmingly large proportion of Medicaid members and are reliant on government payers for over 80 percent of their revenue.

Medicaid utilization for a typical nursing home is between 62 – 68 percent. For context on disproportional share (DSH) payments to hospitals, hospitals with over 14 percent Medicaid currently get additional payments to reflect that "high" Medicaid utilization. We strongly disagree with any policy that does not raise Medicaid rates for all facilities because of the high number of Medicaid residents they already serve.



Our members are doing everything they can to fill existing vacancies—from increasing pay and offering bonuses—but still cannot find all the caregivers they need. **Efforts to grow their staff have been limited not only by workforce shortages, but also by the current reimbursement rates they receive. It would be useful to examine the natural effect of better coverage of the actual costs of care today.** Coupling better cost coverage with the value-based purchasing program under development by DMAS and a DSH-like payment to encourage further quality improvement, related to staffing or otherwise, would be a more comprehensive solution.

We applaud and concur with the options presented to promote the workforce. We would be supportive of this and more efforts to boost the pipeline of caregivers to the level needed. US Bureau of Labor Statistics data indicates that workforce in nursing facilities is **down 11.2 percent** since the pandemic hit. Building a sufficient number of caregivers will take considerable time and collaboration with secondary education, higher education, technical schools, and even enhanced recognition and funding of nursing facility based programs.

We believe there are other funding options that should be considered rather than the only option presented in the report, a provider tax. VHCA-VCAL and a significant number of members of the General Assembly believe improving nursing facility care in Virginia is an important goal that requires significant investment. VHCA-VCAL has been advocating for such improvements and investments each year. The Commonwealth has an opportunity to make a transformational investment in nursing home care to properly fund the nursing care Virginia seniors deserve.

VHCA-VCAL's written comments include additional input on the report as well as well as concrete solutions we believe will better address the mutual goals presented therein. We stand ready to continue this discussion toward improved care for the citizens VHCA-VCAL members tirelessly care for.

In terms of a summary of the formal options, we would offer the following comments:

- **Option 1:** We **support** this idea if general cost coverage is better addressed in Medicaid rates and this is a method to supplement payments for truly "disproportionately" high Medicaid utilization.
- **Options 2 and 3:** We **oppose** these options and believe the better way to address staffing is through recognition of both existing nursing facility costs and opportunities for supplemental payment rewarding quality improvement or the aforementioned disproportionate utilization payments, among other additional ideas. Evidence already suggests that additional funding translates to additional staffing
- **Option 4:** We **oppose** this option as it is an unstable funding source for the purposes stated in this report. Provider taxes are under constant federal scrutiny and are unreliable in the long term. The traditional Medicaid funding approach should be used first to address underfunding of nursing home care.
- **Options 5 and 6:** We **support** these options. Additional measures will also need to be taken to relieve the workforce issues facing nursing facilities sufficiently and substantially.
- **Option 7:** We **support** a thorough review of the value-based purchasing (VBP) program currently under development by DMAS at the appropriate time. We believe the current budget language already implies this and have no concern with formalizing it with the request that it continue to involve stakeholders in the review.
- **Option 8:** We **support** this option and concur with the problem it is attempting to address.

Comments on the JCHC Report:
Workforce Challenges in Virginia's Nursing Homes

A Staffing Crisis in Virginia's Nursing Homes

As VHCA-VCAL has articulated both before and during the COVID pandemic, a staffing crisis has existed for many years, made exponentially worse by the COVID-19 pandemic. Note this startling statistic: since February 2020 (the beginning of COVID), **the nursing facility workforce in Virginia has shrunk by 11.2 percent** and is trending flat to lower as of August 2021 (Federal Reserve Bank of St. Louis, February 1990 through August 2021). Staffing hit its lowest mark in May 2021 and the current (August) figure is the lowest (not including May) since November 2012—almost nine years ago.

When comparing Virginia's staffing ratings to other states, it is important to emphasize, as the report does, that the acuity of Virginia's nursing facility residents is higher than in other states. Virginia's nursing home residents rank ninth nationwide in their acuity, meaning residents need a much higher level of care. It stands to reason that if CMS calculates a higher "expected" staff level in the midst of a historic national staffing crisis, facilities with that higher expectation would disproportionately fail to meet their expected levels despite efforts to do so.

In looking at the data JCHC used, it is actually remarkable that 79 percent of facilities were able to meet the "expected" staffing given the breadth of the staffing crisis. According to a VHCA-VCAL member survey conducted in September, **92 percent of facilities have staff working overtime or taking extra shifts and 66 percent are using agency staff to fill shifts**. The use of agency personnel comes at a considerably higher expense—higher than those labor costs assumed in the calculated Medicaid rates currently in effect.

Medicaid's History of Underfunding Care Costs and the Impact on Staffing

The report states "Medicaid reimbursements are designed to just cover cost" (JCHC report, p. 4). While Medicaid reimbursement is complex and it is understandable that the general perception is cost coverage, the truth is far from that in Virginia's Medicaid reimbursement for nursing facilities. In fact, the Medicaid methodology starts with the assumption that it will only cover the Medicaid allowable costs for 50 percent of the days for which the program is responsible for payment. Thus, **one-half of the Medicaid days in Virginia are reimbursed at a level below the actual, Medicaid-calculated cost of care**. That result is based on existing staffing levels and before any recalculations due to the recent minimum wage changes and the resulting wage compression.

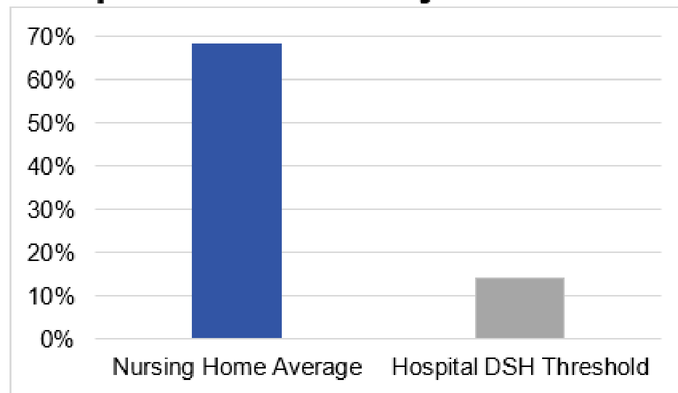
Because the clear majority of nursing home residents rely on Medicaid to pay for their care and the underfunding in the Medicaid payment methodology, it can be very difficult for a nursing home to manage its finances. Nursing facilities must operate within their means; because of low reimbursement from Medicaid, that involves subsidization from other payers, to the extent possible, and/or cost controls. Medicaid on average is approximately 62-68 percent of utilization (pre-COVID) in nursing facilities. Based on payment levels, it only provides 46 percent of a facility's operating revenue. In the distant past, facilities were able to rely on private payers; today, this category represents only 11

percent of utilization and 11 percent of operating revenue. It has been proposed that nursing homes could increase their private pay charges. This would only serve to accelerate a private-pay individual's need to access Medicaid coverage as the vast majority of private pay individuals in a nursing facility are paying down assets and come to rely upon Medicaid coverage.

Nursing facilities have been able to provide short-term rehabilitation services to Medicare recipients to subsidize the Medicaid population. Medicare accounts for approximately 15.5 percent of utilization and 30.5 percent of operating revenue. Unfortunately, the advent and spread of managed Medicare and other cost containment strategies invoked by the federal government have caused immense downward pressure on this payer source for nursing facilities.

Nursing Homes Care for an Overwhelmingly Large Proportion of Medicaid Members

Nursing homes already care for an overwhelmingly large proportion of Medicaid members and are reliant on government payers for over 80 percent of their revenue. It is difficult to assess which facilities would have a disproportionately high percentage of nursing facility residents when Medicaid utilization for a typical nursing home is between 62 – 68 percent. For context on disproportional share (DSH) payments to hospitals, hospitals with over 14 percent Medicaid currently get additional payments to reflect that "high" Medicaid utilization.



Any approach that does not provide better cost coverage for all facilities due to the high number of Medicaid residents they already serve will not fully address the issue. We have no concern with the concept of an additional payment for high volume Medicaid facilities, but with cost coverage of only 50 percent of Medicaid days in nursing facilities by design, either that threshold utilization percentage needs to be set extremely low or additional general reimbursement reforms need to be applied to cover a higher percentage of the existing Medicaid days. The best approach would be the latter with the additional payment threshold at a meaningfully high level so that it truly targets "abnormal" facilities in terms of high Medicaid utilization.

VHCA-VCAL suggested that Virginia's Medicaid program move from the median peer group cost in the rate setting methodology to the 75th percentile peer group cost as the foundational basis of the rates. This methodology shift would better recognize the existing cost structures at facilities that are under reimbursed and would encourage facilities with lower costs to increase their staff by allowing more

upward room in the rate structure. Currently, no single facility is guaranteed that investments, such as additional staff, will be reflected in their payment rate. Many facilities that are already under reimbursed relative to their cost are guaranteed that they will not be reimbursed for added costs (staff or anything else). This approach would allow for more of the investments that are necessary to move forward on staffing once that staff is available. Coupled with a meaningful disproportionate share payment and the value-based program currently under design, this could be an effective financing model that will allow for the addition of staff.

VHCA-VCAL recommends that the reimbursement methodology be amended to utilize the 75th percentile day in place of the current median (50th percentile) day to recognize a higher percentage of Medicaid days at their actual cost of care in the payment rates.

Information Presented on Resident Acuity Is Unclear

The report states, “Virginia’s nursing home data indicates that, in line with national trends, facilities are not adjusting staffing significantly based on resident acuity,” (JCHC report, p. 11). This statement and the discussion that precedes it are difficult to understand without an explanation of the actual research that is referenced as its basis. Earlier in the report, it is pointed out that 79 percent of nursing facilities in Virginia are meeting the CMS-expected level of staffing, which is based on patient acuity, yet the statement in this section is broadly applied to say the opposite, despite nearly 4 out of every 5 facilities apparently doing so.

Nursing facilities adjust staffing based on a comprehensive assessment of the number of residents and their individual care needs. As needs arise, staffing is adjusted, but it is a more complex process that takes time. More appropriately, nursing facilities limit, accept or decline admissions based on the availability of their existing staff. This is problematic from a finance side as a bed may remain unused as a result. However, these decisions are made every day on-site based on the resources available and the individual circumstances presented, which is why generic ratios are inefficient at best.

VHCA-VCAL Opposes One-Size Fits All Staffing Ratios/Requirements

VHCA-VCAL opposes mandated staffing requirements for the reasons articulated by the administrators and leadership cited in the report (JCHC report, p. 12). Mandating a staffing ratio before the Commonwealth corrects the historic underfunding of Medicaid nursing care and invests in the needed workforce initiatives to attract caregivers to this sector will not be a successful approach. As health care providers that rely almost entirely on government reimbursement (Medicaid and Medicare), nursing homes cannot make substantial reforms on their own. Until these underlying issues are sufficiently addressed, nursing facilities will continue to struggle to maintain qualified staff and meet the demands of an older population with complex care needs.

The JCHC’s Cost Estimates Likely Underestimate the Cost of a Staffing Mandate

We are unable to verify the JCHC’s estimates of the cost of the two proposed staffing ratios (JCHC Report, p. 12-13) since limited information is provided on how the estimate calculated the costs of CNAs and LPNs and the component costs do not total the presented overall costs. It is worth noting that the actual cost of a staffing mandate is likely underestimated by the report since the establishment of a staffing ratio would increase demand for both employed staff and agency personnel, and demand is a driver of wages and agency staffing costs.

Thousands of Positions in Nursing Homes across the Commonwealth are Unfilled

While we appreciate that the workforce supply issues are discussed later in the report, the assumption of availability of both employed and agency staff inherent in the ratio discussion is just not a realistic assessment of the current market (or even the pre-COVID market). Based on a VHCA-VCAL member survey conducted in September 2021 (attached), 96 percent of respondents indicated they have vacancies/recruitment for CNAs; 92 percent for LPNs; and 75 percent for RNs. Further, when asked why these positions are open, 62 percent indicated “no applicants.” In terms of agency staff, 53 percent indicated that in the past six months, agency staff costs have increased, in many cases doubling or more. Equally distressing, 64 percent of respondents indicated they had lost clinical staff to staffing agencies, some at very significant percentages. This demonstrates the **churn of existing staff to a higher-cost staffing model as opposed to an actual increase in the availability of new workers**. To that point, 40 percent of respondents indicated they are not using agency staff because they cannot access agency staff (i.e., it is not available to them).

As far as regulatory enforcement, any potential use of a staffing ratio should recognize the employee market restraints and the length of time it takes to properly adjust staffing, the latter being particularly relevant in an acuity-based standard. Frequency of “testing” relative to the standard needs to recognize that nursing facilities cannot create staff overnight, nor can they adjust staff immediately based on an assessment that modifies the resource needs of a resident. Any enforcement of a staffing ratio should reflect the labor market in which the nursing facility is drawing employees. Obviously, a lack of effort to employ staff would be a relevant issue, but the inability to hire staff despite significant effort should not result in sanctions.

The Report Shifts between a Discussion of Staffing Ratios and Wages

It is unclear to VHCA-VCAL why the report shifts from increasing direct care staff through the imposition of ratios to ensuring staff receive higher wages in the discussion of Medicaid funding (JCHC Report, p. 15). The effect of minimum wage changes implemented in the Commonwealth already puts nursing facilities at a competitive disadvantage in recruiting clinical and non-clinical staffs as reimbursement levels do not prospectively reflect the scheduled changes. The report does not address wage levels and suggests what increases would be necessary to attract and retain workers, yet it discusses that any funding be tied directly to wage pass-through.

VHCA-VCAL is in full agreement that the Medicaid reimbursement structure should prospectively recognize wage pressure, either market or government driven. The current system does not do that. Facilities cannot spend resources that they do not have in a sustainable manner. As stated above in these comments, the Medicaid program does not even fully fund the cost structure for approximately 50 percent of the days for which the program is responsible for payment, which would include the **current** wages and positions prior to the addition of new positions and increased wages as articulated in this report.

Increased Medicaid reimbursement does not ensure higher wages, but wages are likely to increase because labor at a typical nursing facility is the highest category of expense. An analysis of the annual wage survey conducted by DMAS shows the two year wage growth for CNAs at 9.3 percent; 5.6 percent for LPNs; and 4.9 percent for RNs (compared to much lower inflationary rate adjustments for those periods). Thanks to the consistent efforts of the General Assembly and administrations over the last several years, nursing facilities have been investing in their staff in order to stay competitive and attract and retain workers, but it is increasingly challenging.

The Report Fails to Consider Covering a Higher Percentage of Current Costs Across All Medicaid-Participating Nursing Homes

The report recognizes the fact that low Medicaid reimbursement over many years has played a major role in severely limiting the ability of nursing facilities to meet the goal of system improvements. This is a goal that nursing homes have shared for many years as well. **Yet when it comes to paying for the necessary investments required to achieve that goal, the options presented offer only limited approaches to better fund this care.**

Option 4 (JCHC Report, p. 16) presents an option to fund increased Medicaid reimbursement using a mechanism by which the providers themselves generate state match to get the federal dollar—a provider tax. Provider taxes are under constant federal scrutiny as legitimate funding approaches. In many states in which they have been invoked, reimbursement gains are gradually overtaken by budget concerns causing the initial influx of funding to settle back to pre-tax trajectories.

The report discusses that increased Medicaid reimbursements to nursing facilities could be funded in the traditional method of appropriating general funds to be matched by federal funds, this was not included as a policy option. We also have concerns about the report's statement that nursing facilities are the "entities that benefit" (JCHC Report, p. 16) from rectifying insufficient Medicaid reimbursement via a provider tax. The most frail and vulnerable citizens of the Commonwealth would be the beneficiaries of system improvements and that future should not be based on what could be an uncertain funding mechanism.

Provider assessments are required to be broad based (meaning the tax is applied to all providers in the particular provider class against which the tax is applied). In almost every provider tax structure, it is difficult to guarantee an individual provider will get enough of the added Medicaid revenue to offset the tax itself (i.e., there are "losers" in provider tax programs). The only formal proposal that would require this additional funding is presented earlier in the report under Option 1 (JCHC Report, p. 6). As stated, this proposal is a targeted supplemental payment to facilities with a "disproportionate share" of Medicaid. It is vital to understand that any targeted approach (i.e., not applied across the board to all the providers paying the tax) serves to significantly increase the amount of "losers" the tax creates. As referenced earlier, the current reimbursement system under-reimburses half of the days for which it is responsible. Facilities that already lose money on Medicaid will lose even more but will be expected to maintain or increase their staffing levels.

Development of a provider tax would take considerable time. VHCA-VCAL has stated previously and would repeat that an alternative to this policy option would be for the Commonwealth to make a transformational investment in Medicaid nursing care using the traditional Medicaid funding approach.

Nursing Homes Cannot Afford to Be Paid Retrospectively

Nursing homes should not be expected to bear the cost of a staffing mandate under a policy that the reimbursement system could recognize those costs in "1-2 years after hiring more staff" (JCHC Report, p. 16). The phrase "already-struggling nursing homes" (JCHC Report, p. 16) applies to the majority of facilities participating in Virginia's Medicaid program. This was true before the COVID-19 pandemic and persists as it continues. The current costs of care, which is under reimbursed in the Medicaid program today, should be covered first; any additional mandates must be paid for prospectively.

We applaud the report for recognizing that there are three components to this issue: increased resources (staffing) to improve patient care, increased reimbursement to support the cost structure of

those increased resources, and the availability of the needed resources in the first place. It is necessary that these components be addressed simultaneously as increasing staff needs both supply and financial support for the increased costs before it can successfully be achieved.

The supply of the necessary workforce in nursing facilities at current desired staffing does not exist today, much less at the proposed staffing levels recommended in the report. The report correctly states that many factors affect an individual's desire to choose to work in long term care and care for residents. All of these factors are relevant and will take time and resources to address. Issues around staffing have been present for many years, and a desire to flip a switch to "fix" the issue is unrealistic. Importantly, there is an opportunity to start the "fix" with discussions like this report.

Supporting Careers in the Direct Care Workforce Requires a Systems Approach

We would support any infusion of general funds to promote loan forgiveness and scholarship programs as presented in Option 5 for the types of clinical staff that provide care in a nursing facility. VHCA-VCAL's own foundation has been providing nurse scholarships since 1997. Through charitable contributions of our members and supporters, we have granted 544 Regirer Nurse Scholarships totaling $804,725 to individuals working in our member facilities who want to continue their nursing careers. We would further support the development of meaningful and proven staff development programs presented in Option 6, among other quality-improvement programs using civil monetary penalty (CMP) funds.

These ideas will help, but they will not fill the pipeline necessary to support the current system, much less any mandated increased staffing. That will take considerable time and collaboration with secondary education, higher education, technical schools, and even enhanced recognition and funding of nursing facility based programs.

Needed Quality Incentives Are Being Developed by DMAS

The General Assembly directed the Department of Medical Assistance Services (DMAS) to create a value-based purchasing (VBP) program for nursing facilities. The budget language directed this effort to include staffing-related metrics. VHCA-VCAL fully supports these efforts and has been an active participant in the stakeholder discussions. We view this program as a significant opportunity to address various quality-related needs in nursing facilities, including the addition of staff. With a supplemental incentive-based payment program, facilities can invest resources as needed to achieve quality improvement for their residents.

VHCA-VCAL would request that the General Assembly allow this incentive-based approach to proceed to implementation in 2022. We can then evaluate if the VBP program has the desired effects articulated in the JCHC report to incentivize and support better staffing and quality. While we remain concerned that on the staffing side that it will be difficult to find the staff due to existing workforce shortages, this program will provide significant Virginia-specific information that will detail where Virginia's nursing homes stand relative to staffing and quality.

As we assess this program's impact going forward, we could begin to address the workforce pipeline and the current underfunding of Medicaid reimbursements and see if these combined approaches lead to the desired staffing levels articulated in this report, without a specific mandate.

Addressing Behavioral Health Needs of Nursing Home Residents Is Critical

VHCA-VCAL fully supports Option 8 to develop an enhanced reimbursement rate for residents with behavioral health diagnoses and the discussion around it. Ideally, the enhanced reimbursement should be effectuated on a faster track, but we fully understand the complexities involved and the legislative process that would need to ensue.

Increased HCBS Will Not Diminish the Need for Nursing Home Care

We do not agree with the discussion in the report around home and community-based services (HCBS). The report implies that an increase of certified nursing facility beds has caused less participation on the HCBS side of long term care (JCHC Report, p. 25). Nursing facility beds are governed by the certificate of public need (COPN) program whereby the Virginia Department of Health only approves the development of new beds if a public need is demonstrated (with some exceptions built into the regulations primarily around continuing care retirement communities). COPN applications are planning district specific, meaning one region, based on population and other factors, may show a need for additional beds, while other regions do not. According to the report, there has been an increase in certified beds of only 8 percent over 18 years. This modest increase is hardly an indication that the COPN program has failed. On the contrary, we would maintain that the number of requests for new beds that have been denied greatly outnumber those that have been approved.

Nursing home occupancy has declined only 6 percent over 18 years (pre COVID analysis), according to the report (JCHC Report, p. 25). This decline in occupancy does seem to correspond to substantial increases in HCBS waiver slots over that same time period, which is precisely the goal of “rebalancing” long term care which VHCA-VCAL has and continues to fully support. We believe this has been successful in delaying the need for institutional long-term care, although it has caused the acuity of the population served in nursing facilities to significantly increase as the patients come in older with more comorbidities and care needs. In other words, the drop in occupancy thus far (not including COVID-related, discussed below) is exactly what the Commonwealth desired in its efforts on the HCBS side.

Besides the individual’s benefits of aging in place for as long as possible prior to accessing nursing facility care, a secondary purpose of the expansion of HCBS and the resultant drop in occupancy is in preparation for the demographic shift we are only starting to experience in Virginia. While not mentioned in the “occupancy” section of the report, this report acknowledges that Virginia is expecting “demographic trends that indicate that an increasing number of Virginians will need nursing home care in the coming years” (JCHC Report, p. 17), which we assume is referring to the aging of the baby boomer generation. This will not only require staffing, which is the section of the report in which this quote appears, but beds for patients.

The modest “statewide” growth in certified beds coupled with a modest “statewide” decline in occupancy does not indicate an over-bedded Commonwealth. While specific analysis may indicate some regions currently have a surplus of beds, it is not a generalizable statement. Until baby boomers fully access Medicaid long-term care, reducing bed capacity should not be a policy consideration.

The report discusses three strategies: bed buyback, expanded Medicaid reimbursement for private rooms, and increased occupancy standards (JCHC Report, p. 26). The occupancy standard serves to artificially limit the Medicaid program’s financial exposure to its share of the capital costs incurred by nursing facilities by artificially increasing the number of days costs will be spread upon, thus reducing the amount of payment associated with the capital component of the per diem payment rate. In other words, if a facility has occupancy below the current threshold, 88 percent, fixed costs would be

allocated to the Medicaid program across fewer days, thus increasing the per diem. By calculating an artificial count of days as if the facility was at 88 percent, the same fixed costs are then spread over more days, thus reducing the per diem amount. Keep in mind that when the rate is actually paid, it is based on the actual (lower) count of days. So a lower per diem is forced by inflating days, but is then only paid over the lower number of days. This is an outdated cost containment strategy for the Medicaid program and has contributed to the situation we find ourselves now in terms the of lack of cost coverage in the Medicaid program.

It is important to note that this policy is about to have a much higher negative effect on nursing facilities than it has in any period in the past, and at a time of significant financial stress for nursing facilities. Occupancy is down significantly due to COVID. Prior to COVID, occupancy around 86 percent, with a very slow downward trend. During the COVID pandemic, occupancy in Virginia hit a low of 71.4 percent (1/10/21). It has recovered somewhat to 78.7 percent (10/3/21) but is still substantially below the 86.4 percent occupancy recorded in December 2019. This reduction in occupancy has had a significant negative effect of the financial stability of nursing facilities. Recovery of that occupancy is vital to the long-term health of the sector. When DMAS calculates the capital rates next spring, this low occupancy will trigger a much higher negative impact on the rate structure, because both the incidence and extent of the actual occupancy below 88 percent will be much higher. Pre-COVID, this was a $4.9 million annual discount taken by the Medicaid program. The data does not yet exist to update this figure to 2021 data, but it will be considerably higher given current occupancy levels.

VHCA-VCAL recommends that the General Assembly eliminate the minimum occupancy threshold from the nursing facility capital rate methodology altogether and pay its share of the costs.

In terms of a bed buyback, we do not know what the potential impact and utilization of such a program would be, especially given the tide of baby boomers on the way. We believe participation would be up to an individual facility's consideration based on circumstances and projections, and also on the details that would have to be worked out (such as the bed value applied to the program). We do not oppose an optional program but would object to a program that penalizes a facility that does not participate in a buy-back program.

Private Room Rate Component Needed

We agree fully that the Medicaid rate structure should routinely recognize the added cost of private rooms as opposed to the current process of medical necessity justification and individual authorization by DMAS. The same wave of individuals getting ready to hit the long term care system in Virginia have very different expectations for that care; for one, they expect to have access to private rooms. The current process for private room authorization is labor intensive and time consuming (i.e., takes time away from direct care). By adjusting rates that often start below the actual cost of a semi-private room, payment can be inadequate relative to that time and effort. VHCA-VCAL has suggested that the capital rate methodology could recognize private room cost differentials by applying a multiplier (1.5) to the imputed gross square feet per bed assumed in a semi-private room which would constitute real recognition of private room costs in the Medicaid program.

VHCA-VCAL recommends that the Medicaid program create a private room rate component using the existing capital rate methodology except that a 1.5 multiplier on imputed gross square feet per bed would be applied to recognize the cost of private rooms in the reimbursement rate.

Investments in Aging Nursing Home Infrastructure Are Needed

The report does not address general infrastructure in nursing facilities. Renovation of aging facilities could be a factor in improving the efficiency of staffing and quality of care provided. Many facilities are dated in their layout and systems are expensive to repair. While there may be some desire to renovate, once a nursing facility's calculated age exceeds 21 years, the Medicaid program's capital rate methodology does not recognize renovation costs in the reimbursement (i.e., the Medicaid program does not pay its share of the renovation costs). The scope of the renovation could cause the calculated age to dip below age 21, but that depends on how much older the building is prior to the renovation. In 2018, the average age was 20.6 years and 54 percent of buildings were older than 21 years.

In order to incentivize renovation to better address infrastructure and patient care needs and models, the Commonwealth could provide a temporary facility age "reset" to a maximum of 21 years for any building above that calculated age. This reset could be in place for seven years (time is required to get approval, financing, etc.). If a facility renovated in that timeline, the calculated age of the building would drop below 21 years by definition due to the value of the renovation, and the Medicaid program's capital rate methodology would therefore recognize the Medicaid program's portion of the renovation cost.

VHCA-VCAL recommends that the Medicaid program institute a facility average age maximum of 21 years for a period of seven years, thereby resetting the facility's age going forward and incentivizing renovation through recognition of the renovation costs in the Medicaid reimbursement methodology.

"Medicaid Allowable" Limit Should Be Eliminated

Finally, though not addressed in the report but relevant to the discussion of Medicaid underfunding of nursing facilities and the effect that has on the ability to improve quality through staffing or otherwise, we would also suggest that the Medicaid program eliminate the discount taken from nursing facilities on dual eligible beneficiaries for which Medicaid is responsible for the patient payment amount under Medicare Part A. Many years ago, Medicaid adopted an optional "Medicaid allowable" limit to its liability for these Medicare patient payment amounts. Under that policy, Medicaid determines what it would have paid for the service compared to Medicare, and if that amount was already exceeded by the Medicare payment, it would pay $0 of the patient payments it was responsible for. When enacted, the nursing facility could claim the patient payment amount as Medicare bad debt and there was no harm, just a process to get full payment.

Over time, the Medicare program reduced the percentage of bad debt reimbursed. So now, while the Medicaid program still saves the state money, the nursing facilities lose approximately 35 cents on the dollar of the patient portion of the cost of these Medicare services. This is a substantial financial hit on nursing facilities because the federal rules upon which this approach was adopted in the first place have subsequently been changed. It is time for Medicaid to recognize that the premise behind this policy is no longer valid and reverse course.

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State of the Long Term Care Industry

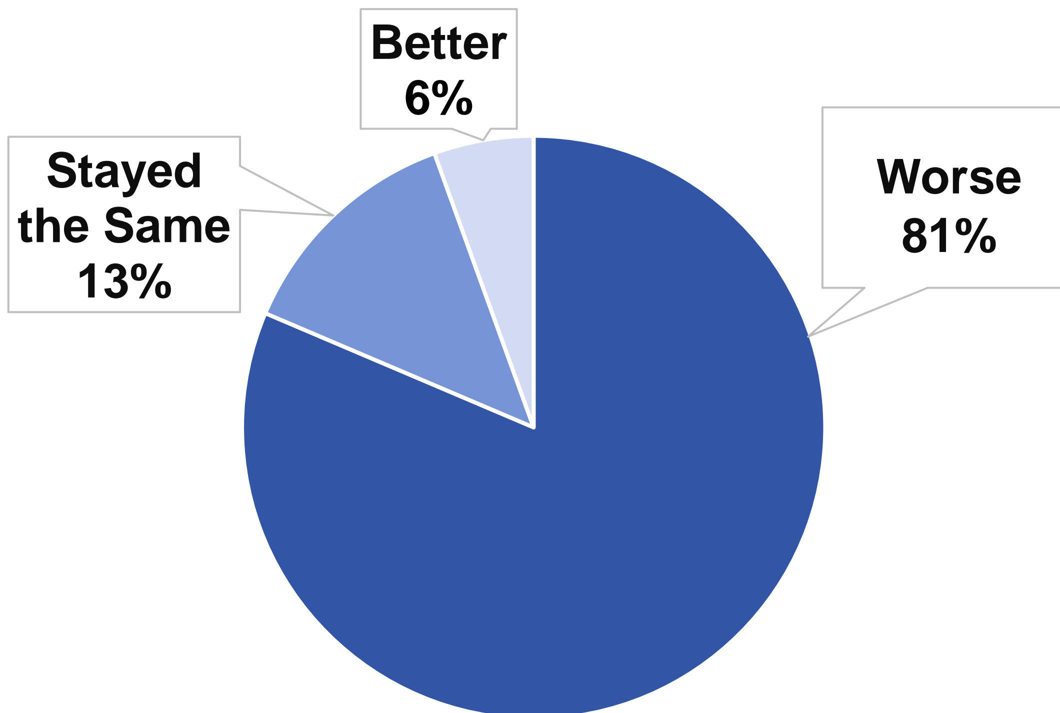
Survey of nursing home and assisted living providers show industry facing severe workforce crisis

Virginia Health Care Association | Virginia Center for Assisted Living

October 2021 | www.vhca.org

VHCAVCAL

Q: Compared with 2020, would you say your organization's overall workforce situation has gotten:



Even though 2020 was the height of the clinical nightmare of the COVID-19 pandemic,

81% of Virginia's long term care providers said their workforce situation has gotten worse this year.

Source: Virginia Health Care Association - Virginia National Center for Assisted Living Survey of 199 Nursing Home and Assisted Living Providers, September 2021

59% indicated there were **few to no applicants** to fill their needs for additional staff.

Q: Describe your current staffing situation:

Response	Percent
Full Staffed	2%
Not bad Just a few open positions	10%
Concerning beginning to have numerous open shifts	29%
Disconcerting Few applicants and need more staff	**31%**
Crisis Numerous open shifts and few or no qualified applicants	**28%**

Source: Virginia Health Care Association - Virginia National Center for Assisted Living Survey of 199 Nursing Home and Assisted Living Providers, September 2021

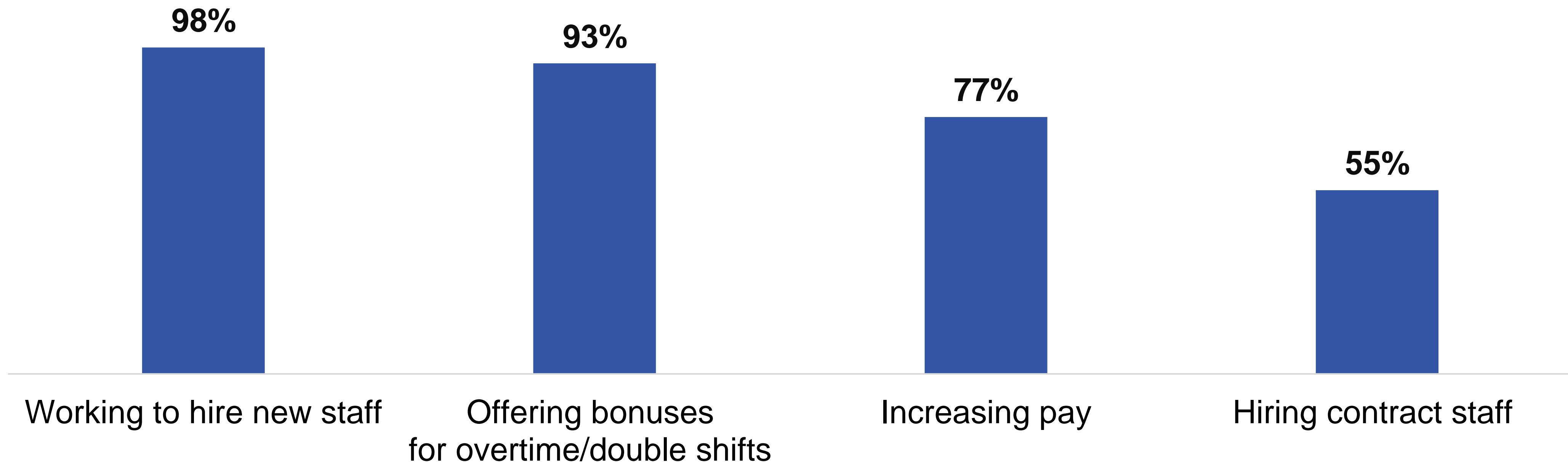
Nearly every facility is asking staff to work **overtime or take extra shifts.**
An alarming **75%** had a shortage of staff to fill all shifts.

Q: In the past 60 days, have you (check all that apply):

Response	Percent
Asked staff to work overtime or take extra shifts	92%
Had a shortage of staff to fill shifts	75%
Turned to agency staff to fill shifts	66%

Source: Virginia Health Care Association - Virginia National Center for Assisted Living Survey of 199 Nursing Home and Assisted Living Providers, September 2021

Nursing homes are taking action but need help.



Use of staffing agencies is up sharply, more expensive, and affects resident care.
Filling a CNA or LPN role with agency staff is **75% more expensive** than direct employment.

Source: Virginia Health Care Association - Virginia National Center for Assisted Living Survey of 199 Nursing Home and Assisted Living Providers, September 2021

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Facilities have **vacancies in critical positions** or are actively recruiting to fill open positions.

96% of facilities have vacancies for CNAs

92% have vacancies for LPNs

75% have vacancies for RNs

66% have vacancies for dietary staff

Source: Virginia Health Care Association - Virginia National Center for Assisted Living Survey of 199 Nursing Home and Assisted Living Providers, September 2021

The staffing crisis is having an impact **on access to care** for our seniors.

Q: Because of staffing challenges over the last six months, has your facility (check all that apply):

Response	Percent
Limited census to amount below capacity because you are unable to staff to full capacity	37%
Placed a hold on new admissions	29%
Turned away hospital admissions	26%

Source: Virginia Health Care Association - Virginia National Center for Assisted Living Survey of 199 Nursing Home and Assisted Living Providers, September 2021