CAHCF/CCAL

Connecticut Association of Health Care Facilities
Connecticut Center for Assisted Living

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Testimony of Matt Barrett, President and CEO of the Connecticut Association of Health Care Facilities / Connecticut Center For Assisted Living (CAHCF/CCAL):

H.B. No. 6577 (RAISED) AN ACT CONCERNING LONG-TERM CARE INSURANCE PREMIUM RATES

H.B. No. 6678 (RAISED) AN ACT CONCERNING NURSING HOME TRANSPARENCY; and

S.B. No. 1026 (RAISED) AN ACT CONCERNING NURSING HOME STAFFING RATIOS.

Good afternoon Senator Hochadel, Representative Garibay and to the distinguished members of the Aging Committee. My name is Matt Barrett. I am President and CEO of the Connecticut Association of Health Care Facilities / Connecticut Center For Assisted Living (CAHCF/CCAL). CAHCF/CCAL is a one hundred and fifty member trade association of skilled nursing facilities and assisted living communities. Thank you for this opportunity to submit testimony on several bills on today's public hearing agenda.

H.B. No. 6577 (RAISED) AN ACT CONCERNING LONG-TERM CARE INSURANCE PREMIUM RATES.

We offer our strong support for the provisions in H.B. No. 6577 that would allow an income tax deduction for long-term care insurance premiums. Connecticut's Partnership for Long Term Care has for many year's encouraged the private purchasing of long term care insurance with Medicaid asset protection incentives. Adoption of a state tax incentive for doing the same will further encourage the private purchasing of long-term care insurance policies.

It has been a longstanding recommendation of our state's Long-Term Care Planning Committee's Long-Term Services and Supports Plan, most recently issued in 2022, entitled "Balancing the System: Working Toward Real Choice for Long-Term Services and Supports in Connecticut" A Report to the Connecticut General Assembly, January 2022 that our state must … "Increase the proportion of costs for long-term services and supports covered by private insurance

and other dedicated sources of private funds because doing so would reduce the burden both on Medicaid and on individuals' out-of-pocket expenses for the cost of long term care in home and community based settings, in assisted living communities, and in skilled nursing facilities. See Goal #2, Balancing the ratio of public and private resources.https://portal.ct.gov/-/media/OPM/HHS/LTC_Planning_Committee/2022-LTSS-Plan_FINAL_Submission.pdf /

According to the 2022 report, national spending from private long-term care insurance and other public sources (State and local programs) for nursing facilities and home health services represented 20 percent of LTSS (long term service and supports) expenditures in 2021 noting that LTSS is one of the most complex and difficult issues for individuals and families to understand and discuss. Many people are under the false impression that Medicare, and other health insurance programs, will cover their LTSS needs. Further, the report notes, this misunderstanding, coupled with the fact that most individuals would rather not face, or discuss, the possibility of becoming disabled and dependent, leads most people to do little or no planning for their future LTSS costs. The lack of Medicare and health insurance coverage for LTSS, combined with the lack of planning, has created a LTSS financing system that is overly reliant on the Medicaid program. Medicaid, by default, at the taxpayer's expense, has become the primary public program for LTSS. In 2022, $3.5 billion was spent in Medicaid home and community-based care (52% of the expenditures) and institutional care (42%).

PROPORTION OF CONNECTICUT MEDICAID EXPENDITURES FOR LONG-TERM CARE OVER TIME

SFY	Home & Community Care	Institutional Care	Total LTC Medicaid Expenditures	Total Medicaid Expenditures	Percentage of Total Medicaid Expenditures for LTC
2003	31%	69%	$1,914,273,731	$3,406,301,048	56%
2004	33%	67%	$1,955,406,395	$3,541,153,371	55%
2005	35%	65%	$1,977,418,433	$3,715,210,091	53%
2006 [a]	32%	68%	$2,227,237,142	$4,003,243,481	56%
2007	33%	67%	$2,299,133,950	$4,016,531,371	57%
2008	33%	67%	$2,403,524,813	$4,361,642,828	55%
2009 [b]	35%	65%	$2,499,416,752	$5,481,108,439	46%
2010 [c, d]	38%	62%	$2,586,673,481	$5,120,011,692	51%
2011	40%	60%	$2,695,265,598	$5,764,332,014	47%
2012	41%	59%	$2,770,265,028	$5,932,580,102	47%
2013	43%	57%	$2,894,062,447	$6,230,395,960	46%
2014 [e]	45%	55%	$2,876,616,284	$6,880,327,373	42%
2015	45%	55%	$2,889,022,951	$7,167,438,562	40%
2016 [f]	49%	51%	$3,063,784,905	$7,424,270,721	41%
2017 [g]	50%	50%	$3,214,941,505	$7,521,804,316	43%
2018	53%	47%	$3,259,286,335	$7,740,843,361	42%
2019	52%	48%	$3,203,349,467	$7,947,891,454	40%
2020	54%	46%	$3,384,915,173	$8,140,654,231	42%
2021	60%	40%	$3,343,831,401	$8,585,047,917	39%
2022	58%	42%	$3,510,263,264	$9,107,625,844	39%

SOURCE: Long-Term Care Planning Committee's annual report on the number of persons receiving long-term services and supports in the community and the number of persons receiving long-term services and supports in institutions. Office of Policy and Management, December 22, 2022

Further, in order to access Medicaid, individuals must first impoverish themselves. Therefore, the report notes that Connecticut has a system that requires individuals to spend all their savings first in order to receive government support for their ongoing needs and that our state needs a better balance between public and private resources. The report concludes that: "An over reliance on the Medicaid program as the primary source for LTSS financing threatens to reduce choices as budget pressures will only mount as the need for LTSS increases. Resources such as insurance benefits and other dedicated sources of private LTSS funding (i.e., reverse annuity mortgages) are needed to help balance the ratio of public and private funds in the system."

For these reasons, we urge adoption of this measure. Finally, if the state fiscal impact in the form of a revenue loss is the reason that this proposal hasn't achieve final passage in previous sessions of the Connecticut General Assembly, perhaps including a statutory sunset provision at the end of the SFY 24/25 biennial budget period could be added to the bill along with a fiscal impact and report from the Department of Revenue Services, in consultation from the Insurance Department and the state Medicaid agency (the Department of Social Services), to inform the question of the sustainability of the state revenue loss against the potential reduction in state Medicaid expenditures beyond SFY 25.

H.B. No. 6678 (RAISED) AN ACT CONCERNING NURSING HOME TRANSPARENCY.

Our CAHCF testimony presented today on these provisions is the same that was presented on Section 6 and 7 of S.B. No. 989 at the joint Human Services Committee and Aging Committee public hearing held on February 16, 2023"

"S.B. No. 989 (RAISED) AN ACT CONCERNING NURSING HOMES.

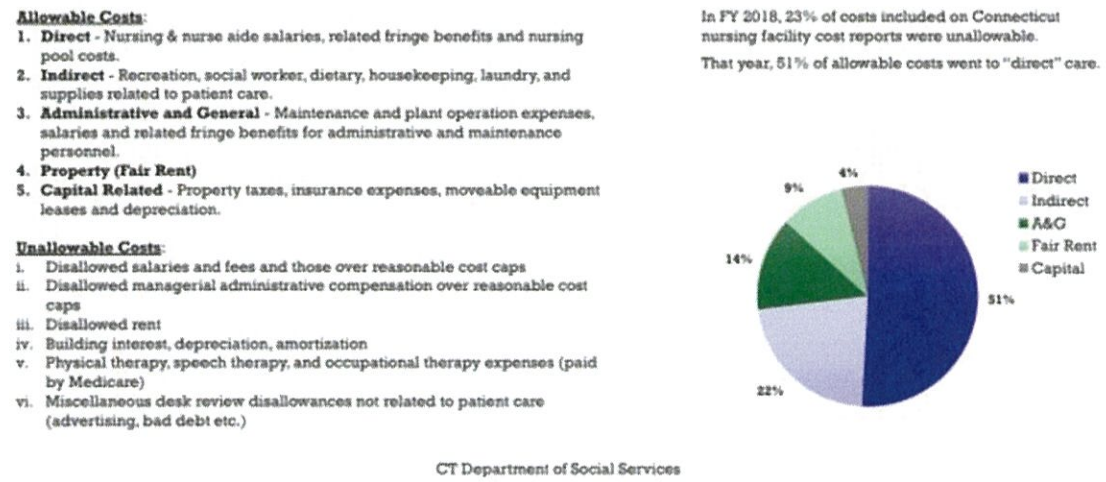
Section 6.

This provision, beginning with the cost report year ending on September 30, 2023, would require annual nursing homes submit summaries of nursing facility Medicaid expenditures in addition to the annual cost reports requirements. The summaries must include the percentage of Medicaid funding allocated to the five cost components of rate allowable costs and include expenditures for each allowable cost component by the nursing home and any related party.

The bill also requires the Commissioner of Social Services to post in a conspicuous area on the department's Internet web site a link to (1) the annual cost reports and the summaries provided by each nursing home facility, (2) comparisons between individual nursing homes by expenditures, and (3) a summary of the average reported expenditures by facility for each category. Further, the bill requires cost report forms utilized by the department to include a glossary and explanation of the terms used and a description of the categories being reported on, including, but not limited to, plain language explanation of formulas used to determine maximum costs for the five allowable

cost components in the rates. Violations of these requirements include a fine of not more than ten thousand dollars for each incident of noncompliance.

The information from which the summaries and comparisons that would be required in this bill is now being reported and maintained at DSS and is summarized and presented in the chart below from a DSS presentation to the Medical Assistance Program Oversight Council (MAPOC) October 2023 meeting and also included in the Leading Age Connecticut and CAHCF/CCAL presentation on Nursing Home Medicaid Reimbursement presentation dated February 10, 2023 to the Appropriations and Human Services Committee.



It would be more efficient and presented in a uniform format if the summaries, comparisons, and explanation of terms could be developed or programmed on the DSS website from the data and reports now in the DSS files and currently on the agency website, rather than individually prepared by each nursing home.

Section 7.

Section 7 of the bill would require under DPH licensure law that if a private equity fund owns any portion of the business, the name of the fund's investment advisor and a copy of the most recent quarterly statement provided to the private fund's investors, including information regarding fees, expenses and performance of the fund. Current licensure rules now require, among other things, disclosure of the name and business address of the owner and a statement of whether the owner is an individual, partnership, corporation or other legal entity; and the names of the officers,

directors, trustees, or managing and general partners of the owner, the names of persons having a ten per cent or greater ownership interest in the owner, and a description of each such person's occupation with the owner; and if the owner is a corporation which is incorporated in another state, a certificate of good standing from the secretary of state of the state of incorporation. The bill would also require in this process audited and certified financial statements of the owner, including a balance sheet as of the end of the most recent fiscal year, and income statements for the most recent fiscal year of the owner or such shorter period of time as the owner shall have been in existence.

We are urging the committees to carefully evaluate the Biden Administration "Disclosure of Ownership and Additional Disclosable Parties Information for Skilled Nursing Facilities" proposed federal rules announced just this week, and the federal rule making comment period that could inform in much more detail the extent to which additional state rules should be needed. The proposed rules announced this week reflect a comprehensive federal ownership and private equity fund disclosures that follow the now implemented greater ownership transparency public reporting that began the September 2023 publicly posting of nursing home ownership data, including percentage of ownership on the ownership section of Care Compare on the Medicare.gov website: https://www.medicare.gov/care-compare/?providerType=NursingHome&redirect=true

This level of ownership detail is now available on the Medicare website, Connecticut's state level rules have been very progressive on ownership reporting for years with state nursing home licensure requirements already including detailed ownership information, such as whether the owner is an individual, partnership, corporation or other legal entity. Similar state level ownership reporting has longstanding been required under state Medicaid cost reporting rules.

Operators are open to improved transparency, but focus and attention should also be on the extraordinary strain and instability the now three-year's long COVID-19 public health emergency has caused on the staff, operators, and residents who work and live in Connecticut's 205 skilled nursing facilities. This nursing home community continues to face severe staffing shortages, ravaging inflation and higher costs requiring recognition and support from state policy makers." We are urging lawmakers to carefully consider the Connecticut specific transparency rules now on the books and to be cautious about passing more state level transparency requirements in advance of the comprehensive proposed federal rules just announced this week. Finally, noting that audited and certified financial statements are not currently required by the state or Medicare, CAHCF preliminarily estimates that these enhanced requires would additionally cost nursing homes between $15,000 and $30,000 per facility."

S.B. No. 1026 (RAISED) AN ACT CONCERNING NURSING HOME STAFFING RATIOS.

Once more, our CAHCF testimony on these provisions is the same that was presented on Section 9 and 10 of S.B. No. 989 at the joint Human Services Committee and Aging Committee public hearing held on February 16, 2023, however please see attached to this testimony an

analysis from the *Center for Health Policy Evaluation in Long Term Care, "Estimating the Cost of Minimum Staffing Ratios in Connecticut Nursing Homes,* requested in 2021 to estimate the number or additional RN, LPN and CNA and the associated fiscal impact of the 4.1 minimum staffing mandated proposed in CT in 2021 in SB 1057 considered in the 2021 session. This session's proposals in SB 989 and SB 1026 are exactly the same as proposed in SB 1057 in CT in 2021: .75 for RN, .54 for LPN and 2.81 for CNA.

"Providers are already doing everything they can to recruit and retain staff with the resources they have. Unfortunately, similar to concerns being expressed by providers across the nation, an expanded staffing mandate simply will not work because the workers are just not available for hire. The staffing shortage is even worse than it was in 2021 when Connecticut's state legislature directed new state regulations to significantly increase staffing minimums for direct care staff to 3.0 hours per patient per day. Today many nursing homes will have challenges even meeting the 3.0 requirement, let alone going to 4.1 as proposed this session. We would welcome the opportunity to assist in developing estimates on the number of new positions that would be needed for compliance and the associated costs.

Also, jobs reports show that nursing homes have lost more workers since the start of the pandemic and despite every effort to hire more staff, provider are making little progress at

recruiting new staff in the current environment. More fines or penalties for failing to meet a new and unachievable staffing mandate will simply further the financial instability that skilled nursing home are now experiencing.

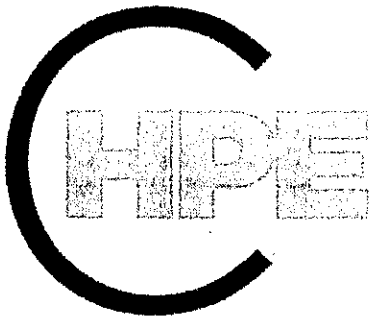
Connecticut's skilled nursing facilities have the same goal as lawmakers have to increase in staff. Operators are urging Connecticut lawmakers to minimally await the findings of a national study and anticipated federal rules on nursing home staffing levels now being conducted by the Biden administration and expected to be released as early as May 2023 that could have the effect of superseding any state staffing minimums. Operators are also urging a more reasonable approach at both the state and federal levels to increasing staffing that includes a phase-in of any new requirements to a time when staff may be available, sufficient new Medicaid resources to pay for the staff, including the full range of staff that are providing direct care beyond RN, LPN and CNA positions and counting total nursing and nurse aid direct care hours from the licensed and certified staff providing direct care, and reasonable waiver provisions when government data indicates an insufficient supply of workers to meet the mandate.

Finally, the provision imposing fines within 7 days without the opportunity for appeal is improper."

Thank you.

For additional information on this testimony, please contact Matt Barrett, President and CEO of CAHCF/CCAL, at mbarrett@cahcf.org.

Attachment: Center for Health Policy Evaluation in Long Term Care, "Estimating the Cost of Minimum Staffing Ratios in Connecticut Nursing Homes. Feb 12, 2021.



THE CENTER FOR
HEALTH POLICY EVALUATION
IN LONG-TERM CARE

Estimating the Cost of Minimum Staffing Ratios in Connecticut Nursing Homes

Prepared by
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Feb 12, 2021

Executive Summary

Minimum staffing levels are proposed as a means to improve nursing home quality. Connecticut is currently considering creating minimum nurse staffing to resident thresholds in nursing homes (RN HPRD = 0.75, LPN HPRD = 0.54, and CNA HPRD = 2.81) for a Total Nursing Staffing HPRD of 4.1. In this report we characterized the facilities currently below this threshold and calculated the number of additional staff and labor costs needed to achieve the proposed minimum staffing. We used staffing levels collected by the Center for Medicare and Medicaid Census (CMS) from nursing home payroll data. To estimate total labor costs, we used average state labor costs, fringe benefits, and payroll tax rates.

Based on Q3 2020 staffing data, 181 (88.7%) of nursing homes in Connecticut are below the proposed minimum staffing threshold. The analysis was repeated using pre-COVID Q4 2019 staffing census data. Under pre-COVID conditions, the number of nursing homes below the minimum staffing threshold rose to 199 (97.5%). A big driver for this increase was a higher census pre-COVID. The average Connecticut nursing home census in Q4 2019 was 104 compared to 86 in Q3 2020. This is a 17% decline, which exceeds the national average decline of 14%.

On average, Connecticut nursing homes below the staffing threshold are larger and have more Medicaid residents than the others. Their November 2020 Five-Star ratings were on average lower.

For Connecticut to implement minimum staffing ratios, we estimate it will require between 1,793-3,364 FTEs and cost $140.9-$273.9 million dollars. The exact figure will depend on resident census.

To get the current 181 nursing homes above the proposed minimum staffing threshold, 1,793 FTEs would be needed statewide at a total annual cost of $140.9 million, including fringe benefits and payroll taxes. CNAs make up most of the needed FTEs (1,426) and cost ($95.0 million). This assumes census stays the same as it is now, which is much lower than before the COVID pandemic.

To estimate the costs when census increases, our simulation was repeated using pre-COVID-19 Q4 2019 PBJ staffing census data. In this analysis, the number of nursing homes below the minimum threshold rose to 199 (97.5%). Also increasing were the number of needed FTEs (3,364) and costs ($273.9 million) to meet the minimum staffing.

Finding individuals to fill the positions will be the most challenging aspect of implementing a minimum staffing threshold. Nursing homes must compete with hospitals and others for a workforce that was in shortage before COVID and has been dwindling since.

Background

The relationship between nursing home staffing and resident quality is multifaceted. For staffing to have an impact on resident quality it requires both having the staff and ensuring they are trained properly and work well together to provide coordinated patient-centered care.

Policymakers and regulators have a challenging responsibility to incentivize and ensure both quantity and quality of staff through various means at various levels. This can range from investing in local nurse training programs to revoking individual nurse licenses when deliberate acts of patient abuse and neglect occur.

Among nursing homes, more attention has been paid to quantity, rather than quality, of staff in large part because it is easier to measure and monitor quantity. Measurements for staff quantity, such as hours per resident day or ratio of staff to residents, are gathered through employment data and publicly reported by the federal government. Measuring staff quality is more difficult. The most often used proxy for staff quality is staff retention and turnover. High retention and low turnover are theorized to reflect staff capable of performing their responsibilities and working well with each other because otherwise they would either be fired or seek employment elsewhere.

Both quantity and low turnover of nursing home staff have been found to be associated with higher resident quality. Castle, et al. found reducing nursing home turnover was associated with better performance on publicly reported quality metrics.[1] Castle estimates the rate of turnover for nursing home nurses to be around 40%.[2] There is no public reporting of nurse turnover, like there is for quantity of nurse staffing through Payroll-Based Journal (PBJ) required federally by the Centers for Medicaid and Medicare Services (CMS).[3]

With the current COVID pandemic, quantity of staffing has been a focus as COVID has had a devastating impact with over 100,000 deaths and approximately 40% of COVID deaths associated with long-term care facilities, which is a broader category than nursing homes alone and includes assisted living, independent living, among others.[4]

Several studies have found cases of COVID in the community to be the biggest driver of COVID cases from occurring in a nursing home, regardless of Five-Star Ratings or prior survey compliance.[5, 6] Some of these studies have found an association between quantity of staffing and limiting spread.[5, 7] It has been theorized that with higher staffing, nursing homes can better adhere to consistent assignments and reduce the risk of spreading cases between patients. Currently, there have been no studies on the quality of staffing and the relationship to preventing or minimizing COVID.

In an effort to mitigate COVID in nursing homes, some state policymakers and U.S. Congress are considering requiring minimum staffing levels. Minimum staffing levels currently vary by state across the country. Studies looking at the impact of minimum staffing on quality in general have shown mixed results with quality improving slightly

but also substitution of staffing occurring.[8-10] Substitution examples include more CNAs in lieu of RNs or decreases in ancillary staff (e.g. housekeeping and dietary) when clinical staff levels are increased.

At both the state and federal level, efforts to increase minimum staffing levels face two implementation challenges. The first is having enough people to fill the positions. The second is the financial cost of employing more people.

The COVID pandemic has exacerbated a pre-existing health care workforce shortage. Health care staff from all sectors, including hospitals, nursing homes, and home health, are burnt out and worried about contracting COVID and spreading it to their families and loved ones.[11, 12] Regardless of how much a provider can pay them, some qualified people will turn down the job.

The costs associated to recruit and retain additional staff may be challenging for nursing homes. According to the latest data from MedPAC, the average total margin for nursing homes in the nation dropped to -0.3% in 2018.[13] Because Medicare reimburses at a higher rate than Medicaid, many nursing homes struggle to find a mix of Medicare and Medicaid patients to make financial ends meet.

As policymakers continue to consider establishing or raising minimum staffing levels for nursing homes, it will be important for them to fully understand the two potential barriers of available staff and cost.

In 2021, the Connecticut General Assembly is considering requiring minimum nurse staffing ratios for nursing homes (See Table 1). To provide a model for what policy makers should consider, this analysis looks to quantify what such a policy would mean in terms of staff needed, as well as the financial cost, for Connecticut.

Table 1: Proposed Minimum Nurse Staffing and Hours Per Resident Day for Connecticut Nursing Homes

Nursing Type	HPRD
RN	0.75
LPN	0.54
CNA	2.81
Total (RN + LPN + CNA)	4.1

Method

On a quarterly basis, nursing homes are required to submit daily payroll data on staffing data to the Centers for Medicaid and Medicare Services (CMS), the federal regulatory agency of nursing homes. CMS uses this Payroll-Based Journal (PBJ) staffing data to calculate Registered Nurse (RN), Licensed Practical Nurse (LPN), Certified Nursing Assistants (CNA), and total nurse (RN + LPN + CNA) staffing hours per resident day (HPRD) and Five-Star Staffing Ratings.

For this report, we categorized nursing homes in Connecticut using PBJ staffing data from Q3 2020 as below the RN, LPN, or CNA threshold or above them. Facility characteristics, such as bed size and ownership, and Five-Star Ratings were compared between the two groups.

For nursing homes below either minimum HPRD threshold, simulations were created to get them above both minimum staffing thresholds. In other words, if a nursing home was above the RN and LPN threshold but below the CNA threshold, only CNA staffing was increased in the simulation. For nursing homes below the RN and LPN HPRD threshold, both RN and LPN staffing were increased to maintain the same ratio in the simulation till the minimum threshold was met.

To determine annual salary costs, the average Connecticut per hour wages from CMS's 2019 wage index were used. For CNAs this was $20.07/hour, LPNs was $29.89/hour, and RNs was $44.72. To provide a more complete picture of labor costs, we calculated fringe benefits and payroll tax. We applied an average 20% fringe benefit costs to the annual salary costs for each additional staff. Payroll tax assumed 1.45% for Medicare, 6.2% for Social Security, 0.96% for federal unemployment insurance, and state unemployment insurance 0.72%.

During the pandemic, census has dropped nationally over 14%. Fewer admissions to nursing homes has been driven by fewer elderly receiving hospital care that needs post-acute care (e.g. cancelling of elective surgeries), family's reluctance to use nursing homes while they have been at home out of work or teleworking, or facilities have been closed to admissions because of COVID-19 outbreaks.

The cost to meet a minimum staffing will vary depending on the census of a facility. We calculated the costs based on the current census but also for the census prior to the COVID-19 pandemic, since census will increase once the COVID vaccine rollout has helped curb the pandemic. Thus, as a sensitivity analysis, the analysis was repeated using PBJ staffing data from Q4 2019, before the COVID pandemic.

Results

Based on Q3 2020 PBJ staffing data, 181 (88.7%) of nursing homes in Connecticut are below either RN = 0.75, LPN = 0.54, or CNA = 2.81 hours per resident day (HPRD). On average, these facilities are larger and have more Medicaid residents than the other 23 (11.3%) nursing homes in Connecticut. A higher proportion of them are also For-Profit and rural (See Table 2).

As for November 2020 Five-Star ratings, the nursing homes below either HPRD threshold have on average lower overall, survey, quality, and staffing ratings, but the difference is smallest among quality ratings (See Table 2).

Table 2: Characteristics and Five-Star Ratings of Connecticut Nursing Homes Above and Below Proposed Minimum Staffing Ratios (Q3 2020)

	Below RN = 0.75, LPN = 0.54, AND CNA = 2.81 HPRD	Above RN = 0.75, LPN = 0.54, AND CNA = 2.81 HPRD
Number of SNFs	181 (89%)	23 (11%)
Bed Size (Average)	123	97
Ownership		
Non-Profit	25 (74%)	9 (26%)
For-Profit	155 (92%)	13 (7%)
Government	1 (50%)	1 (50%)
Rural	11 (92%)	1 (8%)
Percent Medicaid (Average)	69%	44%
Five-Star Ratings (Nov 2020 Average)		
Overall	3.44	4.64
Survey	2.76	3.73
Quality	4.13	4.41
Staffing	3.57	4.70

To get the 135 nursing homes above the RN, LPN, and CNA thresholds, 1,793 FTEs would be needed statewide at a total annual cost of $140.1 million, including fringe benefits and payroll taxes. CNAs make up most of the needed FTEs (1,426) and cost ($95.0 million). (See Table 3). This assumes census stays the same as it is now, which is much lower than pre-COVID-19.

Table 3: Staff and Cost Estimates for Achieving Minimum Staffing Ratios Using Q3 2020 PBJ Staffing Data

Nurse Type	Daily Hours Needed	FTE Needed	Annual Salary Cost Increase	Annual Fringe Benefit Cost Increase	Annual Payroll Tax Cost Increase	Total Annual Cost Increase
RN	2,064	334	$33,684,415.45	$6,736,883.09	$3,142,755.96	$43,564,054.50
LPN	167	33	$1,818,133.16	$363,626.63	$169,631.82	$2,351,391.62
CNA	10,032	1,426	$73,485,055.08	$14,697,011.02	$6,856,155.64	$95,038,221.74
Total	**12,263**	**1,793**	**$108,987,603.69**	**$21,797,520.74**	**$10,168,543.42**	**$140,953,667.86**

Note: Hourly wages used $44.72 for RN, $29.89 for LPN, and $20.07 for CNA. This table reflects getting 181 nursing homes to RN = 0.75, LPN = 0.54, and CNA = 2.81 HPRD. FTE = Full Time Equivalent.

To understand the cost to Connecticut when census returns to pre-COVID-19 levels, we conducted a sensitivity analysis to understand the possible range in costs of setting minimum staffing ratios that translate the above staffing hours per resident day. Our simulation was repeated using pre-COVID-19 Q4 2019 PBJ staffing data. Using this pre-COVID pandemic data, the number of nursing homes below either HPRD threshold rose to 176 (86%).

A big driver for this increase was a higher census. The average Connecticut nursing home census in Q4 2019 104 compared to 86 in Q3 2020. This is a 17% decline.

In pre-COVID times and using Q4 2019 PBJ staffing data, it is more costly to get the Connecticut's nursing homes above RN, LPN, and CNA thresholds. A total of 3,364 FTEs would be needed at a total annual cost of $273.9 million, including fringe benefits and payroll taxes. Similar to the analysis using Q3 2020 staffing data, CNAs are the majority of the FTEs needed (2,694) and costs ($184.3 million). (See Table 4).

Table 4: Staff and Cost Estimates for Achieving Minimum Staffing Ratios Using Q4 2019 (Pre-COVID) PBJ Staffing Data

Nurse Type	Daily Hours Needed	FTE Needed	Annual Salary Cost Increase	Annual Fringe Benefit Cost Increase	Annual Payroll Tax Cost Increase	Total Annual Cost Increase
RN	4,023	608	$65,664,703.70	$13,132,940.74	$6,126,516.86	$84,924,161.30
LPN	332	62	$3,617,129.22	$723,425.84	$337,478.16	$4,678,033.22
CNA	19,454	2,694	$142,503,987.45	$28,500,779.49	$13,295,613.63	$184,300,290.58
Total	**23,809**	**3,364**	**$211,785,730.37**	**$42,357,146.07**	**$19,759,608.64**	**$273,902,485.09**

Note: Hourly wages used $44.72 for RN, $29.89 for LPN, and $20.07 for CNA. This table reflects getting 199 nursing homes to RN = 0.75, LPN = 0.54, and CNA = 2.81 HPRD. FTE = Full Time Equivalent.

Discussion

For Connecticut to implement shift-level minimum nursing home staffing ratios, we estimate it will require between 1,793-3,364 FTEs and cost $140.9-$273.9 million dollars. The exact figure will depend on resident census.

This is a good time to mention that in order to monitor and enforce shift-level minimum staffing ratios, nursing homes and state regulators may have to invest in additional reporting systems above what has already been setup at the federal level through CMS's Payroll-Based Journal (PBJ). For nursing homes, that could involve using staff's time to track and report hours as opposed to providing care to residents.

Finding individuals to fill the positions will be the most challenging aspect of implementing a minimum staffing threshold. Nursing homes must compete with hospitals and others for a workforce that was in shortage before COVID and has been dwindling since.

To alleviate the staff shortage, policy makers should consider efforts to increase the supply. Such actions could include investing in more training programs or reducing barriers for such training programs to exist. CNA training programs often are limited by the federal policy on what facilities can and cannot provide onsite training. Local community colleges could be incentivized to expand their CNA training.

Another option for increasing supply is to incentivize workers to switch jobs and enter the industry. Often this involves providing higher wages. For example, hospitality and gig economy workers could be trained fairly quickly to become CNAs, but if the CNA pay is worse than their current source of income, they have little incentive to pursue it.

States may also have to look to attract workforce from other states. State authorities could review and revise state licensure requirements to allow easier transfer of licenses from other states. For example, COMPACT states for RN licensure make it easier to attract RNs from other states.

By themselves, Connecticut nursing homes are highly unlikely to be able to cover the costs associated with minimum staffing ratios. The average nursing home in the nation operates at a negative total margin. Nursing homes often need the higher Medicare reimbursement rates to offset low Medicaid reimbursement rates. Our analysis found the Connecticut nursing homes below the minimum staffing threshold to be caring for a larger proportion of Medicaid residents. Thus, it could be challenging for them to find additional Medicare revenue to cover the costs of higher staffing without sacrificing care to vulnerable residents on Medicaid.

References

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