



OFFICE OF RESEARCH AND EDUCATION ACCOUNTABILITY

TEMPORARY STAFFING IN LONG-TERM CARE FACILITIES IN TENNESSEE



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Introduction

Staff shortages have existed for decades in long-term care facilities, but the effects of the pandemic significantly worsened shortages beginning in 2020.¹ To alleviate the shortages, many nursing facilities and some assisted care living facilities contracted with healthcare staffing agencies to hire temporary nursing staff (licensed nurses and nurse aides). Responding to news reports during the pandemic and to concerns expressed by the nursing home industry in Tennessee, state legislators wanted to learn more about the reportedly excessive costs charged by healthcare staffing agencies and the potential effects on the state's Medicaid program known as TennCare.

The Tennessee General Assembly passed Senate Bill 2463/HB 2347 in 2022, which became Public Chapter 1118 (2022).² The law requires the Comptroller of the Treasury (COT) to coordinate a study with the Division of TennCare and the Department of Health examining the use of temporary staff provided by healthcare staffing agencies in long-term care facilities. For purposes of the study, the facilities considered are nursing home facilities and assisted care living facilities. The study was to examine:

- the costs paid by nursing homes for temporary staff provided by healthcare staffing agencies and what effect those costs have on the TennCare program;
- the impact that increases in charges for temporary healthcare staffing has on assisted care living facilities; and
- practices that would improve the quality of long-term care facility resident care while reducing costs to the TennCare program.

The Comptroller's Office of Research and Education Accountability (OREA) completed the study on behalf of the COT. As required, this report is being delivered to the Speaker of the Senate, the Speaker of the House, and the legislative librarian by January 1, 2023.

Methodology

To collect information for this study, OREA analysts surveyed nursing facilities and assisted care living facilities in Tennessee, reviewed academic studies and news accounts, and interviewed several stakeholders and agency personnel.

Surveys

OREA analysts conducted two surveys for both nursing facilities and assisted care living facilities in Tennessee. The first survey focused on learning whether facilities had experienced a direct care staffing shortage, whether they had to limit admissions as a result, and whether they used temporary staffing agencies to alleviate shortages of licensed nurses (RNs and LPNs), and/or certified nurse assistants (CNAs), i.e., direct care staff, at any time from 2019 (a base year prior to the start of the pandemic) through the first half of 2022. Of those facilities that had used agencies, the survey requested the total dollar amounts that facilities had paid temporary staffing agencies and the hours of work those expenditures represented – this information was collected separately for RNs, LPNs, and CNAs. The second survey was sent only to those facilities that reported using staffing agencies, asking for the names and contact information of the staffing agencies used.

This report describes survey results from both nursing facilities and assisted care living facilities in Tennessee. There are several types of long-term care facilities, such as residential homes for the aged and residential community intermediate care facilities for individuals with intellectual disabilities, among others. For the purposes of this report, the term “long-term care facilities” refers only to nursing facilities and assisted care living facilities. Also, the terms “nursing facilities” and “nursing homes” are interchangeable.

Nursing facilities

The first survey was sent to 307 nursing facilities and 289 (94 percent) responded. Of those responding, 186 (64 percent) reported contracting with one or more healthcare staffing agencies at some point in 2019, 2020, 2021, and/or the first half of 2022; 85 facilities (29 percent) reported never contracting with agencies during this period. Of those that reported contracting, 167 (90 percent) reported the amounts they paid to healthcare staffing agencies and, in most cases, the number of staff hours those expenditures represented; 19 (10 percent) did not report the amounts paid to staffing agencies or the number of staff hours.^A

The second survey was sent to the 186 nursing facilities that reported using staffing agencies; 78 (42 percent) responded with contact information for the staffing agencies they used.

Assisted care living facilities

The first survey was sent to 297 assisted care living facilities and 119 (40 percent) responded. Of those responding, 53 (45 percent) reported contracting with one or more healthcare staffing agencies at some point in 2019, 2020, 2021, and/or the first half of 2022; 39 (33 percent) reported never contracting with agencies during this period. Of those that reported contracting, 32 (60 percent) reported the amounts they paid to healthcare staffing agencies and, in most cases, the number of staff hours those expenditures represented; 21 (40 percent) did not report the amounts paid to staffing agencies or the number of staff hours.^B

The second survey was sent to the 53 assisted care living facilities that reported using staffing agencies; 14 (26 percent) responded with contact information for the staffing agencies they used.

Exhibit 1: OREA survey responses

	Nursing facilities		Assisted care living facilities	
	Number	Percent	Number	Percent
Total surveyed	307		297	
Total responses	289	94%	119	40%
Contracted with staffing agencies	186 of 289	64%	53 of 119	45%
Reported expenditures for temporary staff	167 of 186	90%	32 of 53	60%

Note: Some facilities did not complete all survey questions.

Source: OREA survey of nursing facilities and assisted care living facilities in Tennessee, 2022.

Interviews

OREA analysts also conducted interviews with and received data and information from officials from the Division of TennCare in the Department of Finance and Administration, the Tennessee Health Care Association, the Tennessee Department of Health, the Tennessee Health Facilities Commission, the Tennessee Commission on Aging and Disability, and the Medicaid/TennCare section of State Audit in the Comptroller's Office. Analysts contacted five healthcare staffing agencies and received a response from one.

^A Six percent (18) of respondents left the contracting question blank.

^B Twenty-three percent (27) of respondents left this question blank. All reported that they did not experience a nursing shortage in an earlier question.

Entities referred to in the report

Federal:

The *Centers for Medicare and Medicaid (CMS)*, part of the U.S. Department of Health and Human Services, enforce the federal regulations concerning long-term care facilities as well as Medicare and Medicaid payments.

State:

TennCare is Tennessee's Medicaid program. The Division of TennCare is part of the Tennessee Department of Finance and Administration. TennCare was established in 1994 under a federal waiver that authorized deviations from the standard Medicaid rules. It was the one of the first state Medicaid programs to enroll all Medicaid recipients in managed care.

The *Health Facilities Commission (HFC)* was created by the General Assembly on July 1, 2022, after the former Office of Health Care Facilities in the Tennessee Department of Health merged with the Health Services and Development Agency, pursuant to Public Chapter 1119. HFC certifies and licenses nursing homes, among other facility types. As the contracted State Survey Agency for CMS, the HFC also certifies health care facilities currently participating or seeking participation in the CMS program. HFC conducts initial licensure/certification surveys, annual renewal surveys, and complaint investigations to ensure compliance with state and federal statutes and regulations. HFC also maintains the Nurse Aide Training and Competency Evaluation Program (NATCEP) and conducts the state competency examination for individuals to become Certified Nursing Aides (CNAs).

Other Tennessee entities:

The *Tennessee Health Care Association (THCA)* and its organization the *Tennessee Center for Assisted Living Facilities (TNCAL)* have a mission to enhance the ability of members to provide essential long-term care services for the elderly and disabled through education, advocacy, and leadership. THCA/TNCAL members are nursing facility and assisted care living facility providers in Tennessee. THCA board members are long-term care providers. TennCare regulations require TennCare, THCA, and the Comptroller to establish the rules for the determination of payment for services provided to Medicaid recipients as part of the state's nursing facility program.

National association:

The American Health Care Association and the National Center for Assisted Living (AHCA/NCAL) is a national association whose membership includes skilled nursing centers, assisted living communities, subacute centers, and homes for individuals with intellectual and developmental disabilities.

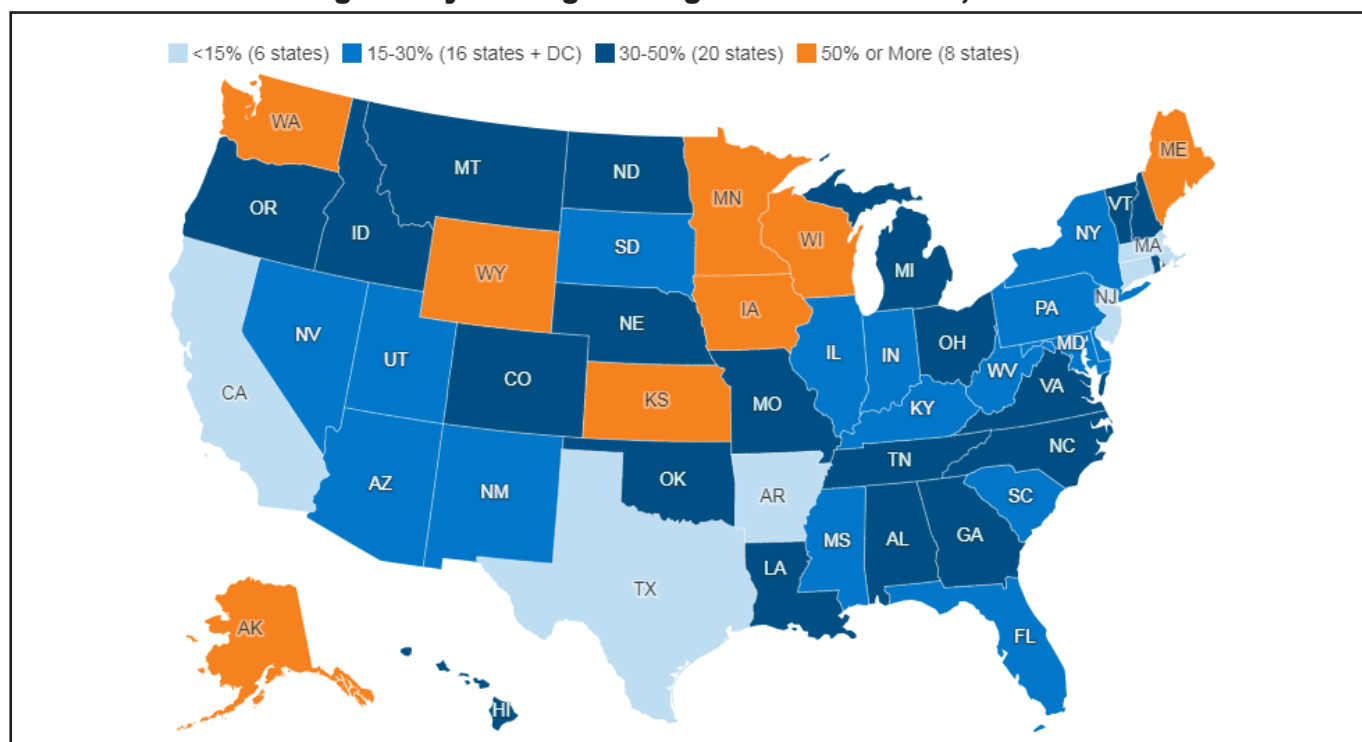
Background

The effects of the pandemic intensified staffing shortages that previously existed in nursing facilities in Tennessee and across the country.³

U.S. Bureau of Labor Statistics (BLS) data show that across the country nursing homes have lost 238,000 workers since the beginning of the pandemic. While the entire healthcare industry is affected, the challenge appears to be greater in the long-term care sector. BLS data indicate that "hospitals have lost 2 percent of their workforce, compared to a 15 percent workforce decline among nursing homes and a 7 percent decline among assisted living communities."⁴ In 2021, the American Health Care Association and the National Center for Assisted Living (AHCA/NCAL) reported that 58 percent of nursing facilities and 28 percent of assisted care living facilities across the country had limited admissions due to staffing shortages.⁵ Exhibit 2 shows Tennessee

with 30 to 50 percent of nursing facilities reporting shortages to a Kaiser Family Foundation survey as of March 2022.

Exhibit 2: State nursing facility staffing shortages as of March 20, 2022



Source: Kaiser Family Foundation analysis of Centers for Medicaid and Medicare (CMS) COVID-19 Nursing Home Data, April 4, 2022.

For all of 2019, state labor data shows that Tennessee nursing facilities employed about 63,000 workers – by January 2022, that number fell to 55,900, reflecting an 11 percent decrease in jobs.⁶ According to the OREA 2022 survey results, staffing shortages became critical in 2021. (See Exhibits 6, 10, and 11.)

Of the nursing facility survey respondents, 253 (88 percent) indicated their facility experienced a staffing shortage and 36 (12 percent) said they did not experience a shortage. A majority of the nursing facilities that experienced a shortage (152, 60 percent) rated the significance of the direct care staffing shortage during the pandemic between 8 and 10 with 10 representing the highest concern, and 67 of these rated their concern at 10. Another 69 (27 percent) rated the significance between 5 and 7 on that scale, and 30 (12 percent) rated it between 1 and 4.

On OREA's survey, more than half of responding nursing facilities (185, 64 percent) reported limiting admissions at some point during the pandemic due to staff shortages.

Exhibit 3: Long-term care facility staffing experiences during the pandemic | OREA survey results

	Nursing facilities		Assisted care living facilities	
	Number	Percent	Number	Percent
Experienced a direct care staffing shortage	253	88%	92	77%
Rated shortage severity between 8 and 10 (10 = most severe)	152	60%	26	28%
Limited admissions because of staffing shortage	185	64%	20	17%

Source: OREA survey results. Responses represent the facilities that responded to the questions shown. Percentages are based on the total number of survey respondents: 289 for nursing facilities and 119 for assisted care living facilities.

Of the assisted care living facilities survey respondents, 92 (77 percent) indicated their facility experienced a staffing shortage and 27 (23 percent) said they did not experience a shortage. In general, assisted care living facilities did not report the shortage as being as high a level of concern as did nursing facilities: 26 (28 percent) rated the shortage severity between 8 and 10 with 10 representing the highest concern, and 17 of these rated their concern at 10. Another 34 (37 percent) rated the significance between 5 and 7 on that scale, and 26 (28 percent) rated it between 1 and 4. Six facilities that reported experiencing a shortage rated its severity at zero.

On OREA's survey, 20 assisted care living facilities reported limiting admissions at some point during the pandemic due to staff shortages; 72 reported not limiting admissions during that period.

OREA survey respondents:

"I have been an administrator in healthcare for approximately 20 years and have not experienced any factors close to the negative effects COVID-19 has had on staffing... Facilities have had to dramatically increase wages, in addition to offering significant bonuses to have sufficient staffing. My current facility continues to have to use agency staff + bonuses in order to provide adequate care. I am concerned that with no end still in sight for staffing coverage many facilities are not going to be able to survive long-term."

"The competition amongst ACLFs, hospitals, and skilled nursing facilities is a large contributing factor if your company cannot offer a higher than average wage and flexible schedule. The raise in wages among other less stressful industries has also contributed to the lack of workforce available in healthcare."

Long-term care facilities experiencing shortages continued attempts to hire staff during the pandemic. In the 2021 AHCA/NCAL survey, more than seven out of 10 long-term care facilities cited a lack of qualified candidates and unemployment benefits as the main obstacles in hiring new staff.⁷ (Exhibit 2 displays nursing facility staffing shortages as of March 2022 for each state and D.C.) In the OREA survey, some nursing facilities suggested that increased American Rescue Plan (ARP) unemployment benefits available during the pandemic kept some employees from returning to work.⁸ Some also cited a lack of CNA instructors and test sites across the state, competition with temporary agency pay scales (i.e., some permanent direct care staff left their jobs to work for healthcare staffing agencies), and competition with other healthcare and non-health care industries.

Some nursing facilities also commented on the OREA survey that nursing facilities compete with each other for staff based on wage levels, but, more recently, non-healthcare-related industries that are offering higher wages, such as Amazon, have further exacerbated facilities' hiring challenges. In late 2021, the average starting pay for an entry-level position at Amazon warehouses and cargo hubs was more than \$18 an hour, with the possibility of a \$3,000 signing bonus, depending on location and shift. The company provides health benefits, training, and parental leave for full-time employees.⁹ In contrast, lower-skilled nursing home positions, such as CNAs, typically pay closer to \$15 an hour.¹⁰

A considerably larger share of TennCare/Medicaid funding goes to nursing facilities, which have a much larger population of Medicaid patients than do assisted care living facilities. This report focuses more on nursing facility spending, but OREA surveyed assisted care living facilities regarding the use of healthcare staffing agencies during the pandemic as well. Information derived from survey responses is included throughout the report.

Long-term care facilities in Tennessee and many other states have tried to alleviate nursing staff shortages by filling positions with temporary workers from healthcare staffing agencies.

Staffing shortages in nursing homes and assisted living facilities across the country worsened during COVID. Facilities in many states, including Tennessee, contracted with healthcare staffing agencies to supply temporary workers, including nurses and certified nursing assistants. The number of facilities contracting with staffing

agencies increased as the pandemic continued. (See the Analysis section of this report for more information about Tennessee facilities' use of healthcare staffing agencies.) In 2022, several states proposed and some enacted legislation requiring healthcare staffing agencies to register with the state as a condition of doing business and pay an annual fee, meet certain requirements, and submit specified financial information about their operations. Other states already had such laws. (See "Other states' actions to address the increased use of healthcare staffing agencies" on page 26.)

In October 2021, the American Health Care Association (AHCA) and the National Center for Assisted Living (NCAL) sent a letter to the Federal Trade Commission asking that the FTC use its authority to investigate reports of anticompetitive pricing by nurse staffing agencies.¹¹ It does not appear that such an investigation is underway at this time.

Long-term care facilities determine staffing needs based on federal and state requirements and on the number and healthcare needs of residents.

Federal law and regulations do not specify a minimum number of direct care nurse and nursing assistant hours per resident per day for nursing facilities, nor does either specify a ratio of nursing staff to residents. Federal and state staffing requirements for nursing facilities are shown in Exhibit 4, along with the state requirements for assisted care living facilities. (The federal government does not establish rates for assisted care living facilities, which are regulated by states.) Other than the requirement for RNs or other licensed nurses (LPNs) to be on duty at specified times in both federal and state law, the number of other direct care staff (CNAs) is not defined. Each facility must determine the appropriate number of RNs, LPNs, and CNAs needed to meet the needs of residents.¹²

Nursing facilities must adhere to the staffing requirements in federal and state law and employ sufficient numbers of staff to meet the healthcare needs of their residents. In June 2012, TennCare changed the medical level of care criteria to make Medicaid eligibility available only to those with high acuity levels. Acuity level refers to the level of care that each individual patient requires. Individuals with high acuity levels have a physical or mental condition, disability, or impairment that, as a practical matter, requires daily inpatient nursing care. To qualify for nursing home care, an individual must be unable to self-perform needed nursing care.¹³ Nursing facilities in Tennessee that participate in the TennCare CHOICES program admit only individuals with high acuity levels who qualify for nursing care and cannot be cared for through home and community-based services.^C

Nursing facilities and assisted care living facilities are staffed by a variety of direct care staff with different levels of training, including:

- registered nurses (RNs), who have at least a two-year degree and are responsible for overseeing residents' care;
- licensed practical nurses (LPNs), who have a one-year degree and typically provide routine bedside care (such as taking vital signs); and
- certified nursing assistants (CNAs), who have at least 75 hours of training and generally assist residents with activities of daily living.

CNAs make up approximately two-thirds of the direct care workforce in long-term care facilities.

Source: MACPAC, State Policy Levers to Address Nursing Facility Staffing Issues, Issue Brief, March 2022.

Most assisted care living facilities do not admit residents who qualify for TennCare (i.e., Medicaid). Of the 297 assisted care living facilities in the state, TennCare reports that 96 (32 percent) have some Medicaid patients.¹⁴ The total amount that TennCare reimbursed these facilities was about \$12 million for FY 2021-22. (Assisted care living facilities are paid monthly – this figure reflects a total paid for all facilities during the fiscal

^C There are three TennCare CHOICES groups. Group 1 is for individuals who meet the criteria for nursing home care and cannot be cared for through home and community-based services. Group 2 meet the criteria for nursing home care but can be cared for in a home and community-based setting. Group 3 do not meet the criteria for nursing home care but are at risk of doing so without being provided some home and community-based services. Division of TennCare, To Qualify for CHOICES, <https://www.tn.gov/tenncare/long-term-services-supports/choices/to-qualify-for-choices.html>.

year.) The average payment for FY 2021-22 was about \$10,000. Annual payments ranged widely from a low of \$525 to a high of \$717,000.

Individuals admitted to assisted care living facilities may require assistance with medication administration, non-medical activities of daily living, and limited medical services, but do not need the same level of care that nursing facility residents require. Tennessee rules require assisted care living facilities to have an administrator, an attendant, and a licensed nurse as needed.¹⁵ A spot check by OREA of Joint Annual Reports submitted by assisted care living facilities to the Tennessee Department of Health shows a wide variety of staff sizes based on the number and the needs of the residents. For example, one facility reported one each of administrator, assistant administrator, LPN, and CNA; another reported one administrator, two LPNs, and five CNAs.¹⁶ OREA survey results, described beginning on page 16, show that assisted care living facilities generally did not contract with healthcare staffing agencies to the extent that nursing facilities did during the pandemic.

Exhibit 4: Direct care staffing requirements in federal and state law and regulations for long-term care facilities

Federal staffing requirements for nursing facilities*	Tennessee staffing requirements for nursing homes	Tennessee staffing requirements for assisted care living facilities*
1 RN 8 consecutive hours/7 days per week and 1 RN/LPN for two remaining daily shifts	1 LPN or RN on duty at all times	A responsible attendant who is alert and awake at all times and a sufficient number of employees to meet residents' needs, including medical services as prescribed
1 RN full-time who is Director of Nursing	At least 2 nursing personnel on duty at each shift	A licensed nurse available as needed
Sufficient nursing staff to meet residents' needs	Adequate numbers of RNs, LPNs, and CNAs to provide nursing care to all residents as needed. A minimum of 2 hours of direct care to each resident daily including 0.4 hours of RN/LPN time. Supervisory and staff personnel for each department or nursing unit to ensure, when needed, availability of a licensed nurse for bedside care of any resident.	

Note: * The federal government does not establish staffing requirements for assisted care living facilities, which are regulated by states. Direct care staffing includes licensed nurses (RNs and LPNs) and certified nursing assistants (CNAs).

Sources: Federal regulations: 42 CFR 483.35 – Requirements for States and Long Term Care Facilities, Nursing services. Federal law: 42 U.S.C. 1395i–3, Requirements for, and assuring quality of care in skilled nursing facilities, https://www.ssa.gov/OP_Home/ssact/title18/1819.htm. State regulations: Nursing facilities – Tennessee Department of Health 1200-08-06(4)(a),(d), <https://publications.tnsosfiles.com/rules/1200/1200-08/1200-08-06.20220215.pdf>. Assisted Care Living Facilities – Tennessee Department of Health 1200-08-25.06(1), <https://publications.tnsosfiles.com/rules/1200/1200-08/1200-08-25.20201126.pdf>.

Long-term care staffing adequacy is linked to quality of care.

Research over many years suggests that higher nurse staffing is linked to nursing home quality. In the 1980s, reports of understaffing in nursing facilities were common. The main goal of the Nursing Home Reform Act passed by Congress in 1987 was to ensure that residents of nursing homes receive quality care that will result in their achieving or maintaining their “highest practicable” physical, mental, and psychosocial well-being.¹⁷ The law upgraded staffing requirements for Medicare and Medicaid nursing homes, requiring facilities to have a registered nurse as director of nursing and licensed practical nurses on duty 24 hours a day, seven days a week, and a required minimum of 75 hours of training for CNAs, who were also required to pass a competency test. It also included general language that require facilities to have sufficient staff to meet the needs of residents but did not define “sufficient.”¹⁸ (See Exhibit 4.) Data from the National Nursing Home Survey suggest that the 1987 law was associated with a 25 percent increase in staffing between 1985 and 1995. Research following the 1987 law concluded that the staffing changes had a positive effect on the quality of care. Since the increases documented in the mid-90s, staffing remained fairly flat for several years even though the disability levels of nursing home residents increased, according to a 2007 report.¹⁹

In 2001, the Centers for Medicare and Medicaid (CMS), the federal agency that enforces the regulations concerning the operation of long-term care facilities, published a study required by Congress titled *Appropriateness of Minimum Nursing Staffing Standards in Nursing Homes*.²⁰ The study hypothesized that some previously unidentified ratio of nurse to patient staffing might substantially increase levels of quality for patients. Researchers analyzed a representative staffing data sample from 10 states and over 5,000 nursing facilities to identify staffing thresholds “below which quality of care was compromised and above which there was no further benefit of additional staffing with respect to quality.” Researchers considered short-stay measures of quality (e.g., urinary tract infections and sepsis) and long-stay measures (e.g., incidence of pressure sores, functional improvement, and weight loss) for nursing home residents. For each measure, researchers found a pattern of incremental benefits of increased staffing associated with a threshold. The study found thresholds for nursing assistants (i.e., CNAs) at 2.4 *hours per resident day* (hprd) for short-stay residents and 2.8 hprd for long-stay residents; thresholds for licensed staff (i.e., RNs and LPNs) were found at 1.15 hprd for short-stay residents and 1.3 hprd for long-stay residents. “Thus, these thresholds provide staffing levels below which facilities were more likely to have quality problems in the quality areas studied...and above which these rates were not improved by increasing staffing ratios.”^{21,D}

The study’s conclusions did not become part of federal law or regulation concerning nursing facilities, but the total number of hours per long-term stay resident per day for nursing assistants and licensed staff (2.8 + 1.3 = 4.1) has since that time been cited as a CMS *recommendation* for nursing facilities. The federal *requirements* in law and regulation, when converted to hours per resident per day measurements based on a 100-bed facility – an RN or LPN available onsite 24 hours a day – is equivalent to 0.3 hprd. A 2022 study by the Medicaid and CHIP Payment and Access Commission found that 38 states and the District of Columbia exceed this federal requirement. Tennessee’s requirements place it at 2.0 hprd, above the federal requirement but below the federal recommendation of 4.1 hprd. Eleven states and the District of Columbia have staffing standards of 3.1 or more hprd, with D.C. being the only jurisdiction that meets the federal recommendation of 4.1.²²

Actual staffing data reported quarterly to CMS by Tennessee’s nursing facilities show that staffing is above the state’s requirements but has decreased from a high point in the last quarter of 2020 to the lowest point in the first quarter of 2022. The state’s average direct care staffing has closely paralleled the national average hprd until it fell in the first quarter of 2022. See Exhibit 5.

Exhibit 5: Tennessee nursing facilities’ actual direct care staffing as reported to CMS exceeds the state’s staffing requirements | expressed as hours per resident per day (hprd)

Quarters	Tennessee hprd	U.S. hprd
2019 (Q4)	3.36	3.37
2020 (Q4)	3.46	3.47
2021 (Q4)	3.36	3.35
2022(Q1)	3.28	3.34

Notes: (1) The Long Term Care Community Coalition (LTCCC), a nonprofit organization, publishes quarterly reports that assemble direct care staffing data reported by all states to CMS. The state reports contain information on each state’s nursing facilities and calculates the hours per resident day (hprd) for various staff categories.

(2) For 2019 and 2020, the direct care staff included CNAs, LPNs, and RNs. For 2021 and 2022, the direct care staff include CNAs, LPNs, RNs, and medication aides and nurse aides in training.

Source: Tennessee data taken from the LTCCC Nursing Home Staffing reports for Q1 2022, Q4 2021, Q4 2020, and Q4 2019 reports, which can be found at <https://nursinghome411.org/data/staffing/>.

^D Short-stay patients typically are transferred to a nursing facility from a hospital following surgery or an illness and remain in the nursing facility for days or weeks. Long-stay patients are generally permanently admitted to a nursing facility.

The Biden administration has proposed the establishment of minimum staffing levels for nursing homes.²³ On August 3, 2022, CMS published a summary of responses to the proposal in the Federal Register and announced the commencement of a study with the expected outcome to be a rule change within one year to require a system of minimum staffing rates for nursing facilities.²⁴

Industry analysts are concerned that any such mandate to require more staff will not change many of the difficulties in hiring staff, including a lack of applicants and continuing high staff turnover, highlighted during the pandemic. The AHCA said nursing facilities cannot meet additional staffing requirements without sufficient numbers of qualified applicants and when they lack the resources to compete against other employers. Nursing homes could have difficulty affording substantial increases in their workforces.²⁵

Weekend staffing levels, staff turnover, and quality

In January 2022, CMS began posting data on weekend staffing levels and staff turnover in nursing facilities. CMS also began adding this data to its Care Compare website in January 2022 and began using the data in its Nursing Home Five Star Quality Rating system in July 2022. Staffing levels in nursing homes often decline on the weekends, a problem in ensuring that residents receive continuing care.²⁶

Everyday tasks, such as medication administration and monitoring, can be adversely affected by both inadequate staffing and a lack of stability in staffing availability. During low staffing days, when residents do not receive needed care, they are more likely to develop various conditions, such as pressure injuries, because staffing was not sufficient to rotate them in bed; exacerbation of wounds when staff is not available to change dressings in a timely fashion; falls with injuries without consistent daily attention to anticipating needs, such as requiring assistance to get to the bathroom. Most of these consequences of short staffing cannot be fixed by additional staff on other days; more turning or toileting on extra-staffing days cannot eliminate the fall or the wound development that occurred when understaffed.²⁷

In its January 2022 announcement, CMS said it had explored the relationship between staff turnover and quality, and found in a preliminary analysis that lower RN, total nurse, and administrator turnover are associated with higher Five Star Ratings. The analysis showed that the average turnover decreases as overall star ratings increase, suggesting that lower turnover is associated with higher overall quality. CMS suggested several factors that may relate to the association: facilities with lower staff turnover may have more staff that are familiar with each resident's condition and may therefore be able to identify a resident's change in condition sooner, which may prevent an adverse event. Facility staff working in a facility with lower turnover may be more familiar with the facility's policies and procedures and can more efficiently and quickly provide a higher quality of care to residents.²⁸

The negative effects of high staff turnover may be similar to the effects of large numbers of temporary staff brought in to mitigate shortages of direct care staff, particularly to the extent that was needed during the pandemic. One nursing facility respondent to the OREA survey commented that "residents are frustrated with agency staff because they don't know the residents' preferences. Agency staff do not know facility procedures and processes, leading to a decline in overall quality." Another commented that because they had to use temporary agencies, the facility could not maintain consistent staffing. Another said that the use of temporary staffing decreases the continuity of care.

The CEO of staffing company OnShift, quoted in a 2021 article in *Skilled Nursing News*:

"If you talk to providers [i.e., nursing facilities], their goal is not to use agency, because it has an impact on staff morale, it has an impact on quality, it has an impact on resident satisfaction; somebody who comes into a building to work a shift doesn't know the policies, procedures, the residents."

Source: Amy Stulick, "Nursing Homes Use of Staffing Agencies Soars During Pandemic as Workforce Crisis Deepens," *Skilled Nursing News*, June 27, 2021, <https://skillednursingnews.com/2021/06/nursing-homes-use-of-staffing-agencies-soars-during-pandemic-as-workforce-crisis-deepens/>.

According to an analysis of the staffing data that nursing facilities report to CMS quarterly,²⁹

- Nationwide, the average nursing home reported a nursing staff turnover rate of 53.5 percent and RN staff turnover rate of 51.9 percent.
- Contract employees accounted for 9.7 percent of all nurse staff hours in the first quarter of 2022, which is nearly double the rate from the first quarter of 2021 (5 percent).
- Staffing levels are significantly lower on weekends.
- Roughly one in four (26.8 percent) nursing homes met the CMS recommended total care staff threshold of 4.1 hprd.

State and federal incentives to sustain and improve nursing facilities' quality standards

Since 2016, a portion of nursing facility reimbursement through TennCare has been based on quality measures through the state's Quality Improvement in Long-Term Services and Supports Initiative (QuILTSS). The quality-based component of each nursing facility provider's per diem payment is based on the facility's volume of Medicaid resident days and the percentage of quality points earned for the measurement period. The four quality measures, for which facilities can earn 100 points total, are based on resident satisfaction (35 points), culture change/quality of life (30 points), staffing/staffing competency (25 points), and clinical performance (10 points). The staffing and staffing competency measures are based on five measures: RN hours per resident per day; Nurse Aide hours per resident per day; RN, LPN, and CNA staff retention; consistent staff assignment; and staff training. During the pandemic, some requirements were temporarily altered due to the staffing difficulties many facilities experienced. For example, reporting the staff retention measures became optional for nursing facilities in calendar year 2021 and previous facility scores were used for those that chose not to report on staff retention.³⁰

TennCare estimates that nursing facilities received the following amounts based on the quality point system under QuILTSS for the state fiscal years shown:

- 2019: \$52.6 million
- 2020: \$55.9 million
- 2021: \$58.9 million

Through the Five-Star Quality Rating System, CMS measures and rates Medicare- and Medicaid-certified nursing facilities based on performance in three domains: results from state health inspections, staffing based on staffing levels and staff turnover, and quality measures. Nursing facilities are given one to five stars, based on their results, and the information is publicly available on the CMS Compare website at <https://www.medicare.gov/care-compare/>.

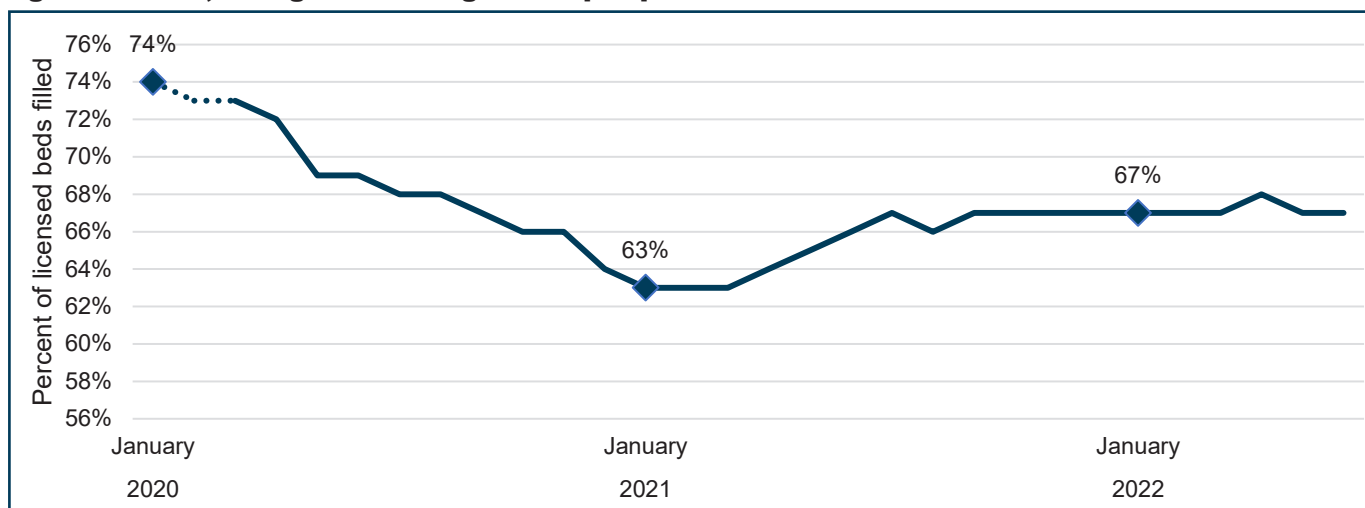
The rating for staffing is based on total nursing hours (i.e., RN, LPN, and CNA hours) per resident per day during the week and separately on weekends; RN hours per resident per day; the percentage of nursing staff that left the nursing facility over a 12-month period; the percentage of RNs that left over a 12-month period; and the number of administrators that left over a 12-month period. These measures are based on both full-time and part-time facility employees and temporary staff hired under a contract.³¹

The rating for quality is based on a broad range of function and health status indicators of nursing facility residents. Nursing facility ratings are based on the types of patients they have. There are separate indicators for long-stay patients (Medicaid) and short-stay patients (Medicare). Some nursing facilities have both types of patients. Measures for long-stay residents are the percent whose need for help with daily activities increased; percent whose ability to move independently worsened; percent of high-risk residents with pressure ulcers; percent who have or had a catheter inserted and left in their bladder; percent with a urinary tract infection; percent experiencing one or more falls with major injury; percent who got an antipsychotic medication; the number of hospitalizations per 1,000 long-stay resident days; and the number outpatient emergency department visits per 1,000 long-stay resident days. Several of the short-stay measures are similar.³² As of August 1, 2022, 43 Tennessee nursing facilities are designated 5-star; 41, 4-star; 60, 3-star; 68, 2-star; and 74, 1-star.)^{33]}

The number of patients in nursing homes declined early in the pandemic and began to increase in 2021, but remain below pre-pandemic numbers.

In January 2020, nursing facilities in Tennessee had a 74 percent occupancy rate, which declined during the pandemic. By January 2021, that rate had declined to 63 percent. By July 2021, the rate increased to 67 percent, where it remained steady through June 2022. (See Exhibit 6.)

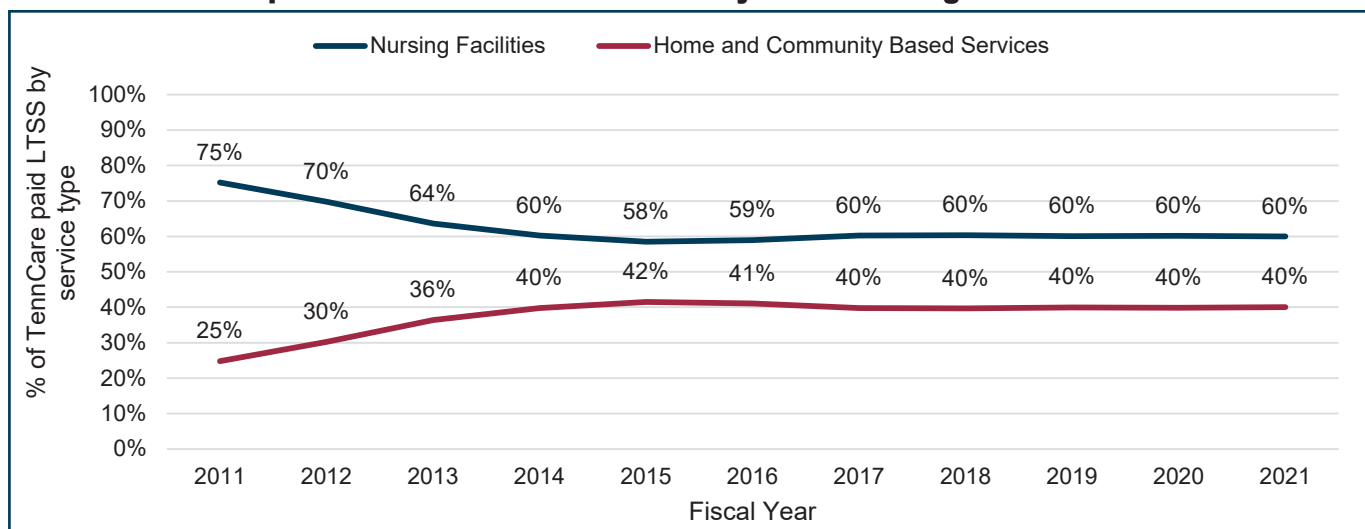
Exhibit 6: Nursing facility occupancy rates declined early in the pandemic and then rose again in 2021, though remaining below pre-pandemic levels



Source: Tennessee Health Care Association.

Nursing home occupancy has shifted over the years with the increase of home and community-based options for those who qualify. In 2010, Tennessee nursing home occupancy rates were at 87 percent. In 2012, TennCare changed the criteria for qualifying for nursing homes, increasing the medical criteria for individuals to qualify. With that change, the occupancy level of nursing homes began decreasing as the number of seniors receiving home and community-based services increased.

Exhibit 7: The percentage of TennCare CHOICES recipients in nursing homes decreased as more individuals qualified for home and community-based settings



Note: This exhibit shows the percentage by fiscal year of individuals in TennCare CHOICES Group 1 (require nursing home care) and Group 2 (meet the criteria for nursing home care but can be cared for in a home and community-based setting). Division of TennCare.
Source: Data from TennCare.

How nursing facilities and assisted care living facilities are reimbursed through TennCare

TennCare reimburses nursing homes for Medicaid patients based on a formula that includes actual staffing costs that occurred in previous years. Current reimbursement in FY 2022 is based on FY 2019 costs plus adjustments for inflation. Nursing homes will not be reimbursed based on the costs incurred during the spike in staffing costs during the pandemic until the rates are redetermined in 2024 based on 2022 costs.

TennCare is the state's managed care Medicaid program. TennCare services, which encompass long-term care services (as well as medical and behavioral services), are offered through managed care entities. Long-term care services provided to Medicaid patients in nursing facilities and assisted care living facilities are covered by three managed care organizations (MCOs). Each participating MCO creates contracts with nursing facility providers. TennCare does not directly reimburse nursing facilities or assisted care living facilities. TennCare revenues, which combine about 66 percent federal and 34 percent state dollars,^E for Medicaid patients flow through the MCOs to nursing facilities and assisted care living facilities. Nursing facilities submit patient claims for payment typically on a weekly or bi-weekly basis while assisted care living facilities are paid monthly. A considerably larger share of TennCare dollars goes to nursing facilities, which have a much larger population of Medicaid patients than do assisted care living facilities. (See Exhibit 8.)

Exhibit 8: TennCare projected and reported expenditures for long-term care facilities with Medicaid patients

	Nursing facilities	Assisted care living facilities
SFY 2023 projected expenditures	\$1,023,190,175	N/A
SFY 2022 projected expenditures	\$996,786,850	N/A
SFY 2021 actual expenditures	\$953,863,000	\$12,184,973

Note: Actual expenditures reflect payments made by MCOs to nursing facilities. TennCare projects expenditures based on expenditure data to date.
Sources: Stephen Smith, Director, Division of TennCare, memos to The Speakers of the General Assembly, Jan. 24, 2022, and June 20, 2022.

Nursing home reimbursements are based on costs in previous years.

Each Tennessee nursing facility that participates in Medicaid^F is required to submit a cost report to the Medicaid/TennCare section of the Comptroller's Division of State Audit annually, which audits the reports for each facility. Cost reports contain the expenditures that nursing facilities report having paid for the fiscal year. Under the Medicaid reimbursement system, every three years TennCare uses cost report expenditure data to establish rates for nursing facilities. Medicaid rates are rebased every three years using new cost report data. In the intervening years, rates are adjusted by an inflationary factor.

TennCare does not foresee that the increases in nursing facility expenses for staffing agencies during the pandemic will materially affect the state's overall costs, and cites what they believe may be a continuing trend: a decline in the number of nursing facility patients. However, nursing facilities say the unexpected spike in staffing costs during the pandemic has affected their operational stability.

TennCare determines the Medicaid rates at which nursing facilities are reimbursed using a complex case-mix rate setting process, consisting of several components and adjustments. Components are direct care, administrative and operating, capital, cost-based (i.e., the portion of the per diem attributable to real estate taxes related to nursing facility services, and nursing facility provider assessment costs), and quality incentive.

^E During the federal declaration of a Public Health Emergency, during which nursing facilities are getting additional funding from the federal government, the federal/state match is about 72/28 percent. The Public Health Emergency has not yet been ended.

^F According to THCA, 24 nursing facilities in the state are not Medicaid providers. These facilities accept Medicare and private pay patients and may have additional sources of funding. One facility in the state is private pay only.

A semiannual adjustment to the Medicaid rates is made for patient acuity (i.e., the level of care that each Medicaid patient requires) and the QuILTSS quality component is updated annually. (For more information about QuILTSS, see the box “State and federal incentives to sustain and improve nursing facilities’ quality standards” on pages 14-15.)

Per a recently promulgated TennCare rule amendment, starting in FY 2023-24 the direct care component will be updated annually with new cost report data. In the information provided to the Joint Government Operations Committee for the hearing on the new rule, TennCare stated that it did not anticipate the rule to have an effect on state government revenues and expenditures.³⁴ According to THCA, the origin of the rule was to address cost reporting issues and was not necessarily a means of reimbursing facilities more for increased costs. THCA believes that implementation of the new rule means that cost reports that nursing facilities submit to State Audit will reflect nursing facilities’ additional costs for direct care expenses closer to when they occur, but adds that facilities will receive reimbursements only to the extent that the General Assembly appropriates funding for this purpose. Reimbursements may not fully cover the expenditures that nursing facilities made to healthcare staffing agencies during 2020, 2021, and 2022.

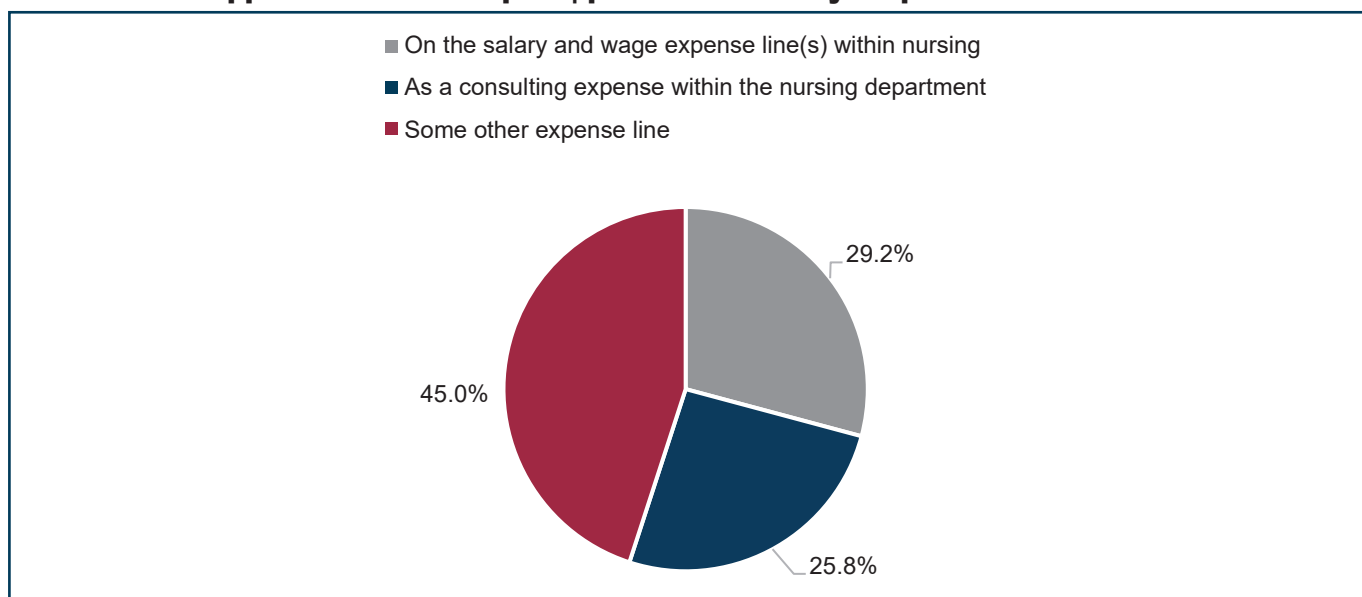
For purposes of this report, which focuses on nursing facility spending during the pandemic for healthcare staffing agencies to supplement direct care staff shortages, the direct care component is the most relevant. The calculation for the direct care component uses expenditures reported by nursing facilities for salaries, contract labor, and payroll tax and employee benefit expenses for both permanent and contracted direct care staff (i.e., temporary staff hired through healthcare staffing agencies): RNs, LPNs, and CNAs. Nursing facilities report these, as well as other, expenditures on the annual supplemental cost report each submits to the Comptroller of the Treasury for audit to verify the expenditures.

Spending on healthcare staffing agency costs cannot be isolated from other staff spending because such costs are not reported uniformly.

Nursing facilities are required to annually report their allowable costs on two reports – the CMS Medicare Cost Report and the Medicaid Supplemental Cost Report. Both reports must be filed with the Comptroller Division of State Audit on a specified due date. The supplemental cost report is audited by the Medicaid/TennCare section of the Division of State Audit. TennCare uses cost report expenditure data to establish reimbursement rates for nursing facilities. Medicaid rates are rebased every three years using new cost report data. In the intervening years, rates are adjusted by an inflationary factor.³⁵

Although OREA was granted permission by State Audit to review the supplemental cost reports containing the amounts that nursing facilities spent for temporary staffing, it was not possible for OREA to isolate those amounts because nursing facilities typically incorporate them in total wages and salaries or in another cost component on the report. OREA analysts found in results from the 2022 survey that nursing facilities are not required to report temporary staffing costs in a uniform location on their annual cost report to the Comptroller, as shown in Exhibit 9. Facilities that responded to the OREA survey indicated where on the cost report they have reported that information for the last few years. The cost reports do not specify that nursing facilities should isolate the costs expended only for temporary staffing agency costs within the amounts reported for salary and wage expenses or for consulting expenses.

Exhibit 9: Nursing facilities do not report temporary staffing costs in a uniform location on their annual supplemental cost report | percent of survey respondents



Source: OREA survey results.

Notes: The results depict the percentage of nursing facilities that responded to a question asking where they supplied the expenditures to healthcare staffing agencies for contracted employees on their annual supplemental cost report. These results depict what they reported for the most recent year, 2022.

TennCare reimburses assisted care living facilities based on the number of Medicaid patients they serve.

Assisted care living facilities in Tennessee provide services to Medicaid-eligible individuals who qualify for home and community-based services. In FY 2020-21, 96 assisted care living facilities provided Medicaid services to individuals. TennCare reimburses these facilities on a monthly basis, based on the number of Medicaid-eligible patients served. For 2022, the monthly amount that TennCare reimbursed assisted care living facilities for each Medicaid patient was \$1,305 per month. In July 2022, for assisted care living facilities that agreed to pass increases to the direct care workforce, this amount was increased to \$1,426.84 per month. The increase was paid for through federal funds from the American Rescue Plan Act (ARPA), which enhanced funding provided to states through the Federal Medical Assistance Percentage (FMAP) rate during the public health emergency declaration. The FMAP is used to reimburse states for the federal share of most Medicaid expenditures. In response to the economic impact of the pandemic, federal law provides a 6.2 percentage point increase to the FMAP rate for all states, beginning January 1, 2020, and ending on the last day of the calendar quarter in which the federally declared public health emergency (PHE) period ends. This increase was also supported by a legislative appropriation to cover the state increases caused by the increased federal funding.³⁶

Analysis

Nursing facilities' use of healthcare staffing agencies increased as the pandemic continued from 2020 through the first part of 2022, according to results from the OREA survey of Tennessee nursing facilities. Contracting for temporary staff significantly increased nursing facilities' expenditures for healthcare staffing agencies during that period, a trend that could continue through the remainder of 2022.

Assisted care living facilities experienced a similar trend, though the amounts expended for temporary staff were lower overall than those for nursing facilities. The first section below details the experiences of Tennessee nursing facilities as reported through surveys. The second section provides experiences of the state's assisted care living facilities.

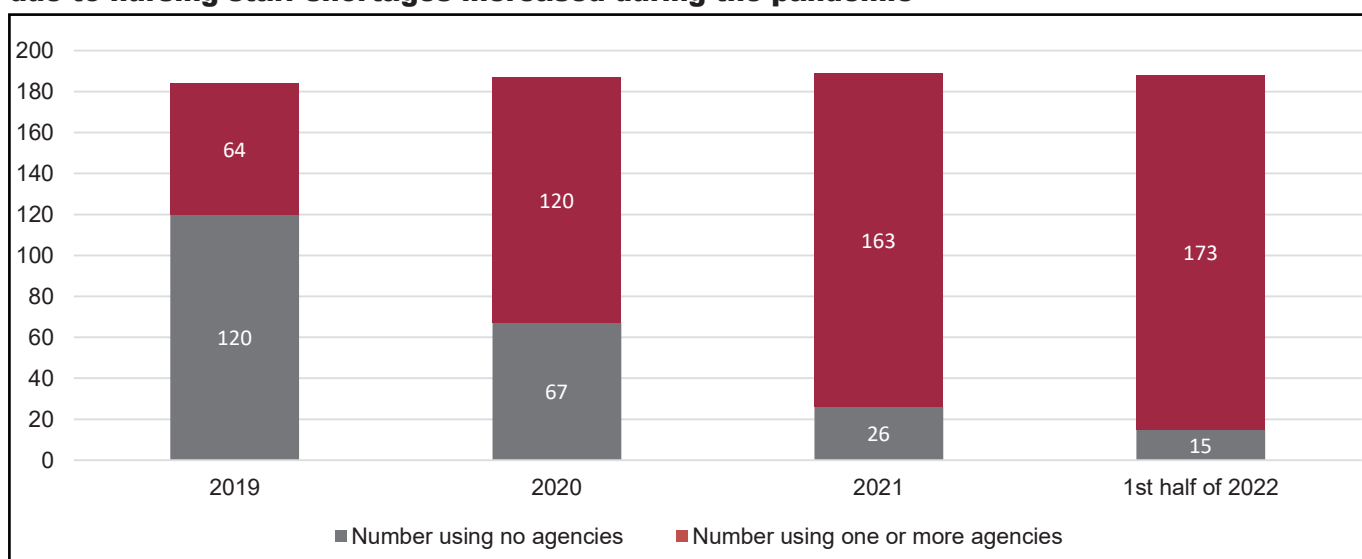
Nursing facilities

In 2019, the year prior to the onset of the pandemic, comparatively few Tennessee nursing facilities contracted with healthcare staffing agencies to supplement staff shortages. The number of nursing facilities that contracted with health care staffing agencies increased over the next two and a half years as effects from the pandemic worsened.

OREA survey results for 2019 showed that 120 nursing facilities that responded to the survey did not contract with any agencies and 64 used one or more agencies. By the end of 2020, with the pandemic well underway, these numbers were reversed with 120 facilities using one or more agencies and 67 using none. In 2021, the number of facilities using agencies rose to 163 with 26 using none. In the first half of 2022, the number of facilities using agencies to shore up staff shortages was only slightly higher, at 173, than the number using agencies in all of 2021, with 15 reporting no use of agencies. Of those facilities that responded to the survey, 86 reported no use of agencies at any time from 2019 through mid-2022.

Federal data support the information the OREA survey collected. Data collected by the Centers for Medicare and Medicaid (CMS) shows that a higher number of nursing facilities reported using staffing agencies during 2019, 2020, and 2021 than reported doing so on the OREA survey, which did not capture data from all nursing facilities. CMS data shows that 129 Tennessee nursing facilities reported using healthcare staffing agencies in 2019. This rose to 150 facilities in 2020 and to 192 facilities in 2021. Exhibit 10 shows the number of facilities that contracted for each year according to OREA survey results. Both sets of data show the same upward trend in the use of healthcare staffing.

Exhibit 10: The number of nursing facilities contracting with healthcare staffing agencies due to nursing staff shortages increased during the pandemic



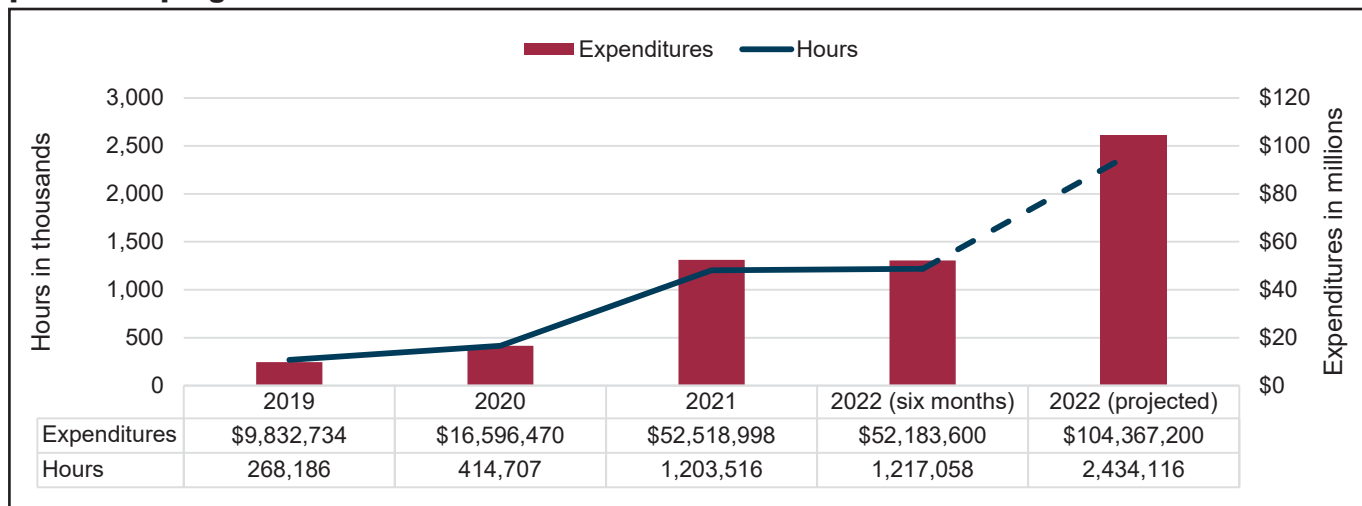
Source: 2022 OREA survey.

Spending by nursing facilities on healthcare staffing agencies increased over this period, with expenditures and hours in the first half of 2022 exceeding those in all of 2021. In 2019, nursing facilities reported expenditures to healthcare staffing agencies of about \$9.8 million. This rose to \$16.6 million in 2020, and more than doubled, reaching \$52.5 million, in 2021. In the first half of 2022, nursing facilities reported expenditures nearly equal to those in all of 2021, at \$52.2 million. If spending levels remain the same for the second half of 2022, nursing facilities will have expended \$104.4 million for temporary staff in 2022.

The expenditures data provided by nursing facilities responding to the OREA survey are based on the number of hours reported for RNs, LPNs, and CNAs temporarily hired from healthcare staffing agencies, using

the rates of pay that staffing agencies charged. In 2019, the number of hours nursing facilities reported for temporary employees was 268,186, and in 2020, the number rose to 414,707. By 2021, that number more than doubled, reaching 1,203,516 hours. For the first half of 2022, the number of hours was 1,217,058.

Exhibit 11: The use of temporary healthcare staff by nursing facilities increased as the pandemic progressed



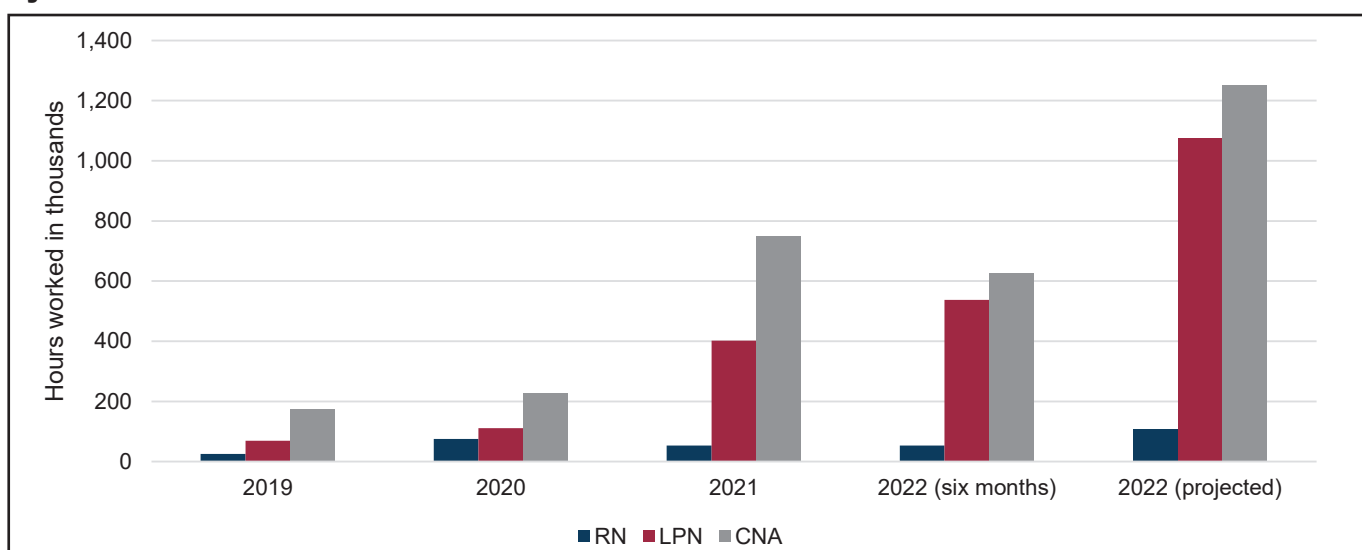
Source: OREA survey results, 2022.

Notes: 167 nursing facilities reported expenditures and hours worked for the years shown. The survey covered the first half of 2022 (January to July). The projection for the entirety of 2022 assumes the same amount of expenditures and hours worked for the final half of 2022.

Detail of increase by staff type

Nursing facilities contracted with staffing agencies most often for certified nursing assistants (CNAs) followed by licensed practical nurses (LPNs). Contracting for registered nurses (RNs) was less frequent. Exhibit 12 shows a comparison of the hours that temporary staff in these three direct care categories worked.

Exhibit 12: Nursing facilities contracted with staffing agencies most often for CNAs followed by LPNs

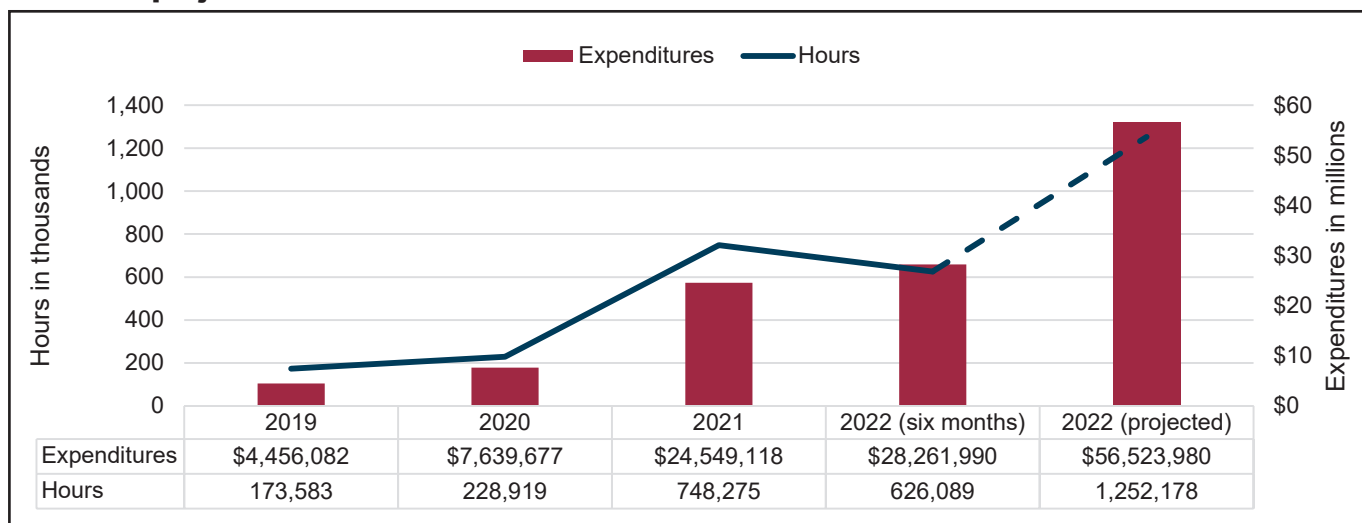


Source: OREA survey results, 2022.

Notes: 167 nursing facilities supplied hours worked for the years shown. The survey covered the first half of 2022 (January to July). The projection for the entirety of 2022 assumes the same amount of hours worked for the final half of 2022.

Exhibit 13 breaks out information for CNA hours only and includes the amounts nursing facilities spent on CNAs just prior to and through the pandemic to mid-2022.

Exhibit 13: Contracted CNA hours and expenditures in nursing facilities | 2019 through mid-2022 and projected



Source: OREA survey results, 2022.

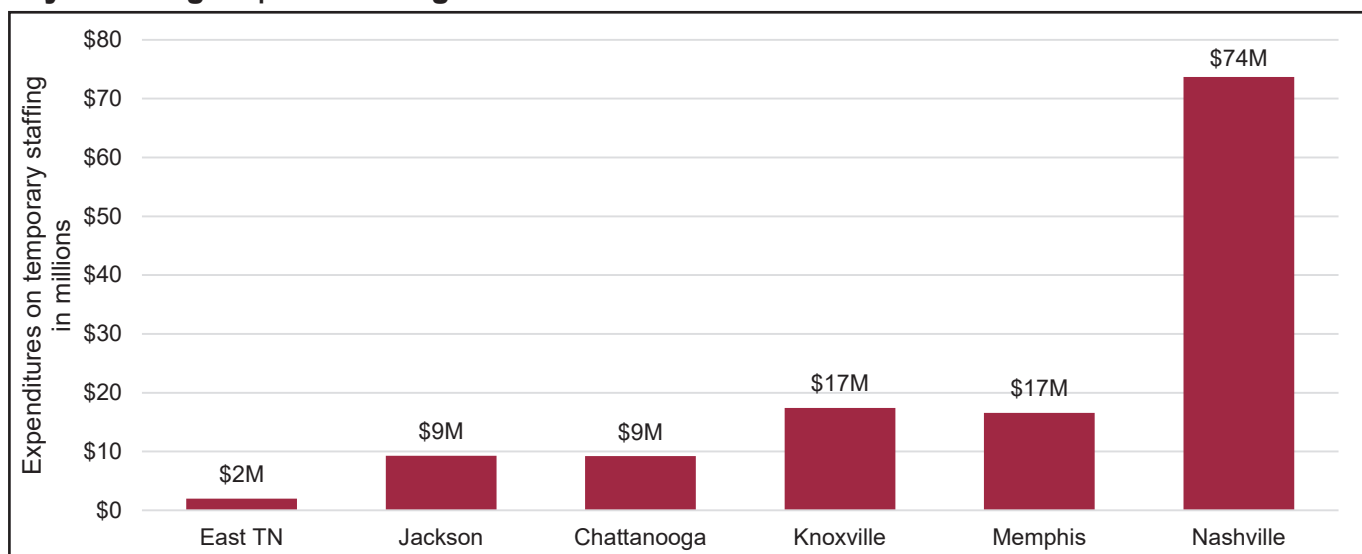
Notes: 167 nursing facilities supplied expenditures and hours worked for the years shown. The survey covered the first half of 2022 (January to July). The projection for the entirety of 2022 assumes the same amount of expenditures and hours worked for the final half of 2022.

Detail by region

Nursing facilities in the Nashville region spent more on temporary staffing than any other region, in total and when considering facility bed size as an equalizing factor.

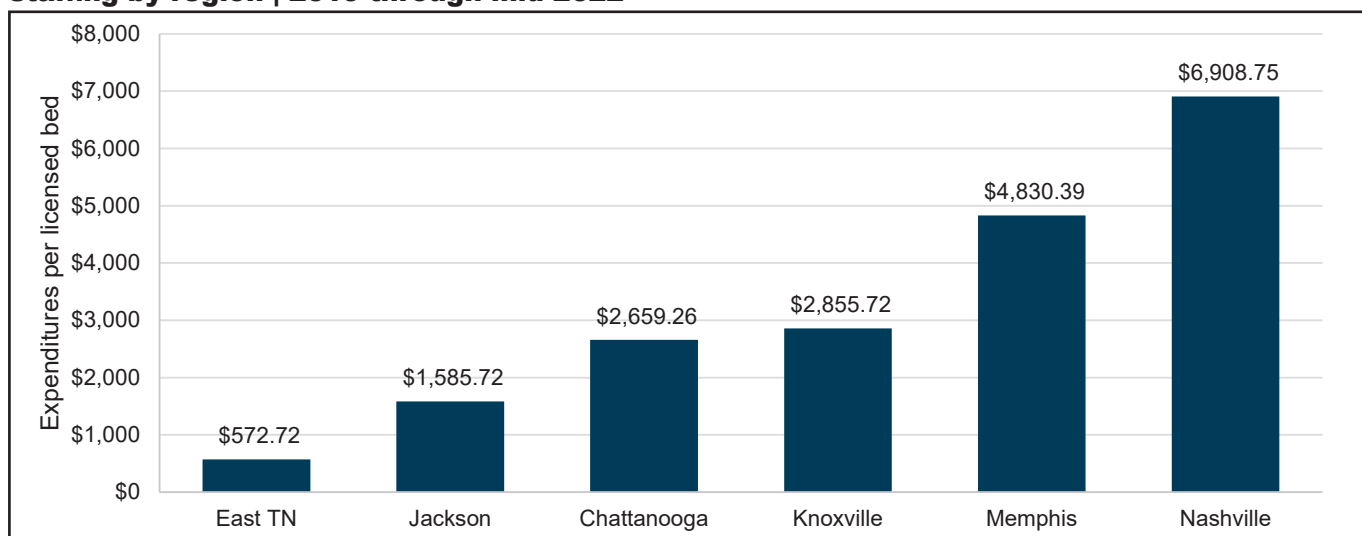
Facilities in the Nashville region spent about \$74 million on temporary staffing from 2019 through mid-2022, which far exceeded the amounts spent in any other region. When considering the cost expended per facility bed size, facilities in the Nashville region spent about \$6,900 per bed, Memphis region facilities spent about \$4,800 per bed, Jackson region facilities spent about \$1,600 per bed, Chattanooga region facilities spent about \$2,700 per bed, Knoxville region facilities spent about \$2,856 per bed, and East Tennessee region facilities spent about \$573 per bed. (See Exhibits 14, 15, and 16.) The larger amounts spent in the Nashville region could be due to a number of factors that OREA's analysis cannot determine. Factors could include, for example, that more temporary staffing agencies are located in the Nashville area, that nursing facility staff in Nashville had higher rates of COVID that prevented staff from returning to work, that nursing facilities in Nashville had patients with higher acuity levels that required more support during the pandemic, or that a higher percentage of direct care staff left nursing facilities to work in other industries or for temporary staffing agencies.

Exhibit 14: Nursing facilities in the Nashville region spent more on temporary staffing than any other region | 2019 through mid-2022



Note: The regions shown on the spreadsheet are defined by the Tennessee Health Care Association.
Source: OREA survey, 2022.

Exhibit 15: The estimated amount per licensed bed that nursing facilities spent on temporary staffing by region | 2019 through mid-2022



Notes: These amounts are based on licensed bed size in those nursing facilities that reported expenditures for temporary staffing agencies on the OREA survey. THCA provided OREA with bed size for each facility. Because bed size is not the same as number of patients, which constantly fluctuates, this is an approximation of cost and is meant only to estimate the difference in per-bed spending among regions.
Source: THCA spreadsheet, 2022. OREA survey, 2022.

Exhibit 16: The number of licensed beds and estimated amount per licensed bed that nursing facilities spent on temporary staffing by region | 2019 through mid-2022

THCA region	Beds	Expenditures	Average expend. per bed
East TN	3,496	\$2,002,216	\$572.72
Jackson	5,842	\$9,263,792	\$1,585.72
Chattanooga	3,459	\$9,198,375	\$2,659.26
Knoxville	6,094	\$17,402,769	\$2,855.72
Memphis	3,428	\$16,558,585	\$4,830.39
Nashville	10,669	\$73,709,498	\$6,908.75
Totals/Average	32,988	\$128,135,235	\$3,235.43

Notes: These figures in the “expenditures per bed column” are based on licensed bed size in those nursing facilities that reported expenditures for temporary staffing agencies on the OREA survey. THCA provided OREA with bed size for each facility. Because bed size is not the same as number of patients, which constantly fluctuates, this approximates cost and is meant only to estimate the difference in per-bed spending among regions.
Source: THCA spreadsheet, 2022. OREA Survey, 2022.

Federal law requires nursing facilities to report staffing data to the Centers for Medicare and Medicaid (CMS)

Section 6106 of the Affordable Care Act (ACA) requires CMS to collect electronic staffing data from nursing facilities. The ACA requires this data to be auditable and verifiable. The data to be reported by nursing facilities includes the hours worked by direct care staff (both employed and contracted) and employee turnover and tenure. CMS developed the Payroll-Based Journal (PBJ) to collect this data. All long-term care facilities have access to the system at no cost. The first mandatory reporting period began July 1, 2016.

In April 2018, CMS began using PBJ data to determine each facility's staffing rating used in the Nursing Home Five-Star Quality Rating System.

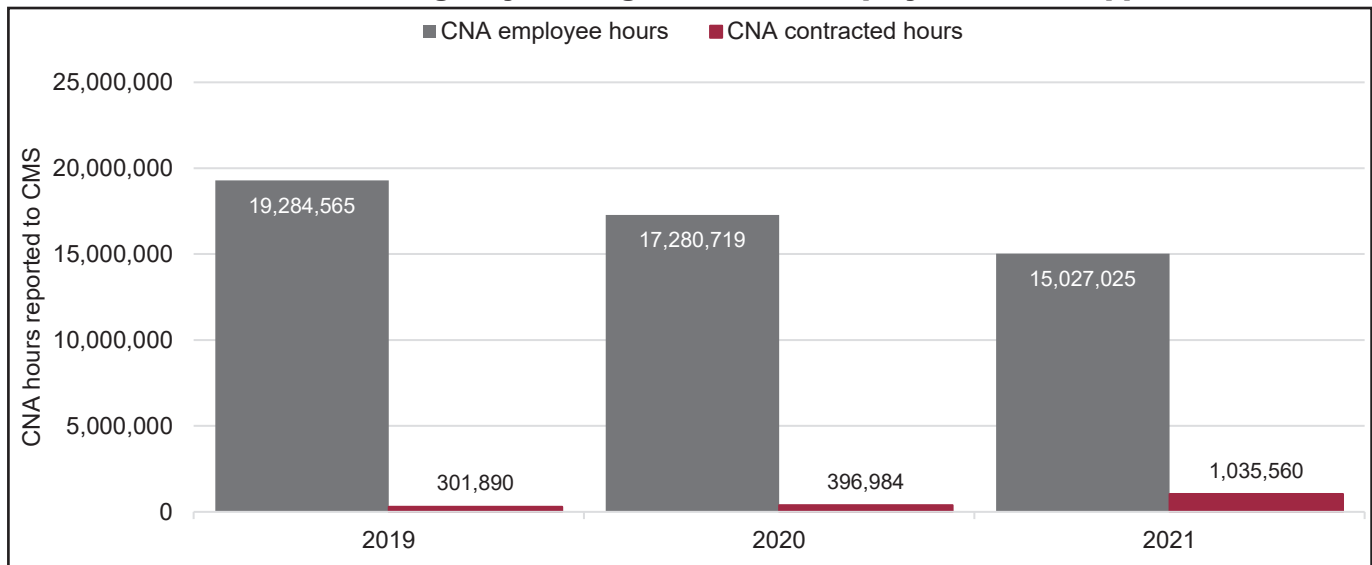
Sources: The United States Social Security Administration, Compilation of the Social Security Laws, Accountability Requirements for Facilities, Social Security Act 11281(g) Submission of Staffing Information Based on Payroll Data in a Uniform Format, https://www.ssa.gov/OP_Home/ssact/title11/11281.htm.

CMS, Staffing Data Submission Payroll Based Journal (PBJ), <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Staffing-Data-Submission-PBJ#:~:text=Section%206106%20of%20the%20Affordable,payroll%20and%20other%20auditable%20data.>

Nursing facility reporting to CMS

Due to 2015 requirements added to federal law and in regulation, nursing facilities must report to CMS the number of hours that direct care staff work for the facility by type, including permanent staffing and contracted staffing. Exhibit 17 shows the increase from before and during the pandemic in the number of hours worked by CNAs that were contracted through healthcare staffing agencies as officially reported to CMS.

Exhibit 17: CNA contracted agency hours grew as CNA employee hours dropped

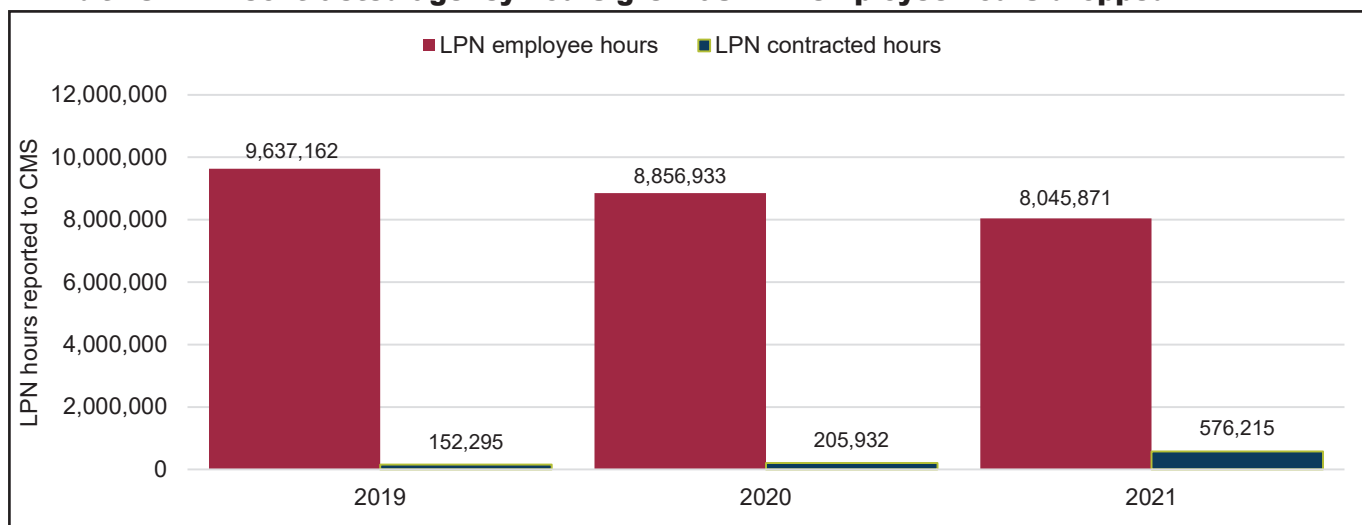


Source: CMS, Payroll Based Journal System, Jan. 2019 through Dec. 2021.

Notes: CMS temporarily suspended reporting requirements for the Payroll Based Journal for the first quarter of 2020 (January through March), and resumed required reporting for the second quarter beginning April 1, 2020. CMS reported that 60 percent of nursing facilities continued to report data during the first quarter of 2020. CMS, Memorandum to State Officials and others, June 25, 2020, <https://www.cms.gov/files/document/qso-20-34-nh.pdf>.

Exhibit 18 shows a similar rise in the number of hours worked by LPNs staffed through a healthcare staffing agency as officially reported to CMS for the same period.

Exhibit 18: LPN contracted agency hours grew as LPN employee hours dropped



Source: CMS, Payroll Based Journal system, Jan. 2019 through Dec. 2021

Notes: CMS temporarily suspended reporting requirements for the PBJ in the first quarter of 2020 and there was a 17.9 percent decline in the number of nursing homes reporting in that quarter. This rose again in the second quarter of 2020 with only a 1.6 percent decline in the number reporting in the fourth quarter of 2019. Norma B. Coe, Nursing Home Staffing Levels Did Not Change Significantly During COVID-19, Health Affairs.org <https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.02351>.]

A consideration of other factors and nursing facilities' use of healthcare staffing agencies

Using data supplied by THCA, OREA analyzed whether certain variables seemed to affect whether or not nursing facilities contracted with staffing agencies. OREA could detect no discernible pattern when comparing nursing facility survey responses to facilities' bed size, quality incentive scores, quality payments, total direct care per diem, the number of annualized Medicaid days, or final Medicaid rate. OREA analysts also conducted a regression analysis, which came to similar conclusions, finding no significance when considering the effects these variables had on whether facilities contracted with healthcare staffing agencies.

This suggests that staffing shortages across all types of facilities were significant enough to require contracting with staffing agencies. Many facilities may have contracted with staffing agencies because they had no other choice in order to provide care for patients. One nursing facility responder said they were unable to retain staff who were leaving to work for staffing agencies because of the higher wages agencies were paying – “then we have to backfill that position with a travel or contract staff member” because there are not enough licensed or certified personnel in their area. Another responder said, “the double-edged sword . . . of using agency to take care of our patients and causing us to operate at a loss is a necessity due to the staffing shortage – while also preventing us from retaining and hiring adequate staff due to [facility staff] being recruited to agencies while in our building.”

Where facilities were located in the state seemed to have a greater effect on the number of facilities that contracted with agencies and the amount of expenditures facilities paid to agencies. See “Detail by region” beginning on page 19.

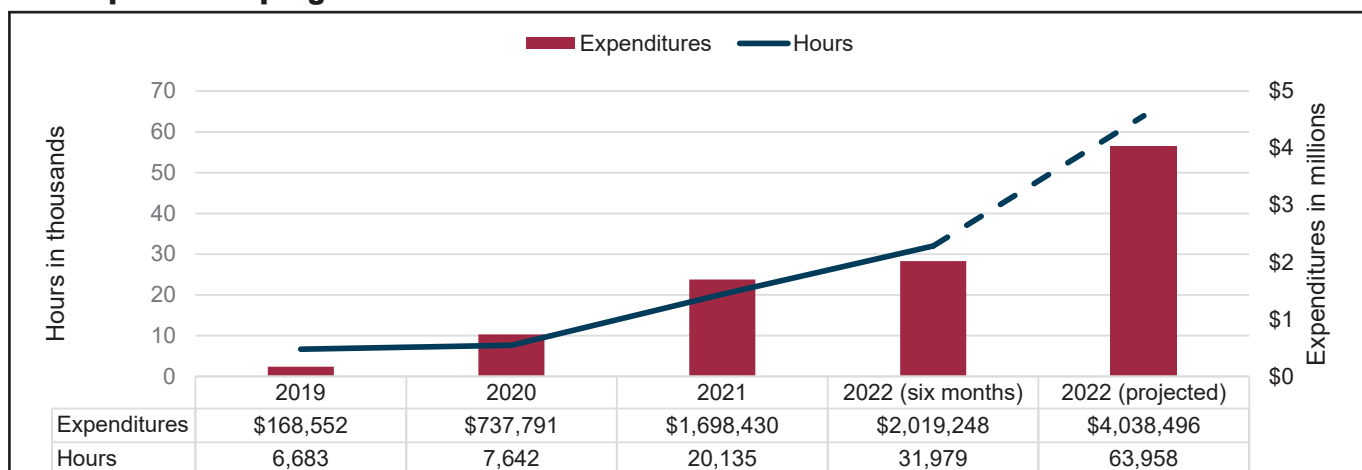
Assisted care living facilities

Like nursing facilities, few assisted care living facilities in Tennessee reported contracting with healthcare staffing agencies to supplement staff shortages in 2019, the year prior to the onset of the pandemic. The number of assisted care living facilities that contracted with health care staffing agencies increased over the next two and a half years as effects from the pandemic worsened.

OREA survey results showed that for the 119 assisted care living facilities responding, 53 reported contracting with one or more agencies and 39 reported contracting with no agencies during the pandemic (2020 until mid-2022); 27 facilities indicated having no staff shortages throughout the pandemic.

Spending by assisted care living facilities on healthcare staffing agencies increased over this period, with expenditures and hours in the first half of 2022 exceeding those in all of 2021. In 2019, assisted care living facilities reported expenditures to healthcare staffing agencies of \$168,552. This rose to \$737,791 in 2020, and more than doubled in 2021, reaching \$1.7 million. In the first half of 2022, assisted care living facilities reported expenditures higher than those in all of 2021, at \$2 million. If spending levels remain the same for the second half of 2022, assisted care living facilities will have expended more than \$4 million for temporary staff in 2022. (See Exhibit 19.) The expenditures data provided by assisted care living facilities is based on the number of hours reported for RNs, LPNs, and CNAs temporarily hired from healthcare staffing agencies, using the rates of pay that staffing agencies charged. In 2019, the number of hours assisted care living facilities reported for temporary employees was 6,683, and in 2020, the number rose to 7,642. By 2021, that number nearly tripled, reaching 20,135 hours. For the first half of 2022, the number of hours again rose to 31,979. (See Exhibit 19.)

Exhibit 19: The use of temporary healthcare staff by assisted care living facilities increased as the pandemic progressed



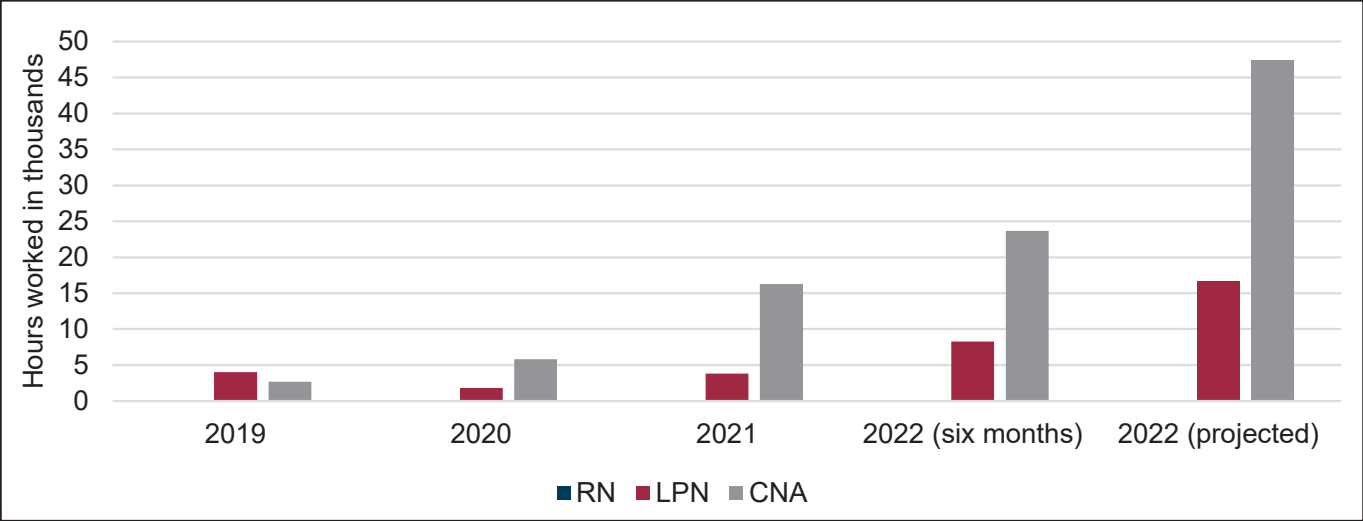
Source: OREA survey results, 2022.

Notes: 32 assisted care living facilities supplied expenditures and hours worked for the years shown. The survey covered the first half of 2022 (January to July). The projection for the entirety of 2022 assumes the same amount of expenditures and hours worked for the final half of 2022.

Detail of increase by staff type

Like nursing facilities, assisted care living facilities contracted with staffing agencies most often for certified nursing assistants (CNAs) followed by licensed practical nurses (LPNs). Contracting for registered nurses (RNs) was less frequent. Exhibit 20 shows a comparison of the hours that temporary staff in these three direct care categories worked.

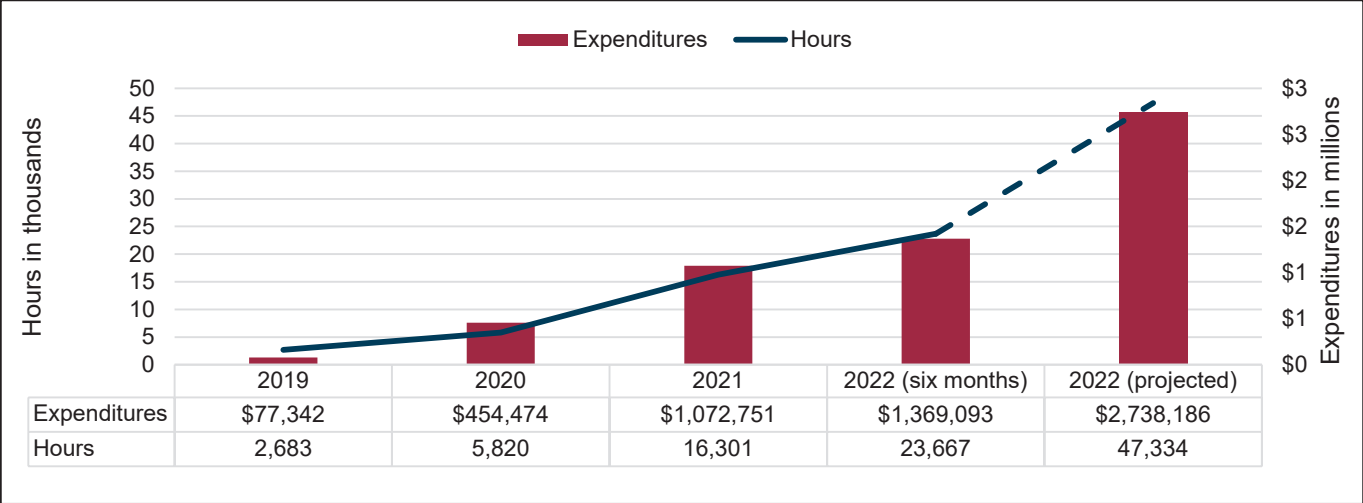
Exhibit 20: Assisted care living facilities contracted with staffing agencies most often for CNAs followed by LPNs



Source: OREA survey results, 2022.
Notes: 32 assisted care living facilities supplied expenditures and hours worked for the years shown. The survey covered the first half of 2022 (January to July). The projection for the entirety of 2022 assumes the same amount of expenditures and hours worked for the final half of 2022.

Exhibit 21 isolates information for CNA contracted hours only and includes the amounts assisted care living facilities spent on contracted CNAs from 2019 and through the pandemic to mid-2022.

Exhibit 21: Contracted CNA hours and expenditures for assisted care living facilities | 2019 through mid-2022 and projected



Source: OREA survey results, 2022.
Notes: 32 assisted care living facilities supplied expenditures and hours worked for the years shown. The survey covered the first half of 2022 (January to July). The projection for the entirety of 2022 assumes the same amount of expenditures and hours worked for the final half of 2022.

Tennessee made efforts to increase the number of certified nursing assistants (CNAs) during the pandemic and continues to work toward this goal.

The OREA survey found that facilities most often contracted with healthcare staffing agencies to hire CNAs, which make up the largest portion of direct care staff in long-term care facilities. CNAs assist facility residents with activities of daily living, such as bathing, eating, and toileting. To increase the number of CNAs in states, beginning in early 2020, CMS, the federal agency that enforces the regulations concerning the operation of long-term care facilities, waived the requirement that an individual could work as a nurse aide no more than four months in a nursing facility without qualifying to become a CNA.³⁷

To work as temporary nurse aides (TNAs), the waiver required individuals to demonstrate competency in the skills and techniques necessary to care for residents' needs. In Tennessee, this was done through completion of an eight-hour training course offered by the American Health Care Association (AHCA) and successful passage of an oral or written exam.³⁸

To become a CNA, individuals must

- receive at least 75 hours of training by not later than four months after beginning work, including at least 16 hours of hands-on training supervised by a nurse.^{39,40}
- achieve certification through satisfactory performance on a competency evaluation and a skills demonstration.⁴¹ The Tennessee Health Facilities Commission (HFC) maintains the Nurse Aide Training and Competency Evaluation Program (NATCEP) and conducts the state competency examination for individuals to become CNAs.

Throughout the pandemic, beginning in June 2021, Tennessee made efforts to get as many Temporary Nurse Aides trained to become CNAs as quickly as possible.

- The Tennessee Temporary Nurse Aide Bridge Program (created via emergency rules through the Board for Licensing Healthcare Facilities in August 2021) allowed TNAs to transition to become CNAs if they met requirements listed below. The program, which was begun under the Tennessee Department of Health, Office of Healthcare Facilities (now transferred by the General Assembly to the HFC) via emergency rule, became effective August 16, 2021, and ended on December 15, 2021.⁴² According to the HFC, as of late October 2022, 1,807 TNAs had qualified to become CNAs through the Bridge Program. Any TNA that did not meet the deadline is subject to the normal requirement of completing a 75-hour nurse aide training program to become certified.
 - Worked at least 200 hours in a nursing home during the public health emergency (PHE);
 - Passed a written or oral test, which could be the initial online test the TNA took to become a TNA (i.e., part of the AHCA TNA training program);
 - Established the individual's competency to perform the duties of a nurse aide by successfully completing an assessment in all areas of required nurse aide training as provided for in federal regulation (relating to requirements for approval of a Nurse Aide Training and Competency Evaluation Exam).
- Individuals who were part of the Temporary Nurse Aide Program (which is separate from the Tennessee Temporary Nurse Aide Bridge Program) were allowed to work as TNAs in nursing facilities until June 6, 2022. CMS later extended this deadline for all states to October 6, 2022, to give TNAs hired under the CMS waiver more time to become CNAs.
- In February 2022, the Emergency Rules promulgated by the Board for Licensing Healthcare Facilities, which created the bridge program, expired.
- In April 2022, the Board for Licensing Health Care Facilities approved a process where a qualified candidate, including a TNA, could "challenge the exam." Challenging the exam entails allowing a TNA to take the skills and knowledge exams without being enrolled in a training program. (Previously, only applicants who had been enrolled in the training program could sit for a skills and knowledge exams.) Qualified candidates had the opportunity to challenge the exams until October 6, 2022.
- Since July 1, 2022, HFC has continued to allow qualified candidates to apply to take the nurse aide competency exam without completing a traditional training and competency evaluation program. Qualified candidates can apply until December 16, 2022. As of September 26, 2022, 876 TNAs had

applied to challenge the test for nurse aide certification. Of these, 173 TNAs have tested and 91 (53 percent) passed to become certified as CNAs. To apply, TNAs must submit all required documentation including:⁴³

- certificate of completion for the AHCA's Temporary Nurse Aide eight-hour online training course, and
 - certification of 100 hours serving as a TNA in a nursing facility under the supervision of a licensed or registered nurse, signed by the director of nursing and/or administrator on the facility's letterhead.
- By October 21, 2022, 3,964 TNAs had registered in the Temporary Nurse Aide Program and were working in Tennessee nursing facilities. Of these, 1,963 have qualified to become CNAs and 2,001 have not yet transitioned.

In fall 2022, applicants in Tennessee reported difficulties obtaining seats in physical testing locations to take the required examination. Because program and testing delays continued in Tennessee and several other states in October, CMS allowed states to document the reasons for continued delays and the plans to alleviate them and submit a waiver request. To reduce the backlog of TNAs awaiting testing, HFC submitted a waiver request to CMS, which approved the request and extended the date for Tennessee to April 5, 2023, (or until the end of the federally declared public health emergency, whichever comes first) allowing TNAs hired during the waiver to challenge the knowledge and skills exams to become CNAs.

In an October 21, 2022, press release, the HFC said that the waiver will allow Tennessee to train and certify 2,650 TNAs by April 5, 2023. Previously, the Tennessee Department of Health, Office of Healthcare Facilities, did not permit virtual testing for nurse aide certification, but HFC is now pursuing that option, which requires a new state contract. HFC is working with the state's Central Procurement Office to issue a request for proposals (RFP) for a testing vendor to conduct online and physical testing. HFC is also working with Tennessee universities to set up mass-testing sites in order to proctor tests for TNAs statewide.⁴⁴

HFC maintains an online list of approved CNA training programs. As of October 27, 2022, there were 306 with 268 approved and 38 being processed.^{45,G} Many of these are also testing sites – the state has 167 testing sites as of late October.

OREA survey respondent:

"The lack of approved CNA training sites for adult learners in the county has provided a challenge in attracting an adequate workforce of CNAs. The costs associated with other training programs and commuting distance to the programs have been reported by applicants as a barrier. The CNA bridge program enabled LTC facilities to attract and train in the local communities as well as provide an income to the trainees. This ended in December 2021. Highly recommend bringing back the CNA bridge program."

Other states' actions to address the increased use of healthcare staffing agencies

In 2022, several states proposed and some enacted legislation to place various restrictions on healthcare staffing agencies. At least seven states (Colorado, Connecticut, Iowa, Kentucky, Louisiana, Missouri, and Oregon) passed new legislation that require healthcare staffing agencies to register with the state, meet certain requirements, submit specified information about their operations, and pay an annual fee.

Some states also included provisions in new 2022 laws or amended existing laws to require specific financial data from healthcare staffing agencies.

^G The list of training programs can be searched by county or a list of all programs can be generated. According to HFC, the largest number of training programs are in east Tennessee. (East Tennessee: 74, Middle: 19, West: 44).

- Colorado's new law requires that staffing agencies submit specific operations and financial data that the state will use to analyze and determine the need for regulation of the staffing agencies.
- Connecticut's new law requires temporary nursing services agencies to submit to the state an annual cost report for the previous calendar year beginning July 1, 2023. Cost reports are to include itemized revenues and costs; average number of nursing personnel employed by the agency; average fees charged by the agency by type of nursing personnel and type of facility; and other information. The law also requires each temporary nursing services agency to enter into a written agreement with each health care facility to which the agency assigns personnel.
- Illinois, which already required registration of healthcare staffing agencies and agencies' adherence to minimum standards, passed a new law requiring such agencies to submit to the state Department of Labor all contracts between the agency and a health care facility to which it assigns or refers nurses or CNAs and copies of all invoices to healthcare facilities personnel. The Department of Labor will publish an annual report by county of average amounts paid to employees and charged to health care facilities by nurse agencies for each individual worker category and the average amount paid by the agency to each individual worker category.

Kentucky, in addition to establishing a new registration system and reporting requirements for healthcare staffing agencies, added direct care services provided by the agencies to its existing price gouging statute.

New laws in three states (Illinois, Louisiana, and Missouri) authorize a complaint system for nursing facilities or others concerning healthcare staffing agencies. Complaints are to be followed up by investigations. In Illinois, complaints may be made by a healthcare facility, nurse staffing agency, or an employee of either. Investigations in Illinois are also to consider the responsibility of health care facilities to supervise nurse agency employees working in the facilities. Pennsylvania has proposed legislation that includes a complaint system.

A new law in Oregon authorizes the state to establish a process to determine annual rates that a temporary staffing agency may charge to or receive from a long-term care facility. Existing laws in two states – Massachusetts and Minnesota – have maximum caps on the hourly rates that healthcare staffing agencies can charge the facilities they provide temporary staff for. Both states increased the caps during the pandemic.

- Maximum caps on hourly rates, which vary by geographic region, took effect in Massachusetts in March 2001. In May 2020, due to the pandemic and increased facility staffing shortages, the state increased the cap by 35 percent across the board and removed the cap altogether for nurses and CNAs who were working with COVID patients. The order to that effect expired in February 2021 and the agencies are again subject to the current maximum rates in regulation.
- Minnesota passed its law concerning maximum hourly rates also in 2001. The law prohibits a healthcare staffing agency from billing or receiving payments from a nursing home at a rate higher than 150 percent of the sum of the weighted average wage rate plus a factor to incorporate payroll taxes. Each year the state calculates the average wages of RNs, LPNs, and CNAs in care centers using the data provided from annual cost reports the staffing agencies are required to submit. It then computes the statutory limits on the amount that healthcare staffing agencies can charge per hour for each type of staff. In May 2020, during the public health emergency due to COVID (now expired), the state allowed a waiver of the caps if necessary to provide adequate staffing. Long-term care facilities could apply for the waivers, which were determined on a case-by-case basis.

Pennsylvania's proposed legislation, which has passed in the House, originally contained a provision that would have capped maximum rates charged by staffing agencies. The provision was removed before final passage of the House bill.

Healthcare staffing agencies' perspectives

OREA contacted the top five most widely used healthcare staffing agencies based on survey responses from long-term care facilities. OREA provided anonymity to any staffing agency that agreed to respond; one of the five sent written responses to analysts' questions. The responding staffing agency provides staffing services to 13 Tennessee facilities throughout the state.

Some other states the agency works in require healthcare staffing agencies to register with the state and submit specified financial and other data annually about its operations. The agency "understands the need to be registered and licensed in a state," and said that it follows all licensing requirements in the states it works in. In Tennessee, it has a standard business license, which it was required to file and register with the Secretary of State.

The agency's responses are summarized here:

- The overall need for staff increased during the pandemic, which further exposed the extent of the national nursing shortages. Nurses were more willing to leave the stability of a full-time role, some because of burnout, better opportunities, retirement, and an overall fear of the virus – these factors contributed to the national nursing shortage and current state of healthcare staffing.
- Rural areas continue to be more difficult to staff. Nurses from rural communities seem to be willing to travel further and consider more lucrative opportunities, often in larger cities.
- Agency contract terms differ from contract to contract. Basic and standard items include term of the contract (usually one year with ability to auto renew), insurance requirements, and billing processes. The contract includes bill rates, which are firm but variable by amendment or through use of a specific assignment confirmation for personnel. Contracts build in the process for capturing rate changes as needed to recruit and retain personnel.
- The agency also indicated that it routinely verifies and monitors nurse licenses through the Tennessee Health Related Board's website verification as well as Nursys.^H It follows applicable state law and its own policies to ensure that temporary staff have the credentials necessary to work in long-term care facilities, and also conducts background checks and screenings using a third party vendor (e.g., sex offenders registry; county, state, and federal criminal checks; etc.).
- The agency complies with all healthcare related staffing agency licensing requirements and "understands the need to be registered and licensed in a state." Because the agency works in several states, it is "well versed in the various requirements in states across the country."

The agency is a member of the American Staffing Association, which represents healthcare staffing agencies as well as agencies from other staffing industry sectors.⁴⁶ In February 2022, the American Staffing Association published a brief titled "What's Really Driving the Cost of Temporary Nurses?" The brief, which addresses staff shortages in all healthcare facilities (e.g., hospitals) and not only long-term facilities, notes that "the unprecedented demand for nurses...has caused the cost of nurse staffing to rise" and argues cost increases are justified.⁴⁷

The cost of services has risen not only because of the unprecedented demand but because the supply of nurses has suffered due to the unusually harsh working conditions caused by COVID. Stress and overwork, stark physical danger, and, in the case of travel nurses, extended periods away from home, all have led to burnout, long leaves of absence, and retirements which have significantly reduced the number of nurses available to work. The supply-demand imbalance required nurse staffing agencies to offer significantly higher wages to attract and retain nurses – which necessarily drove up the cost of the agencies' services.⁴⁸

^HNursys.com provides online verification for endorsement to a nurse requesting to practice in another state and anyone who wants to verify a nurse license. The Nursys licensure and disciplinary database is the repository of the data provided directly from state boards of nursing.

The association also argues against the use of rate caps, which some states have implemented or are considering implementing. They assert that if agencies are prevented from paying market wages, nurses will go elsewhere or leave the profession. They suggest that continued competition is a better approach and that “hospitals and nursing homes should aggressively shop for the best price among the multiple agencies on the market.” They believe Medicaid and Medicare rates should be increased and that staffing agencies that are suspected of price gouging should be investigated.⁴⁹

In September 2021, Staffing Industry Analysts (SIA) released a report predicting the outlook for healthcare staffing to be “even brighter” than that of the whole U.S. staffing sector. It projected growth of 24 percent year over year in 2021 for healthcare staffing to reach \$24.7 billion. In 2020, growth in the healthcare staffing sector was 8 percent, the report said. It also forecast a 9 percent decline in the healthcare staffing sector in 2022, “assuming easing of the pandemic and fewer assignments with crisis pay rates.”⁵⁰

Policy options

The following are policy options the General Assembly may wish to consider in addressing the increased use of healthcare staffing agencies and staffing shortages at long-term care facilities.

1. The General Assembly could, as some other states have done, require healthcare staffing agencies to register with the state and submit specified information about agency operations. In addition, the state’s price gouging law could be expanded to include direct care services provided by healthcare staffing agencies.

Over the course of the pandemic, Tennessee and many (if not all) states experienced an upward trend in long-term care facilities seeking to fill substantial direct care staffing shortages with temporary workers from healthcare staffing agencies. As discussed in more detail in the full report, other states’ recently adopted laws are based on a concern that healthcare staffing agencies have charged nursing facilities excessively high rates for the temporary staff needed during the pandemic.

The new laws passed in other states generally focus on gathering operational and financial information from the staffing agencies and stop short of imposing maximum rates that the agencies could charge long-term care facilities. However, some of the laws include the possibility of developing such rates once sufficient data is collected and required studies are completed to make more informed decisions about the extent to which such agencies should be regulated.

Based on other states’ laws, the General Assembly could choose among several options:

Require healthcare staffing agencies to register with the state as a condition of operation. Beyond registration, healthcare staffing agencies could be required to:

- ***Annually submit specified information about agency operations.*** This could include, for example:
 - ownership of the agency;
 - a detailed list of the average amount charged each quarter of the reporting period to a healthcare facility for each category of healthcare worker providing services to the facility;
 - a detailed list of the average amount paid during each quarter of the reporting period to healthcare workers for their services for each category of healthcare worker providing services;
 - an annual cost report including the agency’s itemized revenues and costs, the average number of nursing personnel the agency employs, and/or the average fees the agency charges by type of

nursing personnel and healthcare facility.

- ***Pay an annual registration fee to cover the administrative costs of any required submission of information to the state.***
- ***Enter into a written agreement with each long-term care facility to which an agency provides nursing personnel.*** Such agreements could contain assurances that nursing personnel have appropriate credentials.
- ***Submit all contracts between an agency and the healthcare facilities with which it contracts,*** including copies of all invoices to long-term care facilities, to a specified state entity.
- ***Submit quarterly reports*** regarding amounts charged to long-term care facilities.

Add direct care services provided by healthcare staffing agencies to the state's price gouging law.

Most states, including Tennessee, have some type of price gouging law, which generally comes into play during a government-declared states of emergency. In 2022, Kentucky revised its price gouging statute to include federal declaration of a public health emergency, such as the pandemic. Kentucky also added “direct care staff services provided by a health care service agency as defined in Section 1 of this Act” to the list of goods and services subject to the law’s provisions. Under Kentucky’s new law, direct care staff services provided by a healthcare staffing agency will be subject to this prohibition:

No person shall sell, rent, or offer to sell or rent, regardless of whether an actual sale or rental occurs, a good or service listed in this paragraph or any repair or reconstruction service for a price which is grossly in excess of the price prior to the declaration and unrelated to any increased cost to the seller.

Kentucky’s price gouging statute already had in place reasons that a price would not violate the statute. For example, if the additional cost imposed by a supplier of a good or service is related to an additional cost for labor, it would not be subject to the price gouging statute. Nor would it be subject to the statute if the higher price was 10 percent or less above the price prior to the declaration. Whether a violation occurs, the statute says, is a question of law. Any court considering such a question is to “consider all relevant circumstances, including prices prevailing in the locality at that time.”

Tennessee’s price gouging law (TCA 47-18-5101 et seq.) was passed in 2002 following the September 11, 2001, terrorist attacks and acknowledges that some businesses in Tennessee engaged in price gouging following that event. The price gouging law is designed to come into play when the governor declares an abnormal economic disruption. Among the goods and services listed in the law for which a person is prohibited from excessively charging a higher price is the sale of medical supplies, but the law does not refer to any kind of healthcare services or staffing agencies. The law states that a price increase is not grossly excessive if the increase was directly attributable to, among other items, “additional costs for labor, services, or materials used to provide the goods and services, including costs of replacement inventory, additional costs to transport goods or services, and additional labor shortages. A complainant may bring a civil action, but the law prohibits any criminal penalty from being imposed for a violation.

2. TennCare could require nursing facilities to enter expenditures for healthcare staffing agencies in a specific part of the annual cost report submitted to the COT.

According to TennCare, such a change to the cost report could be made. OREA analysts were unable to isolate expenditures for salaries and wages for contract personnel using the Medicaid Supplemental Cost Report submitted annually by nursing facilities to the TennCare/Medicaid Audit division in the Comptroller's Office. Facilities reported on the OREA survey that they accounted for these expenditures in various places on the cost reports: some included them with the salary and wage expenses for the nursing department, some as a consulting expense, and others used various expense lines. If nursing facilities' need for and use of healthcare staffing agencies continues in the future, this change would provide a means to track those actual costs.

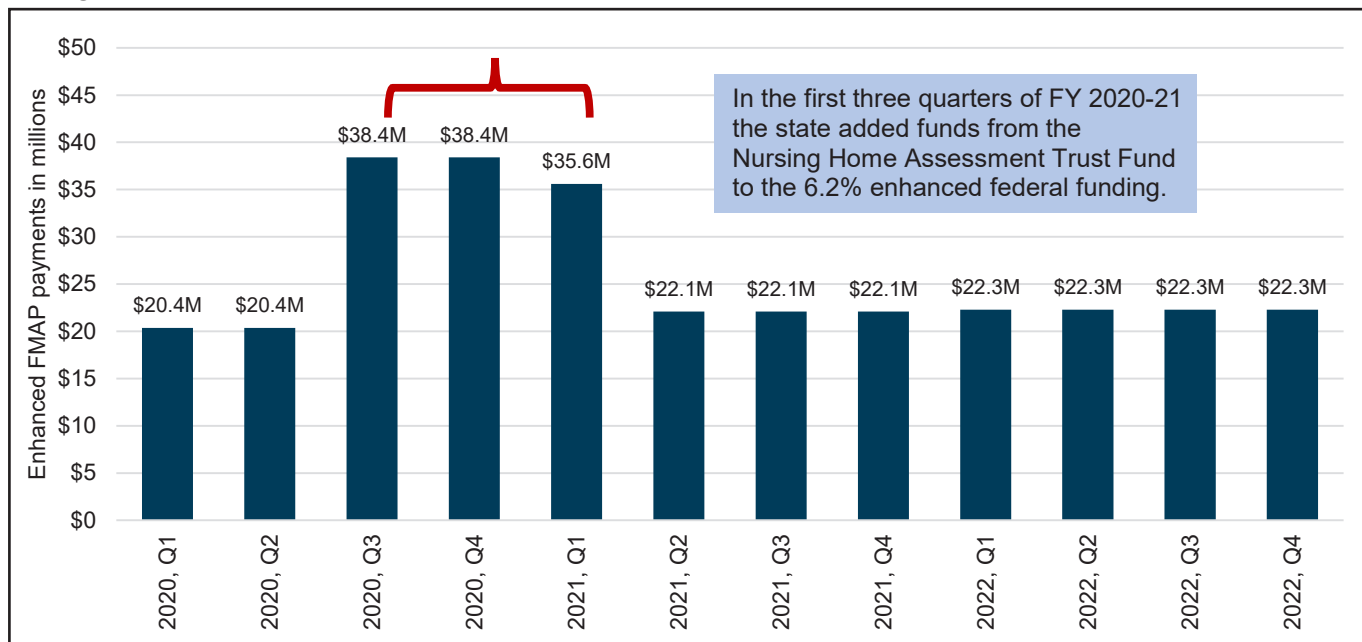
3. The General Assembly could consider continuing the support that nursing facilities have received during the federal public health emergency declaration until 2024, when the next rebasing for reimbursement rates is scheduled to occur.

TennCare does not foresee that the increases in nursing facility costs for staffing agencies will materially affect the state's overall costs, and cites what they believe may be a continuing trend: the decrease in the number of nursing facility patients. However, nursing facilities say the unexpected spike in staffing costs during the pandemic, which may continue in the second half of 2022, has affected their operational stability. Although nursing facilities have received federal assistance during the pandemic, this will end once the federal government declares the public health emergency (PHE) at an end.

Nursing facilities, among other healthcare providers, have received additional federal funds to mitigate the financial effects of the pandemic in the short term. The Federal Medical Assistance Percentage (FMAP) is used to reimburse states for the federal share of most Medicaid expenditures. In response to the economic impact of the pandemic, federal law provides a 6.2 percentage point increase to the FMAP rate for all states, beginning January 1, 2020, and ending on the last day of the calendar quarter in which the federally declared public health emergency (PHE) period ends.

Tennessee began receiving enhanced FMAP funding for distribution to nursing facilities in the first quarter of 2020. In total, the state has received \$308.6 million for distribution to nursing facilities from 2020 through the end of 2022. (See Exhibit 22.) This funding is distributed to nursing facilities not in rate adjustments but in quarterly payments. The amount per quarter has been about \$22.4 million, except for the first three quarters of 2021, when funds were added from the Tennessee Nursing Home Assessment Trust Fund to augment the enhanced FMAP quarterly payment. This additional funding is tied to the federal declaration of a PHE, which is still in effect as of October 21, 2022. Tennessee is assured that it will receive the enhanced funding through the end of 2022, but the future of the FMAP payments is unclear. There is some speculation that the PHE may be declared at an end in the first part of 2023. Once the federal government declares the PHE at an end, these additional funds for nursing facilities will cease.

Exhibit 22: Enhanced federal funding for Tennessee nursing facilities during the pandemic health emergency with additional state reserve funds added during the first three quarters of FY 2021



Note: The enhanced FMAP funding is distributed to Tennessee nursing facilities in quarterly payments and not in rate adjustments. The graph reflects the additional funding added from the Tennessee Nursing Home Assessment Trust Fund in fiscal year 2021 (i.e., the third and fourth quarters of 2020 and the first quarter of 2021). The Nursing Home Assessment Trust Fund was created by the General Assembly in Public Chapter 859 in 2014. Nursing facilities pay an annual assessment fee that is deposited into the fund, which earns interest and maintains a reserve. Collected assessment funds are used to secure federal matching funds available through the state Medicaid plan. TCA 71-5-1002.

Source: Tennessee Health Care Association, email, Oct. 21, 2022.

OREA analysts estimate that the state costs to continue the amount of FMAP funding to nursing facilities for FY 2023-24 would be \$33 million with federal costs estimated at \$63 million for a total of \$96 million. If this additional funding were to be included in reimbursement rates rather than as quarterly payments, the overall current average rate would increase from \$236.34 to \$253.73, which is a 7.36 percent increase. (See Exhibit 23.)

Exhibit 23: Estimate of state and federal costs to replace enhanced FMAP funding for nursing facilities

	FY 2023-24 estimate	FY 2023-24 FMAP split
State	\$32,971,400	34.515%
Federal	\$62,556,200	65.485%
Total	\$95,527,600	100%

Note: OREA used the most current FMAP quarterly payment, \$22.3 million, to determine the annual payment amount of \$89.2 million. The estimate assumes a 4.7 percent increase based on the prior trend in previous quarterly payments.

Source: OREA analysis.

The pandemic exposed weaknesses in long-term care facilities' financial ability to staff adequately to ensure quality patient care amidst a public health emergency and a fluctuating workforce. In the OREA survey, facilities indicated that direct care staff shortages continue in 2022 and have been exacerbated by other economic pressures, including inflation and competitive offers from healthcare staff staffing agencies and industries not related to healthcare.

In 2022, some state legislatures passed laws to continue increased Medicaid funding for nursing facilities after the PHE is declared at an end.

- Illinois approved a \$700 million increase, inclusive of federal and state matching funds, to nursing home funding, which took effect July 1, 2022. The increased funding is tied to improving staffing levels for CNAs and quality of care, and nursing homes must meet certain criteria to receive the increased funding. The quality of care funds are tied to nursing facilities' CMS star ratings for long-term care staffing. Additional CNA funding is tied to the tenure, promotion, and training of CNAs employed by nursing homes.
- Florida's Fiscal Year 2022-23 approved state budget includes a 7.8 percent increase in Medicaid reimbursement rates for nursing homes, amounting to \$293 million in additional funding. The budget also includes a \$15 per hour minimum wage for health care employees working for Medicaid providers. The appropriations bill requires the state's Medicaid agency to enter into a supplemental wage agreement with each provider to include the minimum wage requirement to ensure compliance and allows employees to bring civil actions against employers for not meeting the requirement.
- Pennsylvania approved a Medicaid annualized rate reimbursement increase of 17.5 percent for the state's nursing homes, effective July 1, 2023. The law also requires Medicaid-approved nursing facilities to spend at least 70 percent of their total costs on resident care and resident related care. The law also includes the state's ARPA payments to nursing facilities at about \$131 million and to assisted care living facilities at about \$27 million.

4. The General Assembly could consider continuing the support that assisted care living facilities are receiving through the American Rescue Plan Act of 2021 for pandemic relief.

Assisted care living facilities in Tennessee are part of Tennessee's continuum of home and community-based services network, which helps delay required nursing services for elderly and disabled individuals. Providing nursing services to individuals costs more in state funding than providing home and community-based services. Few residents of assisted care living facilities receive Medicaid services, and TennCare is prevented from expending Medicaid funding on any non-Medicaid services, such as room and board, in these facilities. To pay for care, residents generally must use long-term care insurance or personal funds.

Survey respondents for both nursing facilities and assisted care living facilities identified many of the same staffing barriers: healthcare agencies cost more than some facilities could afford, there were not enough CNAs in their region to hire, non-healthcare industries as well as other healthcare facilities were paying higher wages, and high staff turnover.

In late fall 2022, assisted care living facilities will be receiving funds through the federal American Rescue Plan Act of 2021, which provided state governments with federal funding to support staffing in long-term care settings. Tennessee's Department of Health will administer this funding through a grant program called Healthcare Facility Staffing Assistance Grants. Facilities are required to apply for the grants. The funding allocation to assisted care living facilities from this grant totals \$12.5 million for 335 facilities.

The General Assembly could consider providing state-funded grants equal to the ARPA federal grants through fiscal year 2023-24 for assisted care living facilities. The state funds necessary to provide an equal, annualized amount for the facilities would total \$12.5 million, an amount equal to the ARPA funds they will receive in FY2022-23. The funding would allow assisted care living facilities additional time to stabilize their funding structures to cover the costs spent during the pandemic for additional staffing.

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³⁵ Rules of the Tennessee Department of Finance and Administration, Division of TennCare, Chapter 1200-13-02-.05 Cost Reports.

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³⁸ Attestation Form for Temporary Nurse Aides to be placed on the Tennessee Nurse Aide Registry, p. 3, <https://www.tn.gov/content/dam/tn/health/program-areas/hcf/TNA-Attestation-Form.pdf>.

³⁹ 42 U.S.C. §§ 1396r(b)(5)(A)(i)(I) 42 C.F.R. §§ 483.35(d)(1)(ii)(A).

⁴⁰ 42 C.F.R. § 483.152(a), (b). At least 16 of the 75 hours must be completed before the aide has contact with residents; the initial training must include communication and interpersonal skills, infection control, safety emergency procedures, promoting residents' independence, and respecting residents' rights. The remaining 59 credit hours must include basic nursing skills, personal care skills, mental health and social service needs, care of cognitively impaired residents, basic restorative services, and residents' rights.

⁴¹ 42 C.F.R. § 483.154.

⁴² Tennessee Department of Health, Temporary Nurse Aide Bridge Program, <https://www.tn.gov/health/health-professionals/hcf-main/nai/temporary-nurse-aide-bridge-program.html> (accessed Sept. 15, 2022).

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⁴⁴ Tennessee Health Facilities Commission, Centers for Medicare and Medicaid Services (CMS) Grants the Tennessee Health Facilities Commission Waiver Extension to Train and Certify Nurse Aides; HFC Extends Deadline to Challenge Nurse Aide Competency Exam, Oct. 21, 2022

⁴⁵ Tennessee Department of Health, Nurse Aide Training Facility, https://apps.health.tn.gov/nurseaide/natf_criteria.aspx. The list of training programs can be searched by county or a list of all programs can be generated. According to HFC, the largest number of training programs are in east Tennessee. (East Tennessee: 74, Middle: 19, West: 44).

⁴⁶ The American Staffing Association, <https://americanstaffing.net/>.

⁴⁷ American Staffing Association, What's Really Driving the Cost of Temporary Nurses?, Feb. 2022, <https://s3.documentcloud.org/documents/21210563/whats-really-driving-the-cost-of-temporary-nurses-asa-february-2022-with-chart.pdf>.

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Appendix A: Summaries of state laws and proposed legislation concerning healthcare staffing agencies

Laws passed in 2022

Colorado: SB 22-210, passed May 5, 2022 / signed by Governor June 3, 2022

Requires supplemental health care staffing agencies to complete certification and annual renewal with the department of labor and employment under an existing statute at 8-70-114, 2016 Colorado Revised Statutes. Agencies in violation of the law are subject to civil fines determined by the Department of Labor and Employment.

Requires supplemental healthcare staffing agencies to report data by October 1, 2022, to the Department of Labor and Employment. Requires the department to analyze the data and determine the need for regulation of the staffing agencies. Reports are continue annually as specified in the law.

Data that staffing agencies are required to report includes, but is not limited to:

- ownership of the agency,
- a detailed list of the average amount charged each quarter of the reporting period to a health care facility for each category of healthcare worker providing services to the facility, and
- a detailed list of the average amount paid during each quarter of the reporting period to healthcare workers for their services for each category of healthcare worker providing services.

See https://leg.colorado.gov/sites/default/files/2022a_210_signed.pdf.

Connecticut: Public Act 22-57, Effective July 1, 2022

Requires the establishment of an annual registration system for temporary nursing services agencies with an annual registration fee up to \$750 by October 1, 2022.

Requires commissioner of the Department of Social Services to evaluate the rates temporary nursing services agencies charge to nursing home and report recommendations to certain legislative committees by October 1, 2023.

Requires the commissioner of the Department of Public Health to establish requirements for temporary nursing services agencies, including minimum qualifications for nursing personnel the agencies provide to healthcare facilities.

Requires temporary nursing services agencies to submit annual cost reports to the DPH commissioner starting July 1, 2023, to include the agency's itemized revenues and costs; the average number of nursing personnel the agency employs; and the average fees the agency charges by type of nursing personnel and health care facility, among other information.

Requires temporary nursing services agencies to enter into a written agreement with a health care facility to which it provides nursing personnel containing assurances the nursing personnel have appropriate credentials.

See <https://www.cga.ct.gov/2022/act/Pa/pdf/2022PA-00057-R00HB-05313-PA.PDF>.

Illinois: Public Act 102-0946, Effective July 1, 2022 (amends existing Nurse Agency Licensing Act)

Illinois statute already required nurse staffing agencies to apply for and periodically renew a license to operate, and authorized the Department of Labor to establish minimum standards for the staffing agencies. The 2022 law amends the Nurse Agency Licensing Act to require staffing agencies to submit all contracts between the agency and a long-term care facility to which it assigns or refers nurses or CNAs and copies of all invoices to healthcare facilities personnel.

Prohibits nurse staffing agencies from entering into covenants not to compete with nurses and CNAs. Prohibits nurse staffing agencies from requiring buy-out fees, placement fees, or other compensation if an employee is hired as a permanent employee of a facility.

Requires wage rates paid to nurses and CNAs to match wage rates identified on the contract. Permits the state Department of Labor to recover underpaid wages to the worker in cases where wage rates do not match.

Requires nurse staffing agencies to submit quarterly reports related to average charges to health care facilities to the state Department of Labor.

Requires the state Department of Labor to publish an annual report by county of average amounts paid to employees and charged to health care facilities by nurse agencies for each individual worker category and the average amount paid by the agency to each individual worker category. The department must publish the annual reports on its website by county.

Requires the department to establish a system of reporting complaints against a health care staffing agency. Complaints may be made by anyone and will be investigated by the Department of Labor.

See <https://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=102-0946&GA=102> (Section 10).

Iowa: House File 2521 and House File 2589, signed by the Governor

Defines “health care employment agency” as “agency that contracts with a health care entity in this state to provide agency workers for temporary, temporary-to-hire, direct hire, or other contract or employee placements.”

Requires health care employment agencies to:

- Register each location of the agency on an annual basis with the Department of Inspections and Appeals (DIA) and pay a \$500 registration fee.
- Ensure that agency workers comply with all applicable requirements relating to health and qualifications of personnel in health care entity settings (i.e., licensing, certification, training, health requirements and continuing education standards) and document that agency workers meet these requirements.
- Maintain records for each agency worker and report, file, or provide documentation to external parties or regulators.
- Maintain professional and general liability insurance coverage with minimum per occurrence of \$1 million and aggregate coverage of \$3 million.
- Submit quarterly reports to DIA regarding amounts charged to health care entities.

Prohibits health care employment agencies from requiring their employees to sign non-compete

agreements as a condition of employment, and health care employment agencies may not require health care entities to pay any kind of “finder’s fee” for directly hiring an agency employee.

A subsequent bill, House File 2589, makes the provisions of House File 2521 retroactive to any contract entered into or executed on or after January 1, 2019, between a health care employment agency and an agency worker or health care entity.

See <https://www.legis.iowa.gov/docs/publications/LGE/89/HF2521.pdf>.

Kentucky: Chapter 110, signed by the Governor April 8, 2022

Requires health care services agencies to register with the Cabinet for Health and Family Services as a condition of operation and submit a registration fee of \$3,000. Registration is effective for one year. The application must include names and addresses of owners and any controlling persons, among other information.

Requires health care services agencies to maintain documentation that each direct care staff person contracted with or employed by the agency meets minimum licensing, certification, training, and continuing education standards. Other requirements concern the maintenance of liability insurance coverage, employee dishonesty bonds, and workers’ compensation.

Prohibits health care services agencies from restricting the employment opportunities of any direct care staff that is contracted with or employed by the agency, including contract buy-out provisions or contract non-complete clauses.

Adds direct care staff services provided by a health services agency to the state’s existing price gouging statute, providing that agencies cannot sell, rent, or offer their services for a “price which is grossly in excess of the price prior to a declaration of an emergency” by the U.S. Department of Homeland Security or by a state of emergency declared by the Governor of Kentucky.

See <https://apps.legislature.ky.gov/record/22RS/hb282.html> where the law may be viewed or downloaded.

Louisiana: Act 577 of 2022, signed by the Governor August 1, 2022

Act 577 is known as the “Nurse Staffing Agency Licensing Law.” It authorizes the Louisiana Department of Health to promulgate rules and regulations for the licensure of nurse staffing agencies.

Requires nurse staffing agencies to apply to the department as a condition of operation in the state and supply information, such as the name and address of the person, partnership, corporation, or other legal entity that is applying. Other information to be submitted is a statement of financial solvency and a statement detailing the experience and qualifications of the applicant to operate a nurse staffing agency. Agencies must submit a nonrefundable fee of \$1,200 at initially licensing and biennially thereafter. Licenses are issued for a two-year period unless revoked or suspended based on other requirements in the law.

The department is to establish minimum standards for the operation of nurse staffing agencies, including the development of personnel policies, licensure application and renewal procedures, survey and complaint investigations, provisions for denial, suspension, revocation, and nonrenewal of licenses, among other provisions.

Allows the department to adopt rules to monitor the usage of nurse staffing agency services to determine their impact.

See <https://legiscan.com/LA/text/HB577/2021> where the law may be viewed or downloaded.

Missouri: SB 710, 2022, Governor signed June 30, 2022

Requires operators of supplemental health care services agency to register annually with the Department of Health and Senior Services, which will establish forms and procedures for processing. Applications must include names and addresses of all owners, proof of compliance with the provisions of SB 710 (described below), and a registration fee to be determined, but which will not be more than \$1,000. Allows for suspension or refusal to issue the registration and permits appeals by the agency. Registration is effective for one year from issuance.

Registered supplemental health care services agencies must meet the following minimum criteria, among other requirements:

- provide documentation to the health care facility to which any temporary health care personnel are supplied that each meets all licensing and certification requirements for the position;
- comply with all health and other qualifications of personnel employed in health care facilities, including background check requirements;
- carry proof of medical malpractice insurance;
- maintain insurance coverage for workers' compensation;
- refrain from requiring any health care personnel or health care facility to pay liquidated damages, employment fees, or other compensation should the health care personnel be hired as a permanent employee of a facility; and
- submit quarterly reports, which will be considered closed records, to the department including detailed lists of the average amount charged and the average amount paid to the health care facility for each individual health care personnel category.

Makes ineligible for five years the registration of a controlling person of a supplemental health care agency whose registration has not been renewed or has been revoked due to noncompliance.

Requires establishment of a complaint reporting system against a supplemental health care services agency or its health care personnel. Complaints may be made by any member of the public.

See <https://legiscan.com/MO/text/SB710/2022> (pages 65-72) where the law may be viewed or downloaded.

Oregon: SB1549, 2022, signed by Governor, March 24, 2022, effective July 1, 2023

Prohibits temporary staffing agencies from operating without a license. Requires the Health Licensing Office (HLO) to issue renewable one-year temporary staffing licenses for temporary staffing agencies that provide temporary work for personnel who provide health care services or services with activities of daily living. Specifies the process for an applicant to receive and renew a temporary staffing license.

Requires the HLO to publish and maintain on its website a list of licensed temporary staffing agencies.

Specifies the duties of a licensed temporary staffing agency, including those related to personnel and records retention.

Directs the Oregon Health Authority to submit a legislative report by December 31, 2022, with a policy proposal and recommendations to determine annual rates that a temporary staffing agency may charge to or receive from an entity that engages the temporary staffing agency. The proposal must prioritize the

compensation of personnel, quality care outcomes for patients, and the fiscal viability of care providers.

To view or download a copy of the law, see <https://olis.oregonlegislature.gov/liz/2022R1/Downloads/MeasureDocument/SB1549/Introduced>.

Laws passed prior to 2022

Delaware: Title 16, Health and Safety, Minimum Staffing levels for Residential health Facilities

Requires that anyone serving as a nursing supervisor must be an employee of the facility, “thus excluding temporary employment agency personnel from serving in this capacity unless exigent circumstances exist.” “Exigent circumstances” means a short-term emergency or other unavoidable situation, and all reasonable alternatives to the use of a temporary employee as a nursing supervisor have been exhausted.

Personnel hired through temporary agencies are required to wear photo identification using their names and titles.

Since January 2002, Delaware has required nursing facilities to meet set minimum staffing levels. The minimum levels were to provide 3.28 hours of direct care per resident per day (subject to appropriations). In 2003, the minimum level was raised to 3.67 hours. Six months after the funds were appropriated to fund the staffing requirements, the Delaware Nursing Home Residents Quality Assurance Commission was required to report on the quality of nursing care in the state and determine the efficacy of the minimum staffing levels required, including, but not limited to, the availability of qualified personnel in the job market to meet the requirement, the cost and availability of nursing home care, and patient outcomes based on scheduled facility surveys, surprise inspections and other reviews.

Delaware required the Division of Health Care Quality to conduct a study of the CNA training programs in the state and publish a report of the findings to include the percentage of each training program’s graduates who passed the CNA certification test and the number of attempts it took each graduate to become certified, along with the total number of hours, divided by classroom and clinical time, spent in the overall CNA training program.

See <https://delcode.delaware.gov/title16/c011/sc07/index.html>.

Massachusetts: General Law, Part I, Title XVI, Chapter 111, Section 72Y

In 1988, Massachusetts enacted a law that provided for the registration and regulation of temporary nursing agencies (also referred to in Massachusetts law as “nursing pools”). The purpose was to ensure an adequate and stable supply of nursing services in long-term care facilities by discouraging staff from leaving permanent positions to take jobs with temporary agencies, and to ensure that nursing homes did not pay excessive amounts for temporary staff. The rate setting commission created a methodology for determination of reasonable rates of payment for services provided by agencies registered with the Department of Public Health, the methods by which such agencies could request rate changes, and the standards the commission would use to approve or reject the requests.

Rate setting was suspended between 1992 and 2000 because the supply of nurses was deemed to be sufficient to meet demand. On February 16, 2001, the division of health care and policy adopted final regulations that set the hourly rates temporary nursing agencies could charge health care facilities, and the rates took effect on March 2, 2001. The regulation provided that hourly rates charged by the agencies could not exceed the maximum rates set forth in the regulations, which vary by geographic region.

In May 2020, due to the pandemic, the Executive Office of Health and Human Services increased the cap by 35 percent across the board and removed the cap altogether for nurses and CNAs who were working with COVID-19 patients. The order that increased/removed the cap expired in February 2021 and temporary nursing agencies are subject to the current maximum rates as provided in regulation.

See <https://malegislature.gov/laws/generallaws/parti/titlexvi/chapter111/section72y>.

Minnesota: Statute 2000, Section 144.057; 144A.70-144A.74, passed in 2001

In 2001, Minnesota passed legislation that requires supplemental nursing services agencies to register annually with the Minnesota Department of Health, submit a registration fee of \$2,035, and complete an application providing information such as policies and procedures, among other items.

As a condition of registration, agencies must:

- document that each temporary employee provided to health care facilities meets the licensing, training, and continuing education required for the position;
- not restrict the employment opportunities of its employees;
- carry medical malpractice insurance;
- carry an employee dishonesty bond in the amount of \$10,000;
- maintain worker's compensation insurance; and
- meet other requirements.

The law prohibits a supplemental nursing services agency from billing or receiving payments from a nursing home at a rate higher than 150 percent of the sum of the weighted average wage rate, plus a factor determined by the commissioner to incorporate payroll taxes as defined in state law.

See <https://www.revisor.mn.gov/statutes/cite/144A.72>.

Laws introduced in 2022

Indiana: House Bill 1332, introduced January 2022 and referred to Committee on Employment, Labor and Pensions

Adds "health care provider employer" to the various businesses to which the state's price gouging law applies. Provides that an employment agency commits price gouging if an agency's charge is in excess of three times the fair market value of the health care services of a health care employee or temporary worker.

Prohibits an employment agency that contracts for services with a health care provider employer from charging fees, charges, or commissions in excess of three times the fair market value of the health care services rendered by the agency or by an applicant referred by the agency.

Raises the surety bond for an agency from \$1,000 to \$10,000. Raises the annual licensing fee for an employment agency from \$150 to \$200.

Prohibits an employment agency from restricting employment opportunities of its personnel. Requires an employment agency to screen prospective employees; conduct background checks on employees before they work for a health care provider; complete an employee performance review; and provide health care providers with certain information on the employees.

Requires an employment agency to submit an annual statistical report to the department including salaries and hourly pay rates of employees by employee type; number of employees; number of employees

terminated; and number of employees reported to the office of the attorney general. The annual report must also include for each person placed for temporary employment with a health care provider, the amount charged for each person, the amount paid to each person, and the amount of payment received that is retained by the employment agency.

See <https://iga.in.gov/legislative/2022/bills/house/1332#document-84b5fb5c>.

Kansas: House Bill 2524, removed from calendar by Rule 1507 February 23, 2022

Requires the secretary for aging and disability services to regulate supplemental nursing services agencies through unannounced surveys, complaint investigations, and other actions to ensure compliance with the act.

Requires operators of supplemental nursing services agencies to register annually with the secretary. An application must include names and addresses of owners of the agency, among other information, and a registration fee of \$2,035.

Creates the supplemental nursing services agency regulation fund in the state treasury, in which all registration fees are to be deposited.

Supplemental nursing services agencies, as a condition of registration, must document that each temporary employee provided to healthcare facilities meets the minimum licensing, training, and continuing education standards for the position in which they will be working. Among other requirements concerning medical malpractice insurance coverage, workers compensation insurance coverage, and more.

Prohibits supplemental nursing services agencies from billing or receiving payments from facilities at a rate higher than 150% of the sum of the weighted average wage rate, plus a factor determined by the secretary to incorporate payroll taxes.

See http://kslegislature.org/li/b2021_22/measures/documents/hb2524_01_0000.pdf.

Maryland: SB0565, unfavorable report to Senate by Finance Committee March 18, 2022, no further action to date

Would prohibit a healthcare staffing services agency during a state of emergency from selling or offering to sell services for a price of 10% or more above the highest price at which the person made actual sales of those essential goods or services between 60 days before the state of emergency declaration and four days before the state of emergency. A person or agency could charge a price of 10% or more for services with proof that the price increase is directly attributable to additional costs imposed by the supplier of the goods or to additional costs for labor or materials used to provide the service.

See <https://www.billtrack50.com/billdetail/1443209/>.

Ohio, House Bill 466, not yet passed

Would require operators of a health care staffing agency to annually register with the department of health, which is to establish registration application forms and procedures. An application must include the names and addresses of all owners, a copy of the agency's policies and procedures designed to comply with the provisions of HB 466 (described below), among other information. Application and annual renewal requires payment of a \$2,000 non-refundable fee. All fees, renewal fees, and fines are to be deposited in the state treasury to the general operations fund, and are to be used solely to administer and enforce this law. Approved registration is valid for one year from issuance.

Registered health care staffing agencies must:

- establish and provide to health care providers a schedule of fees and charges that cannot be modified except after providing 30 days' written notice before modification occurs;
- provide upon request by a health care provider documentation that each individual working for the provider as a temporary health care worker meets these requirements, among others:
 - licensing, training, and continuing education requirements for the position;
 - criminal records check requirements;
 - requirements for reviewing registries of persons with findings of abuse or neglect;
 - all health care requirements of the health care provider and any other requirement maintained by the health care provider for its employees;
 - prohibit all health care staffing agency employees from recruiting employees of the health care provider;
 - make health care staffing agency records immediately available to the director of health during normal business hours;
 - carry professional liability insurance and maintain workers' compensation coverage; and
 - carry a surety bond for employee dishonesty for not less than \$100,000.

Prohibits health care staffing agencies from restricting the employee opportunities of its employees, including a requirement to pay for termination of employment or enter into a non-complete agreement.

Prohibits health care staffing agencies from contracting with independent contractors for use by the agency in providing temporary health care personnel to health care providers.

Prohibits a health care staffing agency from billing or receiving payments from a health care provider at a rate that is higher than 150% of the statewide direct care median hourly wage for that category of personnel, as that wage is determined by the department of Medicaid and multiplied by the rate of inflation, using a method described in the bill.

Requires the department of Medicaid to calculate and publish statewide direct care median hourly wages for all personnel categories reported on the Medicaid cost reports as soon as possible after receiving the reports.

Requires the director of health to establish a system for reporting complaints against a health care staffing agency or its employees. Complaints may be made by any individual.

See https://search-prod.lis.state.oh.us/solarapi/v1/general_assembly_134/bills/hb466/RCH/02/hb466_02_RCH?format=pdf.

Pennsylvania: House Bill 2293 passed in the House July 1, 2022, and referred to Senate Health and Human Services

Would require temporary health care services agencies to register with the Department of Human Services, verify that employees are properly credentialed, disclose ownership, and pay a \$500 annual registration fee.

Would require agencies to provide any health care facilities for which it supplies temporary staff documentation that each temporary employee meets all licensing or certification, training and continuing education standards for the position they will be working in.

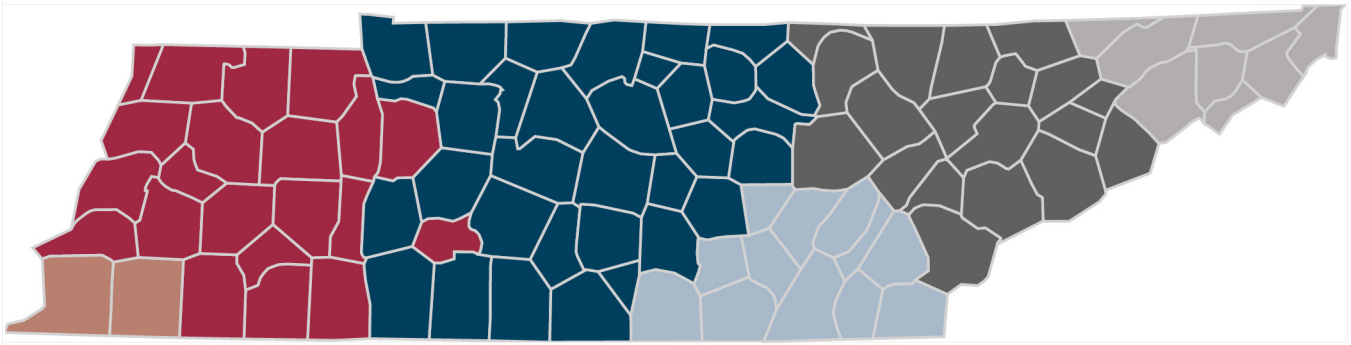
Would require agencies to carry medical malpractice insurance of not less than \$500,000.

Would require the Department of Human services to provide oversight of temporary health care services agencies through complaint investigations. Complaints may be made by any member of the public.

A previous section that would have imposed caps on what agencies can charge was removed from HB 2293 before passage in the House.

See <https://legiscan.com/PA/text/HB2293/2021>.

Appendix B: Counties in regions as defined by the Tennessee Health Care Association



Memphis region
Fayette
Shelby

Jackson region
Benton
Carroll
Chester
Crockett
Decatur
Dyer
Gibson
Hardeman
Hardin
Haywood
Henderson
Henry
Humphreys
Lake
Lauderdale
Lewis
Madison
McNairy
Obion
Tipton
Weakley

Nashville region
Bedford
Cannon
Cheatham
Clay
Coffee
Davidson
DeKalb
Dickson
Giles
Hickman
Houston
Jackson
Lawrence
Lincoln
Macon
Marshall
Maury
Montgomery
Moore
Overton
Perry
Putnam
Robertson
Rutherford
Smith
Stewart
Sumner
Trousdale
Warren
Wayne
White
Williamson
Wilson

Knoxville region
Anderson
Blount
Campbell
Claiborne
Cocke
Cumberland
Fentress
Grainger
Hamblen
Jefferson
Knox
Loudon
Monroe
Morgan
Pickett
Roane
Scott
Sevier
Union

Chattanooga region
Bledsoe
Bradley
Franklin
Grundy
Hamilton
Marion
McMinn
Meigs
Polk
Rhea
Sequatchie
Van Buren

East Tennessee region
Carter
Greene
Hancock
Hawkins
Johnson
Sullivan
Unicoi
Washington

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