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Special Issue: Translational Research on the Future of U.S. Nursing Home Care: Invited Article

Putting the Nursing and Home in Nursing Homes

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Abstract

As the late Robert Kane observed, the term nursing home is often a misnomer. Most U.S. nursing homes lack adequate nursing staff, and they are typically not very homelike in either their physical structure or culture. These problems were magnified during the pandemic. The underlying reasons for these longstanding issues are that most state Medicaid payment systems reimburse nursing homes at a relatively low level and the government does not hold nursing homes accountable for spending dollars on direct resident care. To encourage increased staffing and more homelike models of care, policymakers need to reform how nursing homes are paid and hold facilities accountable for how they spend government dollars. With these reforms, the term nursing home will become more appropriate in the United States.

Translational Significance: Many U.S. nursing homes are insufficiently staffed and not very homelike in either their physical structure or culture. Through increased Medicaid investment and better financial accountability, nursing homes can be transformed into well-staffed, homelike models of care.

Keywords: Long-term care, Person-centered care, Quality of care, Quality of life, Workforce issues

The late Robert Kane often questioned why nursing homes were called nursing homes. He pointed out that most nursing homes were short on nursing staff and not very homelike (Kane, 2011). This very basic observation is at the root of many problems with nursing homes that persist today. U.S. nursing homes are critically understaffed, and they are far too institutional in both their physical structure and their culture. These issues have been present for decades, but they were magnified during the pandemic.

The production of nursing home care relies heavily on staff, with roughly two thirds of facility expenditures devoted to labor. A range of different staff types work in nursing homes, but the three predominant ones involved in direct resident care are registered nurses (RNs), licensed practical nurses (LPNs), and certified nurse aides (CNAs). All three types are essential for good quality nursing home care. Yet, U.S. nursing homes are often severely understaffed across all three categories. Using the Payroll-Based Journal data, a recent study found daily staffing levels are often below the expectations of the Centers for Medicare and Medicaid Services (CMS) (Geng et al., 2019). Specifically, over half of facilities met the expected CMS level less than 20% of the time. Staffing levels were also quite variable across days, with lower levels observed during the weekends.

The turnover of nursing home staff members is also quite high (Gandhi et al., 2021). The average nursing home was recently found to have 128% annual staff turnover,

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suggesting the typical nursing home had each position at the facility turnover annually at least once on average. Some nursing homes had annual staff turnover rates above 200% and 300%. RNs had the highest mean turnover rate (140.7%), while turnover for LPNs (114.1%) and CNAs (129.1%) was also substantial. Turnover rates were higher in for-profit nursing homes, high Medicaid facilities, and nursing homes with lower star ratings.

In addition to low staffing, many U.S. nursing homes are institutional in both their physical structure and their culture (Grabowski et al., 2014). U.S. nursing homes are often built and run like antiquated hospitals with desolate environments that feel more like a facility than a home. The typical nursing home has shared bedrooms and bathrooms. In the average U.S. nursing home, residents have relatively little direction over their daily lives as they would in their own home. For example, they are not able to set their own schedules in terms of when they eat or sleep.

A few small-home, resident-directed models have emerged in the United States over the last several decades. One of the most prominent and well-studied small-home models is the Green House project, which is associated with better quality of life (Zimmerman et al., 2016) and quality of care (Afendulis et al., 2016). However, for a variety of reasons including the high capital costs associated with renovations and new construction, small-home models have not been widely adopted.

Many facilities have also experienced severe staffing shortfalls during the pandemic (McGarry et al., 2020a). Based on U.S. Bureau of Labor Statistics (2022) data, over 400,000 workers left the nursing home sector between January 2020 and January 2022. Administrators report staffing to be one of the most challenging issues they have faced during the pandemic (SteelFisher et al., 2021). Staff were also found to be at-risk themselves. Facilities often did not have adequate personal protective equipment (McGarry et al., 2020a) or testing (McGarry et al., 2021b). Staff working across nursing homes was found to contribute to the cross-facility spread of the virus (Chen et al., 2021). The number of unique nursing home employees was found to be positively related to the coronavirus disease (COVID) cases and deaths regardless of facility size (McGarry et al., 2021a). This result suggests facilities that employed more part-time and agency staff were more likely to have COVID outbreaks. Given the exposure to the virus coupled with poor infection control, nursing home worker was found to be the most dangerous job in America during the pandemic (McGarry et al., 2020b).

Beyond staffing, there was also evidence supporting the fact that larger facilities were more likely to have outbreaks (Abrams et al., 2020; Konetzka et al., 2021). Smaller home models like Green House had lower COVID incidence and mortality relative to traditional facilities (Zimmerman et al., 2021). Fewer people living, working, visiting, and being admitted to these small-home models, along with private rooms and bathrooms, likely led to fewer COVID outbreaks.

Explanations for Chronic Low Nursing Home Performance

There are two related explanations for why these issues—poor staffing and the lack of homelike models—have persisted in the nursing home sector for decades. Nursing homes are largely reimbursed by government payers. Medicare is a relatively generous payer, reimbursing nursing homes for post-acute, short-stay care. Medicare margins are typically in the double digits (Medicare Payment Advisory Commission, 2021), while private-pay prices are set by the facility. However, Medicaid is the dominant payer of nursing home services, accounting for roughly half of all revenue and two thirds of all bed-days. Nursing home cost report data suggest state Medicaid reimbursements are, on average, below the costs of care. Over the 5-year period 2015–2019, the annual non-Medicare margin, which predominantly consists of Medicaid residents, ranged from –2% to –3.2% (Medicare Payment Advisory Commission, 2021).

There are two ways in which Medicaid payment rates might be considered inadequate. First, Medicaid rates might be lower than the average daily cost of care. Second, Medicaid rates might be lower than the cost to provide a minimally acceptable level of quality, a condition that is particularly difficult to assess; this might be higher than the current average cost of care. Nevertheless, because Medicare and private-pay cover fixed costs, nursing homes will admit Medicaid recipients if the reimbursement rate covers the marginal cost of treating the resident. However, a nursing home could not exist on Medicaid payments alone in this instance. Indeed, high Medicaid nursing homes are much more likely to close (Feng et al., 2011). Thus, most nursing homes depend on Medicare and private-pay to cross-subsidize Medicaid. When all these payer types are combined, the average U.S. nursing home had an operating margin of 0.6% in 2019 (Medicare Payment Advisory Commission, 2021). Given the role that tax-funded programs have in financing nursing homes through Medicaid and Medicare, it is uncertain what constitutes an appropriate margin for taxpayer dollars to support profits and shareholders as opposed to encouraging nonprofit options.

The extent to which reported margins reflect the reality of finance is unclear and may be obscured by the fact that not all reported costs may be necessary for delivering care. Toward this end, roughly two thirds of U.S. nursing homes are for-profit-owned, with roughly half being chain-owned. Many of these for-profit facilities are owned and operated under complex ownership structures. For example, it is estimated that roughly 12% of nursing homes are private equity-owned. Many others operate with real estate investment trusts with separation across ownership

and operation. The lack of transparency and accountability around these complex ownership structures facilitates the transfer of dollars away from direct care (Harrington et al., 2021). One recent study suggested these facilities acquired by private equity firms shifted spending to nonpatient care items such as monitoring fees, interest, and lease payments (Gupta et al., 2020). In the absence of improved financial accountability and auditing, it is difficult to definitively determine the extent of underfunding in Medicaid. Nevertheless, there is strong evidence that states that pay higher Medicaid rates have higher staffing (Bowblis & Applebaum, 2017), more innovative care models (Grabowski et al., 2014), and better care outcomes (Mor et al., 2011).

Thus, both low Medicaid reimbursement rates and poor financial accountability likely contribute to staffing shortfalls and low quality of care and quality of life. As noted earlier, many nursing homes have staffing levels that are well below recommended levels. RNs and LPNs working in nursing homes are typically paid below their counterparts in hospitals and other health care settings (Wagner et al., 2021). CNAs are paid close to minimum wage, often lacking benefits such as health insurance and paid sick leave. Low pay contributes to the fluidity of the workforce mentioned earlier. CNAs often leave nursing homes for higher paying jobs in retail and restaurants.

Although the Medicare Payment Advisory Commission (2021) has generally concluded that the nursing home industry has adequate access to capital, there is a severe lack of capital innovation in the nursing home sector. Many of the current sources of capital like real investment trust and private equity investors may be more extractive than investment-oriented. As such, the average age of U.S. nursing homes is over 30 years old (Lewis, 2005). As noted earlier, most of these older nursing homes lack private bedrooms and bathrooms. Importantly, relatively few small-home or neighborhood type nursing homes are developed each year. Green House homes, the most prevalent small-house model, care for roughly 3,200 (or 0.2%) of residents nationally (Waters, 2021).

Potential Solutions

If the policy goals are to improve nursing home staffing and make the facilities more homelike, the first step for policymakers is to change how nursing homes are paid and regulated. Given public payers provide the majority of nursing home revenue, public dollars will be needed to fund these improvements. For facilities caring for predominantly Medicaid residents, it is particularly challenging to invest in improved care delivery. These facilities cannot simply raise private prices to hire more staff or raise the capital to build a small-house model of care. Some of the shortfall can likely be recouped through increased accountability of existing government payments, but it is unclear whether the transformative changes highlighted in this piece—large increases in staffing and the construction of small-home, resident-directed models—can be achieved via accountability alone.

Moving forward, paying a government rate that is commensurate with the costs of care is an important step toward financing meaningful reform. This could entail changes to the existing Medicaid and Medicare payment systems. A more comprehensive approach would be to create a federal program to cover long-term care needs (Favreault et al., 2015). Countries in Northern Europe like The Netherlands and Switzerland have comprehensive long-term care systems in which nursing homes have more staff and more homelike models. However, these countries spend significantly more on services relative to the United States (Grabowski, 2021).

Regardless of the financing and payment approach, there will also need to be other steps to ensure that these dollars are used for their intended effect. As noted earlier, nursing homes with complex ownership structures often shift dollars away from direct resident care. Policymakers need to take steps to ensure that public dollars are being spent as intended.

There are different ways to do this. First, a minimum medical loss ratio (MLR) policy would require that nursing homes put a fixed percentage of revenue toward direct care. In September of 2020, New Jersey put in place an MLR policy that requires nursing homes to spend 90% of their revenue on direct care, while only the remaining 10% can go to profits and administrative salaries. New York and Massachusetts have also proposed similar policies for nursing homes. If properly enforced, these policies can ensure that dollars are spent on direct care. However, given the complexity associated with nursing home ownership and financial reporting, MLR policies can also be challenging to monitor. Moreover, some might argue that they will stifle innovation and nursing home entry by limiting flexibility on the part of the nursing home industry.

Second, a related policy is targeted payments to nursing homes. For example, states have used Medicaid wage pass-throughs in the past to provide nursing homes with more dollars for staffing. These policies have been found to both increase wages (Baughman & Smith, 2010) and staffing numbers (Feng et al., 2010). However, a criticism of these policies is that it is hard to track whether every additional dollar is used for its intended purpose. One idea to address the lack of accountability of these policies would be to pair these rate enhancements with minimum staffing standards and wage floors. Relative to an MLR, these requirements are easier to observe and less susceptible to misreporting in the cost reports.

Similar policies can be used to ensure facilities become more homelike. Dollars specifically targeted for capital improvements would be necessary. Moreover, certificate-of-need (CON) policies, which limit new entry, have been a major barrier to innovation in many states. For example, Massachusetts had to pass legislation in July 2006 as a workaround to the state CON to allow the construction

of 100 new skilled beds as part of a Green House model, which was the first approval of new nursing home beds in 10 years (Chi Partners, 2012). CON also distorts market competition in that facilities in states with these laws are generally larger (Rahman et al., 2016). Repealing CON will be necessary to encourage more small-home, resident-directed models.

Much of the shift toward smaller nursing home models like Green House has been part of the broader culture change movement. This movement consists of a series of innovative care models that reconceptualize the structure, roles, and processes of nursing home care to transform nursing homes from health care institutions to person-centered homes offering long-term care services. Key elements of culture change nursing homes include resident direction, homelike atmosphere, close relationships, staff empowerment, collaborative decision making, and quality-improvement processes (Koren, 2010). The shift to "small-home models" ideally encompasses a change in environment in terms of the home itself but also the empowerment of the residents and staff. It is harder for policymakers to encourage this type of culture change through policy alone. Much of this change occurs at the organization level. However, there are ways for policymakers to encourage greater investment in these models.

Once again, payment policy can be an important first step toward expanding the number of facilities implementing small-home models. The overall generosity of state nursing home Medicaid payment is significantly associated with the implementation of intensive culture change, as defined by experts (Grabowski et al., 2014). However, given the large upfront capital costs associated with small-home models like the Green House model (Jenkens et al., 2011), a higher Medicare per diem alone may not induce facilities to implement these small-home models. Arkansas House Bills 1363 and 1364 are an example of a policy that tries to address the large, fixed costs associated with implementing small-home models (Chi Partners, 2012). Signed into law in 2007, these Bills allow money collected under civil monetary penalties to be used for specialized reimbursements for facilities that implement a small-home model like a Green House project or an Eden Alternative program. Today, Arkansas is among the national leaders in Green House penetration with 46 Green Houses across six nursing home campuses caring for roughly 550 residents at a given time.

A key concern is how to ensure all nursing homes, and all nursing home residents, have access to improved staffing and small-house, resident-directed models. The nursing home sector has been characterized as a two-tiered system (Mor et al., 2004), with the lower tier consisting of facilities that care for predominantly Medicaid residents with lower quality of care. Abundant staffing and small-home models are almost nonexistent in this lower tier. These nursing homes are disproportionately located in the poorest counties and more likely to care for persons of color. Different policies can be used to lessen the disparity in staffing and small-home models across high- and low-tier nursing homes, but policymakers should limit any potential unintended consequences of different policies that further exacerbate disparities (Konetzka & Werner, 2009). Ideally, policies must serve the dual purpose of both improving quality broadly, while also specifically targeting resource-challenged providers.

A final point is recognizing that nursing homes are just one part of a larger long-term care system. The overarching goal is to ensure that individuals have access to the services that they need in the setting that they prefer. There will always be some individuals that need nursing home care (Guo et al., 2015; Wolff et al., 2008), but many individuals will prefer home- and community-based services (HCBS). Currently, the investment in Medicaid HCBS varies considerably across states. Many states have long waitlists for Medicaid HCBS slots, and individuals are often unable to access care in the community. Thus, a key goal is the expansion of Medicaid HCBS such that individuals can access services in the setting they prefer.

Summary

The nursing home sector has been plagued for decades by a series of performance issues including inadequate staffing and a lack of homelike models. These issues were both magnified during the pandemic. Many nursing homes experienced further staffing shortfalls and larger nursing homes were more susceptible to COVID outbreaks. The reasons for these problems both before and during the pandemic are twofold: inadequate Medicaid reimbursement and poor nursing home oversight and enforcement on spending. Moving forward, policymakers have an opportunity to put forward a set of reforms to encourage nursing homes to employ more staff and build more homelike models. Any meaningful policy solution will need to encompass both increased reimbursement but also improved accountability.

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Conflict of Interest

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