HMA

HEALTH MANAGEMENT ASSOCIATES

# *THE STAFFING CRISIS IN PENNSYLVANIA NURSING FACILITIES*

## *Impact Analysis*

PREPARED FOR THE PENNSYLVANIA HEALTH CARE ASSOCIATION

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# Introduction

Staffing is considered to be an important quality measure for nursing facilities and is used to evaluate and comparatively profile these facilities for potential beneficiaries and their families (Geng, 2019). Staffing per resident is a well-established quality-of-care measurement and has shown a positive relationship between the number of clinical or direct care staff, in this report defined as registered nurses (RNs), Licensed Practical Nurses (LPNs), or Certified Nurse Assistants (CNAs), supporting residents and quality of care outcomes including improvements in clinical outcomes and reductions in nursing home complaints and deficiencies (KFF, 2015). The Centers for Medicare and Medicaid Services (CMS), the federal regulatory agency for SNFs that provides reimbursement for Medicare facility-based skilled nursing care, acknowledged this by introducing the Long-term Care Facility Staffing Payroll-Based Journal (PBJ) system in 2016 as a way to support this quality measure to those evaluating SNF services (Geng, 2019).

As a measure to increase quality in nursing facilities and in line with this perspective, the Pennsylvania Department of Health (DOH) announced its plan for a series of regulatory changes affecting skilled nursing facilities (SNFs)[1] licensed in the Commonwealth of Pennsylvania The first such package of changes was released and included an increase in the minimum number of direct care hours per resident per day. The change would require SNFs to increase their direct care staffing ratios from the current 2.7 hours to a proposed 4.1 hours per resident per day (Independent Regulatory Review Commission (ICRC) 2021).

DOH's offered the following reasoning for this change (ICRC 2021):

- DOH has the "duty to protect the health [wellbeing and safety] of all Pennsylvanians including those who are 65 and older."
- Pennsylvania is experiencing a significant increase in the population of individuals who are 65 years of age and older and this increase in population will have a corresponding increase in DOH's responsibility to protect the health, wellbeing, and safety of those individuals.
- DOH believes that the staffing levels in nursing facilities has a direct relationship with the health, wellbeing, and safety of residents supported by significant research including a 2016 study conducted by the Centers for Medicare and Medicaid Services (CMS) (CMS 2016; Shin 2012).
- The study cited by CMS (Harrington, 2016) concluded that the optimum direct care hours per resident per day is 4.1 hours.

Prior to this increase in direct care staffing ratios, PA's SNF regulations required 2.7 hours per resident per day. Therefore, DOH believed the increase to 4.1 would address adequacy in care requirements for the facilities and would be in line with federal recommendations.

[1] . For the purposes of this report, SNF and nursing facilities will be used interchangeably because most writing refers to them that way; although the intensity of services may be different in a SNF compared to a nursing facility.

SNFs and their representatives, such as the Pennsylvania Health Care Association (PHCA), have stated that this change in regulation, while well intended and appropriately promoting quality of care in nursing facilities, represents a significant challenge for compliance largely due the lack of available clinical staff to support the measure and do to structural financial challenges to the funding of facility-based long-term care. SNFs and the PHCA are generally supportive of initiatives that improve the quality of service delivery in long-term services and supports (LTSS); however, from their perspective, the increase in direct care hours per resident per day face the following significant barriers currently affecting facility based LTSS:

- The healthcare and long-term care system in Pennsylvania and across the United States is currently experiencing a staffing crisis. Facilities are struggling to meet existing staffing requirements because it has been difficult to recruit new staff.
- SNFs are challenged to cover their costs of care with current reimbursement levels, especially through the Pennsylvania Medicaid program from which the majority of SNF funding is derived. Medicaid currently does not cover SNF's cost of care under the 2.7 hours per resident-per-day. An increase in staffing level requirements will exacerbate the financial challenges of SNFs.
- Pennsylvania's population is aging and demand for SNF and other long-term care services will increase in the years ahead. This demographic trend will add pressure on providers to meet service delivery requirements.
- Facility-based long-term care providers are facing fierce competition for the LTSS labor force from home and community-based providers. These providers are receiving augmented funding to support recruitment, retention, wage, and benefit support from the federal government through the American Rescue Plan Act.
- The additional funding the Governor's proposed 2022-2023 budget included to fund the new staffing requirement for SNFs ($91 million increase state funds) does not adequately reflect the cost increase SNFs will experience as a result of the new staffing regulation.

The purpose of this report is to evaluate the concerns raised by the SNFs and their representatives regarding staffing in nursing facilities and its relationship to quality. This evaluation will use primary and secondary data sources to examine the merits of the above-listed concerns and will include a qualitative evaluation on how those who are responsible for implementing this change, SNF administrators or individuals in facility leadership roles, perceive how it will directly and indirectly affect their facilities, the residents, and the communities where they operate. This report is designed to be an independent evaluation of the staffing proposal and its impact on the Pennsylvania nursing facility industry.

## Long-term Care Staffing Crisis

Nursing facilities are facing an unprecedented staffing crisis with challenges to recruitment and retention that predate but were exacerbated by the COVID-19 public health emergency. This crisis involves a mass exodus through resignations and retirements attributed to staff experiencing a combination of workload, physical and emotional strain, and a challenging work environment (Reiland, 2022; JAMA, 2022). Nursing facilities have seen the second largest employment decline of any employer

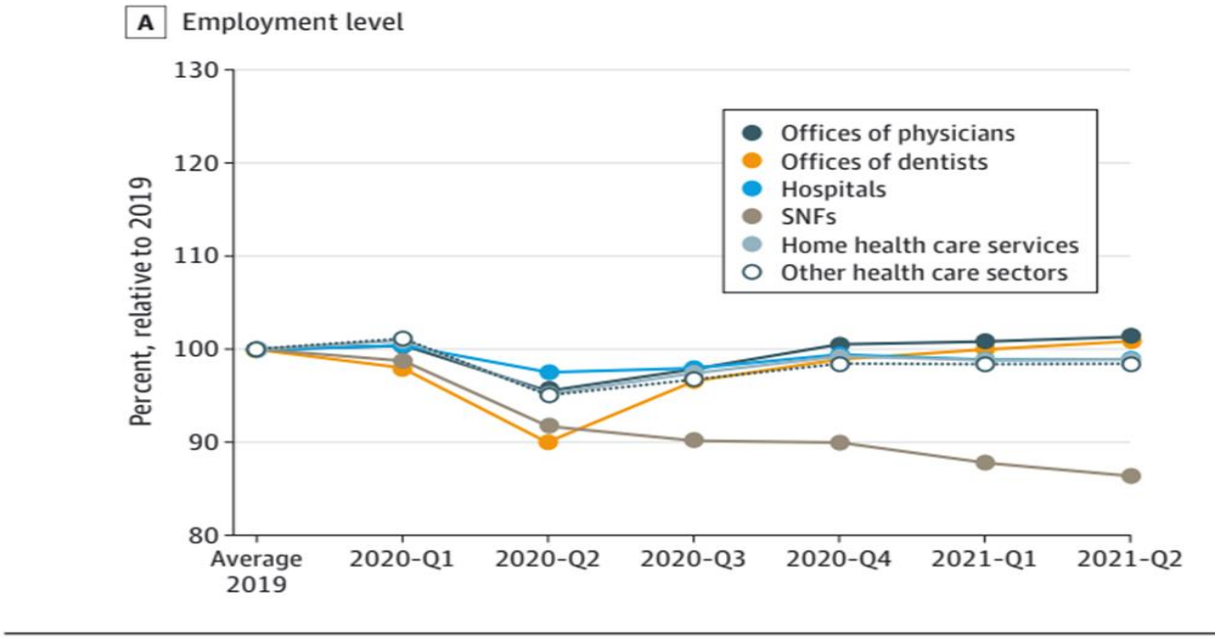
category in the last two years (JAMA, 2022). This decline has occurred in spite of the fact that this industry saw the largest wage increases in history at 9.5% in 2020 (BLS, 2022).

Even before the COVID-19 public health emergency, the recruitment and retention of long-term care workers in Pennsylvania, both clinically skilled and unskilled, was a significant focus of policymakers and long-term care providers. This focus was demonstrated by the publication of the report *A Blueprint for Strengthening Pennsylvania's Direct Care Workforce* (2019) published by the Governor Wolf Administration and the Pennsylvania Long-term Care Council. This report concluded that Pennsylvania continues to "face a growing paid caregiving crisis due to a shortage of direct care workers and high turnover." The report projected that 37,000 additional direct care workers would be needed to support the LTSS population both in nursing facilities and in the community by 2026. The report also presented recommendations focused on training, public outreach, wages and benefits, and other initiatives designed to address and support the stability of the long-term care workforce while acknowledging how challenging those recommendations would be to implement.

Staffing shortages and retention issues for long-term care workers intensified during the COVID-19 Public Health emergency (Denny-Brown, 2021). As a result of the existing circumstances of low pay and challenging working conditions and the added high risk of COVID-19 infection, some of these long-term care workers left their jobs. This occurred despite the fact that these staff were highly in demand. Other conditions that supported this exodus included new challenges caused by the pandemic such as limited childcare coverage and mental health support (Yang, 2021). These conditions, coupled with the lack of a unified national testing strategy, distribution of test kits, limited supplies of personal protective equipment, and policies to cover cost for testing, reportedly delayed timely testing of residents and nursing home staff early on, and hindered understanding about the risk of COVID-19 transmission (Denny-Brown, 2021; Yang, 2021).

This exodus occurred even in an environment where nursing facility employees were receiving unprecedented wage increases. The JAMA Health Forum (2022) published a study of health care workers impacted by the pandemic. As the two charts below demonstrate, even with dramatic increases in weekly wage, nursing facilities were the once sector that continued to see declines in employment levels even with a substantial increase in their weekly wages.

***Figure 1: Health Care Employment Levels 2019-2021***



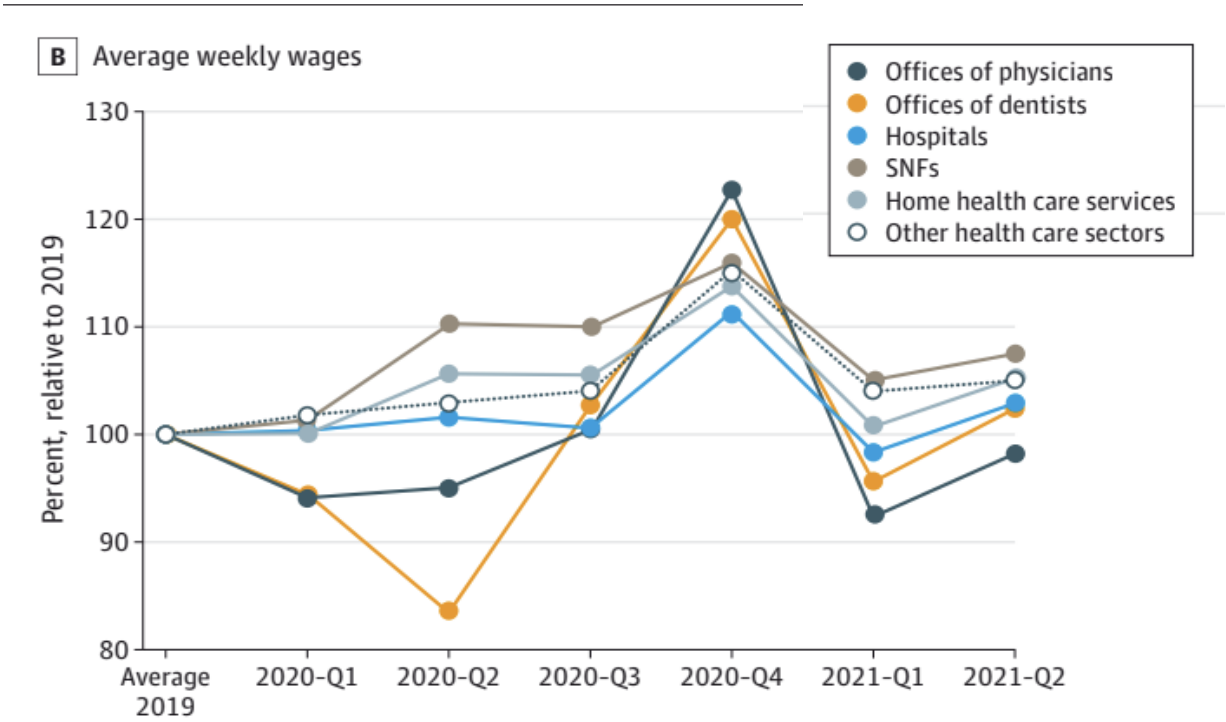




***Figure 2: Health Care Average Weekly Wage 2019-2021***

***Figure 1: Health Care Sector Average Weekly Wage 2019-2021:***

According to a survey by the American Association of Retired Persons (AARP, 2021), as much as 60 percent of Pennsylvania's SNFs are experiencing a shortfall of clinical staff and nurse assistants at

current staffing requirements. Other SNFs have been required to reduce census, close admissions, and start waitlists to manage their resident care with available staffing. A PHCA (2022) survey conducted in March 2022 found that nearly 50% of SNFs who responded to the survey were unable to use more than 30 of their licensed beds because of staffing shortages increasing the need for waitlists. The staffing interviews in the final section of this report highlight the concerns on this issue raised by administrators and other leaders of SNFs in Pennsylvania.

Even though evidence supports the broad objective of DOH to use an increased staffing ratio for nursing facilities as a means to improve quality of service (JAMA, 2022; Denny-Brown, 2021; Harrington, 2016), a preexisting long-term care staffing shortage exacerbated by the COVID-19 public health emergency severely undermines the ability of the SNFs to meet the requirements of the mandate. Clinical staff do not appear to be available to meet the needs of existing staffing levels let alone the proposed increases to the regulations for staff per-resident-per-day.

## Reimbursement for Nursing Facility Cost of Care

SNFs in Pennsylvania primarily receive reimbursement for the delivery of their services from four sources (DOH, 2022):

***Figure 3: Reimbursement for Nursing Facilities 2020-2021***

| Payor Source | Service Configuration | Percentage of Reimbursement by Source |
|---|---|---|
| Medicare | Non-custodial, time-limited coverage for services such as short-term rehabilitation following a surgery | 14% |
| Medicaid | Coverage primarily for custodial care for long-term services and supports without a set time limit and also for Non-custodial, time-limited coverage for services such as short-term rehabilitation following a surgery if the beneficiary is not covered by Medicare | 64% |
| Commercial Insurances | Primarily for non-custodial, time-limited coverage for services such as short-term rehabilitation following a surgery but occasionally cover custodial long-term services and supports on a time-limited basis | 2% |
| Self-Pay and Other Sources | Primarily custodial care for long-term services and supports | 20% |

Source: Annual Nursing Facility Reports, 2022

The required increase in staffing will translate to additional operational costs for nursing facilities. Understanding how the Pennsylvania Medicaid program and other payors will address this change is an important consideration. As noted above, in the 2020-2021 state fiscal year (SFY), Medicaid represented 64 percent of reimbursement for nursing facilities overall, although the individual facility percentage by payor may vary significantly depending upon their population and the types of services they provide. This percentage is a reduction from the 2017-2018 SFY where Medicaid accounted for 68 percent of the reported reimbursement for nursing facilities with funding offsets appearing to fall to

both the Medicare program and self-pay. This Medicaid percentage does not take into consideration days of care by payor, as well, which may increase the Medicaid payr Because the vast majority of funding for nursing facilities is sourced from the Medicaid program, the level of its funding is a significant consideration for any new regulatory requirement that will involve an increase in expenditures for nursing facilities. Medicaid funding levels and rates are set by state governments or their subcontracted managed care organizations.

Since the 4.1 per resident per day staffing requirement will increase operational costs for nursing facilities not currently staffed at that level, it is important to understand whether Medicaid and the other payor sources listed above are able to support these increasing costs. A historical review of payment by funding source and cost of care information from 2002 to 2021-2022 SFYs was used to consider this question (DOH Reports, 2002 to 2020-2021; MDS Reports 2022).

***Figure 4: Reimbursement and Cost of Care Comparison***

| Year | Average Daily Reimbursement | | | Average Cost of Care | |
|---|---|---|---|---|---|
| | Medicare | Medicaid | Commercial Insurance | Private Room | Semi-Private Room |
| 2002 | $262.59 | $125.31 | $198.74 | $191.05 | $172.49 |
| 2003 | $268.28 | $126.83 | $205.44 | $193.62 | $174.76 |
| 2004 | $274.67 | $137.97 | $207.14 | $210.99 | $206.69 |
| 2005 | $301.86 | $144.42 | $218.43 | $216.72 | $203.49 |
| 2006 | $318.48 | $147.02 | $242.92 | $228.98 | $216.91 |
| 2007 | $337.83 | $155.44 | $249.05 | $241.29 | $224.44 |
| 2008 | $357.45 | $160.89 | $269.16 | $241.68 | $228.35 |
| 2009 | $381.24 | $163.76 | $282.41 | $264.96 | $245.27 |
| 2010 | $418.02 | $170.34 | $299.69 | $272.81 | $252.86 |
| 2011 | $432.57 | $170.53 | $305.52 | $274.74 | $258.18 |
| 2012 | $416.46 | $168.34 | $307.50 | $283.89 | $267.06 |
| 2013 | $414.88 | $172.71 | $315.81 | $289.67 | $269.40 |
| 2014 | $430.71 | $179.36 | $318.86 | $311.38 | $279.98 |
| 2015-2016 | $438.01 | $176.74 | $311.90 | $325.63 | $299.92 |
| 2016-2017 | $445.86 | $178.22 | $313.90 | $325.03 | $306.35 |
| 2017-2018 | $448.97 | $179.27 | $321.29 | $343.84 | $313.98 |
| 2020-2021 | $487.98 | $186.64 | $329.06 | $366.13 | $320.43 |

Source: SNF Reports 2002 to 2020-2021

Note: The 2018-2019 and 2019-2020 Reports were excluded from this analysis because they did not include reimbursement information by payor source and because of 2019-2020 reporting anomalies related to COVID-19 stimulus funding.

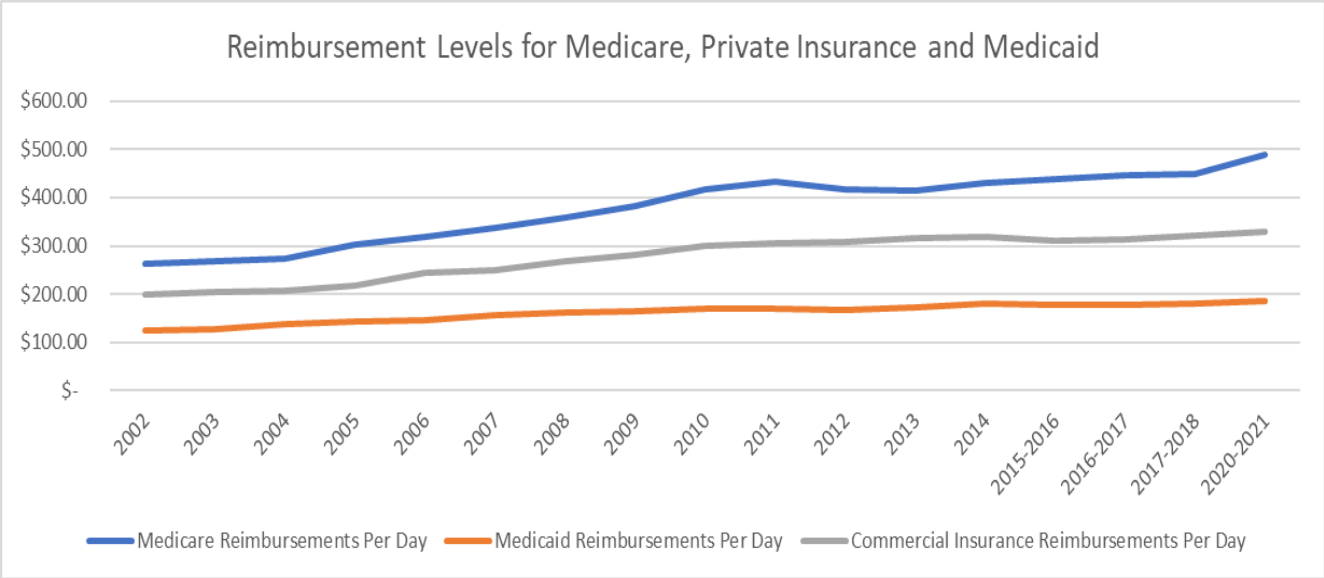
Note: A change in reporting starting in 2017-2018 eliminated the daily cost from private pay and other sources so this category was eliminated from the analysis as well.

As the table above demonstrates, the average daily reimbursement for the Medicaid program does not currently cover the SNF cost of care for residents of either a private or semi-private room. By contrast, average reimbursement rates of Medicare and commercial insurance either meet or exceed the average cost of care. As a result, it is likely that SNFs rely on a mix of payors to cover the costs of services provided to patients. Facilities more heavily reliant on Medicaid will, as a requirement for operation, have a lower cost of care.

Data from the table also demonstrates that the inflationary growth of Medicaid is significantly lower than the other payors and the cost of care. Over the 19-year span of reimbursement, Medicaid's average daily reimbursement increased by 49 percent compared to Medicare at 88 percent and commercial insurance at 66 percent. The slower growth of Medicaid rates is attributable to the fact the funding is subject to a budget adjustment factor that requires SNF rates to be set to the level of the commonwealth of Pennsylvania's appropriation in the Medicaid budget (PA Bulletin, 2021). Unfortunately for nursing facilities, the cost of care exceeded reimbursement increases of all payor sources. For private rooms, cost of care increased by 92 percent and semi-private room cost of care increased by 88 percent.

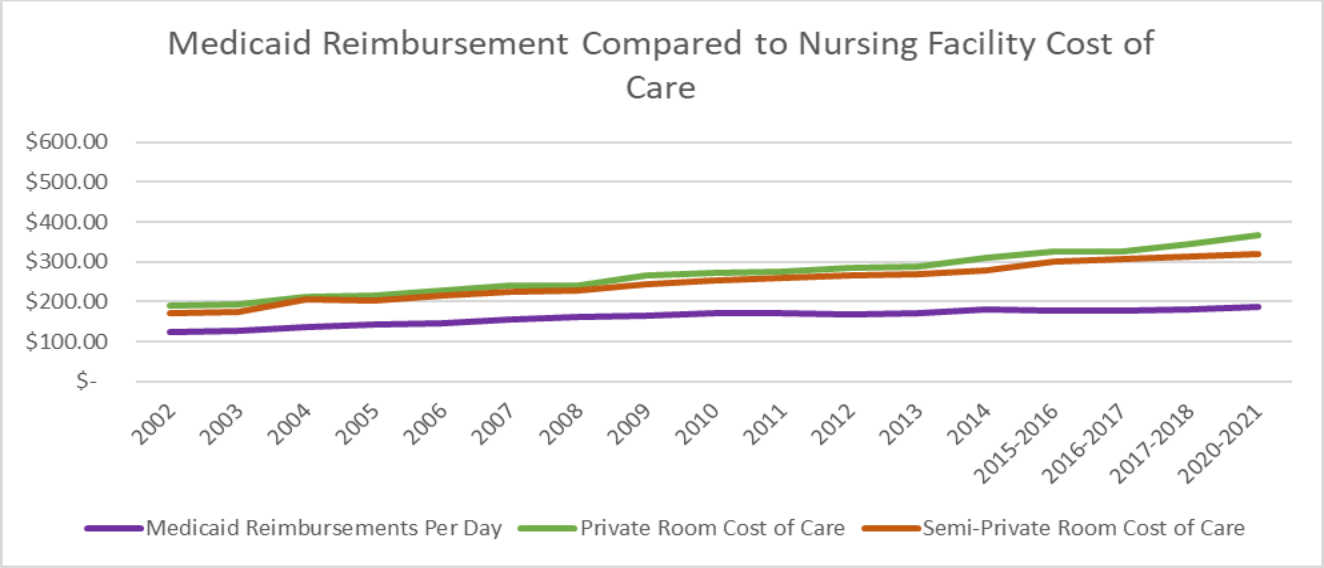
The chart below demonstrates the gradual growth of reimbursement by payor source. Daily reimbursements have increased at the lowest rate for the Medicaid program.

***Figure 5: 18-Year Reimbursement Changes for Nursing Facilities***




When growth in the Medicaid daily rate is compared to growth in the daily average cost-of-care, an evolving and increasing gap exists. This gap has always existed but has increased dramatically in the last 20 years. In 2002, the Medicaid rate was an average of $125.31 per day. The private room cost of care was $191.05 and the semi-private charge was $172.49. In 2021, the average Medicaid rate was $186.64 while private room cost of care was $343.84 and the semi-private cost of care was $313.98. The Medicaid inflation rate for this time was 49% while the private room cost of care was 92% and the semi-private cost of care was 86%. The chart below demonstrates the increasing gap.

***Figure 6: Medicaid Reimbursement and Cost-of-Care Comparison***




Even without the regulatory staffing change per resident per day, the reimbursement environment for SNFs is challenged in Pennsylvania especially with the Medicaid program. One may only assume that those financial environmental challenges will be dramatically exacerbated by the implementation of this regulatory change and by the increasing costs to care that will result from the increase in clinical staffing.

## Pennsylvania's Aging Demographics and the Need for LTSS

Pennsylvania's demographic composition and relevant population growth create an additional challenge to meet the requirements of the proposed regulatory staffing change. Pennsylvania already has a large elder population, and that population is growing rapidly (US Census Bureau, 2022). The relatively slow growth of the state's general population overshadows an important trend in Pennsylvania's changing composition especially with the elderly population. The rate of growth of Pennsylvania's elderly population (age 65 and over) is more than 20 times higher than the growth rate of the state's general population. Pennsylvania is ranked fifth among the fifty states by the sheer size of its elderly population (2.2 million) and seventh by percentage (17.8 percent) of the total population. The total elderly population grew from 15.4 percent (1.96 million persons) of Pennsylvania's total population in 2010 to 17.8 percent (2.27 million persons) of the state's population in 2020.

AARP (2020) has estimated that 52 percent of elderly individuals will need some type of LTSS in their lifetime. Using Pennsylvania's 2020 elderly population (2.27 million), the estimated number of individuals who will need LTSS may exceed 1.18 million individuals over the next 20 to 30 years. Pennsylvania is fortunate to have a robust LTSS system with large number facility-based and community-based providers that serve its current elder and disabled populations. There are currently 86,922 licensed SNF beds in 685 SNFs and more than 2,000 home care providers statewide in Pennsylvania, and even with that capacity, providers struggle to meet existing LTSS needs. Nursing facility closures, especially those facilities that focus on complex populations such as technology-dependent residents, will add to that struggle. As this population continues to grow and ages into the need for LTSS, the existing system will face extreme strain to support their care requirements. The proposal to increase direct care staffing ratios will likely exacerbate the strain and potential risk of the system being unable to meet the rising demand.

Nationally, an additional 1.3 million direct-care workers will be needed over the next decade to meet the needs of the aging U.S. population—creating a total of 7.4 million direct-care job openings (BLS, 2022). Even without the proposed increase in staffing from the DOH and the staffing crisis created by the COVID-19 exodus, Pennsylvania will be facing a significant increase in need just based on growing demographics. The other conditions exacerbate a crisis.

## Workforce Competition from Home and Community-Based Services

Nursing facilities also face an increasingly competitive environment with Home and Community-based (HCBS) providers to hire clinical workers including registered nurses, licensed practical nurses, and especially certified nurse assistants to support individuals receiving LTSS. Competition for this workforce is most directly sourced to providers of HCBS that have received significant augmentation to their rates specifically to support the HCBS direct care workforce. The funding source is the American Rescue Plan (ARP) Act and was intended to support an increase in the use of HCBS and to underwrite better wages, benefits, and training for direct care workers employed by HCBS Providers.

Section 9817 of the ARP provides states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid HCBS from April 1, 2021 through March 31, 2022 to improve HCBS under the Medicaid program. The additional funding may be spent by states until March 31, 2024 (CMS, 2022). For Pennsylvania alone, this may represent an increase to HCBS services in excess of $400 million dollars. Pennsylvania published a plan on how they plan to spend this funding and many of these initiatives related to workforce support. Some components of this plan, including rate increases, will have to be funded by the state even after the enhanced FMAP increase expires. Highlights include (Department of Human Services, 2022):

- An 8 percent increase in personal care rates starting January 1, 2022 and continuing indefinitely, even after the increased FMAP expires
- Sign-on bonuses (new workers)
- Retention payments (existing workers)
- Leave benefits –health insurance premiums or other employee benefits
- COVID-related paid time off/ offering paid sick leave
- Incentives for vaccination along with paid time off
- Purchase personal protective equipment and testing supplies

Nursing facilities were not part of this ARP funding initiative, do not have a similar federal augmentation of funding, and do not have the same level resources available to support these types of workforce initiatives. While no independent analysis is yet available to determine if these initiatives have influenced workforce competition between nursing facilities and HCBS providers for long-term care workers, one may assume that these ARP funded supports may offer HCBS providers a competitive advantage at least until the augmented funding is no longer available. For the purposes of this report, however, no evidence is yet available to validate this concern.

## Budget Proposal to Support Nursing Facilities

On February 8, 2022, Pennsylvania's Governor Wolf released his proposed 2022-2023 budget that included an increase in Medicaid long-term care funding for nursing facilities that would total $90.1 million dollar in state funding (Wolf, 2022). The additional funding was specifically targeted for "key reforms such as increased staffing in nursing facilities" (Wolf, 2022). Nursing facilities and their representatives immediately reacted to this proposal stating that the additional funding will not cover the costs associated with the additional staffing.

To evaluate the validity of the concerns of the nursing facilities and their representatives, a model was built from relevant variables related to the costs of SNF services to estimate the actual cost of the proposed staffing change from 2.7 hours per resident per day to 4.1 hours per resident per day. The variables used in the analysis in the list detailed in Figure 5.

***Figure 7: Variables for Proposed Staffing Cost Calculation***

| | |
|---|---|
| **January 2022 SNF Proposed Condensed Rates** | The January 2022 Nursing Facility Proposed Condensed Rates (Department of Human Services, 2022) includes proposed rate information and current SNF bed counts. The rate information established the threshold of current payment to nursing facilities. The Medicaid bed counts were used to identify the total capacity that will have to be managed by SNFs with the 4.1 hours per resident per day. Two classification of public facilities, those affiliated with Pennsylvania county government and those that are overseen by the Pennsylvania Department of Military and Veterans Affairs, were excluded from this report due to differences in wage calculation that are inconsistent with the data made available by the Pennsylvania Department of Labor and Industry. |
| **Average Occupancy Rate** | The Pennsylvania DOH published an average occupancy rate for nursing facilities from July 1, 2020 to June 30, 2021, to be 77.11 percent (DOH, 2021). While occupancy may have been skewed resulting from changes in utilization related to the COVID-19 public health emergency, this percent establishes a utilization assumption that helps this model avoid overestimating the actual cost of the staffing change. |
| **Pennsylvania-Based Wage Rates** | The Pennsylvania Department of Labor and Industry (2020) publishes Pennsylvania-based wage rates by job classification. The most current wage rates for those job classifications are from 2020. According to SNF providers, trade associations, and the DOH, the three classifications that will be most directly affected by this change include registered nurses, licensed practical nurses, and certified nurse assistants. The details of these variables include: |
| **Mean Rate** | • Mean wage rates from 2020 were used with a wage inflation factor for those job classifications that will be affected by the proposed change, specifically registered nurses, licensed practical nurses, and certified nurse assistants drawn from the Pennsylvania Department of Labor and Industry (2022); |

**Wage Inflation Factor**

- The wage inflation factors are derived from the federal Bureau of Labor Statistics (Available Data Retrieval Tools (bls.gov) to estimate a change in wages for 2021 and 2022 and to help provide a range. BLS uses a 5 percent inflation factor for 2021 and a 4% inflation factor for 2022. This inflation factor was blended to estimate a 2022 wage rate.

**Staffing Agency Costs**

Staffing agency costs for registered nurses, licensed practical nurses, and certified nurse assistance were used in the model because providers are not currently able to meet the 2.7 or clinical staffing requirements without them. An assumption was made in the model that the use of staffing agencies will increase with the requirement to meet the 4.1 per resident per day level. Eighty facilities participated in the survey and the average agency rate per category was:

- Registered Nurse $77 per hour
- Licensed Practical Nurse: $59 per hour
- Certified Nurse Assistant $36 per hour

**Staffing Agency Cost Proportion**

Providers have a wide range of the proportion of their direct care staff supplied by staffing agencies. A 2021 staffing report from Nursing Solutions Incorporated (NSI) attributed an average agency staffing utilization at 11 percent. This was used in the analysis because of the variability in the Pennsylvania-based SNF reporting. This may also have only enabled facilities to meet staffing minimums.

**Recruitment and Retention Costs**

Recruitment and retention costs are also a consideration since new staff will have to be hired to cover the additional 1.4 hours per-resident-per-day. The 2021 NSI report was used for this calculation as well. This report estimated the cost for the recruitment of a RN at $40,038.

**Recruitment and Retention Cost Assumptions**

The NSI report (2021) did not identify a cost of recruitment for LPNs and CNAs. A recruitment and retention cost for both categories were estimated based upon the differences in the respective wage rates relative to RNs. An estimate for the recruitment for these categories calculated to be:

- Licensed practical nurse $29,292.45
- Certified nurse assistant $19,458.56

**Turnover Rate**

The NSI report (2021) provided turnover percentages for registered nurses and certified nurse assistance. The third category of focus, licensed practical nurse was not available so this report will assume the same turnover rates as registered nurse. These turnover rates are:

- Registered Nurse 19%
- Licensed Practical Nurse 19%

- Certified Nurse Assistant 51%

**Benefit Costs**

The BLS (2021) quotes that employee benefits -- including insurances, time off, additional compensation, and retirement – may total approximately 31% of employee wages. Since the number or percentage of employees who receive benefits in SNFs is unknown and since the employee contributions to these benefits is also unknown, an assumption was made with regard to the benefit cost calculation as follows:

- CNA benefit rate: 30% of wages
- LPN benefit rate: 28% of wages
- RN benefit rate: 25% of wages

**Accurate Staffing Calculations**

The Nursing Facility Submission Payroll Based Journal from CMS (2021) was used to appropriately weight existing SNF staffing and to calculate the gap between the 2.7 hours per resident per day to the 4.1 hours per resident per day. This variable more accurately calculates the impact of the quality initiative in a situation where nursing facilities may already be exceeding the existing 2.7 hours per resident per day threshold.

These variables were used to model the cost of the proposed staffing change. A blended wage was developed using a weighted proportion between real wage data and agency cost. The model developed from these variables produced the following results:

***Figure 8: Cost Model for Proposed Staffing Change***

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **RESIDENT DAYS** | | | | | | | | |
| average occupancy | 77% | | | | | | | |
| **NURSING COST PER HOUR** | | | | | | | | |
| | 2020 mean wage | inflation to 2022 | 2022 mean wage | benefit rate | 2022 with benefits | skill mix | staff to agency mix | blended wage |
| Employed staff | | | | | | | | |
| Nurse assistant | $15.65 | 1.09 | $17.06 | 30% | $22.18 | 77.6% | 89.0% | $15.32 |
| LPN | $24.16 | 1.09 | $26.33 | 28% | $33.58 | 13.0% | 89.0% | $3.89 |
| RN | $35.60 | 1.09 | $38.80 | 25% | $48.51 | 9.3% | 89.0% | $4.03 |
| Agency nursing | | | | | | | | |
| Nurse assistant | | | | | $36.00 | 77.6% | 11.0% | $3.07 |
| LPN | | | | | $59.00 | 13.0% | 11.0% | $0.84 |
| RN | | | | | $77.00 | 9.3% | 11.0% | $0.79 |
| blended cost per hour | | | | | | | | $27.96 |
| **RECRUITMENT,** | | | | | | | | |
| | cost per FTE | turnover rate | | | | | | |
| Nurse assistant | $19,458.00 | 51% | | | | | | |
| LPN | $29,292.00 | 19% | | | | | | |
| RN | $40,038.00 | 19% | | | | | | |
| blended | $22,660.559 | 44.1% | | | | | | |
| **RESULTS** | | | | | | | | |
| licensed beds | | 75,515 | | | | | | |
| estimated resident days | | 21,223,500 | | | | | | |
| hours at current minimum | | 63,670,500 | | | | | | |
| hours at proposed minimum | | 89,138,700 | | | | | | |
| net hours with current | | 14,581,919 | | | | | | |
| increase in FTE | | 6,980 | | | | | | |
| increase in FTE turnover | | 3,076 | | | | | | |
| | | | | | | | | |
| increase in nursing cost | | $405,905,286 | | | | | | |
| recruitment cost | | $227,889,035 | | | | | | |
| **total increase in cost** | | **$633,794,321** | | | | | | |
| Difference from the budget proposal | | $443,694,321 | | | | | | |

According to this calculation and based on the above-described variables and assumptions, the proposed increase will increase staffing costs by $634 million per year. As Medicaid represents approximately 64% of reimbursement for SNF services, the Medicaid program's share of the cost increase is an estimated $405 million, significantly more than the annual increase proposed in the Commonwealth budget.

The projection for the increase in the number of staff to cover this change in staffing levels is 6,980 full time equivalents including RNs, LPNs, and CNAs with a projected annual turnover rate of 3,076. In an environment where clinical staff recruitment and retention is in crisis, meeting this projected volume through recruitment and retention will be challenging.

This model is likely conservative in its calculation because wages in long-term care facilities are facing significant pressure for increase due to competition from other providers, provider types, and employers outside healthcare, and because of a large number of vacancies that have been created due to the COVID-19 Public Health Emergency. The turnover rate from 2021 may also be an underestimated variable, as well, which would increase the cost of recruitment and retention. The model's calculation is based on known values to the variables listed in Figure 5 and may be adjusted with more current data.

## Nursing Facility Administrator and Leader Perspective on the Staffing Proposal

To understand the impact of this change from the perspective of those who will be charged with implementing it, nine (9) SNF administrators and leaders were asked to engage in open-ended interviews to discuss their considerations and concerns with the DOH staffing proposal. From these interviews, and the 57 responses they provided, clear themes emerged and included:

*Figure 9: Key themes drawn from Interviews with SNF Administrators and Leaders on Staffing Proposal*

| | |
|---|---|
| **Staffing Shortages** | This concept is drawn from responses that cited the lack of available or appropriate staffing as a significant challenge to the implementation of the regulatory change. Staffing Shortages is the coding term and will be used to determine the frequency of this specific concept in the interviewee responses. |
| **Quality Misconception** | In this instance, respondents offered that the DOH's proposition that increased staffing of 4.1 hours per resident-per-day does not or does not necessarily translate to their objective to increase the quality of facility-based long-term care. Quality Misconception is the coding term for these responses. |
| **Compound Challenges** | Respondents here offered that a combination of issues and challenges relate to some component of the regulatory change and not one part of those issues or challenges supersedes the others. Compound Challenges is the coding term for these responses. |
| **COVID-19 Phenomena** | In these responses, interviewees connected their perception of the issues and challenges of the regulatory change directly to the COVID-19 public health emergency. COVID-19 Phenomena is used as the coding term for these responses. |
| **Funding Inadequacy** | In this concept, interviewees tied their perception of challenges and issues with the regulatory change to inadequate funding of services in the Pennsylvania Medicaid long-term care program or the Medicare short-term rehabilitation rates. Funding Inadequacy is used as the coding term for these responses. |

## Staffing Shortages

In reviewing the preliminary analysis, respondents appear to view *Staffing Shortages* as the primary challenge that will be presented by the new staffing regulatory requirements. Fifty-seven of the responses to questions attributed this as the primary challenge. Some of the respondents viewed the new staffing requirements as "frankly unreasonable" or "not even feasible." Some reasons for concerns related to recruitment challenges including the recruitment of "nurse staff" and other staff due to "stigma" related to working nursing homes, "wage pressure" from competing industries, and the fact that "staff are not there to be recruited." Respondents believe that the lack of staffing will make compliance with the new regulatory change impossible, may lead to "reduction in nursing facility census" (which at 77 percent is already low, and will likely result in "facilities closing their doors" because they cannot "meet the metrics" specified by the DOH.

*The media and other public voices, according to one SNF leader, "have been so hard on nursing homes through the pandemic" and have directly blamed the facilities for the COVID deaths. In an emotional response, one SNF leader stated that media and these other public voices "beat up nursing homes" creating a perception of nursing homes as "terrible" and as evidenced by the federal and state government actions to push for SNF restrictions and for these punitive regulatory changes. Because of this perception, "nobody wants to work in a" SNF.*

To further illustrate why staffing is the primary challenge, the interviewees provided a great deal of context with the challenges they are facing in their current staffing situation. One SNF leader stated they budget staffing at 4.2 hours per resident per day which is above the proposed regulatory limit but can only maintain a 3.3-hour level because staff are unavailable to hire even with raising starting wages by as much as $2 dollars per hour. Another interviewee stated that their facility cannot hire staff because they do not have any applicants and are not seeing any applicants for vacant positions.

Skilled nurses, such as Licensed Practical Nurses (LPN) or Registered Nurses, are completely unavailable to nursing facilities per the respondents. This is in part because trade schools do not offer LPN courses anymore and in part because skilled clinicians are able to make a great deal more money working in hospitals or staffing agencies. Competition for licensed clinicians is fierce and SNFs are unable to hire them.

Administrators stated that these staffing challenges existed in the pre-pandemic period, but these challenges have been magnified because of a generated stigma associated with SNFs and COVID-19. The media and other public voices, according to one SNF leader, "have been so hard on nursing homes through the pandemic" and have directly blamed the facilities for the COVID deaths. In an emotional response, one SNF leader stated that media and these other public voices "beat up nursing homes" creating a perception of nursing homes as "terrible" and as evidenced by the federal and state government actions to push for SNF restrictions and for these punitive regulatory changes. Because of this perception, "nobody wants to work in a" SNF. Hospitals were labeled as "heroes" and nursing

facilities as "villains". Administrators stated they are often in a position where they are unable to take new admissions because of unavailable staffing.

## Compound Challenges

*Compound challenges* followed staffing shortages as the most frequently cited issues with the new regulatory proposals. Thirty-two of the responses cited a combination of issues and challenges related to some component of the regulatory change. One of the most frequently cited compound challenges related to the stress of staff and staffing levels to the COVID-19 public health emergency. Staff morale and mental health for those working in the SNF industry through this experience was characterized as terrible. During the early part of the pandemic, one leader noted, "the whole world shut down, but we did not have a chance to shut down." Staff felt abandoned and felt the "whole world left them out to die." All staff had issues such as unavailable childcare and isolation from their families to avoid risk of infection even when they still had to go to work.

Staffing levels and the COVID-19 vaccine were also a frequently cited compound challenge issue. From one perspective, staff view was that "public was not grateful for the sacrifices of these workers" as evidenced by the fact that the "people who don't get vaccinated" against COVID-19 show they view that "healthcare worker lives do not matter." A contrary perspective related to vaccines was that staffing shortages may be tied a mandatory COVID-19 vaccine mandate. Staff who worked throughout the pandemic may now leave their jobs "because of religious or other objectives to getting the vaccine" and no people are available to be hired to take their place.

*Several of the leaders of SNFs stated that they were "not against any more staff" as stipulated by the proposed change in regulation but "it's really about how we afford to do it."*

Several respondents also connected staffing shortages to funding inadequacy as a compound challenge issue. SNFs are heavily reliant on revenues from Medicaid and Medicare and funding from these sources is viewed as inadequate to increase wages to attract new or retain existing staff. To illustrate, one SNF leader stated that "Medicaid rates haven't changed in 7 years" in Pennsylvania. Staff want better wages in SNFs to stay working there but these funding streams do not support it, from the perspective of multiple SNF leaders. Several of the leaders stated that they were "not against any more staff" as stipulated by the proposed change in regulation but "it's really about how we afford to do it."

## Quality Misconceptions

*Quality misconceptions*, or the perception that increased staffing of 4.1 hours per resident-per-day may not increase the quality of facility-based long-term care as DOH attests, was highlighted 22 times in the responses. Many of the respondents agree that more staffing would be beneficial but specifically challenge if the "4.1 hours makes sense when considering resident acuity" as well as the contributions of non-counted "staffing roles such as activity leaders and cognitive support professionals."

SNF leaders who challenged the 4.1 hours stated that numbers do not take into consideration differences in resident acuity. Lower acuity residents, for example, would require different staffing numbers and, even in aggregate, the 4.1 staffing per resident per day number "does not unilaterally make sense." Also related to acuity, the number does not take into consideration support staff required for services such as cognitive support for individuals with dementia and Alzheimer's disease.

A related misconception to the proposed staffing level is that it does not take into consideration "other staff who are engaged in resident care" and only focuses on "nursing and other clinical staff." Individuals involved in the delivery of therapies, activity support, and even dietary staff are not part of the proposed calculation. "We are not allowed to count the director of nursing, "one SNF leader cited, "and we are not allowed to count any administrative staff. These individuals provide direct care such as training for nurses and infection control. This is direct resident care."

## Funding Inadequacy

*Funding inadequacy* was cited specifically 14 times as a barrier to the proposed staffing change although it was frequently related to other problems as a compound challenge. Funding inadequacy responses were all directly tied to "reimbursement" and most specifically for rates paid through the "Pennsylvania Medicaid program" for long-term care. One leader stated that the state proposes a change but does not "give us a way to achieve it" through better program funding in the Medicaid program. "Something has to change on the state and federal revenue side to pay for these changes. More money to care for these frail elders." The leader continued that, with regard to SNF reimbursement, "nothing has changed on their side. On our side, food costs, utility costs, wages, have all gone up in cost. Insurance has gone up 13-28%." From her perspective, this change is an unfunded mandate.

*"Something has to change on the state and federal revenue side to pay for these changes. More money to care for these frail elders."*

## COVID-19 Related Phenomena

*COVID-19-related phenomena* responses were specifically cited 12 times but were also frequently cited as part of compound challenges. The specific focus of the pandemic and the challenges to maintaining current staffing levels through recruitment and retention due to COVID-19 related "staff fatigue" and "worker burnout." Staffing related challenges were tied to the fact that the "stress was unprecedented and the SNF staff were required to carry a yeoman's weight." All respondents stated they did lose employees during the pandemic citing that "employees had to leave because they had to take care of children and those people have not come back. They have adapted to a new lifestyle that no longer includes full time employment in a nursing home."

# Conclusion

The purpose of this report is to evaluate the concerns raised by nursing facilities and their representatives regarding the nursing facility staffing crisis and the conditions that are both

expanding the challenge it creates and are acting as barriers to address it. This evaluation used both primary and secondary data sources to examine the merits of these concerns and used qualitative interviews to consider the perspective of leaders and administrators in nursing facilities charged with implementing the change.

Based on this evaluation, four of the five concerns have significant merit. Of the five concerns raised by nursing facilities and their representatives, the effect of competing with HCBS providers for staff could not be evaluated. HCBS providers have recently received additional workforce-related financial support through ARP. However, this initiative appears to be too new to have an evidence-based evaluation of its impact on the workforce and cannot be substantiated as a valid challenge to the ability of nursing facilities to meet the staffing requirements. Otherwise, the contextual challenges raised regarding the proposal appear to have merit. The interviews with leaders and administrators further illustrated the challenges the staffing proposal creates. The remaining four appear to should some validity as described below:

1. *Labor Market Shortages & Wage Competition:* The LTSS system is experiencing a staffing crisis that predates the COVID-19 Public Health Emergency but was also exacerbated by it. The Commonwealth of Pennsylvania has been engaged in initiatives to address this crisis as demonstrated by the publication of a blueprint for addressing the problem in 2019. The COVID-19 Public Health Emergency has only increased the crisis condition of staffing. In this context, and as confirmed by the SNF leaders and administrators interviewed in this report, significant challenges exist in meeting the requirements of the 4.1 staffing level proposal.
2. *Historically Inadequate Medicaid Reimbursement:* For many years growth rates in overall SNF reimbursement have been slower than growth rates in the costs of providing care within SNFs. The differential in growth rates is more pronounced for Medicaid reimbursement. . Nursing facilities in Pennsylvania are operating in a financial environment of constrained reimbursement when compared to cost of care. If this trend continues, additional costs from additional required staffing levels will not be supported by existing reimbursement levels.
3. *Aging Demographics Driving Need for Skilled Nursing Care:* Pennsylvania's population of individuals over the age of 65 is growing rapidly and will require LTSS in the years ahead. This rapid growth of this demographic group will pressure the LTSS system. This pressure will be compounded by the pressure created by the proposed augmentation in staffing per resident per day.
4. *State Budget:* The Governor's proposed budget increase for SNF reimbursement, $90.1 million, appears to be significantly short of the estimated actual costs of the proposed staffing change. Based on variables including wage and benefit data, agency support, turnover, recruitment and retention costs, and inflation factors, the Governor's proposed budget underestimates the cost of the regulatory staffing change (from 2.7 hours to 4.1 hours per resident per day) by $434 million dollars as an additional annual cost.

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