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To: Leadership of WAMD, The Wisconsin Society for Post-Acute and Long-Term Care
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First of all, thank you for seeking our input. The challenges of today eclipse those of the past and we've hit the critical convergence of the workforce crisis, the pandemic, and historic underfunding of our long-term care system, especially compared to other sectors. Thus, all reasonable strategies should be pursued for the benefit of those we serve.

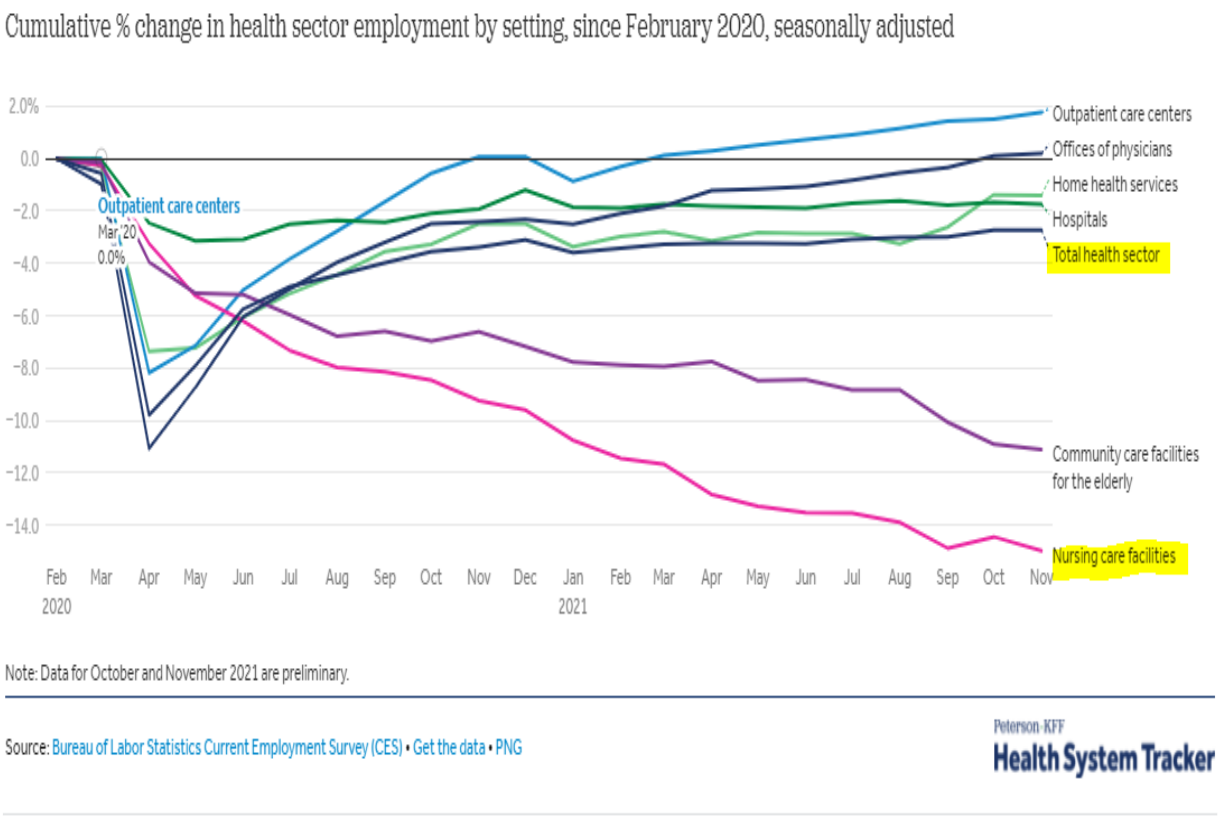
Background and Perspective—Workforce, Budget Pressures and Bed Access

I'd like to offer some additional comments and perspectives and then suggest additional steps to be taken.

Earlier this month I shared with DHS some data and reports that highlight the workforce challenge, particularly for the LTC sector. The recent **Kaiser Foundation report** graphically highlights what was presented in our earlier report to DHS documenting the continued and worsening workforce challenge facing our long-term care provider community. The Kaiser report underscores the reality that we need to act now to protect the current level of access to nursing home care and pursue additional initiatives, if we have any hope of achieving the nursing home access we had prior to the pandemic.

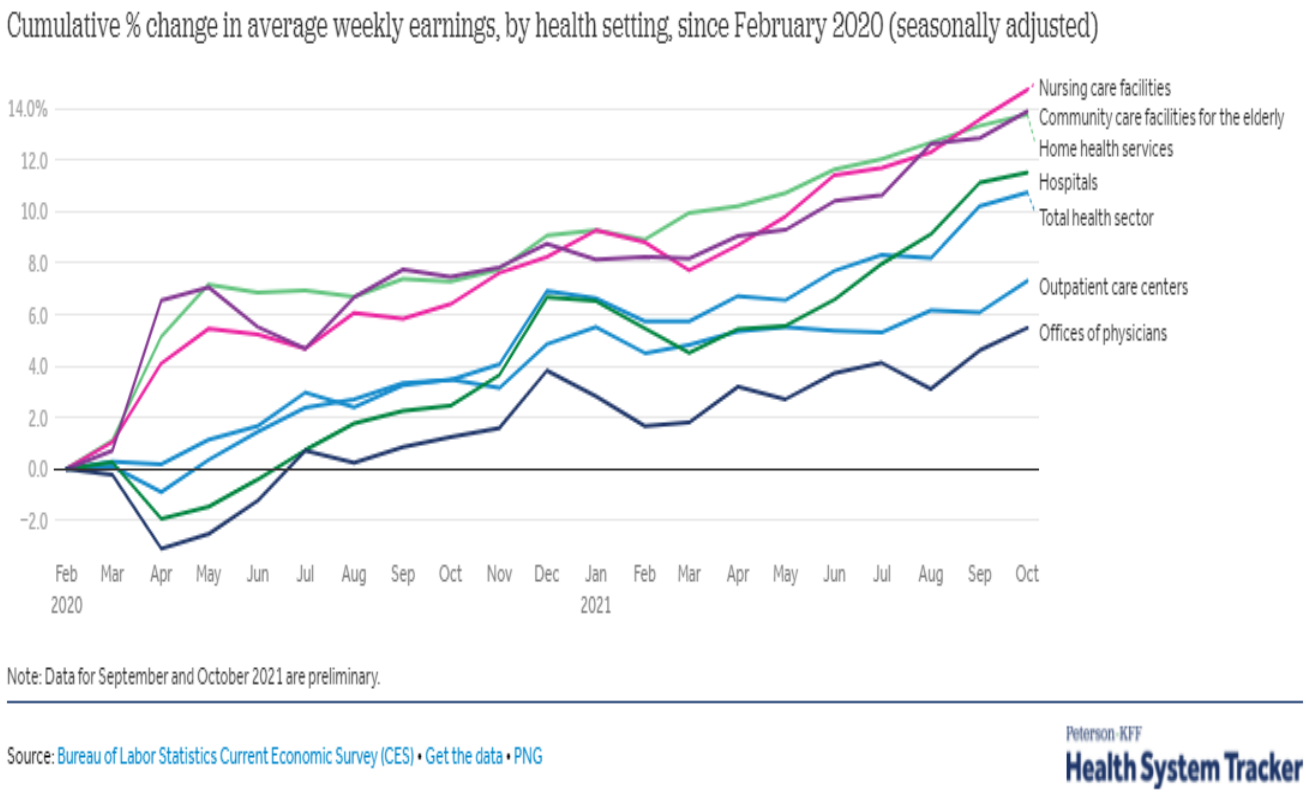
How bad is staffing and aren't all healthcare sectors having staffing challenges?

The graph below illustrates that overall healthcare employment is down since the pandemic began, but this is due in large part to the continued decline of workers in our *long-term care facilities*:



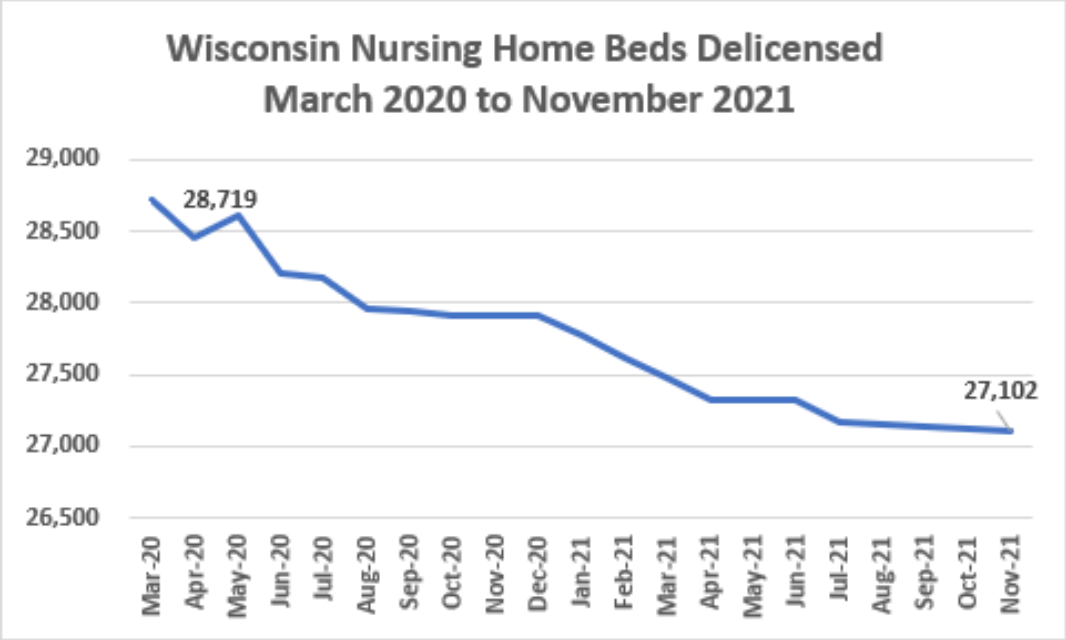
These staffing declines are on top of the pre-pandemic staffing challenges (23% caregiver vacancy rate: see **2020 Workforce Crisis Report**).

Some have asked what nursing homes did with the federal CARES Act funding (last provided in 2020) by the State of Wisconsin, the last allocation occurring in December of that year. The short answer is, those dollars were spent months ago. As noted by the Kaiser Foundation, nationally, long-term care organizations have given the largest increases to wages compared to other health care sectors. From the linked **article**: "***The upward trend in average health sector wages has been unequally distributed among health settings. Nursing home and elder care facility employees have seen the largest drop in employment in the aftermath of the pandemic; they have also seen the highest average wage increases. Among nursing home employees, average earnings rose by over 14.7% between February 2020 and October 2021***." *(Emphasis added):*



Overall, wages in the health sector have risen by 10.8% since the pandemic began. This overall 10.8% figure is higher that it would be otherwise because it reflects the 14.7% increase in wage increases that nursing care facilities have committed to their staff since the start of pandemic. Further, members have indicated their escalating operating cost increases, coupled with revenue declines resulting from their inability (or their reduced ability) to admit new residents, have severely eroded the expected results of the significant Medicaid budget increases provided to nursing homes by the Governor and Legislature via the 2021-2023 State Budget. And, as you may be aware, prior to passage of the State Budget, the Wisconsin nursing home reimbursement system was one of the very worst in the country, relative to paying for the actual cost of care. So, despite these investments, many facilities are trending water, at best.

With nursing homes facing mounting staffing and financial challenges, many facilities have been forced to downsize their operations, with a few facilities forced to close during the pandemic (see attached list). The following graph shows the loss of Wisconsin licensed nursing home beds:



	Beds Closed	Equivalent number of 70-bed facilities Closed
Beds Closed During COVID+ (since March 2020)	1,617	23.1
Beds Closed Last 12 months	812	11.6
Beds Closed Since 1-1-21 (thru Nov.)	667	9.5

As referenced above, since the start of the pandemic, over 1,600 nursing home beds have been erased from the system, the equivalent of twenty-three 70-bed nursing homes, primarily because organizations were unable to fill these beds due the lack of staff (It is troubling that organizations are delicensing nursing home beds at a time when nursing home placements are so necessary and hospitals are in desperate need of nursing home access to relieve their overcrowding.

All of the above provides documentation as to why nursing facilities are unable to admit more residents than currently is the case. ***They are simply and quite clearly unable to admit individuals for whom they have no staff available to provide the necessary and required resident care and services. Further, it is important to note that nursing facilities are prohibited by State and federal regulations from admitting persons if the facility knows it will not be able to meet their residents' care and service needs.*** Violating these regulations could (highly likely) subject the facility to a variety of possible punitive actions, including substantial civil money penalties (CMPs), denial of payments for new admissions, loss of their nurse aide training programs, and at the extreme, termination from the Medicare and Medicaid programs.

So, what can be done to address the current situation? I'll offer suggestions on two fronts, first, the workforce/capacity crisis and, second, the need for regulatory reform and improvement.

Workforce and Capacity Strategies

- With respect to addressing the workforce crisis, LeadingAge Wisconsin and WHCA have aggressively responded to requests for assistance from DHS and hospitals. We have surveyed our respective members and **identified over 70 facilities that have space and beds available** to assist hospitals in relocating patients to a post-acute care setting. However, almost without exception, these facilities have indicated their offer to assist is entirely dependent on whether DHS, hospitals or other partners are able to provide nurse aides and nurses required to meet the care and services needs of these patients (space and beds are available, caregivers are not). In response, DHS is working with selected facilities to provide staff via the Wisconsin National Guard (WING) and the State staffing agency contracts (which provide temporary caregivers at rates dramatically above the level paid to permanent staff), to open nursing home units for new admissions. Our suggestion is that DHS should target temporary staff (State contracts and WING deployment) to those facilities that are prepared to open available space and beds.

- At our request, DHS clarified its previous **nursing home admission guidance** regarding the appropriate facility response during a COVID-19 breakout. In the DHS memo **BCD 2021-13**, dated December 23, 2021, a section on *Temporary Halting of New Admissions: COVID-19 Outbreaks* (pp 7-8), includes the following:

  > Facilities should determine admission practices during outbreaks in consultation with the medical director and facility leadership that take the CDC and CMS guidance into account, including the CMS guidance in QSO-20-14 that says, "Nursing homes should admit any individuals that they would normally admit to their facility." If facilities can safely admit new residents, they should facilitate the admission. Facilities should assess pertinent factors to disease transmission, as well as their capacity for adequate staffing, space, DPH Memo Page 8 of 10 and PPE to accommodate new admissions during the outbreak. Potential new admissions and their representatives should be made aware of the outbreak and steps taken to ensure patient safety. As part of outbreak management, facilities can discuss plans to admit residents during active outbreaks with their local health department (LHD). LHDs do not need to approve the admission plan, but should be notified for awareness. LHDs and the DHS website will still officially note the outbreak as being a minimum of two incubation periods (28 days) in length from the last identified case, regardless of the selected outbreak testing approach or number of testing cycles.

  We believe issuance of **BCD 2021-13** will help clarify the ability of nursing facilities to admit new residents during a COVID outbreak, at least in certain parts of the State where local DPHs were more hesitant in allowing facilities to resume admissions. With greater statewide distribution and awareness, this guidance should prove especially helpful as the Omicron variant appears to be spreading rapidly across the country.

- The DHS recently announced it will allocate up to $6.0 million to relaunch the **WisCaregiver Career Program** (see: **www.dhs.wisconsin.gov/caregiver-career/index.htm**). Under this initiative, in partnership with DHS, WHCA and LeadingAge Wisconsin, the grant will pay for CNA training and testing for up to 2,500 individuals to join long-term care employment. As presently contemplated, once a person is placed on the CNA registry and works in a facility for 6 months, they also will receive a $500 employment incentive payment. The original WisCaregiver program has proven to be quite successful in increasing LTC employment and we are optimistic the 2.0 version will help attract

more caregivers at a time when they are so desperately needed. Version 2.0 will begin in early 2022. Relatedly, we have also asked DHS to work with DWD to direct unemployed persons to the WisCaregiver Career Program and other long-term care employment opportunities.

- We have asked DHS to examine creative ways to use the **State's $11.5 million allocation of federal nursing home assistance (strike) team/ARPA infection control funding** to address the workforce challenges. DHS responded by allocating $6.0 million of this amount for the WisCaregiver Career Program, referenced above, with plans to use the balance for nursing home grants related to staffing retention and recruitment; ancillary and supplies (e.g., PPE, testing, and lab expenses); and HVAC improvements. We fully support this DHS initiative.

- Our hope is that additional dollars will be allocated to long-term care facilities to address the growing workforce challenges. We have asked DHS to identify what **State and Federal Funds are available to address the staffing crisis** and suggest using these funds to create incentive programs assist facilities with their efforts to retain and attract staff. The $50 million program presently offered by the State of Minnesota could serve as a model for consideration: **https://mn.gov/dhs/assets/Emergency-grants-nursing-facilities-staff-hiring-retention_tcm1053-512540.pdf**.

- LeadingAge Wisconsin and WHCA have been in dialogue with WHA on the need for a pilot program to address the hospitals' inability to discharge especially hard-to-care-for patients who no longer needed inpatient hospital services. The difficulty of placing these hard-to-care-for patients existed pre-COVID and will continue well after the COVID battle is won if changes are not made. We need to address those patients who are inappropriately living in hospitals with little likelihood of being placed in a "typical" geriatric care facility. A pilot program would help identify the specific care and services needs of these patients and align the incentives to create special care units or facilities capable of meeting their needs in the most appropriate environment. We stand ready to move on this pilot with our partners.

- A number of States that have **capped rates charged by temporary staffing agencies** and we asked DHS to consider supporting such an initiative in Wisconsin. At this time DHS does not support capping rates due to concerns that it could negate access to traveling nurses needed to provide emergency staffing and otherwise curtail the availability of staff made available through the DHS' temporary staffing contracts with private vendors.

- Earlier this month we asked if DHS could **direct the Family Care MCOs to give high priority status to those Family Care members who are in hospitals or nursing homes** but are ready for discharge. Presently the MCOs lack incentives to relocate these members to a lower level of care setting. If more intentional case management practices are pursued, we believe some individuals could be relocated from hospitals and nursing homes, thereby freeing up beds and staff to serve others in need of more intensive care and services. State Medicaid officials have indicated they have initiated conversations with the Medicaid HMOs and MCOs on this matter.

Note: Earlier this week CMS elected to release its regulation and enforcement requirements related to the COVID vaccination mandate for health care workers. It is worth noting CMS elected to publish this mandate even though they are prohibited by the Courts from implementing the mandate in 25 States (those covered by court rulings suspending the mandate). **The COVID vaccination mandate <u>will</u> be enforced in Wisconsin, starting on January 27, 2022** (See: **https://www.cms.gov/files/document/qso-22-07-all-attachment-ltc.pdf**). CDC data indicates that 76.1% of all nursing facility staff have been vaccinated in Wisconsin, compared to the national

average of 78.3%. Source: **https://www.cdc.gov/nhsn/covid19/ltc-vaccination-dashboard.html**, December 20, 2022). Although some unvaccinated staff will be granted religious or medical exemptions allowing them to continue their nursing home employment, the mandate will result in a troubling reduction in facility staff, at a time when we are so desperately in need of workers. **Click here to access the most recent data (12-29-21) on WI nursing home staff vaccination rates.**

Regulatory Reform and Improvement

You have asked about efforts to improve the regulatory environment and I suspect facilities' medical directors are prepared to offer their own suggestions based on their experiences. Recently, **LeadingAge Wisconsin advanced several regulatory reforms ideas** to the Division of Quality Assurance (DQA). The response from DQA was disappointing. The Associations will be meeting with DQA early in 2022 to discuss our call for regulatory reforms and we hope progress can be made. Here are some of our reform ideas:

- Seek a federal **nursing home survey pilot** to allow abbreviated surveys for high performing facilities. Qualifying facilities could be surveyed every 3rd year. Inside the 3-year period, high performing facilities could be subject to random validation surveys that would target a small subset of the higher performers. This would free up additional survey resources to aid lower performing facilities.

- Ensure that some type of **surveyor Trauma Informed Care education** (DQA staff orientation and ongoing in-service training) has been implemented so that surveyors have sensitivity (empathy) training related to what providers, staff, and residents have experienced, particularly during this pandemic. The goal is to create a culture within DQA that is more empathic and understanding of the challenges facing the long-term care provider community. We have asked DQA to modify its surveyor education/training to improve DQA-Provider relationships and suggested it is time to update the **DQA Shared Expectations Document**. DQA has agreed to make some changes to this document.

- Nursing homes are spending an inordinate amount of scarce time entering data in the **NHSN reporting system.** Facilities were initially required to report to NHSN on the vaccination status for the following categories: employees, non-employee health care provider, Adult/student/trainee/volunteer and other. Now, healthcare personnel are required to provide even more granular data on the following: ancillary services, nurses, aides/assistants or techs, therapists, physicians or licensed practitioners, and other HCPs. As a result, facilities are now reporting on the vaccination status of healthcare personnel, broken down into ten different categories, and then further broken down into how many doses of vaccine received, for each of the three different types of vaccine (and a reporting requirement on boosters has been added), such that there are now up to 60 different possible categories that a healthcare personnel can fall into for vaccination status. This reporting take time away from resident care. The vaccination status reporting is in addition to the other 240 plus data elements that providers report on each week.

  Our Suggestions: (1) Switch reporting frequency to monthly rather than weekly. Switch reporting positive tests from within 24 hours to weekly; (2) Do not require NHSN reporting to be tied to Medicare annual payment update compliance; (3) Remove some unnecessary data elements to ease reporting burden; (4) CMS should issue reminders and offer a grace-period, not fines, for missed reporting before issuing citations.

- Under current federal law, a nursing home automatically **loses its ability to provide a nursing assistant (CNA) training program** if it is cited for deficiencies during the survey process that result in CMP greater than $10,843. This automatic consequence may bear no relationship to the cited deficiencies. Furthermore, the prohibition is enforced for two years, and it applies to a facility's in-house training program, and if the facility serves as a clinical training site. Currently, 83 facilities in Wisconsin nursing homes are impacted by this prohibition. Preventing a nursing home from training staff is a major barrier to improving quality of care, and it only exacerbates the increasing workforce challenges they face. We support changing federal law to impose the CNA training prohibition only in instances where the deficient practice impacts training or quality of student's education in the program.

- **Suspend the use of CMPs as an enforcement mechanism**, except in the most egregious cases. Instead, and when appropriate, enforce the direction of dollars into quality improvement remediation plans.

- **Revisit IJ determination as "potential for harm".** The word "potential" leaves a lot of room for surveyor interpretation and has led to varying levels of enforcement among different survey teams.

- Allow appropriately **trained or experienced non-CNA staff** (e.g., dietary or activity aides) to assist CNAs with certain resident assistance duties. Expand acceptable tasks on the **Noncertified Individuals in Delivery of Non-Hands-On Services** beyond what DQA/CMS currently allows (e.g., add assistance with grooming and putting on a sweater).

- **Suspend One-star rating for missed/late PBJ (staffing levels)submission**: Allow a grace period for late submission. Another potential solution would be the dropping of only one-star from the prior quarter (moving from a five-star to a four-star), with a one-star rating given after two consecutive quarters of missed data. Many good facilities get hit with a one-star rating mostly due to turnover and a missed submission and the only time that is discovered is when new 5-star ratings are issued when it is too late. This impacts referrals and rates paid to facilities by insurance companies.

- Extend **temporary and emergency aide programs** indefinitely (continue after the Public Health Emergency ends). These programs have proven to be invaluable to facilities and the workforce crisis is going to be our reality for the foreseeable future. Also, we have asked DQA to **expedite the review and approval of applications** submitted by provider organizations interested in starting their own 75-hour CNA training program.

- Allow **DON hours** (and other managers that are RNs or CNAs or have completed the emergency/temporary nurse aide training) spent working as direct caregivers to count towards staffing hours for PBJ purposes to recognize the reality of the workforce crisis.

In addition to the above items and other proposals submitted to DQA, we also support federal initiatives for **immigration reform** to address the workforce crisis. Foreign-born workers already play a valued role in the long-term care field. More than a quarter of the current national nursing home and home care workforce is comprised of people born in other countries. A paper published by LeadingAge (national) has proposed an immigration package referred to as: **IMAGINE—International Migration of Aging and Geriatric Workers in Response to the Needs of Elders.** IMAGINE's key proposals include:

1. Enact an 'H2Age" temporary guest worker program for certified nurse aides (CNA) and home care aides.
2. Expand the EB-3 visa program to allow more foreign-born direct care workers to enter the U.S.
3. Modify the EB-3 visa to increase the number of visas available specifically to address LTSS needs.
4. Modify the R-1 visa program to provide religious visas to temporary workers in faith-based organizations.
5. Enact "Carer Pairer," a new authority under the J-1 visa program, to include aging services workers in addition to childcare workers.
6. Amend the North American Free Trade Agreement (NAFTA) to include aging services workers.
7. Increase the number of refugees permitted to enter the U.S. and take steps to employ those refugees in the LTSS sector.

Concluding Comments

LeadingAge Wisconsin will continue to work aggressively to improve our State's health and long-term care delivery system…It's a system and should not be thought of as siloed components. In addition to the actionable items above, we will be preparing, in planned partnership with the other long-term care associations, 2023-2025 State budget initiatives for consideration by the Governor and the Legislature. These initiatives will undoubtedly include continued workforce and system measures to: establish appropriate nursing home payment standards to better align the reimbursement rates with the actual cost of care; improve the Family Care program to ensure greater attention and investment in the direct provision of care compared to the program's infrastructure; create incentives and appropriate settings to address the care and services needs of hard-to-care-for individuals; and seek regulatory changes that are within the State's jurisdiction. Working alongside our national association, LeadingAge, we also will give priority to nursing home regulatory, payment and regulatory reforms. The full identification and prioritization of our public policy objectives will be developed via our member engagement and Board processes beginning in 2022.

With great understatement, there is much to do and many challenges before us. However, I am convinced that productive changes are possible, particularly if stakeholders collectively harness their energies and commitment to the advancement of solutions. I further believe that the leadership and members of WAMD, The Wisconsin Society for Post-Acute and Long-Term Care, play an important role in driving change. My thoughts are that the WAMD could prove especially helpful in: (1) Helping with regulatory reform and changing the culture of the current system; (2) Helping all parties understand the expertise and capabilities of nursing facilities and their role in the health care system. This includes building support for appropriate care and settings for all persons in need of post-acute care, regardless of their medical or behavioral conditions; and (3) Advancing quality improvement by identifying what is working or not working within our care settings, from your unique perspectives.

In closing, thank you for seeking our input and considering the observations, recommendations and advocacy perspectives offered in this document. Over the few weeks I hope to grab the opportunity to learn about your long-term care goals and objectives, and how we can best collaborate on bringing important changes to the LTC system.

I look forward to working with you in 2022 and sincerely appreciate your devotion to our long-term care field and those in need of your care and services.