

# New England ADMINISTRATOR

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NURSING HOME QUALITY COALITION



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Private equity investment in LTC • International recruiting • The Marketing Guru  
Perceptions versus reality: Who are the real rogues? • Where is Your Elephant?  
Stereotyping and aging • States address inadequate reimbursement and staffing shortages



# MDS 3.0 FY 2024 changes effective October

by Kris Mastrangelo,  
OTR/L, MBA, LNHA

The Minimum Data Set (MDS) is a standardized assessment tool used in long-term care facilities to collect and transmit data about nursing home residents and to support care planning, quality measurement, and payment. Starting October 1, 2023, the MDS 3.0 will be refined to a more detailed version referenced as MDS 3.0 (1.18.11). These refinements require providers to adjust practices within the facility including, but not limited to coding practices, data collection processes, documentation practices, form changes, patient care, policies, procedures, quality measure standards, and reimbursement expectations.

The Standardized Patient Assessment Data Elements assists with creating an individualized care plan that is based on the needs, priorities, and preferences of the resident. Modifications with the SPADES are essential to:

- Compare quality across PAC settings,
- Improve hospital/PAC discharge planning, and
- Collect data to determine the reform of PAC payments.

The intent of the MDS tool is to ensure that information gathering facilitates care coordination and interoperability in which the resident is the source and start of the process. While the MDS was initially implemented as a source document, today the



medical record documentation must support both the plan of care and coding on the MDS.

These initiatives began with the Improving Medicare Post-Acute Care Transformation Act of 2014 which required CMS to address the post-acute care information gap. The IMPACT Act supports the exchange of patient assessment data across PAC providers (HHAs, IRFs, LTCHs, and SNFs) for better Medicare beneficiary outcomes.

The MDS is used to evaluate and monitor the health status of residents; however, over the years, this assessment tool has evolved into a source for many other areas in the long-term care industry. Some of the major changes include revisions to Sections A, C, D, G, GG, J, K, N and O. These new and revised items also will be required for SNF QRP compliance and to receive full market basket payment updates.

Staff training on these MDS changes is essential for providers to prepare, implement, and ensure MDS compliance. The list below efficiently summarizes the MDS 3.0 changes:

- Terminology
- Section A. – Identification Information: SPADES incorporated five additional categories. Social Determinants of Health (SDOH)
  1. A1005. Ethnicity.
  2. A1010. Race.
  3. A1250. Transportation.
  4. B13000. Health Literacy.
  5. D0700. Social Isolation.

Non-Social Determinants of Health (SDOH)

6. A2121. Provision of Current Reconciled



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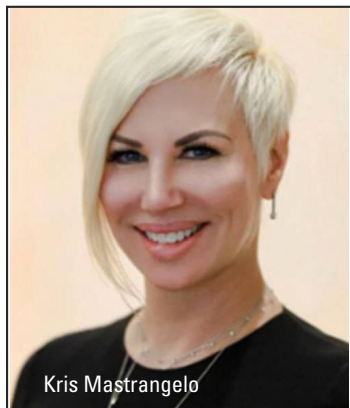
Medication List to Subsequent Provider at Discharge.

7. A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider.
  8. A2123. Provision of Current Reconciled Medication List to Resident at Discharge.
  9. A2124. Route of Current Reconciled Medication List Transmission to Resident.
  10. Transfer of Health Information. (QRP quality measures NEW).
- Section B. – Hearing, Speech, and Vision.
  - Section C. – Cognitive Patterns.
    1. Delirium (from CAM©).
    2. Health Literacy.
  - Section D. – Mood.
    1. DO150. Resident Mood Interview (PHQ-2 to 9©). Guidance added for non-

sensical responses, symptom frequency enhanced coding instructions and logic added on determining need for resident interview.

2. DO160. Total Severity Score Guidance on Interpretation.
- Section G - Functional Status.
    1. Section G (Functional Status) (Elimination through Functional Limitation in Range of Motion and Mobility Devices have been retained), except for certain Medicaid Case Mix States that opt to retain Section G until 2025.
    2. Section G (Functional Status) Elimination renders the acuity adjustment obsolete for the staffing stars based

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Kris Mastrangelo

# INTO ACTION?

## THE NATIONAL IMPERATIVE TO IMPROVE NURSING HOME QUALITY

Honoring Our Commitment to Residents, Families, and Staff

### The NASEM report aftermath

by Irving L. Stackpole, RRT, MEd

One of the risks of working in a field for almost 4 decades is skepticism. My personal tolerance for platitudes has declined precipitously.

A brief history of the NASEM report puts it in a market and marketing context. By “marketing” I mean the management of who gets what, where, when, and why. In long-term care, and for SNFs, IRFs, LTACHs in particular, marketplace dynamics have nothing to do with what consumers want but exclusively with what consumers need and how this need is intermediated by insurance, managed care, and providers themselves.

When the pandemic struck,



Irving L. Stackpole

and over 200,000 consumers and staff tragically died in nursing centers<sup>1</sup>, it was inevitable there would be political fallout. For the first time ever, long-term care was mentioned by the President of United States in the State of the Union Address; that’s a pretty big deal! Note however, that this “attention” was not very constructive. The White House document about nursing homes was judgmental and, for the most part, punitive in nature.

Then in 2020 the prestigious National Academy of Science Engineering and Medicine (NASEM) pulled together individuals and assembled committees to make “bold and actionable” suggestions about how to fix the long-term care system in the US, which could only charitably be described as a “hot mess.” The committees further accessed hundreds of others for opinions and inputs. My skepticism was set aside momentarily as the process began.

The committees did their work, and in 2022 produced an epic-sized report, “The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Families, and Staff” which can be accessed on the Stackpole & Associates website ([bit.ly/44fb1S2](http://bit.ly/44fb1S2).)

Straw poll: how many of you read it? (*I didn’t think so.*)

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The Report included 7 goals. Not to clog up my arteries, they’re listed as an appendix at the end of this article.

All the goals make sense, none of them are “news,” and all of them have been promulgated by the very same people that populated the committees and provided the prodigious inputs.

The conclusion of the report on page 568 (no kidding!) reads:

“The urgency to reform how care is financed, delivered, and regulated in nursing home settings is undeniable. Failure to act will guarantee the continuation of many shortcomings that prevent the delivery of high-quality care in all nursing homes. The COVID-19 pandemic provided powerful evidence of the deleterious impact of inaction and inattention to long-standing quality problems on residents, families, and staff. The disruption of the pandemic, however, also serves as a stark reminder that nursing homes need to be better prepared to respond effectively to the next

public health emergency, and serves as an impetus to drive critically important and urgently needed innovations to improve the quality of nursing home care. Implementing the committee’s integrated set of recommendations will move the nation closer to making high-quality, person-centered, and equitable care a reality. It has been 35 years since the passage of OBRA 87 and landmark nursing home reform measures. It is of the utmost importance that all nursing home partners work together to ensure that residents, their chosen families, and staff will no longer have to wait for needed improvements to the quality of care in nursing homes. The time to act is now.”

Well, OK! This sounds promising, right? The “work” didn’t stop there. In July 2022, the “Moving Forward Nursing Home Quality Coalition” convened. A select group went further and created an action agenda based on the recommendations. The synthesis was

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# Progress and action: Updates from the Moving Forward Coalition

by Isaac Longobardi, Moving Forward director and Alice Bonner, Moving Forward chair

**YOU'VE PROBABLY HEARD SOMETHING LIKE THE FOLLOWING:** Nursing home residents share that they haven't gotten a chance to tell staff what they want from their care or their time in a nursing home. Or maybe you've received gratitude for taking the time to listen to residents or their care partners describe a set of unique needs and goals and some anxiety about meeting them. hours apart.

In our discussions with residents across the country, we've heard time and time again that these conversations are vital, but they don't happen nearly enough. Many residents feel they have no role in deciding what sort of care they receive or how they live their lives each day.

Discussing goals, documenting them thoroughly, and providing care to meet them may be challenging at times. We need the tools to do these things well, as well as the ability to see if we've been successful. And in the face of staffing shortages, these tools need to be easy to use, digitally based, and workflow compatible.

The Moving Forward Coalition is excited to bring together the people and resources to develop those tools, as one of our 2024 action plans.

## Nine action plans launched

In July, the Moving Forward Nursing Home Quality Coalition launched our nine action plans. Based on recommendations from the 2022 NASEM report on nursing home quality, our plans outline near-term goals to improve nursing home quality, steps the Coalition will take to achieve those goals, and the partners and infrastructure needed along the way.

Over the last year, committees composed of nursing home residents, care partners, family members, administrators, researchers, advocates, and others worked tirelessly to develop and refine these plans. During the process, over 1,000 people raised their hands to get involved, and many provided invaluable insight and assistance along the way. Now, in year two, we're busy making these plans a reality.

As one New England-based senior services executive put it on the call, "Why [are

the action plans] important? Because the pandemic exposed how broken our long-term care system is in the U.S. The NASEM report articulated much of what I was feeling and thinking. At this point, it's a human rights issue. It has to be fixed." The action plans offer one opportunity to be part of that solution.

All the action plans speak to that urgency—addressing head-on issues of equity, resident experience, and workforce support in nursing home communities. And they offer feasible solutions rather than reiterating old problems. Each describes how nursing homes, state agencies, federal policymakers and others can collaborate in the short term, while also identifying core funding needs for long-term success and sustainability.

You can read all nine plans here.

## We need you

To be successful in accomplishing our goals, we need nursing home leaders—administrators, direct care staff, directors of nursing, medical directors, executive teams, and owners—to work with us.

We're grateful for the participation of many of these leaders in our first year of work—prioritizing NASEM recommendations and developing action plans. Now, we're eager to build this network further to help develop useful resources, test and spread best practices, and advocate at the state and federal level for policies that will make high quality nursing home care feasible now.

For example, the Coalition is working on a guide to help nursing homes develop the health information technology (HIT) infrastructure necessary to participate in value-based purchasing relationships and contracts. The Centers for Medicare & Medicaid Services (CMS) has set a goal that all Original Medicare and most Medicaid beneficiaries will be covered under an accountable or value-based care arrangement by 2030.

As the action plan puts it, "The complexity of this changing landscape and lack of incentive pathways may leave nursing home leaders without a clear source of



direction." But to build the guide we need insights from nursing homes with both robust HIT systems and those without—to understand what path successful adopters have taken and what guidance others need going forward. We will also need help testing the resource in early 2024.

Another action plan asks nursing homes to work with us to test and refine a set of best practices for launching, sustaining, and empowering resident councils. Could your nursing home be one of them? Do you have a colleague at another home who has found leading their resident council a continuous challenge? Or maybe you'd like to be the first home to test one of Moving Forward's goals, preferences, and priorities collection tool?

## Educating policymakers

We also need to work with and educate national policymakers, as well as state and local community leaders. Many people serving in Congress or federal or state agencies are not familiar with what nursing homes are, who lives there, who works there, and what kinds of care and support are provided. As we propose, design, and promote policy improvements, such as financial incentives for conversion of traditional homes to household models, we want to continue to build a diverse and collaborative Coalition to spread our message. We're working hard to bring nursing home leaders, residents, advocates, and external advisors together behind a common set of practical goals for policy improvement.

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Isaac Longobardi



Alice Bonner



# International recruiting

by K.R. Kaffenberger, PhD

**HEALTH CARE WORKER SHORTAGES HAVE BEEN EXTENSIVE IN THE LONG-TERM CARE FIELD FOR YEARS** and were exacerbated by the COVID crisis. Skilled nursing facilities and hospitals in particular share a concern about a shortage of nurses. One prospective solution to the shortage is international recruiting.

In a front-page Wall Street Journal article in August, Stuart Condie and Gabriele Steinhäuser chronicled some of the conflicts in international recruiting of health care workers. "Shortages of Nurses Fuels Global Battle" summarizes a conflict between poor country losses of personnel to rich countries in need of health care workers.

The Australian state of Tasmania ran an ad highlighting the pleasures of life there in the British Medical Journal. Similar ads were placed elsewhere in the UK as national health care nurses were about to go on strike. Australia is one of the most aggressive international health recruiters. But the UK is also an aggressive recruiter. It has drawn significant numbers of health workers from India, Zimbabwe, and Nigeria.

The drain on Zimbabwe is a source of great concern there. The health minister and vice president, Constantino Chiwenga, suggested passing a law that would criminalize the active recruitment of health workers for work outside the country.

The Wall Street Journal quotes him as saying, "If people die in hospitals because there are no nurses or doctors—and somebody who has been so irresponsible for not training their own nationals, but wanting poor countries to train for them—it's a crime that must be taken seriously."

The World Health Organization has asked that 55 poor countries not be subjected to re-

cruiting efforts by wealthier countries.

Despite the apparent unfairness of recruiting nurses from countries that are massively understaffed for nursing, those efforts continue. Obviously, an understaffed facility in the United States will seek legal and longer-term solutions to their staffing problems. Anecdotally, we expect that international recruiting has met that goal on some occasions.

In their Health Affairs research article, "Why International Recruitment Won't Solve the US Nursing Staffing Crisis" published in May, Tony Yang, Roy Thompson, and Allison Squires explain why the title statement is true. The authors redefine the issue with reference to other studies. They say that nurses "...do not want to work in places where they are undervalued and underappreciated." This situation is exacerbated by the willingness of some to pay travel nurses and agency staff far more than they pay their own personnel. In some instances, employers are paid twice the rate.

There appears to be an assumption on the part of employers that internationally trained nurses (IENs) will accept the undesirable working conditions over time that US trained nurses avoid. This may not be true.

In addition, recruiting IENs has become more difficult. These changes may have gone unnoticed by SNFs seeking IENs. For one thing, the NCLEX-RN (National Council Licensing Exam-Registered Nurse) pass rate has been declining for IENs. Passing the exam is necessary to move forward toward obtaining a work visa.

The visa process has always been complicated and is now becoming more complicated. It also takes more time. Visa processing may take several years. The authors go into a more detailed explanation of the available visas and the different processes and qualifications they involve. For recruiters, employers and IENs this means that the fruition of the recruiting process is a year or more down the road in many cases.

In addition, the authors point to employment law in the US and in IENs native countries which may complicate the international recruitment process.

The authors offer 5 solutions to the nursing crisis:

- Employers should be incentivized to retain nurses.
- Nursing could be designated a STEM field which would open up other visa possibilities.
- Recruitment could be ordered on language needs.
- Offer IENs a multiyear culturally humble education/support program.
- Identify and recruit IENs who are in the US but not currently working as nurses. The authors use sources to estimate 20,000 such IENs.

We often think of pay as the primary incentive to encourage nurses and other employees to find work important and rewarding. The amount of pay is important to all workers. Other things also matter, and in surveys and conversations they emerge with equal or greater importance.

Verena Cimarolli and Natasha Bryant of the LeadingAge LTSS Center at UMass Boston have published a research report, "Job Satisfaction and Intent to

Remain on the Job among Direct Care Professionals in Nursing Homes." Particularly in recent years, many direct care workers have left their jobs. This study is an effort to use established research techniques to see why some direct care nursing home workers (nurses and CNAs) remained in their jobs.

Like many recent reports this one is couched in terms of the COVID crisis. In this summation of the authors work we will turn only to the ongoing elements which other research indicate predated COVID and probably continue.

They summarize three primary elements as keys to retention of these professionals:

- Job Satisfaction: "...The only factor directly associated with intent to remain on the job was high job satisfaction."
- Contributors: "Direct care professionals with higher job satisfaction rates reported high quality communication..." They had "...more optimal relationships with their supervisors and felt appreciated for the job they do by their employer..."
- Support: "Most direct care professionals [in the study] reported feeling appreciated for the job they do (76%) and safe at work (92%)."
- Implications: "Findings from this research reinforce the importance of implementing high quality communication,...helping them feel prepared to care for residents and developing quality relationships ... " with supervisors.

So, these are good things to do in the face of staff shortages. Robyn Stone, also of the LTSS center, has done detailed, careful research for decades that has repeatedly proven that relationship-centered, team-based

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## Perceptions versus reality: Who are the real rogues?

by Al Terego, PhD

**THE HEADLINES SCREAM OUT ON NEWSPAPERS ACROSS OUR REGION:** “Owner of 3 RI nursing homes stole millions in federal funds, neglected patients...while understaffing its facilities.”

This time, it’s a NY-based company that owns homes in RI, and allegedly has diverted profits to fund a private airline, but there have been other, out-of-state corporations with dubious track records and tentacles that extend far into New England.

In another recent case, a “change of effective control” application was submitted to a state DOH from a New Jersey-based company, stating their intentions to reduce payroll and increase the facility’s profits while paying their own companies more than \$1 million a year in rent and consulting fees.

A company operating nursing homes across southern New England has agreed to pay a fine of nearly \$2 million to the state of Massachusetts after violations were identified. Connecticut and Rhode Island have experienced similar issues with the same organization.

Is this what long-term care has come to? Many out-of-state corporations have their fingerprints all over older, established, previously family-owned nursing homes, while the footprints of their owners may never reach New England.

This begs the question: Why are these out-of-state owners and investors buying nursing homes that are teetering on the edge of solvency?

Here is where perceptions differ from reality for elected officials, elder advocates, and those who work in our profession. State legislators view these purchases as proof that the nursing home business is lucrative. After all, why else would these investors be interested in buying? This perception, along with the usual dose of ageism, influences our public financial policy.

In reality, those corporations likely own related ancillary services, such as a pharmacy or hospice, which assures additional cash flow and profit, even if the nursing home is losing money. For example, if a 150-bed nursing home is purchased, and residents are successfully transitioned to a pharmacy under ownership’s control, it practically guarantees that investors and/or

stockholders will see a financial return.

Hospice services are another opportunity. Often, the marketing materials used for the affiliated businesses purposely disguise who the owners are by not using the organization’s name. Unsuspecting nursing homes contract with a hospice company owned by the same out-of-state corporation that operates a building in their market.

The perception of many consumer advocacy groups is that nursing homes are an inefficient, multi-billion-dollar industry that is abusive and deadly, and additional Medicaid funds need not be allocated to an industry that siphons off tax dollars to related parties for rent, pharmacy services, hospices, etc.

There are corporations and owners that do this, but many others have good intentions and ethics, and are trying to do what is right. We will never hear about them in the media, however, as they quietly provide quality care under the radar, as efficiently as possible.

Yes, there are bad actors in the nursing home business, and they need to be weeded out. But advocacy groups and elected officials also need a reality check. Most long-term care providers are barely hanging on due to the four winds of a perfect storm: inadequate Medicaid reimbursement, an unprecedented nationwide staffing shortage, a consumer shift from traditional Medicare to Medicare Advantage plans that pay less and demand faster discharges, and a pandemic that drove occupancy levels to historic lows. The sector has not recovered yet, and some prognosticators forecast that nursing homes, irreparably stained by COVID, will never return to pre-COVID occupancy levels.

Not that Pre-COVID was the land of milk and honey. In 2019, 81% of nursing homes across the country were losing money on Medicaid residents. Now that staff wages have increased by double-digit percentages, and the costs of liability insurance, food costs, supplies, and temporary help have gone through the roof, how wide is that gap today?

One active investment firm estimates that currently, just one in five nursing homes is



making money, and those that are close to breakeven can weather the storm only if they have related-party profits to sustain them. The deathwatch is on for smaller, stand-alone communities, and states seem perfectly comfortable to stand by and watch this contraction take place.

In July alone, costs for nursing homes and adult care increased by 2.4% according to the Bureau of Labor Statistics. Grappling with this steady march of escalating expenses is a stark reality that differs from how the nursing home sector is viewed by eldercare advocates who rail against us with an immovable understanding of a broken reimbursement system.

At the highest levels of our government, advocates call for greater ownership transparency through more regulations, including a cap on profit for nursing homes that rely predominantly on government reimbursement. They fail to see how this will impact on ethical investors as well, who will find the additional regulatory requirements too burdensome and invasive, and will seek other financial opportunities, further reducing the sector’s access to necessary capital.

While it’s true that some nursing home investors/owners qualify as “rogues,” there is another party that is perhaps equally culpable and has skated by thus far. Why are New England states welcoming so many out-of-state for-profit corporations in, even when they have a documented history of regulatory and quality issues? Each state has a review process, with gatekeepers set up to presumably protect their citizens’ in-

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# Federal plans for private equity investment in LTC

by Larry Vernaglia, Ajita Hanel, Lori Rubin Garber, Michelle A. Freeman, and Samantha Robbins Jamali of Foley & Lardner LLP

The presence of private equity (PE) investment in long-term care facilities (as with other health care providers) has exploded in recent years. PE investment in long-term care facilities is a good thing when done right: It can pave the way for much needed innovation, investment in essential facilities, efficiencies, and nontraditional care delivery models. However, government regulators, media journalists, some health care practitioners, and private parties are watching PE investment with growing suspicion that profit-driven goals may conflict with the quality of care for long-term care patients. Indeed, PE firms (unlike historic family-owned or nonprofit facilities) often do not have the luxury of extended horizons for their investments and often have investors that expect relatively quick financial returns.

News outlets have added fuel to concerns by publishing reports alleging decreases in quality care when PE firms acquire health care businesses. Moreover, some PE firms do not always appreciate the complex regulatory environment in which health care operates — an environment where a regulatory misstep can result in a major fraud and abuse or other compliance issue. Consequently, PE investment in long-term care facilities is drawing the focus of government enforcers, especially at the federal level. This article will discuss proposed regulatory and statutory provisions by CMS and Congress, respectively, that target PE investment in long-term care facilities and how these requirements will affect PE firms if effectuated.

The expansion of PE investment in long-term care facilities has led the Biden administration

to take steps with the stated aim of improving the quality and safety of long-term care facilities through an increase in transparency and accountability.<sup>1</sup> As part of this effort, the Centers for Medicare and Medicaid Services (CMS) set forth a 2023 proposed rule that would require long-term care facilities enrolled in Medicare or Medicaid to disclose additional information about their owners, operators, and management.<sup>2</sup> Additionally, the proposed rule would require further disclosure about entities that lease or sublease property to [long-term care facilities] largely because the facilities and property owners may be formed as different corporate entities despite working closely together.<sup>3</sup> The inclusion of this required disclosure in the proposed rule stems from long-term care facilities frequently using other companies to provide major services or support (often for perfectly justifiable reasons) but families often not knowing about the use of these companies and how they are connected to the owners of a long-term care facility.

CMS's proposed rule also seeks to require long-term care facilities to disclose whether or not they qualify as a "private equity company" or as a "real estate investment trust (REIT)."<sup>4</sup> CMS introduced new definitions of "private equity company" and "REIT" in the proposed rule, and the final definitions will be used as part of an updated nursing home facility enrollment application, which is expected to be ready for public use by the summer of 2023.<sup>5</sup> The proposed rule was promulgated on February 13, 2023, and the comment period ended on April 14, 2023.<sup>6</sup>

Along with the proposed rule, as of June 28, 2023, CMS is now making additional ownership data available on Nursing Home Care Compare, a website that allows public users to find and compare local nursing homes.<sup>7</sup> The additional ownership data includes the names of affiliated

owners.<sup>8</sup> Further, CMS is publishing aggregate data on the safety, staffing, and quality for groups of nursing homes sharing ownership/operatorship on data.CMS.gov.<sup>9</sup> These data updates to Nursing Home Care Compare and data.CMS.gov are made with the purpose of carrying out the Biden Administration's goals for improving the safety and quality of long-term care facilities.<sup>10</sup>

Like CMS, Congress also seeks to increase transparency and "accountability" of PE in-

vestment in long-term care facilities. In March 2023, representative Pramila Jayapal of Washington State's 7th District introduced the Healthcare Ownership Transparency Act (HOT Act), which would require additional disclosures from PE firms.<sup>11</sup> These required disclosures would include "the identities of those with interests in the fund and their ownership interests, the debt held by the fund and its covered healthcare

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## FROM THE DISTRICT ONE DIRECTOR

This is a friendly reminder to get involved and enjoy the benefits of your membership. There are so many exciting resources that are available to you.

Did you know that ACHCA is offering the following?

- ACHCA Membership Drive  
Start date: May 15  
End date: November 30
- CNHA: Nursing Home Administrator Certification  
<https://achca.memberclicks.net/certification#CertificationInformation>
- Save the date- May 6 to 9, 2024 Convocation in Myrtle Beach

I am looking forward to seeing you at our annual convocation in Myrtle Beach in May 2024. This will be another opportunity to get back to "nor-

mal" by connecting in person with our colleagues and friends from around the country, making new connections, getting updated on topics that impact our day-to-day operations and how we care for our residents, and enjoying a destination getaway. Invite or sponsor an AIT (or several) and emerging professional who is eager and enthusiastic to build relationships and tools to be a strong leader with confidence. Let's all get rejuvenated and back to pre-pandemic opportunities to reach out and touch someone without a TEAMS or Zoom meeting. There is nothing more pleasant than having a conversation or interaction that is not dependent on an electronic device.

If you desire to become more involved in your local chapters, please do not hesitate to contact me and I will put you in contact with your state leadership.

Due to the ever-changing regulatory climate it is even more imperative for us all to reunite, share best practices, and strengthen our collegiality to address the issues that impact the quality of care provided to our residents.

Do not hesitate to reach out to me with any questions, comments, or feedback to serve your needs.



Angela Perry, LNHA, FACHCA, ACHCA District One Director



# States address inadequate reimbursement and staffing shortages

Compiled by Rick Gamache

## Iowa's lawmakers help, but SNFs keep on closing

Iowa has increased its Medicaid rate, put millions of dollars into workforce development, approved tort reform, and enacted a moratorium on new nursing home licenses, but the state continues to see nursing homes closing. Countryside Health Care Center in Sioux City is the most recent to close its doors. The state has lost 29 nursing homes since 2020—26 of them in the past year and another 1238 beds have been taken offline. Staffing is the issue, even though wages are up 32% (36% for CNAs). Currently about 5800 nursing positions are vacant in Iowa. McKnight's, 07/10/2023

## Montana SNFs to see 33% Medicaid boost

Montana now has 65 nursing homes after losing 12 since February 2022, most due to financial considerations. The state's facilities are in for a big Medicaid increase, from \$209 PPD to \$268 in fiscal year 2024. Another increase from \$268 to \$278 will come in fiscal 2025. That's the good news; the bad news is that the Montana Health Care Asso-

ciation says the daily cost of care averages \$349. Two bills that would have provided funding for communities to reopen closed facilities died in the Senate. McKnight's, 05/15/2023

## Over \$1 million for some Minnesota nursing homes

Senate Republicans released details of a \$300 million deal to help Minnesota nursing homes. The agreement will include direct grants totaling \$173.5 million split into two payments in August 2023 and August 2024, as well as facility rate increases, and a workforce incentive fund that adds up to about \$1.1 million for every nursing home in the state. Each facility would receive at least \$225,000, plus additional funds based on active beds. An average 50 bed SNF could receive \$465,000 in grant funding. "Ultimately, this is the right thing to do, and it shouldn't have required a strong negotiation to get it done," Minnesota Senate Minority Leader Mark Johnson said about the just-passed \$300-million nursing home package. Minnesota Senate Republican Caucus, news release, 05/22/2023

Also, In the waning hours of the of the



state's legislative session, Minnesota lawmakers approved funds for three different buckets totaling about \$300 million. In the first of the grants, to be distributed in two payments this year and next, a 50- bed facility will receive about \$465,000. A second bucket of about \$50 million can be used for wages and benefits. The final funding, approximately \$75 million, is for workforce development grants that facilities must apply for and explain how they plan to use the money, which is aimed at recruiting and retaining employees who earn \$30 per hour or less. McKnight's, 08/08/2023

Finally, Brown County Commissioners in Minnesota have unanimously approved a resolution asking state lawmakers to spend \$1 billion over the next four years to alleviate the workforce crisis that is disproportionately hitting rural nursing homes. The commissioners also want to see wages for caregiving start at \$22 per hour. How bad is it? The administrator of a 94- bed SNF said it has an admissions waitlist of about 200 people and declined to admit 240 seniors last year. He said they are just now receiving reimbursement for 2020 expenses. In addition, Medicaid is reimbursing 80% of care costs. New Ulm Journal, 04/06/2023

## South Dakota

Providers received a 25.3% Medicaid increase effective July 1, according to McKnight's.

## California

The state will pay bonuses to all nursing homes that hire additional staff, reduce turnover, or improve the quality of care, regardless of star rating. Higher-scoring facilities will earn larger bonuses, but any facility that meets the new metrics will be eligible for some of the program's \$280 million. The bonus program is "comparable" to the level of temporary funding available to nursing homes during the pandemic. McKnight's

Continued on page 18



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## STEREOTYPING AND AGING



by Sheldon Ornstein Ed.D, RN,  
LNHA

I would like you to participate in a brief mental exercise. Close your eyes and visualize the images you see when you say the following words: "old man, elderly gentleman, old woman, elderly lady." I won't elaborate on these responses right now, but if you visualize different images you will begin to understand the extent to which stereotypes can influence our perceptions.

There is a word association technique I have often used when speaking before various groups. Using the word "old," I ask the audience for phrases or descriptions of old people. It is rather difficult to find words that bear a positive description for the word itself. For example, when speaking about old men we tend to describe them as old geezers, old crocks, old codgers, and yes, even dirty old men. When describing women who are old, I've heard terms such as old witch, old biddy, old crone, old hag, and old battle axe. However, when we talk about old things, it's always in the positive vein: old painting masterpieces, old fine wines, old finely embroidered lace, etc.

Question: How old is old?

A 15-year-old girl watches as

her younger sister and friends play with their dolls. She has an impulse to join them. Why doesn't she? "Because I am too old to play with dolls," she declares!

Later the same girl races excitedly with cell phone in hand to ask mother if she can go on a date with a boy who has a car and a license. "No dear," is mother's reply. "Absolutely not! You're not old enough for that activity. Maybe when you are older."

Question: How old is old?

A 60-year-old man is overlooked for a promotion in pay and position with little consideration by his superior. "Why," he asks. The supervisor's response, "You are too old to understand the updated techniques required to do this job and you may fail."

Question: How old is old?

Another candidate applies for the same position. He is 25 years old! He too, is passed over and informed he is not old enough to take on the responsibilities of so complex a job which also includes employees who are older than he and they would reject someone bossing them around, especially at "his young age."

We are that group in 10 or 20 or even 40 years ahead. Some of us, I gather, may already be there.

We tend to make numerous decisions or have them made for us based on false assumptions about age. We are often made aware that we are either too old or not old enough for activities, opportunities, and experiences we wish for. And in the same way, we tend to pre-judge other people according to their age. To better understand how old is old, let's try and imagine the following questions and how you would answer them.

1. Have you ever considered how the aging image came on to the American scene, and if so, how did you react?
2. Is there a point when the nation began seriously looking at the aging phenomenon in an emerging society?

Here are, what I call concrete facts, that offer an understanding of the issue of aging and how it has profoundly influenced change on the American landscape.

Fact: During the early part of the 20th century those who turned 65 years of age numbered 5 million. At present that number is 40 million and is expected to leapfrog to 50 million by 2030.

Fact: In 1997 the world's population of aging (561 million) was approximately 10%, whereas this statistic is now projected to rise to 20% by 2025.

Fact: At present, those who are turning 75 years and older has increased 40% while the population of those under 65 rose to only 12%.

Fact: Increases in life expectancy has its advantages and drawbacks, and as we add additional years to our lives, we run the risk of increases in multiple body organ decline due to the physiology that is incurred as we age.

Fact: Ageism can "encourage" a younger generation to view the older population as different from themselves and will

cease to identify with the aged individual's collective years of experience and wisdom.

Fact: Ageism "allows" a younger generation to view their elders as inflexible and unable to change or adapt with time.

Final thoughts: As a society we've come the route from 16th-century isolation and lack of concern for the aged, to a more viable population with economic and social possibilities. It is therefore our obligation to reject the numerous and fallacious beliefs that abound with aging, and to reject the false fixed belief that aging is an inevitable process that ultimately ends in deterioration.

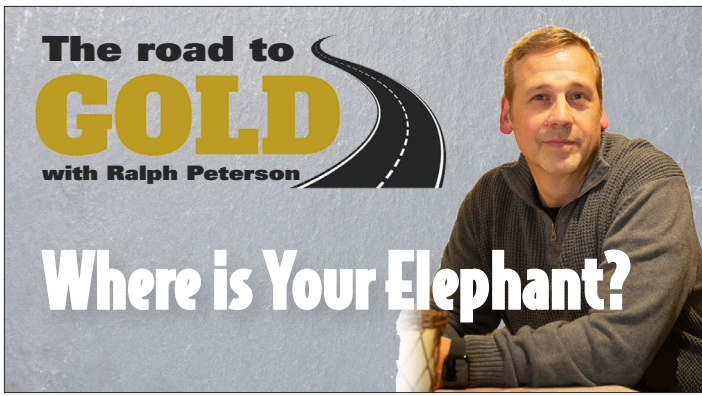
When I began this article I posed the question, "how old is old?" Much of the answer can be found in the kind of person we are and what we have become as we go forth. Incidentally, the title of this article is "Stereotyping and Aging." According to the dictionary, stereotype is defined as "an idea that many people have about a thing or group and that may often be untrue."

### Quotable Quote

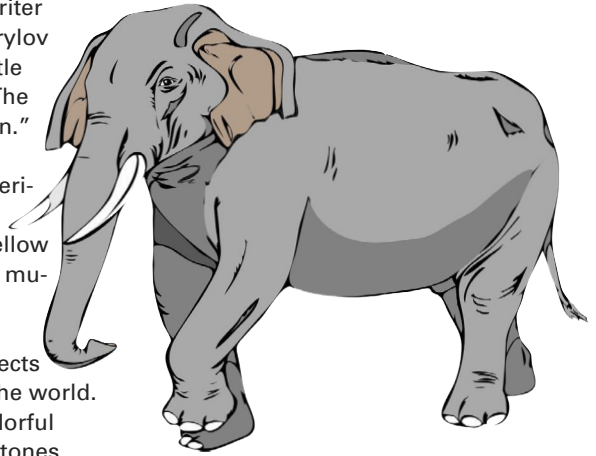
**"Hope is the mainspring which keeps us more or less interested in life until we reach the windup."**  
- My beloved father-in-law, Sam Schuman.

In 1959 Dr. Sheldon Ornstein received his nursing diploma from the Mills-Bellevue Schools of Nursing becoming a registered professional nurse. He continued to earn several degrees including a Post Masters Certificate in Gerontology from Yeshiva University in 1979 and a Doctor of Education in Nursing Organization from Columbia University in 1997. He began his clinical career as head nurse on a rehabilitation unit, and nurse educator providing in-service education and clinical instruction for Nursing students and colleagues alike. He taught at several colleges and was an adjunct professor at Hunter College. Over the course of a 50+ year career, he held the position of Director of Nursing Services in long term care facilities before retiring in September of 2010 as Distinguished Lecturer/Associate Professor in the Department of Nursing at Lehman College, CUNY in the Bronx.





In 1814, a writer named Ivan Krylov wrote a fun little fable called "The Inquisitive Man." It is a story about a very serious and detail-oriented fellow who goes to a museum and admires all the wonderful objects from around the world.



#### DID YOU KNOW ELEPHANTS CAN'T HIDE? IT'S TRUE!

No matter how hard an elephant tries to hide by covering themselves up in mud or standing in a clump of trees, they always end up looking like a mud-covered elephant standing in a clump of trees.

The big question is: Why do elephants try to hide in the first place? They are one of the largest and strongest animals on the planet. What could they possibly be hiding from?

It turns out, elephants, despite their large size and strength, have very sensitive skin and as a result, are always trying to hide from the sun. That is why they cover themselves in mud and prefer to hang out in the shadows of trees; to avoid the sun.

He notices everything, from big colorful birds, to dragonflies, to sparkling stones and emeralds, and to the tiniest of insects.

However, despite his attention for detail, he never notices the massive, fifteen-foot elephant on display in the middle of the room.

How is this possible, you may wonder?

It turns out, even though elephants can't hide, they can be ignored.

Ever since this story was written, (over two hundred years ago) the phrase "the elephant in the room," has become synonymous with challenging or difficult situations that people know they should be dealing with but choose to ignore.

I remember the first time I had to confront an elephant. It was a Monday afternoon; one of my employees left early without telling anyone and without finishing her job. I probably wouldn't have said anything, if another employee didn't complain to me that she was always skipping out early and leaving her work for everyone else to finish.

"Really," I said trying my best to sound exasperated. She nodded with big eyes.

"You have to talk to her," she said. It was my turn to nod.

Continued on page 15



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## OPINION Less is more

by Bruce Glass, MBA, FACHCA

In the July/August issue of McK-nights, John O'Connor discusses the trend toward shorter work weeks—specifically three 12-hour shifts as a step toward dealing with the staffing shortage. My first reaction was that it'd never fly. If we can't staff with five-day weeks, how could a three-day schedule help?

But, on further consideration, it offers many advantages. Who wouldn't like a four-day week-end? With those four days off, occasional weekend duty would



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New EP/P members who join before November 30 will receive \$100 off Convocation 2024 registration.

Details are available at [achca.org](http://achca.org).

## A summary of MDS changes

Continued from page 2

- on the STRIVE study and RUGs 66 categorization.
- Section GG – Functional Abilities and Goals.
  1. GG0130. Self-Care Instructions Added.
  2. GG0130E. Shower/Bath Self.
  3. GG0130F. Upper Body Dressing.
  4. GG0130G. Lower Body Dressing.
  5. GG0130H. Donning/Doffing Footwear.
  6. GG0130I. Personal Hygiene. (NEW)
  7. GG0170. Mobility Instructions Added.
  8. GG0170FF. Tub/Shower Transfer. (NEW)
  9. Change in Source Documents.
- Section J. – Health Conditions.
  1. J0510. Pain Effect on Sleep.
  2. J0520. Pain Interference with Therapy Activities.
  3. J0530. Pain Interference with Day-to-Day Activities.
- Section K. – Swallowing/Nutritional Status.
  1. Nutritional Ap-

proaches.

2. Prior to Admission, While a Resident, While Not a Resident, At Discharge.
- Section N. – Medications.
  1. N0415. High Risk Drug Classification Use and Indication: Section N0415. replaced section N0410.
  2. The medication list has been significantly expanded and now includes hypoglycemics and antiplatelets.
  3. Two columns: Is Taking (Refined) and Indication Noted (NEW).
- Section O. – Special Treatments, Procedures and Programs.
  1. On Admission, While Resident, At Discharge.
  2. Oxygen Therapy.

Staff training on these MDS changes is essential for providers to prepare, implement, and ensure MDS compliance.

KrisBHarmony, LLC provides ongoing MDS Training. For more information, see website: [www.KrisBHarmony.com](http://www.KrisBHarmony.com).

Kris Mastrangelo, OTR, MBA, NHA, is a nationally-recognized authority of Medicare issues. She is a regular contributor to the New England Administrator. Contact Kris : [kristenbharmony@gmail.com](mailto:kristenbharmony@gmail.com)



be less onerous. Transportation needs would be reduced. Child-care, too, would be reduced.

The transition would take some planning and preparation, but, as O'Conner pointed out, we need to think outside the box because the problem is not going to fix itself.

If you try it for your organization, please share the results.

Bruce Glass, MBA, FACHCA, is licensed for both nursing homes and assisted living in several New England states. He is currently principal of BruJan Management, an independent consulting firm. He can be reached at [bruceglass@rocketmail.com](mailto:bruceglass@rocketmail.com)

## SEEKING YOUR CONTENT

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Send queries to  
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# Recruiting

Continued from page 6

frameworks are the key to successful nursing home care.

She emphasized this point in a recent letter published in "Research in Gerontological Nursing." It is worth quoting in part:

"NHs are great places for nurses to work for a number of reasons. First, unlike the acute care sector, nurses play a major role in leadership, management, and clinical care. Second, NH organizational structure is relatively flat, providing nurses with



the opportunity to cultivate and sustain productive relationships with other members of the clinical team, frontline managers, and certified nursing assistants, who provide the lion's share of hands-on services and supports. Third, nurses in this setting are also able to develop authentic relationships with residents in short-term, post-acute care, but even more so in the long stay NH where most people will live until death. Nurses have the time to build, nurture, and sustain a relationship-centered team."

This approach may be more difficult to do than a simple top-down approach because it involves four elements that Stone emphasizes. They are communication, empowerment, mentoring, and family involvement. However if it can free a facility from the burden of staffing shortages within a reasonable financial framework, it is well worth examining and attempting in a suitable manner for your facility.

KR Kaffenberger, Ph.D., M.P.H., is a fellow of the Gerontology Institute at UMass Boston and a former nursing home administrator.

# The Road to Gold

Continued from page 13

"I will," I said, trying to sound confident.

Thankfully, the employee in question had the next day off, which gave me another day to figure out what I was going to say and to collect my nerve. I'd never talked to anyone before, and to say I was nervous was a huge understatement.

It's now Friday morning and I'm pacing in my office. I still haven't talked to her and, honestly, I don't want to. Like the elephant avoiding the sun, I too don't want to get burned.

Reluctantly, I leave my office just before lunch. I take the long way to the third floor, letting anything and everything distract me. I found her talking with the same employee who had complained. She looks at me and smiles. I smile back and say hello, thinking she will excuse herself, she doesn't. Instead, she gives me an expectant look that says, 'I know you haven't talked to her yet.'

I swallow hard. Take in some air and nod. "Can I talk with you for a minute?" I said, trying not to sound nervous or scared.

The two of them look at each other. One is smiling, and the other isn't. The smiling one excuses herself. We both watch her go. "About Monday," I said. She nods and studies the floor.

It turns out, she was just as nervous as I was. While I was busy trying to get the nerve up to speak, she was bracing herself for the consequences.

In the end, the conversation cast light on both of us, and for the first time, I understood what it means to be a leader. Everyone wants to avoid the elephant in the room, and for most people, they can get away with it. Managers, however, can't.

Where is your elephant?

As always, I hope I made you think and smile.

Ralph Peterson of The Core Fourteen works with senior care organizations on leadership training, Quality Awards and QAPI. To learn more call or text Ralph directly: (914) 656-0190

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## The real rogues

Continued from page 7

terests. It's as if our state governments have called "olly olly oxen free," and left the gates wide open. Do states bear any responsibility for what is occurring to the residents entrusted to these organizations for care?

In the post-COVID rear-view mirror, people see different things. Some advocacy groups would like to see nursing homes in the crosshairs, where they all can be punished for the misdeeds of some greedy and unscrupulous owners. I spoke to one individual who testified before a congressional panel in Washington recently and asked him if he understood the impact that additional regulations and unfunded staffing mandates would have on smaller

providers. "There's going to be collateral damage," he told me. "We expect there will be some acceptable losses."

So, it's come to this. On the cusp of needing many more congregate care options for elders to keep pace with demand, we're bruised and battered from the bad actors within our profession. At the same time, we're being hunted by angry advocacy groups that lump us in with them. We will all feel the wrath of what may be coming. Meanwhile, our state officials insulate themselves and focus on their own survival, even as their decisions will create casualties.

We need to stay in the fight. We need to distance ourselves from the bad actors, and we need to adhere to the ethical standards we pledged when we joined ACHCA (see below).

## ACHCA Code of Ethics

**Expectation I** Individuals shall hold paramount the welfare of persons for whom care is provided.

**Expectation II** Individuals shall maintain high standards of professional competence and personal conduct.

**Expectation III** Individuals shall strive, in all matters relating to their professional functions, to maintain a professional posture that places paramount the interests of the facility and its residents.

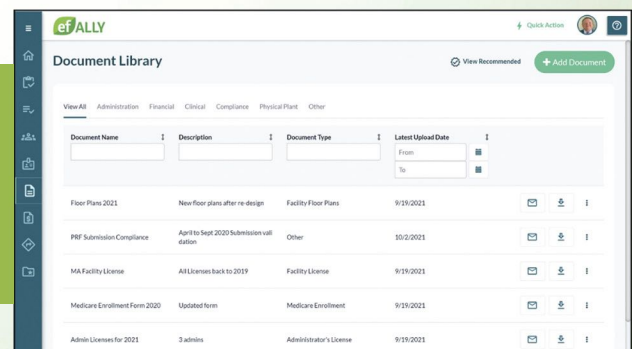
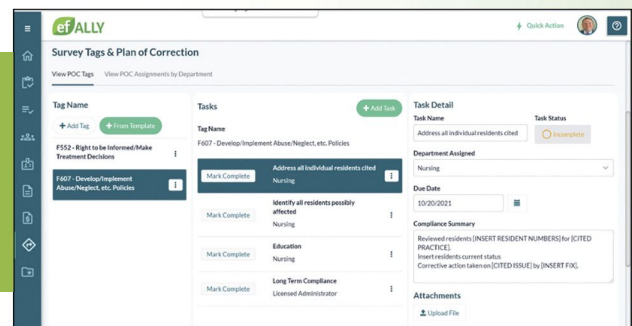
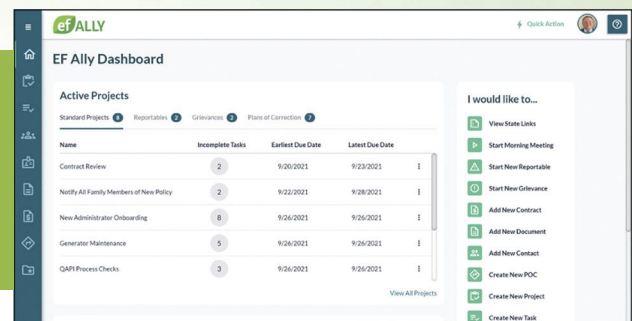
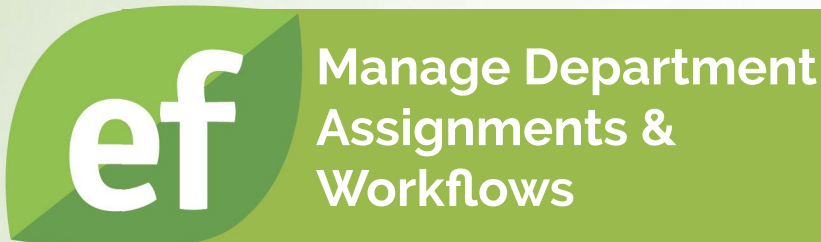
**Expectation IV** Individuals shall honor their responsibilities to the public, their profession, and their relationships with colleagues and members of related professions.





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## Private equity investment in LTC

Continued from page 9

firms, the performance of the portfolio companies, fees and payments collected by the firm, and all political spending related to health care by the private equity fund and affiliates.”<sup>12</sup>

Furthermore, the HOT Act would permit the Government Accountability Office (GAO) to examine PE investment in long-term care facilities by “[d]irecting the GAO to write a report on how [health care] consolidation and private equity contribute to various health quality and cost indicators, including cost to charge ratios, payor mix, quality ratings, regulation compliance violations, staffing levels and ratios, and employee wages among others.”<sup>13</sup> Moreover, the HOT Act would “[d]irect the Secretary of the U.S. Department of Health and Human Services (HHS) to create a Task Force to identify best practices and provide regulatory and legislative recommendations to Congress to address and limit the role of private equity and consolidation in health care.”<sup>14</sup>

Additionally, the HOT Act would permit the Secretary to direct the Task Force to “study and identify” whether “abuses” are taking place in “specific health care sectors or by health care entities related to price gauging, understaffing, regulation compliance violations, or other such metrics” that the Secretary may deem appropriate.<sup>15</sup> Until the Secretary has determined that the Task Force had sufficient time to “study and identify” potential “abuses,” the HOT Act would allow the Secretary to enact a moratorium that would “prohibit . . . private equity fund[s] from purchasing voting securities of a covered firm” and “prohibit any merger or acquisition that would result in a private equity fund gaining control of voting securities of a covered firm.”<sup>16</sup> The HOT Act broadly defines a “covered firm” as “a corporation that is (a) a provider of services or supplier that meets all applicable require-

ments under title XVIII for participating in the Medicare program under such title; or (b) any other person or entity who may receive reimbursements, payments, or other funds from the Centers for Medicare & Medicaid Services.”<sup>17</sup> As proposed, the HOT Act’s broad definition of “covered firm” coupled with the Secretary’s ability to enact a moratorium without prescribing a maximum time limit for the moratorium could halt future PE investment in long-term care facilities indefinitely if a moratorium is enacted.<sup>18</sup>

While the HOT Act attempts to improve perceived suboptimal patient outcomes through federal oversight and disclosure,<sup>19</sup> its reach is overly broad and will affect well-intentioned and responsible investors who are not the intended target of the Biden Administration’s efforts and the HOT Act.<sup>20</sup> It also ignores the reality that facility closure due to inability to bring in new investment is a worse outcome than permitting a regulated new operator, even if that operator shares some of the characteristics of a PE investor. However, the HOT Act only has a few cosponsors, and it has no Senate counterpart.<sup>21</sup> It is unlikely that the bill will move forward in Congress, especially since this is the HOT Act’s second proposal after it failed to move out of the committee following its introduction last year.<sup>22</sup>

Nevertheless, the unflattering commentary and scrutiny surrounding PE investment in long-term care facilities is likely to continue throughout 2023 and 2024, despite PE firms investing money into facilities that are perceived as risky investments to others due to the high cost of staff and unreasonably low reimbursement rates for public payors. As such, investors should seek to anticipate CMS’s proposed rule and the HOT Act’s requirements to respond accordingly.

<sup>1</sup> FACT SHEET: Protecting Seniors by Improving Safety and Quality of Care in the Nation’s Nursing Homes, THE WHITE HOUSE, (Oct. 21, 2022), [\[room/statements-releases/2022/02/28/fact-sheet-protecting-seniors-and-people-with-disabilities-by-improving-safety-and-quality-of-care-in-the-nation-s-nursing-homes/\]\(https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/28/fact-sheet-protecting-seniors-and-people-with-disabilities-by-improving-safety-and-quality-of-care-in-the-nation-s-nursing-homes/\).](https://www.whitehouse.gov/briefing-</a></p></div><div data-bbox=)

<sup>2</sup> Biden-Harris Administration Continues Unprecedented Efforts to Increase Transparency of Nursing Home Ownership, CTRS. FOR MEDICARE AND MEDICAID SERVS., (Feb. 13, 2023), <https://www.cms.gov/newsroom/press-releases/biden-harris-administration-continues-unprecedented-efforts-increase-transparency-nursing-home>; 88 FR 9820

<sup>3</sup> Biden-Harris Administration Continues Unprecedented Efforts to Increase Transparency of Nursing Home Ownership, supra, note 2; 88 FR 9820; See also Alexandra Maulden et al., Biden’s nursing home industry reforms, NEW ENGLAND ADM’R, Mar. 2023, at 13

<sup>4</sup> Biden-Harris Administration Continues Unprecedented Efforts to Increase Transparency of Nursing Home Ownership, supra, note 2; 88 FR 9820

<sup>5</sup> Biden-Harris Administration Continues Unprecedented Efforts to Increase Transparency of Nursing Home Ownership, supra, note 2; 88 FR 9820

<sup>6</sup> Biden-Harris Administration Continues Unprecedented Efforts to Increase Transparency of Nursing Home Ownership, supra, note 2; 88 FR 9820

<sup>7</sup> See Find & compare providers near you, MEDICARE.GOV, <https://www.medicare.gov/care-compare/?providerType=NursingHome> (last visited: June 29, 2023) [hereinafter Nursing Home Care Compare]

<sup>8</sup> See id.

<sup>9</sup> CMS Datasets for Public Use, CTRS. FOR MEDICARE AND MEDICAID SERVS., <https://data.cms.gov/>, (last visited: June 29, 2023)

<sup>10</sup> Nursing Home Care Compare, supra, note 7; CMS Datasets for Public Use, supra, note 9; Biden-Harris Administration Continues Unprecedented Efforts to Increase Transparency of Nursing Home Ownership, supra, note 2; See also Biden-Harris Administration Makes More Medicare Nursing Home Ownership Data Publicly Available, Improving Identification of Multiple Facilities Under Common Ownership, U.S. DEP’T. OF HEALTH AND HUM. SERVS., (Sept. 22, 2022); <https://www.hhs.gov/about/news/2022/09/26/biden-harris-administration-makes-more-medicare-nursing-home-ownership-data-publicly-available-improving-identification-of-multiple-facilities-under-common-ownership.html>

<sup>11</sup> Jayapal Introduces Bill to Improve Transparency in Health Care, PRAMILA JAYAPAL, (Mar. 23, 2023), <https://jayapal.house.gov/2023/03/23/jayapal-introduces-bill-to-improve-transparency-in-health-care/>

<sup>12</sup> Jayapal Introduces Bill to Improve Transparency in Health Care, supra, note 11; H.R. 1754, 118th Cong. (2023-2024)

<sup>13</sup> Jayapal Introduces Bill to Improve Transparency in Health Care, supra, note 11

<sup>14</sup> Jayapal Introduces Bill to Improve Transparency in Health Care, supra, note 11; H.R. 1754, 118th Cong. (2023-2024)

<sup>15</sup> H.R. 1754, 118th Cong. (2023-2024)

<sup>16</sup> Id.

<sup>17</sup> Id.

<sup>18</sup> Id.

<sup>19</sup> See id.

<sup>20</sup> See id.

<sup>21</sup> See H.R. 1754, 118th Cong. (2023-2024)

<sup>22</sup> Laura Coleman-Lochner, Wall Street Owners of Nursing Homes Face Data Demand in US Bill, Bloomberg L., (Mar. 22, 2023), <https://www.bloomberglaw.com/bloomberglawnews/private-equity/X4DHL2VG000000>

## Moving Forward action plans

Continued from page 5

### Acting locally

At the state level, we have launched two state-based Coalition teams, one in Michigan and the other in Pennsylvania. Led by champions with long-standing relationships among aging professionals, local legislators, advocates, and nursing home communities, these teams are building collaborative networks to drive state policy and nursing home practice changes aligned with the nine action plans.

### Join the Coalition

Our list of participants continues to grow each week. We’re happy to grow each week. We’re happy to schedule one-on-one conversations with individuals and teams that want to learn more about the Moving Forward Coalition and get involved. Please read our action plans and consider how you can help to make one or more a reality in your community or state. The time is now for collaborative and actionable nursing home quality improvement so that every nursing home is a community in which lives are nurtured, residents are empowered and where people want to work.



# A roundup of how states are addressing reimbursement and staffing issues

Continued from page 10

## **Nursing homes may be big winners in new Ohio budget**

The now-being-debated Ohio House budget reflects new spending in assisted living and other home and community-based care. It provides 48% more in the state's Medicaid-funded assisted living waiver program and \$18/hour for home health care workers. But nursing homes scored better in the proposed budget. It increases the frequency with which SNFs can adjust reimbursement figures for inflation, reworks the state's quality incentive program, rewarding homes with higher occupancy rates, and offers an add-on payment to facilities that put Medicaid patients in private rooms. The Cleveland Plain Dealer, 04/24/2023

## **Pennsylvania investing millions in nursing homes**

The Pennsylvania Department of Health today announced 127 long-term care facilities in 43 counties will receive a portion of Pennsylvania's \$14.2 million in federal CDC funding to help sustain quality care as the Commonwealth's population ages and residents' needs change. The funds will help the facilities improve workforce development, staff retention, and infrastructure that supports infection prevention control and emergency preparedness. Governor Josh Shapiro's budget proposal includes a \$1.9-million investment in regulatory oversight to help ensure long term care facilities provide safe and stable services for residents. Pennsylvania Pressroom, 03/27/2023 Also, Pennsylvania providers were given a significant 17% Medicaid increase in 2022. McKnight's

## **Kentucky law looks to boost the LTC workforce**

A new law in Kentucky could serve as a national model to help stem the workforce crisis in nursing homes. The state's new Healthcare Workforce Collaborative will use part of a \$10 million appropriation to offer training scholarships that the Kentucky Association of Health Care Facilities hopes will create an employment pipeline. Statewide, nursing homes are at 15% below staffing levels of March 2020. Approximately 65% of the \$10 million allocated in the workforce law will be used for scholarships. The remaining 35% will go toward grants for public universities, community, and technical colleges to expand training programs. McKnight's, 03/28/2023

Also, Kentucky nursing home providers breathed a collective sigh of relief in June,

when Gov. Andy Beshear (D) approved \$99.6 million to boost daily rates until Medicaid rebasing kicks in next year. The state's Department of Medicaid Services designated the funds, meant to help nursing homes cope with inflationary pressures, as a "forecast error" to provide the funds quickly. The result is an overall adjustment of about 8%, though exact bumps will vary by facility. The governor committed to reexamining cost reports to rebase rates effective July 1. Rural providers can expect an increase of approximately 8% while urban facilities will get an additional 7.9% due to the emergency bridge funding. McKnight's

## **Colorado providers may get big jump in Medicaid rates**

A Colorado House committee has unanimously approved a bill that would increase Medicaid rates to skilled nursing facilities 14.5% by 2026. As proposed, increase would jump 10% next year, 3% in 2025 and 1.5% in 2026. The state's Department of Health Care Policy and Financing has estimated it also would double the share of funding that supports pay-for performance models. The proposal lifts a cap that has until now limited annual increases to 3%. Colorado providers experienced a 2% Medicaid pay rate cut that kicked in just as COVID was ramping up in 2020. McKnight's, 03/27/2023

## **Reimbursement boost for Florida LTC facilities**

The Florida Senate and Florida House of Representatives released their 2023-2024 initial budget recommendations this week, both of which included an increase to Medicaid funding for nursing center care. The Senate budget proposal includes a 4% increase to the quality component in the Prospective Payment System (PPS) for nursing center Medicaid reimbursement. The Senate proposal also raises the Medicaid personal needs allowance from \$130/month to \$160/month for nursing center residents. The House proposal includes a 3% increase in the PPS quality component. Florida Health Care Assn., news release, 03/22/2023

## **New York providers beg for rate increase**

Nursing home operators in New York state are looking for a 20% hike in the Medicaid rate. The governor has proposed 5%; the legislature 10%. The state's LTC association said the cost of caring for a Medicaid resident is \$265 PPD. "However," said CEO Stephen Hanse, "New York's statewide average daily reimbursement for such care is \$211 per resident per day. This \$54 shortfall is the largest in the nation." Lawmakers are backing allocations that would shore up

home care and funnel funds away from nursing homes. The state's budget deadline is April 1. McKnight's 03/24/2023

## **Connecticut SNFs say they need more—a lot more**

Connecticut SNFs received, on average, \$282 PPD from Medicaid and say they need an additional \$45 PPD. But a legislature-mandated stop-loss provision capped the inflationary adjustment at \$6.50 per patient per day—one-seventh of what the industry says it needs. While the state's social services budget allows for an additional \$28 million, Connecticut nursing homes, stung by chronic staffing issues and wage pressure, have asked for \$193 million more in aid to help sustain struggling facilities. Lawmakers and advocates aren't exactly opposed, but say they want to see greater transparency on how nursing homes spend the funds. CT Mirror, 01/30/2023

## **Nebraska**

Lawmakers bumped the Medicaid rate by close to 20% last year, followed by 3% this year. McKnight's

## **Wisconsin**

Historic Medicaid increases in the 2021-23 budget will be maintained because they were added to the Wisconsin's rate-setting methodology. The uptick brought the state's direct nursing care component of the rate to 125% of median cost. A similar increase could occur in the next two-year state budget, which could mean a much-needed Medicaid funding infusion of \$55 to \$70 per patient day. McKnight's

## **Washington state LTC tax plan**

For those who do not have their own private LTC insurance, the new LTC payroll tax of 58 cents on every \$100 earned will provide a state-supplied Lifetime Benefit of \$36,500 for long term care needs. Washington State's average annual cost for nursing home care is over \$125,000, and is projected to be over \$225,000 in 20 years. A home health aide for in-home care is almost \$80,000 (44 hours per week) and is projected to cost over \$140,000 in 20 years. With this tax, lawmakers are seeking to shore up the Medicaid program, the country's number one payor of LTC costs.

Following Washington state's lead, several other states are moving to start their own LTC tax programs. California, Michigan, Minnesota, and New York appear the closest to implementing one. Here's a partial list of states considering similar laws: Alaska, Colorado, Hawaii, Illinois, Maine, Missouri, Montana, North Carolina, Oregon, Pennsylvania, and Utah. LTC Insurance Consultants





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# The Marketing Guru: Does the NASEM report offer real change?

Continued from page 3

published in February 2023, and it summarizes:

“The way the United States finances, delivers, and regulates care in nursing home settings is ineffective, inefficient, inequitable, fragmented, and unsustainable. The failings of the US healthcare system regarding nursing homes are reflected in poor resident outcomes, substantial government spending, pervasive inequities, and an underpaid and demoralized workforce.”<sup>2</sup>

From the very promising, authoritative start in February 2020 to February 2023 we have a fundamental repeat of what everyone inside the nursing home sector already knew.

I feel my skepticism returning.

A summary of the domains from this article is:

- Creating a Well-Prepared Workforce
- Transforming Care Delivery
- Improving the Working Conditions for Certified Nursing Assistants
- Improving Payment and Quality
- Advancing Health Information Technology

How could anyone disagree with any of this?

The problem is that we’ve spent three years refining our platitudes, and as far as I can tell we are no closer to changing who gets what, where, when, or how.<sup>3</sup>

Those of us working in long-term care are painfully aware that we have the combined crisis of occupancy, revenue, unavailable labor, declining public confidence, and contracting supply. The path we’re on is not sustainable. The United States can no longer afford to agonize over the sources or root causes of this crisis; these are all too well known. We must consider what’s possible for the sector.<sup>4</sup>

The body of research, typically applied to urban planning, into comparative historical analysis and critical junctures is instructive in understanding what’s possible.<sup>5</sup> We need to look at how institutional change occurs and what’s likely for the long-term care sector.

## Incremental or disruptive?

Based on critical juncture analysis, “... there are two general modes of institutional change: incremental and more or less continuous adjustment and adaptation; and

critical junctures of sudden and transformative change.”<sup>6</sup> For example, the passage of the Social Security Amendments of 1965<sup>7</sup> (SSA) represent a disruptive change at the time. The SSA was drafted to protect the aged, children, and other vulnerable persons from destitution and hardship; a clear and present memory among the legislators and the public at that time. And the institutions and systems that the SSA created have been extremely durable and long lasting, despite the fact that they are now, in many ways, no longer fit for purpose.

The changes we’ve seen since 1965, which effect long term care are incremental changes brought to us through the institutions created by or empowered through the SSA. Considering this type of incremental change, there’s no doubt that LTC will continue to see more accretive regulatory pressure to mandate staffing, control certain prescriptions, master contagion, and mitigate loneliness through regulatory dictates. Are we at the point (or perhaps there) where more incremental change produces no meaningful results?

Unfortunately, the NASEM report and its aftermath looks like “more of the same.”

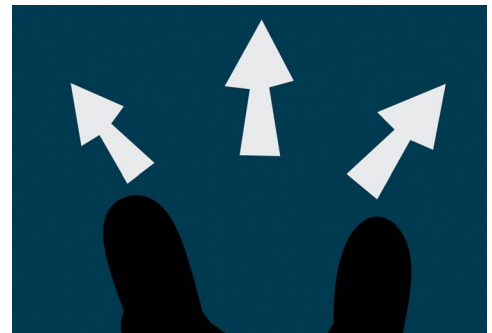
## Are we at a critical juncture?

Critical junctures are types of social, political and economic disruptions, which can occur in relatively brief periods, and where previously stable institutions are transformed and new approaches—new pathways—established. Critical juncture is the point at which the social contract can no longer be fulfilled, available alternatives are reviewed, and choices are made based on the unacceptability of the current situation.

QUESTION: Is the current crisis or the NASEM report enough to prompt substantial changes to:

- How CMS regulates (political);
- How capital is formed and invested in the sector (infrastructure);
- How intermediaries pay for services (economic);
- How the public sees long-term care (social);
- Substantially increase the technologies deployed (technology);
- The body of jurisprudence (legal), and/or;
- Make the sector environmentally more sustainable?

American society overall is racing away from the experience of the pandemic and its related issues is fast as possible. The deaths and failures of our long-term care institutions are already receding from the public



Is this a critical juncture for the industry?

consciousness. The publicly acknowledged inadequacy of the direct care workforce is morphing into labor actions such as strikes and walkouts, shifting the rhetoric away from the underlying inadequacy (demographic, immigration, status & economics) toward less relevant planning topics. One of the critical ingredients to critical junctures (apologies for the play on words) is a widespread acknowledgment that the current institutions aren’t working, and that the publicly identified problem is intractable by the solutions at hand.

The health and social care “systems” in the United States are so extraordinarily fragmented that few understand how to navigate them. So-called cross continuum collaborations are local, uphill battles.<sup>8</sup> Among the best (disruptive) outcomes for nursing homes would be to become fully, federally integrated with other healthcare and social care providers in the US healthcare “system”. This would require a harmonization and rationalization of regulations and legislation, which would truly be disruptive.

Another fundamental fracture in the aging services infrastructure in the US is where care occurs. There are generally two venues: institutions (nursing homes and hospitals), and home. The latter might be an apartment, standalone house, or even an assisted or independent living residence. The public has finally become aware that hospitals are the deadliest places in which to receive care.<sup>9</sup> Most nursing homes were built before the era of Certificate of Need requirements, and they are decades-old and decrepit. What’s needed is a new Hill Burton act to rebuild them.

Inadequacy of the direct care workforce may be another factor leading to a critical juncture. The inadequacy of the direct care workforce has been recognized. The political fixes include; depoliticize regulations around nurse qualifications and bring back nurse and caregiver Visas. Such changes would increase the supply, while relying very heavily upon established institutions to monitor quality and outcomes. The underlying

Continued on next page

# The Marketing Guru

Continued from previous page

ing demographics is like the looming, biggest part of an iceberg beneath the surface of public attention.

## The iceberg & deck chairs

Inadequate workforce, increasingly profiteering, rent-seeking intermediaries, slow adoption of technological efficiencies and inflationary pressures are forcing nursing homes to close, and home health agencies to delay, ration, or decline starting services. While home care agencies are more supply/demand elastic, nursing homes are having a hard time, with many of them on the brink of fiscal collapse ("zombies"). If the current political, economic, social, and legal quagmire isn't enough to bring the sector in the US to a critical juncture, would losing 10, 20 or 30% of our capacity precipitate real change?

Are the NASEM outputs more platitudes or a real change in course? Are we polishing the deck chairs?

If the SNF capacity remains as is, by 2040 based on my estimates, the US will be short 3,000 to 4,000 nursing home beds, and unable to staff 6,000 to 8,000 home care visits. The US is unprepared for this market demand.

As the situation evolves without major change, more nursing home and home health agency capacity will be lost, leading to backed up hospitals, negative political attention, more punitive media attention, and regulatory pressure. Has the NASEM report addressed these?

## Change in the social contract

In considering this environment, the crisis we are in and what's possible, in particular, looking just a little farther down the road, consider the following questions:

- Will baby boomers' children (Generation X and Millennials) accept the maddeningly complicated, fractured means of supply-

ing long-term care to their aging Boomer parents?

- Will they tolerate the erosion of their inheritance, the largest inter-generational wealth transfer in history, to pay for long-term care?
- How will Xers and Millennials respond to declining, unavailable, inadequate, and/or unacceptable supply as they attempt to find support in services in this extraordinarily complex institutional environment?

The signs of this crisis are all around us and even bigger challenges are looming just around the corner. The NASEM report and follow up, while it is impressive, doesn't seem to offer real change. In the past, changes in the social contract, such as the Social Security Amendments of 1965, have occurred at a critical juncture to create new capacity. Those of us working in the sector, while navigating incremental change must be ready with policy alternatives when the opportunity arises for a new social contract in long-term care.

As time goes on, the consequences get worse.

## APPENDIX Seven goals from the NASEM Report

- Goal 1: Deliver Comprehensive, Person-Centered, Equitable Care that Ensures Residents' Health, Quality of Life, and Safety; Promotes Autonomy; and Manages Risks
- Goal 2: Ensure a Well-Prepared, Empowered, and Appropriately Compensated Workforce
- Goal 3: Increase Transparency and Accountability of Finances, Operations, and Ownership
- Goal 4: Create a More Rational and Robust Financing System
- Goal 5: Design a More Ef-

fective and Responsive System of Quality Assurance

- Goal 6: Expand and Enhance Quality Measurement and Continuous Quality Improvement
- Goal 7: Adopt Health Information Technology in All Nursing Homes

<sup>1</sup> KFF – See: <https://www.kff.org/policy-watch/over-200000-residents-and-staff-in-long-term-care-facilities-have-died-from-covid-19/>

<sup>2</sup> ravers, JL, et al, 2022 NASEM Quality of Nursing Home Report: Moving Recommendations to Action, Public Policy & Aging Report, Volume 33, Issue Supplement\_1, 2023, Pages S1-S4, <https://doi.org/10.1093/ppar/prac039>

<sup>3</sup> As I write this article, I have transferred my in-laws from a hospital in PA into a nursing home in NJ, and I can assure you that very little has changed in the past 38 years

<sup>4</sup> If the reader would like to go over some of these precipitating factors, please see: Fatal Contraction: Healthcare Adjusts to a Shrinking LTC Sector, <https://bit.ly/3iNb6e0>.

<sup>5</sup> Sorensen, A. Taking critical junctures seriously: theory and method for causal analysis of rapid institutional change, Planning Perspectives. 2022

<sup>6</sup> David, "Clio and the Economics of QWERTY"; Pearson, Politics and Time

<sup>7</sup> <https://www.ssa.gov/policy/docs/ssb/v28n9/v28n9p3.pdf>

IS IT TIME  
FOR A NEW  
SOCIAL CONTRACT  
IN LTC?

<sup>6</sup> See: Bridging the Divide: Transitions to Cross-Continuum Collaborations in Healthcare: <https://stackpoleassociates.com/transitions-cross-continuum-collaborations-healthcare/>

<sup>9</sup> The pandemic has raised public awareness regarding the rapid rate of contagion within all institutions, hospitals included. The public seems generally unaware, however that iatrogenic deaths in hospitals are routinely over 200,000 per year making hospitals far deadlier by almost any measure than nursing homes.

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