JOINT COMMISSION ON HEALTH CARE

WORKFORCE CHALLENGES IN VIRGINIA'S NURSING HOMES

REPORT TO THE GOVERNOR AND THE
GENERAL ASSEMBLY OF VIRGINIA

REPORT DOCUMENT #464

COMMONWEALTH OF VIRGINIA
RICHMOND
2021

Code of Virginia § 30-168.

The Joint Commission on Health Care (the Commission) is established in the legislative branch of state government. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care. Further, the Commission shall encourage the development of uniform policies and services to ensure the availability of quality, affordable and accessible health services and provide a forum for continuing the review and study of programs and services.

The Commission may make recommendations and coordinate the proposals and recommendations of all commissions and agencies as to legislation affecting the provision and delivery of health care. For the purposes of this chapter, "health care" shall include behavioral health care.

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Workforce Challenges in Virginia's Nursing Homes

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Workforce Challenges in Virginia's Nursing Homes

POLICY OPTIONS IN BRIEF

There are 8 policy options in the report for Member consideration. Below are highlighted options.

Option: Increase Medicaid reimbursement for nursing homes with a high Medicaid population (Option 1, page 6).

Option: Require all nursing homes to meet a baseline staffing level using an across-the-board standard or an acuity-based standard (Options 2 and 3, pages 13-14).

Option: Fund evaluation of incentive payments for nursing homes that meet higher staffing levels, above the required baseline (Option 7, page 23).

Option: Implement workforce development programs, including loan repayment and leadership development (Options 5 and 6, pages 21).

Option: Develop a plan to increase Medicaid reimbursement for residents with specific behavioral health diagnoses (Option 8, page 24).

FINDINGS IN BRIEF

One-fifth of Virginia's nursing homes are not meeting expected staffing levels, disproportionately impacting low-income residents

All nursing homes in Virginia struggle to recruit and retain staff, and 21 percent of facilities are not providing enough hours of direct care. A shortage of certified nursing assistants (CNAs), who provide a majority of direct patient care, is the biggest challenge for Virginia's nursing homes. In general, facilities with fewer staff also have a higher concentration of Medicaid recipients and Black residents.

Low staffing increases the risk of low-quality care

More than 60 percent of facilities with low staffing receive poor health inspection ratings, which include criteria such as medication management and resident quality of life. When staffing falls below a minimum threshold, it becomes increasingly difficult for staff to manage the workload and provide quality care, leading to burnout that exacerbates these challenges. Increasing the number of hours of direct care per resident is shown to improve clinical outcomes and resident satisfaction.

Shrinking workforce is a contributing factor to staffing challenges

There are a decreasing number of (LPNs) and CNAs in Virginia. Recruitment can be difficult as nursing home jobs are considered less desirable, compared to other health care settings. Retention is dependent on wages, benefits, training and advancement opportunities, workplace culture, and leadership. The COVID-19 pandemic significantly exacerbated existing workforce challenges.

Residents' behavioral health needs are not adequately accounted for in reimbursement rates

An increasing number of nursing home residents have behavioral health needs that require additional time and attention from staff. Providing quality care to these residents requires increased staff time, but current Medicaid reimbursement rates do not fully compensate for these needs.

Workforce Challenges in Virginia's Nursing Homes

Nursing home operators and resident advocates have been concerned about staffing challenges in Virginia's nursing homes for more than twenty years. The COVID-19 pandemic exacerbated many of these existing issues, and in December of 2020 the Joint Commission on Health Care directed staff to study staffing in Virginia's nursing homes and its impact on the quality of care residents receive. (See Appendix 5 for JCHC study resolution.) Specifically, the study resolution directed staff to:

- Assess the extent to which there are staffing shortages for nursing homes in Virginia and understand the underlying causes;
- Evaluate the impact of staffing shortages on the quality of care provided in nursing homes;
- Analyze whether these impacts are disproportionately impacting certain populations in Virginia based on race, socioeconomic status, or other factors;
- Assess whether Virginia's current licensing requirements and oversight are appropriately identifying and addressing quality of care issues in nursing homes; and
- Identify strategies to improve recruitment and retention of the necessary workforce.

Staffing is a challenge across Virginia nursing homes, particularly for those serving low-income residents

Different Types of Nursing Homes

Nursing homes can be for-profit, non-profit, or government-owned. They may be independent, standalone facilities or be part of larger multi-facility chains.

Nursing homes that participate in Medicare and/or Medicaid are called **certified** facilities. Most nursing homes in Virginia (more than 90%) are certified for both, with a small group that take only Medicare or only Medicaid. There are also a handful of nursing homes that take no federal dollars at all. (See Appendix 1 for a breakdown of Virginia's nursing homes.)

Hours Per Resident Day (HPRD)

CMS calculates the number of hours that should be provided for each participating nursing facility based on the acuity of its residents. This is measured using 'hours per resident day'(HPRD), and the results are factored into each facility's Staffing star rating. Nursing homes that do not participate in Medicaid and/or Medicare do not have to report the hours of care they provide and are not subject to CMS ratings.

In Virginia, many facilities have difficulty with recruitment and retention of nursing staff. Staffing is a major component of quality care, and a significant body of research has found that sufficient staffing is important for high-quality care. Direct care staff, comprised of registered nurses (RNs), licensed practical nurses (LPNs), and certified nurse aides (CNAs) provide essential services to residents, which include managing medications and assisting with mobility and other daily activities. Regardless of payer mix, size, facility structure, and other factors, all nursing homes need appropriate staffing, commensurate with the needs of their residents, to ensure quality resident care.

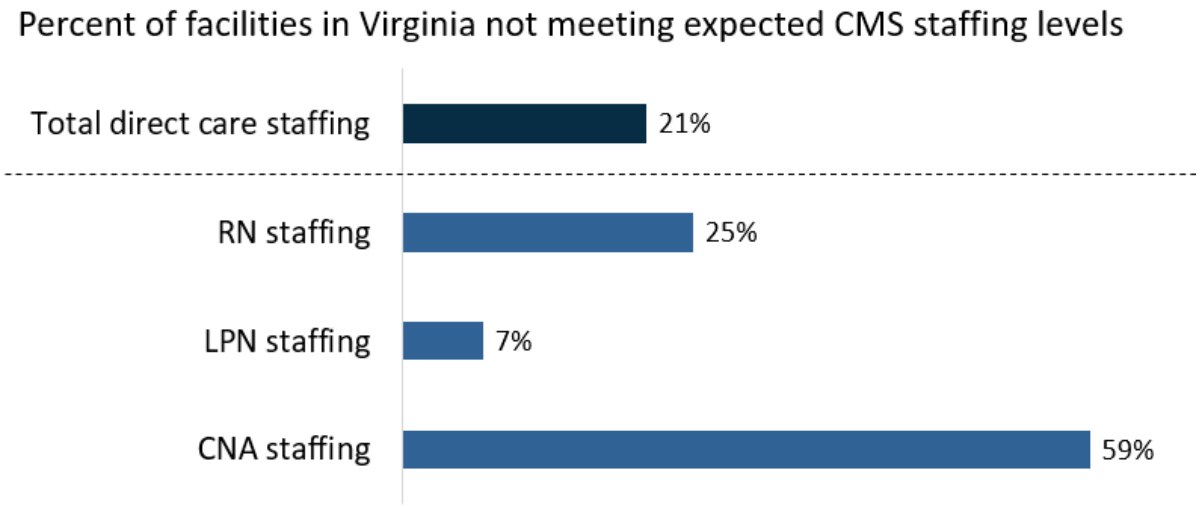
One-fifth of Virginia's nursing homes are not meeting CMS expectations for total direct care hours per resident

As of August 2021, 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). These shortfalls vary greatly by type of staff (FIGURE 1), with the shortfall being greatest for CNA hours. Statewide, 59% of facilities reported CNA hours that were less than those expected by CMS; 25% reported less RN hours than expected; and 7% reported insufficient LPN hours.

As a result of these staffing shortages, 43% of Virginia's nursing homes received a 1- or 2-star Staffing rating from CMS, indicating inadequate staffing. By comparison, across the U.S., 31% of nursing homes received a 1- or 2-star Staffing rating (FIGURE 2).

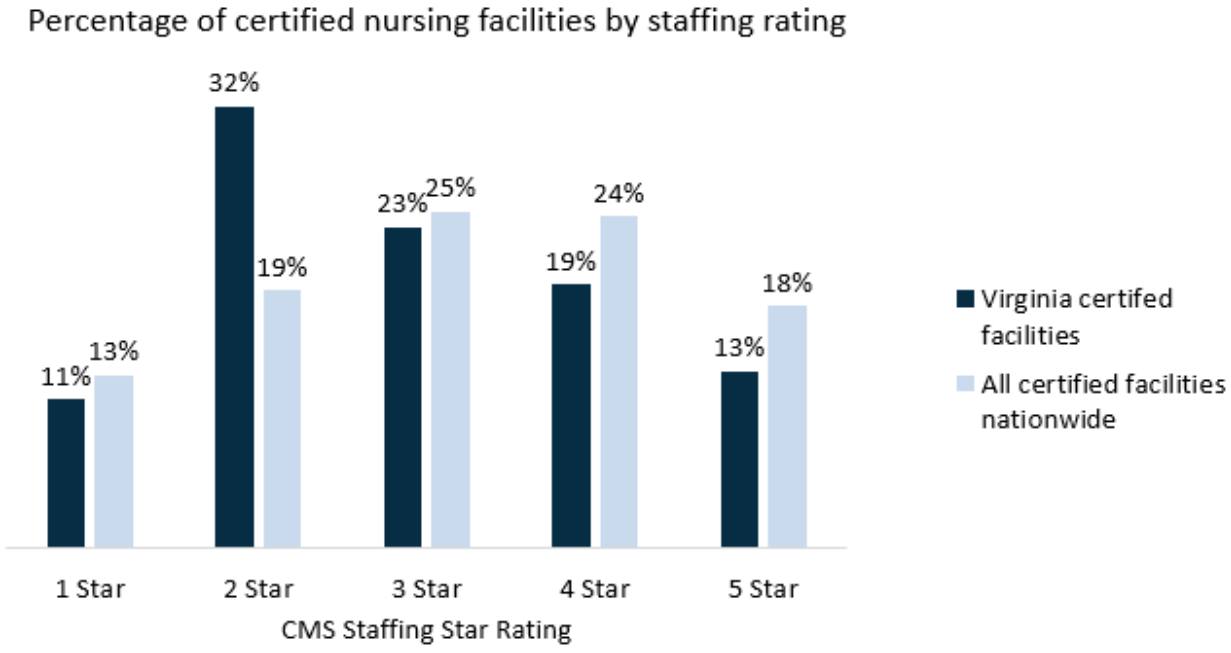
CMS uses a Five-Star Quality Rating System for facility performance based on staffing, health inspections, and quality measures. A 3-star score indicates that the facility is generally meeting but not exceeding expectations. A score of 1 or 2 stars generally means that the facility is performing below average and needs to improve. (See Appendix 2 for more information on how CMS assigns Staffing star ratings.)

FIGURE 1: Shortages are occuring in all nursing categories, and greatest shortage is of CNA staff (2021)



SOURCE: Centers for Medicare & Medicaid Services Nursing Home Compare, "Provider Information." Updated August 1, 2021. Data includes all certified nursing facilities, some of which are not licensed as nursing homes by the Virginia Department of Health (e.g., long-term care units operating inside hospitals). Data do not include any information about nursing homes that are not certified.

FIGURE 2: Virginia has more facilities with low staffing ratings than other states (2021)



SOURCE: Centers for Medicare & Medicaid Services Nursing Home Compare, "Provider Information." Updated August 1, 2021. Data includes all certified nursing facilities in Virginia, some of which are not licensed as nursing homes by the Virginia Department of Health (e.g., long-term care units operating inside hospitals). Data do not include any information about nursing homes that are not certified.

Some nursing homes in Virginia are not staffing as high as their average resident acuity requires, leading to lower CMS staffing ratings. On average, nursing homes in Virginia have higher average acuity residents than nursing homes in most other states, and higher acuity requires more skilled staff hours. For example, although nursing facilities in Virginia and Massachusetts both provided an average of 0.52 hours of RN care per resident in 2018, average acuity in Virginia is higher than in Massachusetts. (See Appendix 3 on nursing home resident acuity across states.)

In interviews, leadership and staff of Virginia nursing homes agreed that lack of staffing is a serious problem. There was consensus that workforce shortages are at the heart of the issue, but the facility-level data indicate that most Virginia nursing homes (79%) are able to overcome the shortages and meet minimum staffing levels based on CMS expectations.

Staffing shortages disproportionately impact facilities with low-income and Black residents

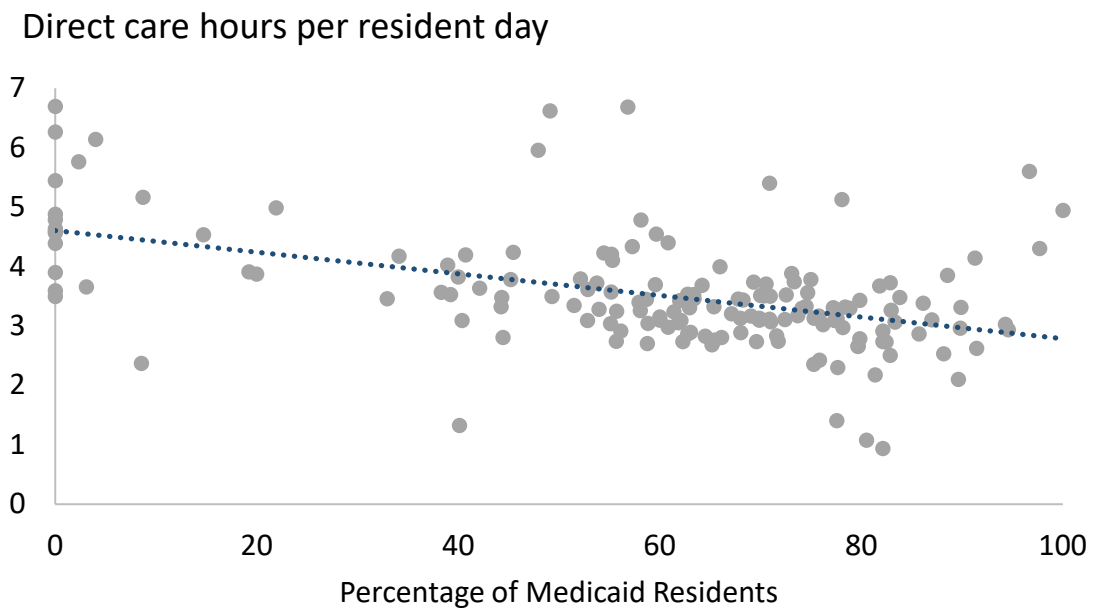
Nursing homes in Virginia with a higher proportion of Medicaid residents have lower staffing levels, on average (FIGURE 3). Additionally, facilities with a higher percentage of Medicaid residents on average receive lower health inspection and quality ratings from CMS. This is in line with national trends – across the U.S., states with a relatively larger percentage of low-income residents also have more nursing homes with lower overall ratings.

The CMS Minimum Data Set (MDS) captures resident race/ethnicity by asking residents to identify the race/ethnicity category that they identify with. If the resident cannot respond, and no family member or significant other is available to respond, the resident's medical record documentation or observer identification may be used.

Medicaid is the primary payer for two-thirds of nursing home residents in Virginia. As Medicaid reimbursements are designed to just cover costs, not to be profitable, most nursing homes balance a payer mix that includes Medicare and private-pay residents. Facilities that take on a greater proportion of Medicaid residents may not have the financial resources to hire more staff or raise wages.

Fewer older Black adults have private insurance than white adults and are more likely to be reliant on Medicaid. Nationwide, Black nursing home residents are much more likely to be in nursing homes where the majority of residents are supported by Medicaid.

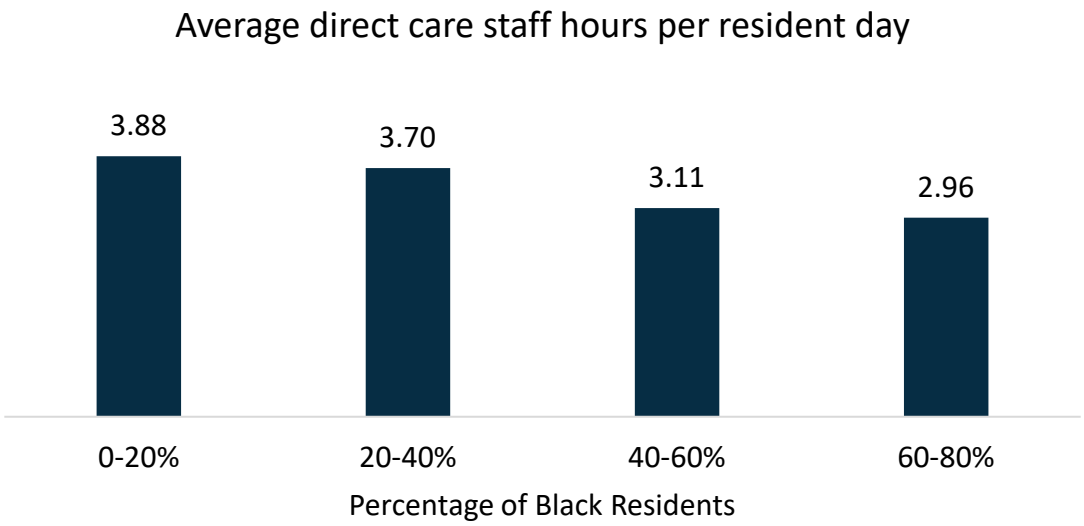
FIGURE 3: Facilities in Virginia with a high percentage of Medicaid residents tend to have fewer direct care staff (2018)



SOURCE: LTCFocus Public Use Data sponsored by the National Institute on Aging (P01 AG027296) through a cooperative agreement with the Brown University School of Public Health. State data from 2018.

Nursing homes in Virginia with a higher proportion of Black residents also have lower overall staffing numbers (FIGURE 4). Though Black residents represent just under 16% of Virginia's total senior population (age 65+), they make up 37% of Virginia's Medicaid enrollees. Additionally, nursing homes with a higher percentage of Black residents on average receive lower health inspection and quality measures ratings from CMS. This is in line with national trends that indicate Black nursing home residents are more likely to be in facilities that have health deficiencies, that are involuntarily or voluntarily terminated from participation in Medicare and Medicaid, and that are understaffed relative to resident acuity.

FIGURE 4: Facilities in Virginia with more Black residents have lower average direct-care staff HPRD (2018)



SOURCE: LTCFocus Public Use Data sponsored by the National Institute on Aging (P01 AG027296) through a cooperative agreement with the Brown University School of Public Health. State data from 2018.
NOTE: Black residents were identified as those who marked "Black, not of Hispanic origin" on their MDS assessment. White residents were identified as those who marked "White, not of Hispanic origin" on their MDS assessment. If race was missing on the assessment, race was drawn from the Medicare denominator file to calculate the proportion of residents in a facility.

Raising Medicaid reimbursement rates for nursing homes with a high concentration of Medicaid beds could improve staffing

Increasing Medicaid reimbursement rates for facilities that have a disproportionately high percentage of Medicaid residents would provide additional resources to invest in staffing. Nursing homes in which 70% or more of the residents receive coverage through Medicaid could receive an additional per diem add-on payment, similar to the COVID-19 pandemic add-on rates. Or, nursing homes could all receive an adjustment based on the percentage of Medicaid recipients in their facility. For example, in Colorado, publicly owned nursing homes receive supplemental payments for Medicaid residents, which bring their reimbursement closer to Medicare payment rates.

Research shows that higher Medicaid reimbursement rates are associated with better staffing and care quality. Increasing reimbursement rates, staffing, and quality would provide greater benefit to facilities with higher concentrations of minorities.

➔**OPTION 1:** JCHC could introduce a budget amendment to include language in the Appropriation Act directing Department of Medical Assistance Services (DMAS) to develop a plan to increase nursing home reimbursement rates for nursing homes with a disproportionate share of Medicaid residents.

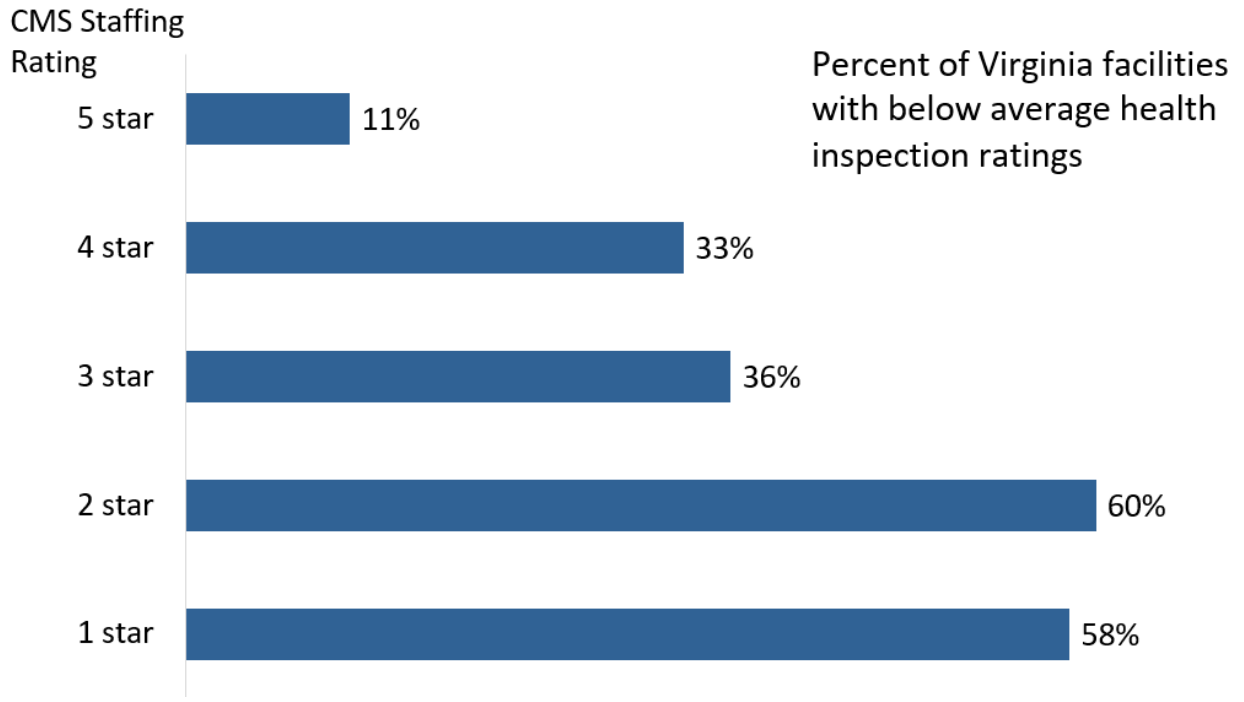
Low staffing increases the risk of low-quality care

JCHC staff analyzed the relationship between staffing and care quality in Virginia's nursing homes by looking at average staffing levels, health inspection scores, and quality ratings. While higher staffing levels are strongly correlated with better resident outcomes, the relationship is not always directly linear. There are many variables that influence both staffing and facility performance, and it is important to understand to what extent staffing shortages are truly affecting care in Virginia's nursing homes in order to tailor potential solutions.

Facilities with the fewest staff per resident are more likely to have lower health inspection and quality ratings

Virginia nursing homes with lower staffing are more likely to have lower health inspection scores (FIGURE 5). More than 60% of facilities with staffing that results in a 1- or 2-star rating, also have a 1- or 2-star rating on their health inspection criteria. CMS Health Inspection ratings are based on the number, scope, and severity of deficiencies identified in a facility, as well as a weighted average of a facility's three most recent health inspections and complaint investigations. Ratings are assigned on a curve based on a facility's relative performance compared to other nursing homes in the state. Direct care staff play an important role in facilities' health inspection performance, as investigators assess residents' quality of life, medication management, and skin care, among other factors. (See Appendix 2 for more information on CMS Health Inspection factors.)

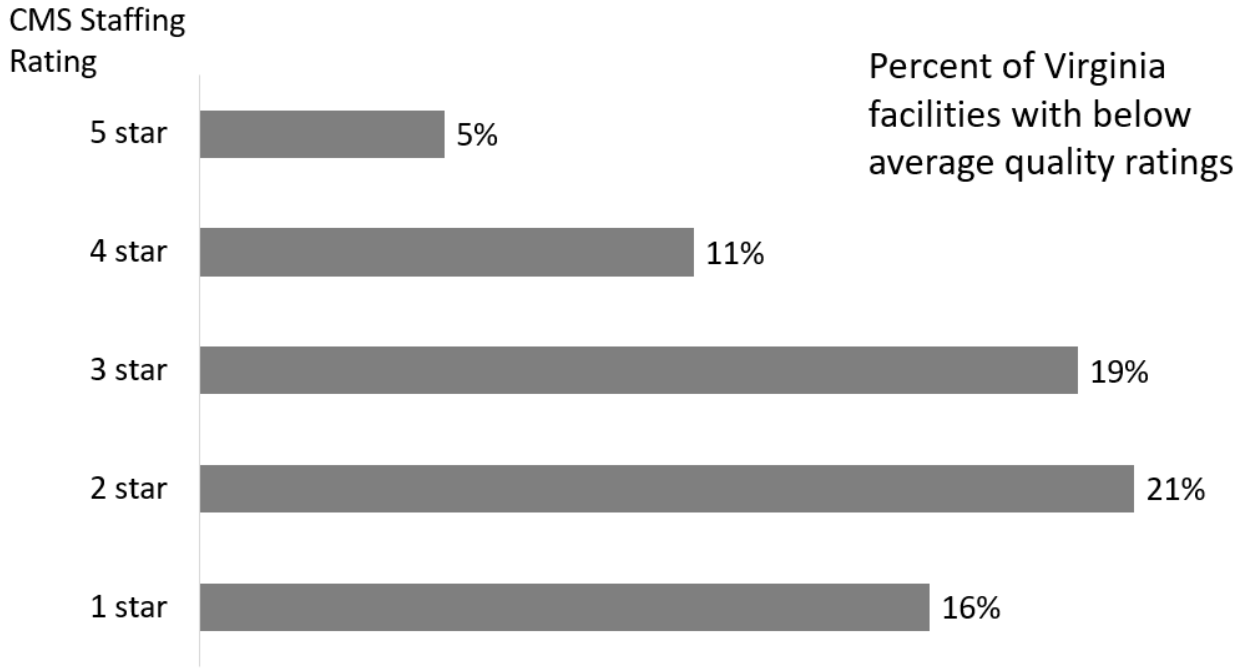
FIGURE 5: Facilities in Virginia with lower staffing ratings are more likely to have low health inspection ratings (2021)



SOURCE: Centers for Medicare & Medicaid Services Nursing Home Compare, "Provider Information." Updated August 1, 2021. Data includes all certified nursing facilities in Virginia, some of which are not licensed as nursing homes by the Virginia Department of Health (e.g., long-term care units operating inside hospitals). Data do not include any information about nursing homes that are not certified.
NOTE: Facilities with CMS health inspection ratings of 1 or 2 stars were considered "below average"

Similarly, Virginia nursing homes with low staffing are more likely to receive low quality ratings (FIGURE 6). CMS Quality Measures comprise 15 functional and health status indicators, such as the percentage of residents with a pressure ulcer, with a urinary tract infection, or who have experienced a fall. These are all considered measures of how well nursing home staff are caring for residents' physical and clinical health needs. (See Appendix 2 for more information on CMS Quality Measures.)

FIGURE 6: Facilities in Virginia with lower staffing ratings are more likely to have low quality ratings (2021)



SOURCE: Centers for Medicare & Medicaid Services Nursing Home Compare, "Provider Information." Updated August 1, 2021. Data includes all certified nursing facilities in Virginia, some of which are not licensed as nursing homes by the Virginia Department of Health (e.g., long-term care units operating inside hospitals). Data do not include any information about nursing homes that are not certified.
NOTE: Facilities with CMS quality measures ratings of 1 or 2 stars were considered "below average"

Nursing home staff and administrators indicate that low staffing leads to a "downward spiral" in recruitment and retention that exacerbates existing staffing challenges and adversely impacts quality of care. Low staffing not only impacts care quality for nursing home residents, but also affects staff well-being and satisfaction. When staff are stretched thin, there is a higher likelihood of burnout and turnover. This makes recruitment increasingly difficult as nursing homes lose employees, putting greater pressure on remaining staff and making recruitment and retention harder to manage.

Staffing issues are often the subject of complaints to the Virginia Office of the State Long-Term Care Ombudsman (LTC Ombudsman). Virginia's LTC Ombudsman receives and investigates complaints from nursing home residents and family members. Complaints in categories that are related to insufficient staffing consistently make up nearly half of total complaints. These complaints are for issues that are associated with staffing, from slow response time and insufficient assistance with daily tasks to gross neglect. (See Appendix 4 for more information about the complaint categories.)

Research literature consistently finds a strong relationship between staffing and quality

A large body of research over the last two decades has established that higher-staffed nursing homes perform significantly better on care processes compared to lower-staffed homes. Facilities with higher staffing tend to have lower mortality rates, fewer pressure ulcers, fewer urinary tract infections, less weight loss and dehydration, and lower hospitalizations among residents. In particular, increased RN hours per resident day are associated with better clinical outcomes. Increased CNA hours and nurse aide retention also improve quality and are believed to improve non-clinical quality such as resident satisfaction.

Virginia is one of 16 states without a nursing home staffing requirement

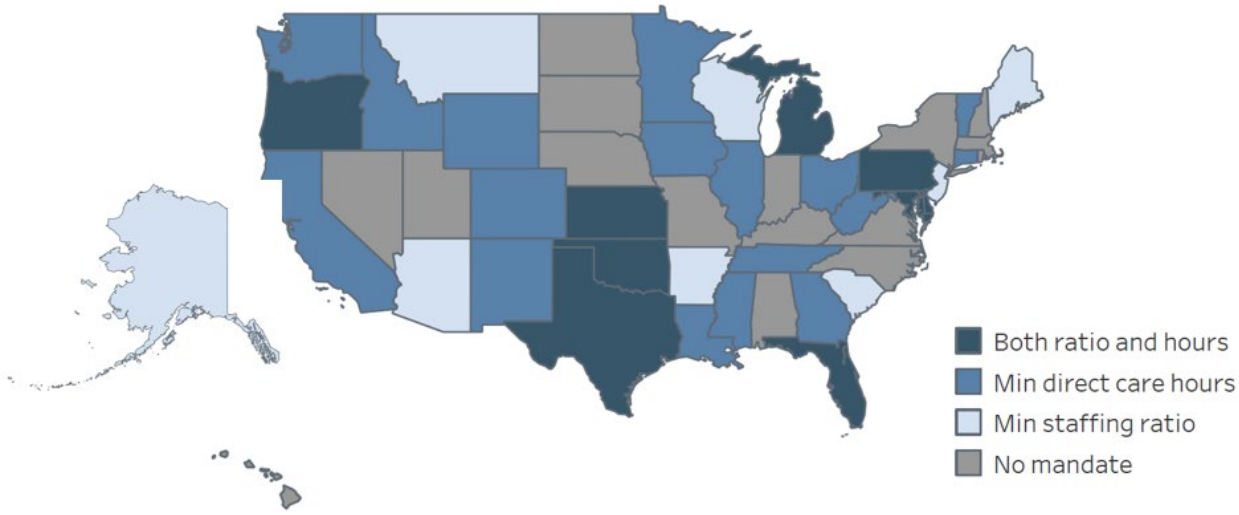
Most states (34 states and the District of Columbia) have passed staffing mandates for nursing homes (FIGURE 7). Other states' staffing mandates are designed with varying degrees of flexibility by using one or both of the following types of requirements:

- **Minimum HPRD** – nursing homes must deliver a certain number of licensed nursing and/or direct care hours per resident day (e.g., West Virginia requires 2.25 nursing care HPRD)
- **Minimum ratio** – nursing homes must maintain a minimum ratio of licensed nursing and/or direct care staff to residents based on facility census (e.g., Arkansas requires 1 direct care staff per 6 resident, and 1 licensed nurse per 40 residents during day shift)
- **Both** – nursing homes must maintain a minimum ratio of licensed nursing / direct care staff, and deliver a certain number of licensed nursing / direct care hours per resident day (e.g., Maryland requires 1 direct care staff per 15 residents, 1 RN per 99 residents, and 3.0 nursing care HPRD)

Of the states that have implemented some form of a staffing mandate, 18 have a minimum HPRD, 8 have a minimum ratio, and 9 have both a minimum HPRD and a minimum ratio. No states have staffing mandates that depend on average resident acuity, although NJ outlines specific HPRD for specific types of care (e.g., oxygen therapy, intravenous care).

Federal requirements are still tied to resident acuity, so in all states that have mandated staffing, nursing homes must meet state required thresholds and still staff appropriately for their resident acuity. This means that in states that have set lower staffing mandates, nursing homes may meet their state minimum but if their staffing levels do not provide the level of care expected by CMS they will face federal actions.

FIGURE 7: Most state staffing mandates for nursing homes are based on minimum direct care hours (2021)



SOURCE: Virginia Department of Health Office of Licensure and Certification. "Availability of Clinical Workforce for Nursing Homes – Report to the General Assembly", 2020.

CMS uses an acuity-based formula to determine the expected staffing level in nursing homes. While this is not a formal staffing mandate, it sets an expected level of staff based on the needs of the residents in each nursing home. Nursing home operators indicate that staffing should be adjusted based on the varying needs of their residents. However, outside of dedicated units for specific types of residents – dementia or individuals on ventilators – research indicates that staffing numbers in nursing homes are primarily driven by the number of residents, rather than level of need. Virginia's nursing home data indicates that, in line with national trends, facilities are not adjusting staffing significantly based on resident acuity.

Virginia could require all nursing homes and certified nursing facilities to meet a baseline staffing level

Establishing a staffing standard that sets a minimum or "floor," for the number of staff in facilities reduces the risk of poor quality of care. In addition to the strong relationship between poorly staffed facilities in Virginia and low quality of care, research shows staffing mandates have the strongest positive effect in facilities with the lowest staffing, as well as in more competitive labor markets. In states that adopted staffing mandates, nursing homes in the bottom quartile for staffing improved the most in reducing deficiencies and pressure ulcers.

Staffing standards have also been shown to have a stronger effect on improving staffing than directly increasing Medicaid reimbursement rates. While wages are important to staff, they are not sufficient for retaining employees, particularly during periods of high stress. The national average hourly rate for CNAs in nursing home has been increasing dramatically over the last few years (up 7.13% in 2021), but so has turnover (up 51.38%).

Better workloads reduce burnout and improve retention. Due to low supply and increased demand for staff, there may be a natural wage increase as the labor market adjusts.

However, nursing home administrators indicate that a one-size-fits-all staffing requirement would not be effective for the wide range of nursing homes across the state. Administrators and nursing home leadership feel a staffing mandate would restrict their ability to flexibly adjust staffing levels up or down based on their residents' acuity and level of need. They point out that CMS already regulates staffing, which is part of all regular federal surveys, and additional state regulation could lead to unnecessarily increased oversight. Administrators noted the possibility of some nursing homes having to shut down as a result of being unable to meet a staffing standard.

A staffing floor would target underperforming facilities by setting a baseline number of direct care hours for all nursing homes

Virginia could implement a staffing mandate using a required number of hours per resident day (HPRD). If a flat, across-the-board standard is set, using a floor of 3.25 total HPRD (including RN, LPN, and CNA hours) would target the lowest staffed and poorest performing nursing homes. As part of this requirement for total hours, 0.4 HPRD of RN staff time would mitigate the risk that nursing homes would limit RN hours to lower the cost of increasing their total staff hours. CMS found that while resident acuity may impact the amount of staff time required, its recommended threshold would still benefit the residents of all facilities.

Based on August 2021 data from CMS, 26% of Virginia's certified nursing facilities (74 facilities) reported less than 3.25 total HPRD. Similarly, 21% (59 facilities) reported less than 0.4 RN HPRD. These are the only facilities that would need to increase their staffing to meet a potential state requirement set at these levels. There were 33 facilities that would not have met a baseline staffing standard for either total staffing or RN hours.

JCHC staff estimate that it would cost at least $28.1 million for all nursing homes to meet this baseline staffing requirement with employee hours. This estimate is based on comparing the average hours per resident day provided at each facility to the proposed standard. It would require an estimated 818,377 additional hours of direct care staff time, and 175,532 hours of RN time, to bring understaffed facilities up to the baseline. An estimated $20.4 million of this cost would be attributed to Virginia's Medicaid program, based on the percentage of Medicaid residents in these facilities. Virginia receives a 50 percent match for its regular Medicaid program, so half of the costs for Medicaid recipients would come from state funds, with the other half coming from federal funds. Facilities would have to cover the additional staffing costs for their non-Medicaid residents, unless the state provides additional funding or increases Medicaid reimbursements beyond the estimated costs of meeting the standard. If nursing facilities are unable to bridge the staffing shortfall with employee time and must turn to agency staff, estimated costs would be higher.

Using an across-the-board standard would be more transparent and easier to implement, but would not account for resident acuity (TABLE 1). The Virginia Department of Health (VDH) could oversee the new standard as part of its regular facility inspections, which occur at least biennially, or develop a new oversight process. To provide some flexibility, facilities could have room to meet an across-the-board standard on an interval determined by the State Board of Health by regulation, such as a weekly or monthly basis, which would allow for daily fluctuations as long as the interval averages meet the minimum hours required.

TABLE 1: An across-the-board staffing requirement would be easier to implement but would not account for resident acuity

Baseline estimated cost	Advantages	Disadvantages
$28.1 million, covered by: • $10.2M federal Medicaid funds • $10.2M state Medicaid funds • $7.6M nursing facility funds	• Establishes a "floor" for lowest performing facilities • Transparent standard that is easy to understand • Nursing home staff know what kind of workload to expect	• Does not account for resident acuity • Requires a new VDH oversight process • Lack of consequences for failing to meet the standard

➔**OPTION 2:** JCHC could introduce legislation to amend section § 32.1-127 of the Code of Virginia to require nursing homes to provide at least 3.25 hours per resident day of total direct patient care (total RN, LPN, CNA hours), including at least 0.4 hours per resident day of RN care.

A staffing standard based on existing CMS expectations would adjust required nursing hours based on resident acuity

Virginia could implement a staffing mandate requiring nursing homes' reported total direct care staffing and reported RN staffing to meet or exceed the expected case-mix total nurse and case-mix RN staffing calculated by CMS based on resident acuity. This means the standard would be a changing, customized target that differs for each facility, rather than a uniform baseline number.

Based on August 2021 data from CMS, 21% of Virginia's certified nursing facilities (60 facilities) failed to meet their CMS expected case-mix numbers based on their resident acuity. When looking at RN hours, 25% of facilities (72 facilities) failed to meet their expected case-mix hours. In August 2021, there were 35 facilities that did not meet their expected case-mix numbers for either total staffing or RN hours.

JCHC staff estimate that it would cost at least a similar amount as an across-the-board staffing standard, $30.1 million, for all nursing facilities to meet this acuity-based staffing

requirement with employee hours. This estimate is based on comparing the reported hours per resident day provided at each facility to the CMS expected hours. It would require an estimated 274,500 additional hours of RN time and 728,705 additional hours of total direct care staff time to bring all facilities up to the expected figures calculated by CMS. An estimated $21.4 million would be attributed to Virginia's Medicaid program, with half of that portion coming from state funds. Facilities would have to cover the additional staffing costs for their non-Medicaid residents, unless the state provides additional funding or increases Medicaid reimbursements beyond the estimated costs of meeting the standard. If nursing facilities are unable to bridge the staffing shortfall with employee time and must turn to agency staff, estimated costs would be higher.

An acuity-based standard would give nursing homes the flexibility to adjust their staffing based on case-mix, but it would be less transparent and require new oversight processes at VDH (TABLE 2). Facilities submit staffing data to CMS on a quarterly basis, and CMS releases Nursing Home Compare data monthly with each nursing home's reported hours, acuity-adjusted expected hours, and Staffing star rating. Using this staffing standard, VDH could track on a quarterly basis if a facility's reported hours fell short of its expected case-mix hours.

TABLE 2: An acuity-based staffing requirement would require new oversight processes but is more targeted to each nursing home's resident mix

Baseline estimated cost	Advantages	Disadvantages
$30.1 million, covered by: • $10.7M federal Medicaid funds • $10.7M state Medicaid funds • $8.7M nursing facility funds	• Establishes a target for all nursing homes • Requirement is specific to each nursing home's resident acuity	• Staffing data is updated quarterly • Case-mix hours are calculated by CMS based on average expected care hours – it is less intuitive and more cumbersome to calculate • Requires a new VDH oversight process • More complicated to calculate for nursing homes that are not certified and do not receive a case-mix HPRD from CMS • Lack of consequences for failing to meet the standard

➔**OPTION 3:** JCHC could introduce legislation to amend section § 32.1-127 of the Code of Virginia to require nursing homes to provide at least the number of expected total direct care hours and total RN hours that are calculated by CMS based on resident acuity in each nursing home.

Implementing a staffing standard will require effective regulation and oversight

Virginia would have to ensure effective oversight of any new staffing standard to realize the expected benefit. It is currently very difficult to prove that a nursing home does not have "adequate" staff under federal rules, and if a state standard is difficult to enforce, it will not result in improved resident care. This would require checking to make sure each facility is meeting the requirement, and then having productive enforcement mechanisms that help struggling nursing homes raise their staffing levels.

Oversight of a staffing mandate would be the responsibility of VDH's Office of Licensure and Certification (OLC), which manages all nursing home licensure, state inspections, federal surveys, and complaint investigations. OLC currently has no authority to issue fines on nursing homes for violations of state law. If inspectors find a violation, OLC's options are only to issue a plan of correction, revoke or suspend a nursing home's license, or restrict new admissions. OLC indicated that this can make it difficult to enforce requirements because they are caught between two extremes of doing very little or issuing severe sanctions. The General Assembly would need to provide VDH with the authority to levy additional, intermediate enforcement measures that would help provide effective oversight of a staffing requirement, without being overly punitive to struggling nursing homes. OLC would also require additional funding to support the administrative costs of creating, implementing, and managing a new oversight process related to a staffing standard.

Funds to support a staffing requirement could come from the general fund or other dedicated revenue

Increasing Medicaid reimbursements does not directly ensure staff receive higher wages – to that end, many states have implemented wage pass-through measures that require nursing homes to use any new Medicaid payment increases on direct care staff compensation. This would only affect facilities with Medicaid residents and substantively help facilities with a greater reliance on Medicaid payments.

Virginia could utilize a couple of different strategies to fund the investments to support a nursing home staffing mandate

Funds could come from the general fund or from dedicated revenue sources that could be generated through provider assessments or other taxes.

- **Nursing home provider assessment.** Implementing a nursing home provider assessment would generate additional state revenue that would then be matched with federal funds, to pay for increased nursing home rates. Virginia is one of only six states that does not currently

Federal limitations for provider-specific taxes

- States can not guarantee providers that the taxes will be returned to them unless the amount returned to the provider is less than the threshold defined by the "hold harmless" rule – currently less than 6% of revenues
- Taxes cannot exceed 25% of the state's share of Medicaid expenditures

have a nursing home provider assessment (the others are Alaska, North Dakota, South Dakota, South Carolina, and Texas). A nursing home provider assessment would be levied on all nursing homes in Virginia, regardless of payer mix, but only those that have Medicaid residents would see increased reimbursement (there are currently 28 nursing homes in Virginia that do not take any Medicaid residents). This approach is subject to federal requirements and would require CMS approval. One primary advantage of this approach is that it does not require general fund appropriations, and in general, the entities paying the assessment are the same entities that benefit from the revenue generated.

DMAS would require additional funding to support the administrative costs of creating, implementing, and managing a nursing home provider assessment.

➔**OPTION 4:** JCHC could introduce a budget amendment to include language in the Appropriation Act directing the Department of Medical Assistance Services to develop a proposal for a nursing home provider assessment that can be submitted to CMS for approval. DMAS should work with appropriate stakeholders, including LeadingAge Virginia and the Virginia Health Care Association, when developing the proposed assessment.

- **Other revenue options.** Another strategy that has been proposed is to reinstate Virginia's estate tax and use the revenue to increase nursing home reimbursement rates. A bill during the 2021 General Assembly Regular Session (HB 2157, Delegate Watts) would have reinstated an estate tax in Virginia for estates that meet certain criteria, and designate revenues from the tax to be used for health care purposes, including a proposed nursing home staffing mandate. Revenues were estimated to reach $60 million per fiscal year.

Virginia has options for how it distributes additional funds to nursing homes

The General Assembly would have a choice between providing additional funds to help nursing homes implement the staffing mandate, or expecting nursing home operators to take on the costs.

- The General Assembly could implement the mandate and allow Medicaid reimbursement rates, which are based on nursing home costs, to increase as a result. This would take time, and because nursing homes would not receive increased reimbursement until 1-2 years after hiring more staff, this approach could place already-struggling nursing homes in a difficult financial situation.
- The General Assembly could provide increased reimbursements targeted to nursing homes with insufficient staff or initial funding to help struggling facilities pay for staff and meet the mandate.
- The General Assembly could adjust the current Medicaid reimbursement formula overall to cover more costs. Currently, facilities who choose to take on increased costs in order to invest more in their staff may not be fully reimbursed, depending

on their peer group rate. While increasing reimbursement would not guarantee facilities will use these increased reimbursements for staff, for those that do, the additional funds could help bridge the gap until reimbursement rates can catch up to the increased costs of meeting a staffing mandate.

Broader health care workforce shortage contributes to staffing problems in nursing homes

While it is clear that adequate staffing is important to ensuring higher care quality in nursing homes, there is broad agreement that there is a larger ongoing workforce shortage that makes it more difficult to find staff. Implementing a staffing standard should be supported by additional programs to bolster the health care workforce in order to ensure a sufficient supply of direct care staff. This is especially important in light of demographic trends that indicate that an increasing number of Virginians will need nursing home care in the coming years. JCHC staff found that while there is a clear decline in workers, additional factors such as culture, leadership, and workload influence whether or not people enter or stay in the field.

Fewer LPNs and CNAs have entered the workforce each year since 2016

The Department of Health Professions has documented decreasing numbers of CNAs and LPNs in Virginia over the last five years, as an increasing number of individuals have left the profession to retire or pursue other careers, and not enough new individuals have entered the profession. From 2016 to 2020, the number of CNAs licensed in VA decreased by 4.3% from 61,302 to 58,669. In the same time period, the number of LPNs licensed in Virginia decreased by 6.4% from 31,102 in 2016 to 29,112 in 2020. While this affects the entire health care industry, it is particularly problematic for nursing homes, which rely mostly on CNAs and LPNs rather than RNs for resident care.

Evidence of relationship between staffing levels and COVID-19 outbreaks in nursing facilities is mixed. Different studies have found rates of infection within facilities can depend on:

- Rates of community transmission
- Number of staff
- Size of facility

In response to the high COVID-19 associated mortality rates in nursing homes, a new federal mandate announced in August 2021 requires all nursing home workers to be vaccinated. This may further shrink the pool of potential employees.

The shrinking workforce is also less interested in working in nursing homes. A survey of staff showed nursing homes are the least desired place of employment for nurse aides. In interviews with JCHC staff, nursing home leadership often mentioned there are many applicants who only turn to nursing homes as a stepping stone to other health care settings, or when they cannot find employment elsewhere. Compared to 2015, fewer CNAs now work in nursing homes and home health care establishments, and more CNAs work in assisted living facilities and inpatient hospital departments. Turnover is

higher for CNAs and LPNs than for RNs, and many nursing homes reported a consistent churn of applicants and employees who regularly jump from facility to facility.

The COVID-19 pandemic continues to significantly exacerbate the labor shortage

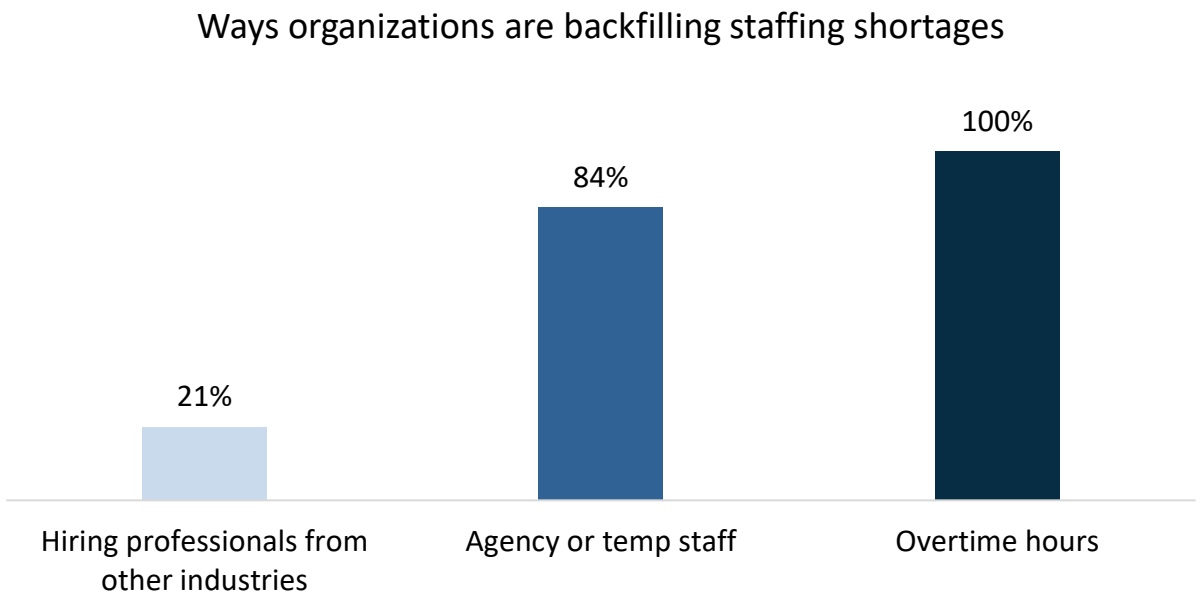
Many nursing homes reported difficulty retaining staff through the COVID-19 pandemic, as nursing staff resigned for various reasons, including infection, fear of infection, and child care issues. While the uncertainty of the early months of the pandemic was a significant challenge, the later easing of restrictions did not ease the staffing shortage. In interviews with JCHC staff, all nursing home leadership reported continued difficulty with finding and retaining staff since March 2021. Administrators attributed this to staff wanting to get away from work to do more activities or travel to see family.

More recently, staff at some nursing homes resigned in response to vaccine mandates. One facility JCHC staff visited reported that they lost 25 full-time employees (out of roughly 120 total staff) when they mandated the COVID-19 vaccine for all staff. Another reported that they gained employees when a nearby nursing home instituted a vaccine mandate. A federal vaccine mandate for all nursing homes that participate in Medicare or Medicaid is expected to go into effect in the fall of 2021.

Virginia's facilities have responded by offering various incentives to attract and retain employees. These include signing bonuses, retention bonuses for employees who stay a certain amount of time, bonuses for overtime shifts, flexibility in scheduling, and free meals. Some states have also responded to the staffing shortages. For example, in April 2020, New Hampshire established a temporary stabilization fund for long-term care workers, granting weekly payments of $300 to full-time and $150 to part-time front-line health care workers including nursing, housekeeping, and dietary staff.

Despite these incentives, most nursing homes are still not able to hire enough staff, and are using additional strategies to provide enough hours of care. As of August 2021, 100% of senior housing and skilled nursing operators across the nation who responded to a survey by the National Investment Center for Seniors Housing & Care (NIC) reported using overtime to backfill their staffing shortages (FIGURE 8). Most are also relying on staff from outside staffing agencies to supplement their workforce needs.

FIGURE 8: Nursing homes are primarily backfilling staffing shortages with overtime hours (2021)



SOURCE: NIC Executive Survey Insights (Wave 31, July 12-August 8, 2021).

Administrators indicate that workforce challenges have been longstanding

All administrators with whom JCHC staff spoke noted staffing was already a problem before COVID-19, and the pandemic has exacerbated the issue. In particular, many administrators feel the enhanced unemployment benefits available as part of COVID-19 relief efforts are disincentivizing people from working, given how low standard industry wages already are. The enhanced unemployment benefit ended September 2021.

There are a variety of ongoing efforts in Virginia to build the health care workforce:

- Governor Northam's Virginia Healthcare Workforce Advisory Council chaired by Dr. Megan Healy
- Governor Northam's G3 Program
- Authorization for Temporary Nurse Aides (TNA) practicing in long-term care facilities in response to the COVID-19 pandemic

Nursing home administrators emphasized that while they are doing their best to recruit new employees to increase or maintain ideal staffing levels, the biggest barrier is a health care workforce shortage. Fewer people are entering nursing or becoming "career CNAs," and those who do would rather work for hospitals, private practices, or staffing agencies for better pay and benefits. Low Medicaid reimbursement means nursing home wages are not competitive, and staff are being asked to do more work for less pay than they could get somewhere else. Additionally, some administrators cited generational differences, with increasing numbers of employees wanting to work flexible hours that best suit their schedules rather than meeting the scheduling needs of the facility. Administrators also

acknowledged the importance of stable leadership and good culture for recruiting and keeping staff.

Staff indicate that multiple factors influence the shortage of direct care workers

Like administrators, staff noted understaffing in nursing homes has been a problem since long before the COVID-19 pandemic. They touched on many of the same points made by the administrators – pay is too low when there are much easier jobs for the same or better pay, and good, stable leadership and strong teamwork make a huge difference in workplace satisfaction. Some did feel there were generational differences in the workforce, with many employees who had been in the field for a long time noting that newer employees had different attitudes about the work and received inadequate training and preparation. Additionally, staff emphasized the physical and emotional difficulty of managing high resident numbers due to insufficient staff, and they cited high ratios of direct care staff to residents (e.g., 1 CNA for 20 residents) as a primary reason for burnout.

Successful recruitment and retention of nursing facility staff depends on many different factors

Nursing leadership and staff agreed that the most important factors to staff are wages, benefits, training and opportunities for continued education and advancement, workplace culture, and leadership. While good wages and benefits are important to staff, they are not the primary driver. JCHC staff consistently heard that working in a direct care role for the elderly is a mission-driven calling, and the staff who stay are those who truly care for their residents and build relationships with their co-workers and residents.

A few staff from staffing agencies indicated that they would be more willing to work as full-time employees of a nursing home if the pay was better and if the leadership were stable and supportive. Many staff pointed to the importance of good leaders who could set a culture of cooperation and teamwork, and were consistent about hearing staff needs and respecting the work that they do.

There are several policy options that JCHC could consider to support nursing home employees and bolster the workforce. Additional options were provided by the 2020 VDH Ch. 932 Work Group report to the General Assembly on the availability of the clinical workforce for nursing homes.

Financial support for direct care staff could be in the form of student loan repayment

Virginia's Mary Marshall Nursing Scholarship is available to undergraduates enrolled in educational programs to become RNs, LPNs, and CNAs who commit to providing full-time services in any health care setting in Virginia for at least one year. However, this program is not targeted to the nursing home or broader long-term care workforce. Participants with eligible educational loans may apply for scholarships of up to $2,000 per year.

The Long-Term Facility Nursing Scholarship was established in 2016 but has not received any funding to award scholarships. This program provides the same $2,000 annual scholarship, with a maximum benefit of $8,000 over four years, but recipients must commit to working in a Virginia nursing facility. Minnesota has a similar program for RNs and LPNs who work at least two years in specific care settings, including nursing homes. Program participants in Minnesota receive $6,000 a year, up to a maximum of $24,000 over four years.

The Nurse Loan Repayment Program is a different program that tries to incentivize RNs, LPNs, and CNAs to work in Virginia. Chapter 238 (2021 Acts of Assembly, Special Session I) added CNAs as eligible recipients to this program. The program does not have any specific eligibility criteria related to nursing homes or long-term care facilities.

➔**OPTION 5:** JCHC could introduce a budget amendment to provide general fund appropriations to the Long-Term Facility Nursing Scholarship program.

Other strategies could be used to incentivize workers to join or stay in the nursing home direct care profession, particularly in the CNA role:

- Reduce or eliminate state income taxes for nursing home direct care workers; RNs, LPNs, and CNAs who verify they were employed full-time in a nursing home for the entire year could receive state income tax relief, with the incentive targeted to those with greatest financial need.
- Pay stipends to help with child care or transportation expenses, similar to the payments authorized under New Hampshire's Long-Term Care Stabilization Program.

Supporting nursing home leadership can help address workforce shortages

Virginia could support nursing homes in developing strong leadership and internal culture. Nursing home staff shared that good leadership, culture, and opportunities for advancement are important to workforce stability. When wages, benefits, and staffing supports are lacking or strained, a good working environment can often be the deciding factor for whether or not nursing home staff stay. Investing in programs to provide grants for nursing homes to engage in staff capacity-building and culture may help facilities with better retention. For example, the Virginia Gold Quality Improvement Program was a pilot project that funded a two-year intervention to develop supportive work environments. The program was funded with penalties collected from certified nursing homes as result of federal violations and non-compliance. During the pilot program, turnover declined and quality of care improved in most participating nursing homes. Facilities spent less than $30,000 per year from the fund to implement their quality improvement projects.

➔**OPTION 6:** JCHC could introduce a budget amendment to include language in the Appropriation Act directing the Department of Medical Assistance Services (DMAS) to design and seek CMS approval for a quality improvement program addressing nursing

home capacity-building with funding from the Civil Monetary Penalties Reinvestment Fund. Program design could be based on the results of the Virginia Gold Quality Improvement Program pilot project.

Additional strategies could incentivize and support better staffing and care quality

Nursing home quality and staffing is dependent on a multitude of factors, and initiatives with a narrow focus are unlikely to adequately address the challenges. In order to improve Virginia's nursing homes, it is important to address not only pure staffing numbers, but also to pay attention to workforce issues, financing, and facility structure. To supplement the policy options listed thus far, JCHC staff have compiled additional legislative options to support nursing homes.

Incentivizing quality can improve care at facilities that already meet staffing standards

Legislators tasked DMAS in 2021 with developing a Value-Based Purchasing program for Virginia's nursing homes. The agency has been convening a workgroup to design the initiative, which is scheduled to go into effect in July 2022.

Performance priorities:

- Maintenance of adequate staffing levels
- Avoidance of negative care events (e.g., hospital admissions)

Additional performance areas:

- Preventive care
- Utilization of home and community-based services
- Other relevant domains of care

While a staffing mandate acts as a floor for nursing homes and is likely to have the greatest impact on low-achieving facilities, pay-for-performance programs can incentivize better quality in nursing homes that are already meeting the minimum. For example, a 2001 study by CMS found that a strong minimum staffing level for nursing homes to provide consistent, timely care was 2.8 HPRD of CNA care. While 85% of nursing homes in Virginia currently fall short of this mark, making it an unrealistic staffing requirement, using 2.8 HPRD or something similar as a target – and providing incentives for nursing homes who meet it –would complement a baseline staffing standard.

Nursing homes that accept Medicare, also known as skilled nursing facilities (SNFs), already participate in Medicare pay-for-performance. CMS withholds 2% of Medicare Part A fee-for-service payments to SNFs and then distributes 60% of that pool as incentive payments. Performance is measured based on risk-adjusted hospital readmissions.

Other states have implemented pay-for-performance or value-based purchasing (VBP) programs as a way to complement staffing minimums. For example, in Tennessee, there is a 2.0 HPRD staffing minimum for all direct care staff and 0.4 HPRD from a licensed nurse, but nursing homes can receive additional payments based on additional performance measures tied to staffing, resident satisfaction, resident quality of life, and clinical performance. In

Georgia, there is also a 2.0 HPRD floor for all direct care staff, but nursing homes can receive a 1% increase in rate if the nurse-to-resident ratio is above 2.5 and they agree to participate in data collection for the program.

The General Assembly directed DMAS in 2021 to develop a VBP program for Virginia's nursing homes, and this project could be used to incentivize stronger staffing and quality in nursing homes that are already meeting a baseline standard. This program prioritizes adequate staffing levels and avoiding negative care events. The agency is convening a workgroup to inform program design, and the program is scheduled to begin implementation by July 2022. DMAS is looking at additional quality metrics and measures for nursing home performance that may be added on in subsequent years.

Pay-for-performance initiatives are highly variable and need to be designed and implemented effectively to improve nursing home quality. If incentive payments are too small, the program may not effectively motivate changes in performance. Additionally, the current directive does not include funding for a formal evaluation of DMAS' nursing home VBP program, which might include elements to assess whether the incentives are working to increase staffing and quality, such as resident satisfaction surveys.

➔**OPTION 7:** JCHC could introduce a budget amendment to include language in the Appropriation Act directing and funding the Department of Medical Assistance Services to include a formal evaluation that includes assessing the program's effectivess at increasing staffing and quality.

Behavioral health needs are increasing, but not sufficiently addressed through reimbursement rates

All of the administrators JCHC staff spoke with noted there has been a steady increase in residents with behavioral health needs. In 2016, nearly half (45.3%) of nursing home residents nationally were reported to have a dementia diagnosis, and a third (32%) had other psychiatric conditions such as schizophrenia or mood disorders.

Residents with behavioral health needs require more attention and staff time but nursing homes are not properly equipped to meet those needs. Administrators and staff shared that when residents are having a behavioral episode and need to be watched closely to make sure they do not harm themselves or other residents, a staff member that could have been helping multiple residents must now spend the majority of their time with one resident. This increases the workload of other staff on the floor. In nursing homes without locked units, confused residents who try to leave the facility require additional attention. Staff often lack the training to appropriately de-escalate or manage behavioral health episodes, and do not have the capacity to spend extra time with agitated or combative residents. Low staff turnover, adequate nurse staffing, and psychiatrically trained RNs and physicians allow nursing homes to better provide behavioral health services to residents.

Administrators noted that while resident behavioral health needs are captured in resident acuity assessments, which are the primary metrics used for reimbursement and staffing, the costs of meeting those needs are not adequately factored into reimbursement rates. When setting reimbursement rates, DMAS considers a facility's average resident acuity (residents are classified into Relative Utilization Groups, or RUGS, based on their assessed level of need), using data collected in the CMS Minimum Data Set (MDS). The MDS is primarily focused on capturing diagnoses, medications, and physical needs, so a nursing home may have higher acuity than documented when taking into account the residents who require less physical care but more mental/behavioral health resources.

Developing a supplemental nursing home reimbursement rate for residents with specific behavioral health needs could help nursing homes improve staffing and quality of care for these residents. Enabling nursing homes to take on more of these residents could also relieve some of the pressure on the struggling state psychiatric facilities that are facing their own staffing shortages and have limited admissions. In Delaware, nursing homes receive an additional 10% of the primary care rate component for residents "exhibiting disruptive psychosocial behaviors on a frequent basis". In Virginia, DMAS currently provides similar, additional payments for nursing facility residents with traumatic brain injury and ventilator dependent care, as well as increased rates for facilities where 80% of the resident population has special diagnoses (e.g., cerebral palsy, multiple sclerosis).

Developing a reimbursement methodology to account for behavioral health needs will require several steps. DMAS would need to identify the specific diagnoses that would qualify for additional reimbursement, and then analyze the additional level of care required to effectively manage these residents. That information can then be used to develop a reimbursement rate that adequately reimburses nursing homes to care for these individuals.

➔**OPTION 8:** JCHC could introduce a budget amendment to include language in the Appropriation Act directing the Department of Medical Assistance Services (DMAS) to develop a plan for an enhanced reimbursement rate to nursing homes for residents with behavioral health diagnoses. The plan should include the diagnoses to be included, the additional care and staff training required, and the estimated cost. The plan should be submitted to the Joint Commission on Health Care, and the Chairs of the House Appropriations and Senate Finance Committees by October 1, 2022.

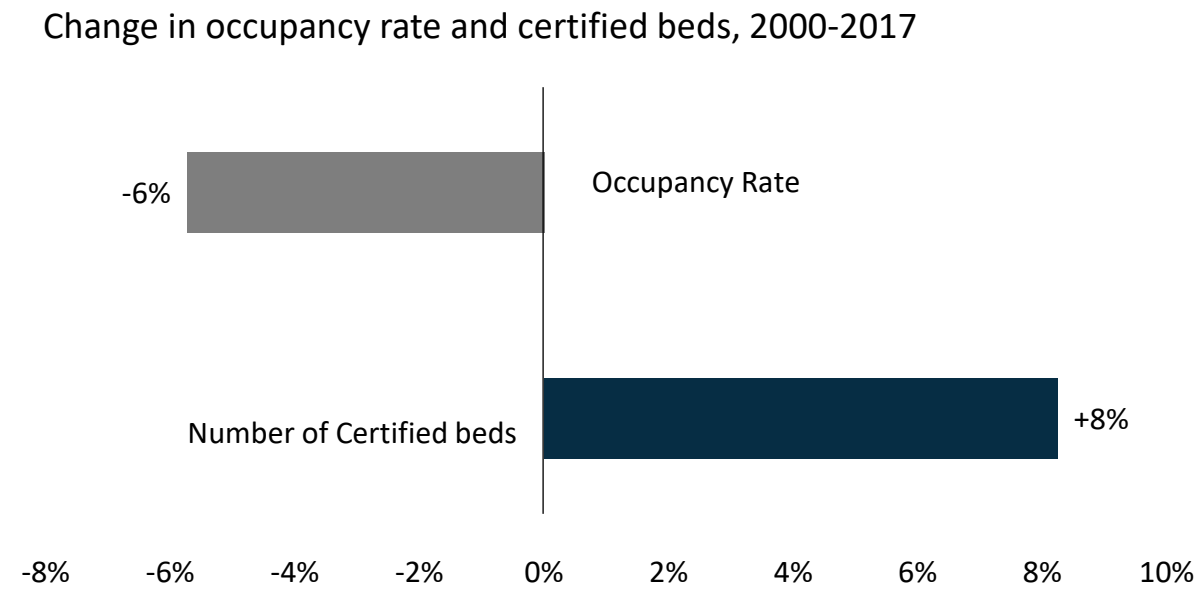
Prioritizing other types of care would reduce need for nursing home workforce over the long term

While there will always be a need for nursing home care, there is a growing emphasis on making home and community-based services (HCBS) available to aging seniors in Virginia. The JCHC study on strategies to support aging in place will have policy options to strengthen HCBS.

One strategy that would support both HCBS and nursing homes would be to reduce the total number of nursing home beds in Virginia. A steady increase in the number of certified beds in Virginia has reduced the occupancy rate of nursing homes over the last two decades as the number of nursing facility residents has remained relatively stable (FIGURE 9).

Many nursing facilities have fixed expenses tied to the number of licensed beds they have, regardless of occupancy, which means reimbursement sometimes covers excess capacity. Smaller facilities with fewer beds tend to have higher overall star ratings than larger nursing homes – and this is true for both for-profit and non-profit nursing homes. Large nursing homes also have higher documented deficiencies, and with more employees and residents, there is greater risk of infection and potential for larger outbreaks. This was evident during the COVID-19 pandemic, when larger nursing homes had more COVID-19 deaths per licensed bed.

FIGURE 9: Occupancy in Virginia's nursing facilities is declining as the number of certified beds has increased without a corresponding increase in residents (2021)



SOURCE: LTCFocus Public Use Data sponsored by the National Institute on Aging (P01 AG027296) through a cooperative agreement with the Brown University School of Public Health. State data from 2000-2017.

Strategies to adjust occupancy rates could limit the amount of excess capacity captured in Medicaid reimbursement rates

Incentivizing bed reductions could lead to cost savings for DMAS, because reimbursement rates would not have to cover as much of the indirect and capital costs for empty beds. Additionally, facilities would have the space and opportunity to convert older, double rooms to single, private rooms. It is possible that a reduction in the availability of beds would

result in fewer individuals being placed in nursing homes, requiring fewer staff. This may be achieved through a variety of strategies:

- **Bed buyback programs**. Incentivizing nursing homes to reduce the number of beds is another strategy that can be effective. Oregon enacted a short-term program in 2013 to reimburse nursing homes that voluntarily reduced their licensed bed capacity. The goal was to increase efficiency and reduce costs for the state. Buy-back was capped at $9.75 per resident day. As of 2021, Oregon's current average nursing home occupancy rate is 66% and most hospital discharges are to community settings (e.g., home, assisted living, independent living) rather than to nursing homes. Similarly, this year, Ohio has proposed a $50 million fund to buy back 5,000 bed licenses from nursing care providers at $10,000 each. This would require one-time funding rather than ongoing funding.
- **Expanded Medicaid reimbursement for private rooms.** Currently, Medicaid residents must meet certain criteria for DMAS to reimburse for a private room. Private rooms are considered necessary when residents must be isolated from others. This means nursing homes have little financial incentive to convert semi-private rooms into private rooms. Adjusting the current reimbursement criteria may make it easier for nursing homes to make this transition, reducing the number of residents in the facility whether or not the number of beds a facility is licensed for changes.
- **Increased occupancy standards**. Occupancy standards are occupancy thresholds that are used for setting Medicaid reimbursement rates. Nursing homes must meet this occupancy rate to receive their maximum reimbursement, discouraging an excess of empty beds. The state Medicaid agency calculates a nursing home's reimbursement rate using their actual occupancy rate and the occupancy standard. If the nursing home's occupancy does not meet the standard, the nursing home receives a lower reimbursement rate. Virginia currently has an occupancy standard of 88%, but some states set higher thresholds. For example, Massachusetts' occupancy standard is 96% - if a facility's occupancy rate is lower than 96%, they will not receive their maximum reimbursement. This encourages facilities to reduce the number of beds or add more residents to ensure sufficient occupancy to make efficient use of state funds. The occupancy standard only applies to capital costs for nursing facilities in Virginia, meaning the impact of adjusting it up or down is marginal.

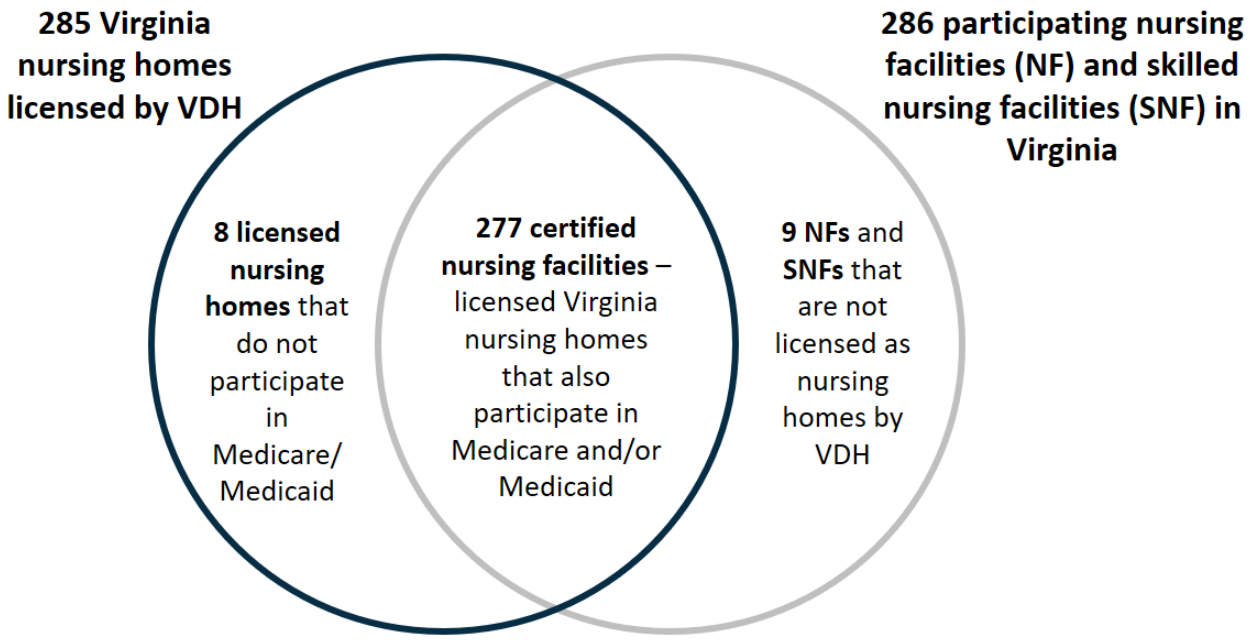
Reducing the number of licensed beds in the state would potentially reduce expenses for DMAS, but would also likely reduce revenue for the VDH Office of Licensure and Certification (OLC). Nursing home licensure fees are a large source of OLC funds, and fees are based on bed count.

Appendix 1: Nursing homes in Virginia

While the terms 'nursing home', 'nursing facility', and 'skilled nursing facility' are often used interchangeably, there are a few distinctions based on federal and state terminology. Virginia refers to nursing homes that participate in Medicare and/or Medicaid as "certified nursing facilities". At a federal level, nursing facilities (NFs) generally refer to nursing homes that provide long-term care and accept Medicaid, and skilled nursing facilities (SNFs) refer to facilities where patients have short-term rehabilitative stays covered by Medicare.

There are currently 285 nursing homes in Virginia, licensed by the Virginia Department of Health (VDH) (FIGURE A1). Most are certified NF/SNFs that participate in both Medicare and Medicaid. There are 10 nursing homes that only participate in Medicaid, 20 nursing homes that only participate in Medicare. There are 32,573 certified beds for Medicare/Medicaid patients across all certified nursing facilities in Virginia. There are eight nursing homes that do not take any federal dollars, and are therefore not subject to any federal reporting requirements or CMS ratings.

FIGURE A1: Different types of nursing facilities in Virginia



SOURCE: Nursing facility licensure data from the Virginia Department of Health.

An entire facility or just a portion of a facility can be licensed as a nursing home – for example, in continuing care retirement communities (CCRC), which may be composed of

independent living, assisted living, and skilled nursing, only a portion of the CCRC is licensed as a nursing home.

The list of Virginia nursing homes does not include long-term care units inside hospitals, which are considered SNFs because they participate in Medicare, but are not state licensed nursing homes as they operate under the licensed hospital. The list also does not include two nursing homes owned and operated by the Virginia Department of Behavioral Health & Development Services that are not licensed by VDH.

Nursing homes in Virginia range in capacity from 18 to 312 beds, with an average of 114 beds. The majority of Virginia's nursing homes are for-profit (70%) and the remainder are non-profit (28%) or government-owned (2%) facilities – this is in line with national trends.

Appendix 2: CMS five-star quality rating system

The Centers for Medicare & Medicaid Services (CMS) uses a rating system for all nursing homes that participate in Medicare and/or Medicaid. Each participating facility receives an overall rating between 1 and 5 stars, where 5-star nursing homes are considered to have above-average quality and 1-star nursing homes are considered to have below-average quality. The overall rating for each nursing home is based on its performance in three areas – staffing, health inspections, and quality measures.

Staffing ratings

CMS grades all participating facilities based on the ratio of nursing staff to residents, measured as hours per resident day (HPRD). The staffing rating is based on two measures - total nursing hours (CNA + LPN + RN) and RN hours per resident day. Facilities submit staffing data quarterly, and these reported hours are adjusted by CMS to account for average resident acuity. Any nursing homes that report 7 days in a quarter without any RN hours automatically receive a 1-star rating for staffing (TABLE A1).

TABLE A1: CMS criteria for staffing star ratings

National Star Cut Points for Staffing Measures, Based on Adjusted Hours per Resident Day (updated April 2019)

Staff type	1 star	2 stars	3 stars	4 stars	5 stars
RN	< 0.317	0.317 - 0.507	0.508–0.730	0.731–1.048	≥1.049
Total	< 3.108	3.108–3.579	3.580 - 4.037	4.038–4.407	≥4.408

Note: Adjusted staffing values are rounded to three decimal places before the cut points are applied.

SOURCE: CMS Design for Care Compare Nursing Home Five-Star Quality Rating System: Technical Users' Guide, updated January 2021.

Health inspection ratings

CMS Health Inspection ratings are based on the number, scope, and severity of deficiencies identified in a facility, as well as a weighted average of a facility's three most recent health inspections and complaint investigations. Ratings are assigned on a curve based on a facility's relative performance compared to other nursing homes in the state.

Assessments include facilities' practices and policies regarding:

- Resident rights
- Medication management
- Skin care

- Quality of life
- Facility administration
- Environment
- Kitchen/food services

Deficiencies that are considered to put residents' health or safety in "immediate jeopardy" are weighted more heavily.

Ratings are based on a facility's relative performance within the state to help control for variation in survey management, state licensure, and Medicaid policy across the United States. As a result, facilities are rated so that:

- Top 10% of scores = 5 Star rating
- Bottom 20% of scores = 1 Star rating
- 2, 3, 4 Stars are equally distributed across the middle 70% of facilities

Quality Measures ratings

Nursing homes receive three quality ratings - overall Quality Measures ratings, Long-Stay Quality, and Short-Stay Quality - based on facility data from the Minimum Data Set (MDS) and Medicare claims. In total, there are 15 function and health status indicators for Long-Stay (residents who are in the nursing home for 100+ days) and Short-Stay residents that measure facility performance (TABLE A2).

TABLE A2: Indicators used in CMS quality ratings

From MDS assessments	From claims data
• Percentage of long-stay residents whose need for help with daily activities has increased • Percentage of long-stay residents whose ability to move independently worsened • Percentage of long-stay high-risk residents with pressure ulcers • Percentage of long-stay residents who have or had a catheter inserted and left in their bladder	• Number of hospitalizations per 1,000 long-stay resident days • Number of outpatient emergency department (ED) visits per 1,000 long-stay resident days • Percentage of short-stay residents who were re-hospitalized after a nursing home admission • Percentage of short-stay residents who have had an outpatient emergency department (ED) visit

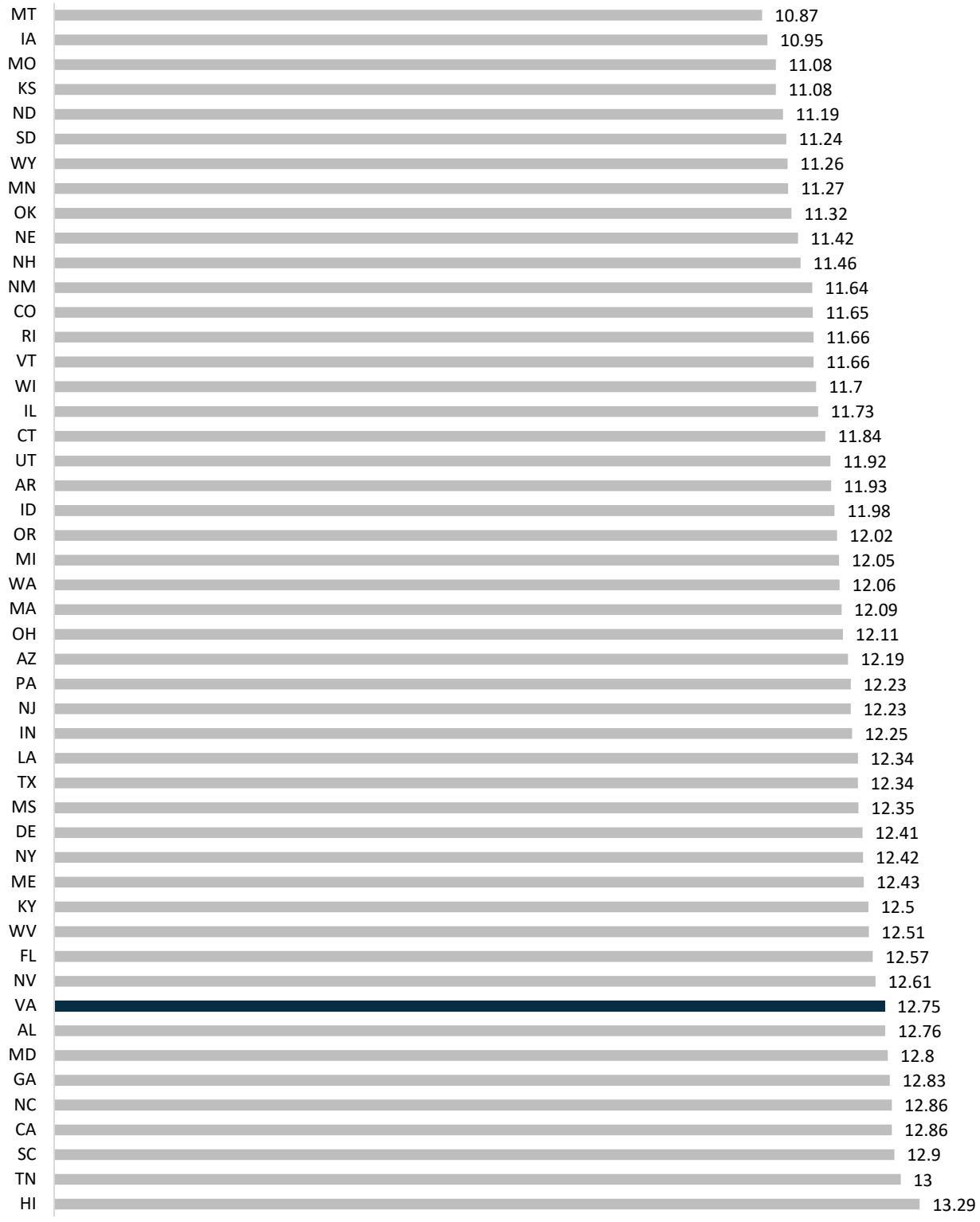
• Percentage of long-stay residents with a urinary tract infection • Percentage of long-stay residents experiencing one or more falls with major injury • Percentage of long-stay residents who got an antipsychotic medication • Percentage of short-stay residents who improved in their ability to move around on their own • Percentage of SNF residents with pressure ulcers/pressure injuries that are new or worsened • Percentage of short-stay residents who got antipsychotic medication for the first time	• Rate of successful return to home and community from a SNF

SOURCE: CMS Design for Care Compare Nursing Home Five-Star Quality Rating System: Technical Users' Guide, updated January 2021.

Appendix 3: Average nursing home acuity

The Brown University Center for Gerontology and Healthcare Research calculated average acuity for each state's nursing facilities based on the number of residents needing various levels of activities of daily living (ADL) assistance and the number of residents receiving special treatment. Data do not include Alaska or Washington, D.C. Data included all certified nursing facilities, some of which are not licensed as nursing homes by the Virginia Department of Health (e.g., long-term care units operating inside hospitals) (FIGURE A2).

FIGURE A2: Average acuity index for all states



SOURCE: LTCFocus Public Use Data sponsored by the National Institute on Aging (P01 AG027296) through a cooperative agreement with the Brown University School of Public Health. State data from 2018.

Appendix 4: Complaints to the Virginia Office of the State Long-Term Care Ombudsman

Almost half of the complaints received by the Virginia Office of the State Long-Term Care Ombudsman are related to staffing – this includes complaints that are verified and not verified (TABLE A3). Complaints might not be verified if the information in the complaint is incorrect, or Ombudsmen were unable to determine what happened due to lack of a corroborating witness or documented evidence. Regardless, Ombudsment follow up to resolve all complaints to the extent possible to address meet residents' concerns.

TABLE A3: Complaints submitted to the LTC Ombudsmen, by year

Major Complaint Category/Type	Number of Complaints Received			
	2017	2018	2019	2020
Complaints Associated with Staffing				
Abuse, gross neglect, exploitation	100	115	129	115
Care	901	990	1144	702
Dining and hydration	33	37	62	35
Facility policies, procedures and practices (staffing)	97	164	202	115
Other Complaints Access to Information Admission, Transfer, Discharge, Eviction Autonomy, Choice, Rights Financial, Property Activities, Community Integration and Social services Dietary Environment Facility policices, procedures and practices (administrative oversight, fiscal management)	1188	1374	1694	1085
Total Complaints	**2319**	**2680**	**3231**	**2052**
Staffing-Related Complaints as Percent of Total	49%	49%	48%	47%

SOURCE: Data provided by the Virginia Office of the State Long-Term Care Ombudsman, Department of Aging and Rehabilitative Services. Received July 2021.

Complaint categories align with those used by the National Ombudsman Reporting System. Complaint code categories were changed in 2019, and reporting codes from previous years may not reflect the categories listed in the table above.

Appendix 5: Study Resolution

Impact of long-term care workforce needs on nursing facility care

Authorized by the Joint Commission on Healthcare on December 15, 2020

WHEREAS, more than 280 nursing facilities in Virginia serve more than 25,000 Virginians, who live and receive care for their daily needs at those facilities; and

WHEREAS, Virginia's nursing facilities employ direct care staff and licensed clinicians, such as Certified Nurse Aides, Licensed Practical Nurses, and Registered Nurses who assist residents with all aspects of daily living, including eating, dressing, and providing healthcare including proper infection control protocols; and

WHEREAS, nursing facilities in Virginia are licensed by the Virginia Department of Health under state and federal laws and regulations; and

WHEREAS, the Centers for Medicaid and Medicare services in 2018 downgraded 19 Virginia nursing facilities on its quality rating system because they did not have enough registered nurses or did not provide necessary staffing data; and

WHEREAS, the COVID-19 pandemic has highlighted the need for adequate staffing in Virginia's nursing facilities, to ensure proper resident care and minimize the risk of infection, now, therefore be it

RESOLVED, by the Joint Commission on Health Care that staff be directed to study the workforces in Virginia's nursing facilities.

In conducting its study, staff shall (i) assess the extent to which there are staffing shortages for nursing facilities in Virginia and understand the underlying causes of those staffing shortages; (ii) evaluate the impact of staffing shortages on the quality of care provided in nursing facilities; (iii) analyze whether these impacts are disproportionately impacting certain populations in Virginia based on race, socioeconomic status, or other factors; (iv) assess whether Virginia's current licensing requirements and oversight are appropriately identifying and addressing quality of care issues in nursing facilities; and (v) identify strategies to improve recruitment and retention of the workforce necessary for Virginia's nursing facilities.

The Joint Commission on Health Care shall make recommendations as necessary and review other related issues as warranted.

In accordance with § 30-169.1 of the Code of Virginia, all agencies of the Commonwealth, including the Virginia Department of Health, the Virginia Department for Aging and Rehabilitative Services, the Virginia Department of Medical Assistance Services, local Area Agencies on Aging, and local Departments of Social Services shall provide assistance, information, and data to the JCHC for this study upon request. Assistance is also requested from the Virginia Health Care Association.

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