State of Wisconsin Department of Health Services

Long-Term Care Market Study 2023

State of Wisconsin Department of Health Services

Table of Contents

Table of Contents

Consultants' Report

State of Wisconsin Department of Health Services

The Department of Health Services requested that Baker Tilly US, LLP (Baker Tilly) conduct a market study of the long-term care industry in Wisconsin and the State of Wisconsin, Department of Health Services' (State's) role in supporting the industry. The State defined "long-term care" to include nursing homes, licensed assisted living facilities, 1- to 2-bed adult family homes, and independent living with medical and home-and-community-based supports (e.g., home health care) for individuals who are elderly or who have physical, intellectual, and developmental disabilities.

The objectives of the assessment were generally to conduct a retrospective analysis considering current challenges facing long-term care providers, conduct a prospective analysis of long-term care services considering consumer preferences in the next 5 to 10 years and the Wisconsin's providers' ability to meet the expected needs, and to provide recommendations and considerations for both the public and private sectors to position Wisconsin's long-term care services for the future.

The enclosed report is intended solely for the use of the State of Wisconsin Department of Health Services. The report and its contents should not be referred to or distributed to any other person or entity without prior approval from Baker Tilly. The work did not constitute an audit, examination, or other attestation service in accordance with standards established by the American Institute of Certified Public Accountants. Accordingly, we are not expressing an opinion, or any other form of assurance, on the findings or any other information.

Baker Tilly's services were limited to the work described in our contracted statement of work. Had we performed additional work, other matters might have come to our attention that would have been reported to you.

Baker Tilly does not and will not have any responsibility or obligation to monitor the implementation or the realized impact of any recommendations identified in this report. We have no responsibility to update this report for circumstances occurring after July 17, 2023, the date representing substantial completion of our work effort.

Philadelphia, Pennsylvania
July 19, 2023

Introduction

The State of Wisconsin, Department of Health Services (DHS) commissioned a market study of the Long-Term Care (LTC) system. DHS has defined "long-term care" to include nursing homes/Skilled Nursing Facility (SNF), licensed assisted living facilities (ALF) including Community Based Residential Facility (CBRF) and Residential Care Apartment Complex (RCAC), 1- and 2-bed Adult Family Homes (AFH), and independent living with medical and Home and Community Based Services (HCBS) and support services (e.g., home health care, personal care services) for individuals who are elderly or who have physical, intellectual, and developmental disabilities. For purposes of this report, we have referred to ALF, CBRF, AFH and RCAC as "assisted living" unless otherwise noted and home health services, hospice services, and personal care services as "HCBS". The market study considered a retrospective and prospective analysis on a regional, state, and national basis to inform recommendations and considerations to position LTC services for the future. The nation is facing unprecedented challenges regarding the care of our at risk and vulnerable populations, while the increasing number of elderly adds to this burden. These challenges cross the clinical, economic, and demographic settings. The United States historically has taken a siloed approach to LTC, considering regulatory, funding, clinical and philosophical approaches which has put tension on a system as providers attempt to meet current and future challenges in workforce, type and settings of care, and financial sustainability.

The solution to these challenges requires a level of planning and collaboration across the spectrum of care in line with transparent communication with public agencies to create the highest return on public investment. There is no universal approach to solving these challenges but many organizations, both public and private, have taken the lead in developing new approaches. The Baker Tilly team has found that the State of Wisconsin and select providers in the community have developed a strong foundation to meet these future challenges. Programs such as Family Care and IRIS (Include, Respect, I Self Direct) are changing the approach to public health. Wisconsin is among national leaders in certain areas; for example, the State has embraced opportunities to assess funding for LTC providers and to consider rate standardization and Managed Care Organization (MCO) practices. Ongoing budget requests to address areas such as workforce development and mental health also highlight an understanding of persistent challenges.

The Baker Tilly team believes that the State of Wisconsin and many key providers possess a strong understanding of the LTC industry and its existing challenges. Therefore, we have used this report as a vehicle to focus on the future. While we have provided research and data to highlight current and past elements, we have put a great deal of emphasis on areas where Wisconsin can use its strong foundation to build a sustainable platform for the future. The recommendations and or items for consideration in this report are generally based on quantitative and qualitative analysis of the data collected at the time of the assessments, including provider interviews and available data. In the circumstances where data was not available, Baker Tilly used accepted national standards and benchmarks to forecast needs in Wisconsin. The respective areas of the report disclose the alternative sources in lieu of requested data. When appropriate, national or other state data may have also been leveraged to inform the reader.

The retrospective analysis assessed past data and trends including program/services utilization. The prospective analysis was intended to project forward through 2030 and estimate service/bed demand based on demographics and trends in the populations in Wisconsin, as well as an assessment of qualitative data collected. Certain assumptions regarding the future state of LTC services were made and noted accordingly herein. Changes in these assumptions, consumer preference, or market conditions may cause a shift in service delivery settings.

For purposes of this report, we have defined the following terms:

- Capacity is defined as licensed beds and or programs for the provider type,
- Supply is defined as the number of beds or programs or services in operation or will be in operation (e.g., adjusted for occupancy), and
- Demand is defined as the potential need compared to the current supply of beds or programs or services to meet the future need for the provider type.

Executive Summary

Long-Term Care Bed and Service Supply and Future Demand

Nursing Home Bed Supply, Accessibility and Future Demand

(The nursing home bed demand assessment is on page 62.)

Capacity and Demand

The nursing home bed need assessment suggested that there is currently (as of 2022) an excess supply of 6,180 beds in the State. We calculated the projected bed demand for 2030 under various scenarios described herein. Scenario 1 for 2030 described on the next page is the most likely to occur in Wisconsin and estimates that there will be 19,798 licensed beds in Wisconsin based on the decrease in capacity trends since 2017. This scenario is most likely because the utilization of nursing home beds will continue to fall over the next several years consistent with the trends of nursing home utilization in Wisconsin, as well as nationally. It is not anticipated that nursing home utilization will increase for the period. The trends in the nursing home industry including changing consumer preferences of where they receive services for long-term care, shifting of long-term care to alternative settings such as assisted living and at-home, and closures and consolidations and downsizing of nursing homes, all suggest that utilization will continue to fall for the foreseeable future. The study suggests that these trends will not reverse in the next several years in Wisconsin. As a result, there will be just over 4,900 excess beds statewide by 2030 to meet the demand for beds/nursing home services. This suggests that for the foreseeable future there will be enough nursing home beds in Wisconsin to meet the potential need/demand, including long-term and short-term nursing home services.

One of the scenarios for the nursing home bed demand estimates indicated there could be a significant shortage of nursing home beds in 2030. Scenario 2 described on the next page assumes that the utilization of nursing homes stabilizes, which is not the trend of the past 20 to 30 years, and the downsizing, closures, and consolidation of licensed beds remains at the current levels or possibly increases. Consumer preference has shown consistently year over year for the past few decades a preference of alternative settings to the nursing home and this trend is not likely to reverse. If this scenario comes to fruition, there could be a shortage statewide of over 7,300 beds by 2030. This scenario also does not consider that those requiring nursing home services, either in a long-term care (i.e., custodial) setting or for transitional care needs, could be cared for in alternative settings (e.g., at home with home health and hospice). The trends in the nursing home industry suggest that this scenario is not likely to happen, and that Wisconsin will have enough nursing home beds for the period assessed, as described above.

The licensed bed demand assessment for 2030 used current demographics and demographic projections, Wisconsin nursing home utilization rates and trends, by Healthcare Emergency Readiness Coalition (HERC), and nursing home bed supply for each HERC and for Wisconsin. Future bed demand is not a simple count of beds or services, but rather a combination of service availability, staff resources and the willingness of providers to accept these patients in the current regulatory and economic environment as well as reimbursement for services.

The table below summarizes for each Region/HERC the nursing home bed capacity for 2022, 2022 utilization rate of nursing homes, 2020 estimated bed demand, which is the supply needed to meet demand based on the utilization rate, and 2022 nursing home excess bed supply anticipated. The bed supply assessment indicates the total number of beds available in 2022 that are in excess of potential demand, based on the use rate calculation method (applying the 2022 utilization rate to the population).

There are currently an estimated 6,180 excess nursing home beds in Wisconsin based on this method. The bed capacity is subject to change and if nursing homes change their licensed capacity (e.g., delicense beds) after the analysis was conducted. Utilization rates vary daily. The excess supply will vary and may be less or more than noted here depending on whether nursing home providers delicensed beds after the analysis.

2022 Bed Need Projections
HERC Regions and Wisconsin

Region/HERC	2022 Licensed Bed Capacity [1]	2022 Projected NH Utilization Rate [2]	2022 Estimated Bed Demand [2]	2022 NH Bed Excess Supply Projections
Northwest	3,194	1.88	2,170	1,024
Western	1,477	2.20	1,219	258
North Central	2,574	1.99	2,031	543
South Central	5,382	1.86	3,929	1,453
Northeast	2,405	1.75	1,612	793
Southeastern	8,677	2.12	8,151	526
Fox Valley	2,745	1.12	1,162	1,583
Wisconsin	26,454	1.91	20,274	6,180

HERC regions: Healthcare Emergency Readiness Coalition. See map in report Appendix C.

[1] Nursing home (NH) capacity and utilization data as of October 2022.
[2] 2022 utilization rate and 2022 bed demand projected by Baker Tilly.
[3] The total number of nursing home beds demanded in excess of current supply.
Data sources: Division of Quality Assurance, Minimum Data Set (MDS), CMS iQIES, October 2022; Department of Administration, Demographic Services Center

The four potential scenarios to estimate the nursing home bed demand and the excess or deficit supply by 2030 based on estimated utilization rates of nursing home services for the period are summarized below. As stated earlier, scenario 1 is the most likely to occur through 2030.

Nursing Home Bed Need/(Deficit) Scenario Assumptions			
Scenario 1	Scenario 2	Scenario 3	Scenario 4
Utilization decreases consistent with 2017 to 2022 declines and NH supply decreased at the same rate as 2017 to 2022.	Utilization remains stable (2022 rate) and NH supply decreased at same rate as 2017 to 2022.	Utilization remains stable (2022 rate) and no reduction in NH supply from 2022 levels (from table on previous page).	Utilization decreases consistent with 2017 to 2022 and no reduction in NH supply from 2022 levels (from table on previous page).

The table on the next page summarizes the potential shortage of nursing home beds (in red) or excess supply (in black) for each of the scenarios described above.

The bed excess/under supply estimates below are an exercise of the four scenario assumptions above, to estimate the potential demand less the supply of nursing home beds for 2030. If the supply exceeds demand, there is an excess supply of nursing home beds, as indicated in the table and if the estimated supply does not meet the demand, there is a shortage projected. The table is summarized by HERC.

2030 Projected Bed Excess/(Under) Supply
HERC Regions and Wisconsin

HERC Region	Scenario 1	Scenario 2	Scenario 3	Scenario 4
Northwest	598	(490)	301	1,390
Western	177	(537)	(126)	587
North Central	(195)	(895)	(106)	595
South Central	1,326	(660)	72	2,058
Northeast	657	(406)	201	1,264
Southeastern	622	(4,197)	(2,106)	2,713
Fox Valley	994	159	1,136	1,971
Wisconsin	4,916	(7,353)	(688)	11,581

HERC regions: Healthcare Emergency Readiness Coalition. See map in report Appendix C.

Data sources: ESRI; Division of Quality Assurance, Minimum Data Set (MDS), CMS iQIES, October 2022; Department of Administration, Demographic Services Center; Baker Tilly

The table below summarizes the estimated nursing home supply by HERC Region and Wisconsin for 2030. The low range assumes that current supply continues to decline at the same rate that occurred for the period 2017 to 2022 for each HERC region. The high range assumes that supply does not decrease from 2022 licensed capacity in each HERC region and that no provider downsizes or closes for the period. This is unlikely to occur.

The supply of beds in Wisconsin by 2030 will be between the low range (which is consistent with scenario 1 findings above) and high range shown below. It is not possible however to estimate the exact supply total by 2030 because it is not known how many providers will close or decrease capacity by 2030. These supply estimates below are not an estimate of demand or utilization. Supply does not indicate demand or utilization, which is shown/discussed on the pages above.

2030 Estimated Nursing Home Bed Supply
By HERC Region and Wisconsin

	2030	
HERC Region	Low Range	High Range
Northwest	2,403	3,194
Western	1,066	1,477
North Central	1,785	2,574
South Central	4,650	5,382
Northeast	1,799	2,405
Southeastern	6,318	8,677
Fox Valley	1,768	2,745
Wisconsin	19,789	26,454

Source: Baker Tilly Demand Model Methodology; ESRI

Significant Factors Effecting Future Supply, Utilization and Demand

The findings suggest that workforce, Medicaid reimbursement shortfalls, and consumer preference changes are noteworthy factors impacting the nursing home industry's ability and willingness to fill to supply and are significant root causes of the current excess bed capacity. Although there is enough bed supply to meet the needs based on demographics and utilization rates, there are also access issues for some populations. Most notably, based on anecdotal information gathered from interviews and surveys of nursing home providers and hospitals and discussions with advocate groups and trade associations, there is not enough supply for high acuity, behaviorally challenging persons, including persons with severe dementia and mental health conditions, on Medicaid or with no-payment at the time they are discharged from the hospital or admitted from elsewhere (referred to herein as "barrier populations"). There are several other factors impacting utilization of nursing homes noted later in the Executive Summary that should also be considered.

The most significant factors of workforce, reimbursement, and consumer preferences (demand) will continue to play the biggest part of whether nursing homes will be able to fully utilize current supply over the next several years. The state is addressing the current healthcare workforce issue, that which can be influenced, and the Medicaid reimbursement issues.

Nursing Home Bed Moratorium Revision for Redistribution of Beds

Currently, there is a nursing home bed moratorium in place that prevents new licensed beds from being issued in Wisconsin, although a nursing home can be replaced (at current licensed capacity, or less) and/or renovations and additions can be made to an existing nursing home. There is the ability of a provider to sell a full nursing home license within their Health Service Area (HSA) to another provider and/or within a county that is immediately adjacent to the HSA, if they decide to close their facility.

Assisted Living Bed Supply, Accessibility and Future Demand

(The assisted living bed demand assessment is found on page 66.)

The assisted living (for frail elderly and people with physical, intellectual, and/or developmental disabilities) and memory care/dementia bed supply is not expected to meet the demand by consumers in the foreseeable future in each region of the state. The assisted living demand model for the period 2022 to 2027 (most current available information) suggests that there is a need for additional supply in Wisconsin across all income stratifications and not just persons with the means and ability to pay privately. The demand model for the under 65 population suggests that there is a need for additional supply, which is assumed to primarily be the AFH provider type.

The findings indicate an opportunity for the private sector to develop assisted living options for those paying privately (households with income of $25,000 or more) and for moderate to lower income households (less than $25,000) to fill the developing needs of these populations. The assisted living assessment models are based on demographics and consider licensed capacity and operating supply. To assess demand, population and income estimates for 2022 and 2027 were assessed, as well as percentages of the populations estimated to have impairments in Activities of Daily Living (ADLs), and cognitive impairments due to Alzheimer's/dementia. Additional considerations such as percentage of persons living alone, persons with developmental disabilities, and others were factored into the models to estimate demand for assisted living beds (elderly and non-elderly). See Appendix O for the assisted living demand methodology.

This table below summarizes the results of the bed demand estimates for 2027 for assisted living facilities serving elderly (65+) in Wisconsin, which is an indicator of the total supply that is needed to meet the future demand by 65+ persons for these settings. The Baker Tilly model assumes that the supply remains consistent for the period assessed when determining future demand (the demand for beds by 2027). This denotes an anticipated shortfall in supply versus projected demand. See page 69 for the under 65 assisted living market demand model.

The private sector is responsible for the supply of beds and for new or expanded services which will likely occur during the period 2022 to 2027 depending on access to capital, cost of workforce, available labor force, demand for services for their region, costs of construction, and other influences, thereby reducing the 2027 deficits estimated below. This analysis is intended to provide an estimate of the supply gap the private sector may need to fill for the next several years. This demand methodology also does not take into consideration alternatives to meet the required assistance, such as housing with home care services or adult day care settings.

The demand model found that there is a total need for a supply of 58,234 assisted living beds for the 65+ elderly population to meet demand by 2027. There is currently a supply of 45,773 beds for this segment of the population, based on the Baker Tilly demand model. This excludes 95% of the AFH bed supply, which is addressed in the next section. See Appendix O.

The table below summarizes the total supply for 2022 of assisted living beds estimated to serve elderly populations (persons over 65) in Wisconsin and the total estimated demand for 2027 for all age eligible households in Wisconsin. The total capacity included in the model is adjusted to 90% occupancy which is standard operating occupancy in the industry because facilities typically are not 100% occupied due to turnover and other factors.

The total deficit projected for 2027 summarizes the total beds needed in addition to the current (2022) supply. The total deficit projection is the number of beds that need to be developed by 2027 to meet the increasing demand (i.e., population growth of persons that will need assisted living). See page 68 for the HERC totals.

Statewide Assisted Living Supply for 2022 and Projected Deficits for 2027

	Total Supply for 2022 [1]	Total Estimated Demand for 2027 [2]	Total Deficit Projected for 2027 [3]
Assisted Living (non-memory care)	35,179	42,738	(7,559)
Memory-care Specific Assisted Living	10,594	15,496	(4,902)
Wisconsin Totals	45,773	58,234	(12,461)

Source: ESRI, Baker Tilly proprietary demand models

[1] Total estimated supply of elderly (65+) assisted living as of October 2022.

[2] Total estimated demand/need, based on Baker Tilly proprietary demand model.

[3] Total number of additional beds that will be needed in Wisconsin by 2027.

The totals in the table below are an estimate of the gap in supply that the private sector will need to develop/fill for the next several years to meet the potential demand (more than current supply) by payor type (private pay and low income/Family Care eligible). The deficit summarized in the table is the demand for 2027 in excess of the current supply for each of these payor types.

Statewide Assisted Living Supply Deficit Projections, by Payor Type

	2027 Private Pay/Market Rate Supply Deficit [1]	2027 Low Income/Family Care Supply Deficit [2]	Total Deficit Projected for 2027
Assisted Living Non-memory Care	(5,271)	(2,288)	(7,559)
Memory-care Specific Assisted Living	(2,331)	(2,570)	(4,902)
Wisconsin Totals	(7,603)	(4,858)	(12,461)

Source: ESRI, Baker Tilly proprietary demand models

[1] Private pay defined as households with more than $25,000 annual household income.

[2] Lower income & Medicaid income defined as households with less than $25,000 annual household income.

The demand model for the Adult Family Home (AFH) segment for the population aged 65 and younger is summarized below. The model assumes that the AFH facilities are primarily serving persons who have physical, intellectual, and/or developmental disabilities. The total number of AFH beds in Wisconsin is 7,639.

The generally accepted benchmark for assisted living market penetration is 20%. The market penetration rate is the percentage of age eligible individuals divided by the available operating supply. The lower the penetration rate, the higher the likelihood that market segment could support additional supply. The demand model indicates a 4.2% market penetration rate which suggests there is room for growth of additional AFH beds in the state to serve this population.

This demand model identifies market penetration, but we are unable project the excess or deficit in supply and provide specific numbers of additional AFHs beds are needed in the state. Community specific market studies would need to be conducted to identify the supply needed for that area.

Adult Family Home Market Penetration Rates/Demand Assessment
For Populations 20-64

2027 Projections	Wisconsin
Total AFH supply for individuals with a developmental disability	7,639
Assumption: 75% AFH serve adults aged 20-64 (c)	5,729
Assumption: AFH operate at 90% occupancy, 95% filled by people within region (c)	4,898
Total age-eligible individuals (d)	115,823
Market Penetration Rate (c)/(d)	4.2%

Source: ESRI®, Wisconsin Department of Health Services, US Census Bureau American Community Survey, 2017-2021 estimates, Baker Tilly proprietary demand models.

*Reflects statewide average of the proportion of individuals aged 18-64 with cognitive (4.4%), ambulatory (3.8%), self-care (1.7%), and/or independent living (3.4%) disability.

The state is currently in the process of making changes to Family Care reimbursement methods. It is unclear the impact these changes, if any, will have to incentivize the private sector to accept more individuals on Family Care and/or to develop more assisted living supply for income qualified households/persons. Provider surveys and interviews with providers and advocacy groups suggest that positive changes to the reimbursement methodology for assisted living (increased reimbursement to providers) should create more access, especially for residents incurring higher cost of care.

The largest deficits of assisted living supply are projected for the Southeast, South Central and Northwest regions of the state. The deficits for the Southeast and South Central regions are primarily due to the demographics of these regions; specifically, population density and projected growth of the 65+ populations in these areas for the next five plus years.

The biggest factor to future expansion of assisted living statewide is the lack of available workforce. The assisted living industry is struggling with workforce shortage issues that are the same as all other industries, which is slowing the development of options statewide. (Workforce in healthcare is addressed later in this report). In addition, costs of construction and trade labor have escalated significantly in the past three to four years which has also slowed construction of assisted living facilities. Finally, interest rates have increased dramatically since 2018 and has impacted the pace of development of facilities due to financial factors such as the financial feasibility and profitability for new developments.

Some regions of the state with a larger percentage of private pay households (higher income regions) have seen and will continue to see increased development of options, while other areas of the state, in particular rural areas, such as the Western and Northwest regions, will not have as high a rate of development of assisted living due to lack of population density and/or the inability of many of the households in these regions to pay privately.

Home and Community Based Services Capacity, Accessibility and Future Demand

(All referenced studies of HCBS programs can be found in Appendix I.)

Home and Community Based Services (HCBS) for the purposes of this report include Home Health Agencies, Hospice services, and Personal Care Agencies and services. The HCBS service community in Wisconsin will face the greatest pressure to meet the future demand of the LTC population based on perceived consumer preferences to remain at home and national trends for payors to leverage HCBS rather than institutional settings to control costs. This sector will need to expand the number and geographic coverage of its providers to meet future demand for patient volume and preference.

The variety of these services provide opportunities to impact patients in a home-based setting which is typically more cost effective than a facility. Baker Tilly has assessed the current HCBS service community in Wisconsin and has identified several key areas of focus to ensure the success of these programs.

Supply Considerations

Wisconsin is expected to need additional HCBS providers across all three provider types (i.e., home health, hospice, personal care, in addition to the assisted living findings above) to meet the change in demographics and consumer preferences. This equates to new providers as well an increase in the geographical areas served, services offered and benefit alignment to community need. As the demographics of LTC recipients and providers change, it is critical that HCBS services evolve to meet the changing system of care.

The state of Wisconsin and the provider community will need to collaborate to ensure that services are available with capacities in the geographies necessary to support demographic shifts and consumer preferences. We also understand that while consumer preferences may favor HCBS, there are the added constraints of workforce issues and payment streams that may be a barrier to growth of services. As the consumer demand and preferences shift towards home-based care, and patient complexity and acuity rise, the planning, disposition, and skills of HCBS providers and related payment streams will need to proactively shift as well.

Provider Innovation

Provider innovation has been a cornerstone of communities who are proactively addressing LTC challenges. Traditional divisions between practices and type of service provider need to be overcome to meet both the financial and care challenges of this expanding population.

There are many forms that innovation can take creating new models of care and collaboration. The success of these programs depends on the patient population, the providers participating, and the financial structures involved. Throughout this report, we have provided examples in other markets to illustrate the concepts and provide context to the practices suggested. These practices include expansion of LTC collaboratives leveraging various HCBS programs to support integration enabling more efficient and effective patient navigation as they transition between levels of care.

- Dallas/Ft Worth 911 Collaboration
  - An example of Tarrant County EMS provider collaborating with a local health system and community home health providers to reduce burden on the local Emergency Departments (ED). They piloted two programs focused on interventions designed to reduce avoidable ED use. One arm of the program embedded Family Nurse Practitioners (FNP) within ambulance crews to provide more timely assessment and intervention for Behavioral Health needs. The other program partnered with a large home health program to provide field support to patients that could be managed under Home Health rather than a trip to the ED. This included situations like catheter change, wound assessment and other urgent, non-emergent needs.

- HCBS, LTC Continuums
  - Owned Model – Masonic Village of Pennsylvania
    - Masonic Village is a mission driven not-for-profit organization based in Pennsylvania which focuses on providing a quality-of-life experience for seniors in their community. They have created a Center of Excellence in providing person-centered residential, health care and wellness services, home and community-based services, outreach services and ancillary operations.
    - Masonic Villages owns all aspects of their continuum including, but not limited to: Independent Living, Assisted Living, Affordable Housing/Charity Care, Skilled Nursing, Home Health, Hospice, Home Care (Personal Care), Memory Care, Nursing Care (Nursing Home Care), Adult Day Care, Pharmacy Services, Rehabilitation Services, and Outreach/Navigation services.

  - Partner Model – Universal Health Services/Bayada
    - The partnership between Universal Health Services and Bayada demonstrates a comprehensive suite of services intended to meet the post-acute and home and community-based needs of the long-term care population as well as create financial sustainability for each of the divisions. As a combined offering, they provide acute care, behavioral health facilities, outpatient and ambulatory care facilities, in-home private duty nursing, home health, rehabilitation, assistance with personal care and hospice.

  - AccessHealth
    - AccessHealth defines care navigation assistance in identifying and accessing the range of available services and support their clients need to stabilize and improve their health and their lives.
    - The *care navigation model* goes well beyond connecting people in need to medical services — it includes behavioral health services and social services as well. AccessHealth's care navigators are experts in the full landscape of services, systems and community-wide support that can help clients address and overcome barriers to care. AccessHealth's clients will be connected to non-medical care or services in addition to referrals for their medical needs. The model is designed to help clients to first understand and navigate the local ecosystem of programs, services and healthcare providers, and then coordinate their care and treatment. Care navigators function as frontline liaisons between clients and community partners working to improve health outcomes for low-income, uninsured Spartanburg, Cherokee, and Union County residents. The result for AccessHealth clients is holistic care plans that produce better and more sustainable outcomes.

State Licensing

There are currently supply challenges nationwide for healthcare providers and key clinical professionals. The key focus in many states includes prioritizing the licensing process in critical areas.

The Prospective Analysis of HCBS services highlight areas of licensing for Wisconsin to implement. We have identified a need for expedited processing of new provider applications for key clinical needs (physicians, nurses, behavioral health providers, certified nursing assistants). Equally important is the licensing of HCBS service providers with priority on geographic and service gaps (HERC specifics or provider type specific).

The analysis was largely based on qualitative data gathered during out provider interview process. At the time of this writing, there was not a centralized supply report available to benchmark this workforce. We encourage the state to develop and implement an annual data collection tool to be completed by Personal Care Agencies (PCA) annually, to inform state database on utilization, trends, costs and ongoing needs. This data collection could coincide for the annual agency license renewal process.

Growth and Expansion of HCBS

There are several key areas which will require growth and investment for the private sector and providers to meet future LTC needs in Wisconsin. Some of these areas will also require the support of the state to be successful.

The Prospective Analysis of HCBS services indicates Wisconsin will need to increase the number of home health, hospice, and personal care agencies across the state in order to meet anticipated care needs for long-term care residents. Structured caregiver training will be critical to the future needs of the LTC population. Baker Tilly recognizes that Wisconsin has already invested in this effort through the Certified Direct Care Professional programs, and suggests the state measure the success and volume of this program in relation to the projected needs for these professionals.

In addition to the recommendations delineated in Recommendation 7, Baker Tilly suggests that the private sector assess the need and impact for expanded telehealth services and remote patient monitoring to meet the needs of people at home, especially in rural settings. Wisconsin residents, providers and the state should also consider conducting a benefit review of all Medicare Advantage Plans offering personal care coverage, to understand access, options, and financial viability for patients wanting to remain at home.

The importance of planning and developing HCBS services is extensively detailed in our Retrospective Analysis on page 32 and our Prospective Analysis on page 61 further in the report.

Recommendations

Baker Tilly has summarized the following recommendations for the public and private sector to address future accessibility, demand, and workforce issues for the State of Wisconsin. Other areas for consideration have also been included in the recommendations section.

Ref #	Recommendation	Responsibility of:
1	Medicaid Expansion	DHS
2	Medicaid Application Process Revision	DHS
3	Increase Use of Civil Monetary Penalty Funds (CMP)	DHS, Private Sector
4	Guardianship Process Revisions for LTC Patients	State of Wisconsin/Not DHS
5	Planning for Complex Patient Populations	Private Sector, DHS, Division of Quality Assurance (DQA)
6	Workforce Considerations to Address Challenges	Private Sector
7	HCBS Initiatives	Private Sector, Public (DHS, DQA)/Partnerships
8	Managed Care Organization (MCO) Discharge Authorization Process	DHS/Private Sector (MCO) Partnership
9	Other Areas for Consideration	DHS, Other State Agency, DHS/Private Sector Partnership

1. Medicaid Expansion

(Referenced studies for Medicaid Expansion can be found in Appendix I.)

Medicaid expansion has been beneficial for many states to expand support and coverage in many key service areas covered herein. However, there are also results which show that there can be unintended consequences of expansion and that each state should develop its own methodology to explore how/when to expand.

Overall, the positives outweigh the negatives, and we recommend that Wisconsin continue to consider Medicaid Expansion as a tool to support future long-term care needs. The expectation is that alternative delivery models are included under Medicaid expansion to limit the potential risk of the woodworking effect – increased utilization of services by those consumers that previously did not seek options with Medicaid funding. The areas our team believes weigh in-favor include:

Strong Clinical Outcomes Tied to Medicaid Expansion

- Reduced rates of maternal, infant, cardiovascular and cancer mortality.
- Increased access for mental health, bariatric/obese, rural, patients with disabilities, and low-income patients with chronic conditions.
- Increase in any LTC use among newly eligible low-income, middle-aged adults.
- Increased access and utilization through community health centers.
- Increased use of mental health services.
- Associated with improved access for adults with obesity.
- Earlier diagnosis of chronic conditions.

Positive Economic Outcomes

- Increased enrollment in Managed Care plans, increasing access and lowering non-covered care without negatively impacting quality of care.
- Improved operating margins for safety-net hospitals and reduced uncompensated care for all hospitals.
- Forecasted employment growth.
- Decrease in medical expense for low-income patients with an average of $1,140 in medical debt.

- Lessen the impending coverage gaps and "patient churn" expected with the end of coverage requirements under the Families First Coronavirus Relief Act.

Workforce Impacts

- Higher average starting salaries for primary care physicians and internists. This has led to a statistical difference in new physicians moving to expansion versus non-expansion states.
- Improvement of nurse staffing ratios in expansion states.

Expansion of Presumptive Eligibility (PE)

Medicaid Expansion offers states the opportunity to leverage presumptive eligibility to support LTC patients.

Previously, presumptive eligibility was an option limited to children or pregnant women and available only in states that selected this option. Effective January 2014, the Affordable Care Act expanded the scope of the policy to allow hospitals to make presumptive eligibility determinations in every state for all individuals eligible for Medicaid on the basis of modified adjusted gross income. For many years, states have had the option to adopt a presumptive eligibility policy that allows healthcare providers, or "qualified entities," including hospitals, to quickly provide pregnant women and children with temporary Medicaid coverage. Based on information about income and household size, qualified entities identify patients who are likely to qualify for Medicaid. These patients are then "presumed eligible" and temporarily enrolled in Medicaid. Presumptive eligibility provides the patient with immediate access to care with payment for services guaranteed to providers. It also creates an opportunity to encourage and assist the patient in submitting a full Medicaid application. Under the Affordable Care Act, in addition to the establishment of hospital PE, states that have already implemented presumptive eligibility for children or pregnant women can now expand the program to include parents and caretaker relatives and other adults covered by the state's Medicaid program, as well as former foster children and individuals in need of family planning services.

Hospital Presumptive Eligibility Program under the Affordable Care Act

More significantly, the Affordable Care Act requires all states to implement hospital Presumptive Eligibility (PE), giving hospitals the opportunity to make presumptive eligibility determinations regardless of whether the state had previously adopted the presumptive eligibility option. Hospitals in every state can now use PE determinations to enroll individuals who are eligible under a state's Medicaid eligibility guidelines, including children, pregnant women, parents and caretaker relatives, and former foster children. Hospitals may also make PE determinations for other groups that are covered by their state Medicaid programs, including individuals with income above 133% of the federal poverty level and under age 65; individuals eligible for family planning services; and individuals needing treatment for breast and cervical cancer. At the discretion of each state, hospitals may also be allowed to make hospital PE determinations for other groups such as aged, blind, and disabled persons, as well as groups whose eligibility is established by section 1115 waivers. Hospital PE determinations are not limited to patients but can also be made for patients' families and eligible individuals from the broader community.
Centers for Disease Control Presumptive Eligibility Brief: https://www.cdc.gov/phlp/docs/hospitalpe-brief.pdf

We recommend further exploration regarding the expansion of presumptive eligibility. Specifically, DHS should consider developing a methodology and process to address reimbursement of providers who followed all required processes but are unable to successfully bill for Medicaid pending patients that were accepted in good faith. These would include patients who received care preceding the retroactive billing period, patients who fail to provide required documentation to complete the Medicaid application (especially in cases of death or discharge before completion) and patients who fail to meet enrollment requirements during the application period.

While Wisconsin does not allow presumptive eligibility for long-term care services, the has expanded Hospital Presumptive Eligibility to adults younger than 65, parents, caretakers, children, and pregnant women. Here is the website with general information. Presumptive eligibility allows more efficient transfer of patients to appropriate care settings. This process serves the purpose of moving appropriate patients out of acute care facilities and to the appropriate level of care in an expeditious manner. The onus is still on the LTC providers to be appropriately screening patients for eligibility but allows them to accept patients without an overwhelming burden.

The lack of these mechanisms in Wisconsin means that patients who are or will be eligible for LTC Medicaid benefits sit in a hospital bed until they are authorized for services in the LTC setting. LTC providers have no incentive and would lose money every day that an unauthorized patient is in their building since there is no way to recoup the cost of care. This leaves the hospitals in a position to either leave the patients in beds needed for acute patients or help defray the cost out of pocket to have a patient placed in an appropriate setting.

This is particularly true for patients pending new Medicaid enrollment. It was noted throughout our interviews that most LTC providers refuse to take a Medicaid-pending patient because they perceive that they cannot retroactively bill for services from date of admission to date of Medicaid approval. Additionally, they report frustration with delays due to incorrect application types started during the hospital stay, delays due to family inability or unwillingness to provide information, poor financial literacy and understanding on both family and LTC staff levels on the completion of the application, and the overall complexity of the application process. Providers also identified that many challenges are exacerbated by inconsistencies in Aging and Disability Resource Center (ADRC) practices related to initial Medicaid enrollments and response time.

Specific state examples where Presumptive Eligibility has expanded include:

- New York
  - An individual, upon application for medical assistance, shall be presumed eligible for such assistance for a period of sixty days from the date of transfer from a general hospital, as defined in section twenty-eight hundred one of the public health law to a certified home health agency or long term home health care program, as defined in section thirty-six hundred two of the public health law, or to a hospice as defined in section four thousand two of the public health law, or to a residential health care facility as defined in section twenty-eight hundred one of the public health law, if the local department of social services determines that the applicant meets each of the following criteria: (a) the applicant is receiving acute care in such hospital; (b) a physician certifies that such applicant no longer requires acute hospital care, but still requires medical care which can be provided by a certified home health agency, long term home health care program, hospice or residential health care facility; (c) the applicant or his representative states that the applicant does not have insurance coverage for the required medical care and that such care cannot be afforded; (d) it reasonably appears that the applicant is otherwise eligible to receive medical assistance; (e) it reasonably appears that the amount expended by the state and the local social services district for medical assistance in a certified home health agency, long term home health care program, hospice or residential health care facility, during the period of presumed eligibility, would be less than the amount the state and the local social services district would expend for continued acute hospital care for such person; and (f) such other determinative criteria as the commissioner shall provide by rule or regulation. If a person has been determined to be presumptively eligible for medical assistance, pursuant to this subdivision, and is subsequently determined to be ineligible for such assistance, the commissioner, on behalf of the state and the local social services district shall have the authority to recoup from the individual the sums expended for such assistance during the period of presumed eligibility.

- Payment for up to sixty days of care for services provided under the medical assistance program shall be made for an applicant presumed eligible for medical assistance pursuant to subdivision one of this section provided, however, that such payment shall not exceed sixty-five percent of the rate payable under this title for services provided by a certified home health agency, long term home health care program, hospice or residential health care facility. Notwithstanding any other provision of law, no federal financial participation shall be claimed for services provided to a person while presumed eligible for medical assistance under this program until such person has been determined to be eligible for medical assistance by the local social services district. During the period of presumed medical assistance eligibility, payment for services provided persons presumed eligible under this program shall be made from state funds. Upon the final determination of eligibility by the local social services district, payment shall be made for the balance of the cost of such care and services provided to such applicant for such period of eligibility and a retroactive adjustment shall be made by the department to appropriately reflect federal financial participation and the local share of costs for the services provided during the period of presumptive eligibility. Such federal and local financial participation shall be the same as that which would have occurred if a final determination of eligibility for medical assistance had been made prior to the provision of the services provided during the period of presumptive eligibility. In instances where an individual who is presumed eligible for medical assistance is subsequently determined to be ineligible, the cost for services provided to such individual shall be reimbursed in accordance with the provisions of section three hundred sixty-eight-a of this article. Provided, however, if upon audit the department determines that there are subsequent determinations of ineligibility for medical assistance in at least fifteen percent of the cases in which presumptive eligibility has been granted in a local social services district, payments for services provided to all persons presumed eligible and subsequently determined ineligible for medical assistance shall be divided equally by the state and the district.

- Washington State: Tailored Supports for Older Adults (TSOA) presumptive eligibility
  - People who are interested in applying for TSOA or Medicaid Alternative Care Programs (MAC) may do so by contacting their local AAA or HCS office. A person may be found presumptively eligible and services may be approved for eligible people pending completion of the application process.
    - Both TSOA and MAC have a presumptive eligibility component that allows services to be authorized based on a quick prescreening of financial and functional eligibility criteria. The goals of both programs are to get services in place quickly to support the person and caregivers taking care of them. If the person is found presumptively eligible (PE) they can receive services for a period of up to about 60 days while the financial application is being processed and while DSHS confirms that the person meets the functional criteria for the programs.
    - As long as a financial application has been filed the PE period continues until the application is completed.
    - If an application isn't filed, the PE period will end at the end of the month after the month in which services were first authorized.
  - TSOA is a program funded under the Medicaid Transformation Project Demonstration and provides services to support unpaid caregivers in Washington State, and provides a small personal care benefit to people who don't have an unpaid family caregiver to help them. It creates a new eligibility category and benefit package for people age 55 or older who are "at risk" of needing long-term services and supports in the future who don't currently meet Medicaid financial eligibility criteria.
  - TSOA doesn't provide health care coverage and is targeted towards people who aren't currently eligible for Medicaid. However, TSOA may be used for people who are currently only eligible for a limited scope program such as the Medicare Savings Programs, or who are only eligible for medically needy coverage.
  - Eligibility for TSOA is determined by reviewing the income and resources of the person (and their spouse) who receives care. The person must also be functionally eligible under WAC 388-106-1910. However, the services authorized are for the benefit of the caregiver, not the care receiver.

2. Medicaid Application Process Revisions

(See Appendix H for more information.)

We recommend the state gather additional information regarding potential revisions to the Medicaid application process. Specifically, Wisconsin DHS Division of Medicaid Services (DMS) should:

- Conduct a focused survey, including health systems, long-term care providers and the contracted ADRCs, to evaluate the knowledgebase, consistency and efficacy of the current processes, communication standards and mechanisms for application and enrollment into Medicaid.
- Collaborate with professional organizations like Leading Age, Wisconsin Association for Home Health and the Wisconsin Hospital Association to create an education campaign for member providers to combat the misconceptions and lack of process fluency impacting care transitions for many Medicaid pending patients.
- Examine alternative data sources for key challenges such as income validation, other insurances, and residential confirmation.
- Create a financial literacy/advocacy support model to help applicants appropriately complete this portion of the application and avoid delays.

There are mixed findings regarding the Medicaid application process for the state of Wisconsin. Quantitatively, the state is in the medium category of speed with 39% of applications processed in under 24 hours. However, our provider interviews indicated the Medicaid application/enrollment is complicated and nonintuitive for the patient populations. This has increased the burden on providers to support and, in some cases, manage the application process. They do so out of necessity to expediate the transition of patients between care settings.

Financial literacy is a challenge for patients and/or their families in the application process. Inaccurate financial information was mentioned frequently as a primary delay in completing the application process. Other states have promulgated rules allowing informal decision makers appointed by the individual, or the individual's physician, to act on behalf of the patient for accessing all information necessary to complete Medicaid applications.

Examples from other states to address these challenges include:

- Colorado Health First
  - Colorado offers a streamlined application process such that individuals can use a single application to apply for Medicaid, CHIP, health insurance coverage available through the exchange, as well as a variety of human services programs available in the state.
  - Applications can be submitted through Connect for Health Colorado or Colorado's Program Eligibility and Application Kit (PEAK) eligibility system any time during the year.
- Maryland Easy Enrollment Program
  - Maryland's Easy Enrollment program, implemented last year, uses the state tax-filing process as a pathway to coverage. On their tax forms, Marylanders can choose to share their insurance status, income, and other relevant information to receive an eligibility determination for Medicaid and subsidized marketplace plans. The marketplace notifies these taxpayers of their eligibility for coverage and, if applicable, offers them the opportunity to enroll in a marketplace plan outside of the open-enrollment period.
  - Maryland recently released enrollment data for the first year of the program.
  - Select Results from First Year of Maryland's Easy Enrollment Program (2020)
    - *Source: Authors' analysis of Maryland marketplace workgroup presentation from March 24, 2021, and Open Enrollment Report from a January 19, 2021, marketplace board meeting*.

  - More than 60,000 people shared their information with the marketplace — most (more than 53,000) were deemed eligible for marketplace coverage or Medicaid.
  - 4,015 people enrolled in coverage, including 15 percent of those found eligible for Medicaid and 11 percent of those found eligible for subsidized marketplace plans; at the time, subsidies were available only to those with household incomes up to 400 percent of the federal poverty level.
  - As of September 2020, 23 percent of marketplace enrollees who signed up through the program were Black, compared with fewer than 17 percent of enrollees who signed up during the recent open-enrollment period.
  - More than 40 percent of marketplace enrollees who signed up were ages 18 to 34, compared with about 28 percent of enrollees who signed up during the recent open-enrollment period.
- NJ Medicaid Application Assistors Program
  - New Jersey provides access for Medicaid applicants to state certified assistors to support applications.

3. Increase Use of Civil Monetary Penalty Funds

Baker Tiller recommends that the state consider applying for Civil Monetary Penalty (CMP) funds to support a position that coordinates the Civil Monetary Penalty Reinvestment Program, communicates with providers regularly about opportunities for provider use, and provides support to providers in understanding the application process.

The Civil Money Penalty Reinvestment Program (CMPRP) initiative, led by CMS and accessible to the State and to providers, has resulted in several successful grant funded programs that promote nursing home quality and staffing initiatives. Wisconsin DHS has already created a user-friendly website that provides information about the Wisconsin CMP program. The site contains information about the use of funds, including past and current projects that were approved by the Quality Assurance and Improvement Committee. A focus on promoting grant funded projects is evident based on the number and variety of programs that have addressed both care and training needs; however, a review of funded projects for calendar year 2021 and 2022 (CMS data) suggests that Wisconsin may be underutilizing funds. There are several examples of opportunities to secure funding in projects that aid in workforce development and stabilization. There is programming that target transitions between care settings, and the provision of care for individuals who exhibit behaviors, which is an increasing population in care settings in Wisconsin and nationally.

One of the allowable areas of focus for CMP use through the CMPRP includes projects focusing on new nursing home populations. Consideration should be given by the DHS to promote a collaborative project between hospitals and nursing homes to identify the population of individuals who are challenging to place due to lack of skillsets necessary to meet the needs of the nontraditional referrals who are “new nursing home populations,” create collaborative training opportunities, and promote competency in nursing homes to care for those individuals in which placement is difficult. The following are examples from other states:

- Pennsylvania’s initiative entitled “Mental Health First Aid: Expanding Pennsylvania Nursing Homes Capacities” was aimed at providing actionable tools to support PA nursing homes in implementing behavioral healthcare. Results are pending.
- Alabama has an approved project entitled “LifeBridge Behavioral Management Program” in progress that is geared toward staff training for development of individualized around the clock programming with a concentration on preventing and responding to behaviors. Florida and Washington also have CMP funded projects for the same program. For more information, visit the download section located at the following link and see page 43 of the projects funded in CY 2021: Civil Money Penalty Reinvestment Program | CMS.

One of the primary focus areas, staffing, is also being addressed in multiple states with the use of CMP grants. Wisconsin's WisCaregiver Careers, a dual grant funded project administered by the Wisconsin Health Care Association (WHCA) and LeadingAge WI is geared toward promoting provider and public awareness of the workforce development program, designed to address the CNA workforce shortage through the provision of free Nurse Aide (NA) training, certification testing and sign-on or retention bonuses. Additional programming could expand upon workforce development projects to aid in the effort. Other examples of workforce development projects include proprietary solutions developed by individual providers such as:

- A project completed in New Jersey between the years of 2013 and 2016 entitled "RN Transition into Practice Residency Model for Long-Term Care". The grant award for this program was $1,605,553, a significant investment in promoting not only retention, but recruitment of nurses into the nursing homes setting. https://heldrich.rutgers.edu/work/evaluation-registered-nurse-transitions-practice-nurse-residency-model-long-term-care
- Kentucky's Department of Medicaid Services was granted funds for a "Quality Staffing Project" that seeks to address patient care and staffing issues in underperforming nursing homes through training and ongoing support. https://www.chfs.ky.gov/agencies/os/oig/Documents/CMPFundGrants.pdf
- Mississippi's "SNF Clinic" project was approved for $738,750 to provide evidence-based training and checklists to improve nursing staff performance at 25 nursing homes with one- or two-star ratings.
- North Carolina's "Caregivers NC" project approved for $2,484,130 aims to implement a multipronged proposal to recruit nurse aides, seeking to add 4,000 new nurse aides to the long-term care workforce. https://www.caregivernc.com/

Wisconsin DHS may want to consider a review of Oklahoma's approach to promote use of CMP funds. Oklahoma secured over $100,000 for an annual position to support a full-time CMP Funds Project Manager, which is renewable. The expanded use of funds for administrative programing could be earmarked to promote more robust and expanded grant funded opportunities that focus on offsetting current barriers such as lack of workforce, removal of admission barriers in nursing homes through staff training, and other collaborative initiatives between care settings.

4. Guardianship Process Revisions for LTC Patients

The State of Wisconsin should consider the following related to the guardianship process:

- Assign a team or partner to review the guardianship application process and technology platform for redundancies, inefficiencies, and opportunities for improvement. We suggest including key representatives from acute and LTC in the review process to enhance partnership and outcomes. Some key areas to consider include:
  - Weighting of the family information versus financial reporting services.
  - Review what should initiate a full restart of the application process versus moving forward.
  - The provider interviews have indicated frustration with state resources in terms of quality, training, number, and scope of subjective determination. We are unable to validate this concern but recommend further study of the matter.
- Explore the use of a third-party partner to manage this process for the State. These partners not only manage the process but provide their own technology platforms. For example:
  - Pennsylvania Guardianship Tracking System
    - The Pennsylvania Guardianship System. Pennsylvania's Guardianship Tracking System (GTS) is a new web-based system for guardians, court staff, Orphans' Court clerks and judges to file, manage, track, and submit reports. The system integrates statewide guardian information, thereby helping to protect Pennsylvania's most vulnerable citizens while streamlining and improving the guardianship filing process.

- This system was developed when the Supreme Court of Pennsylvania convened a multi-disciplinary Elder Law Task Force designed to study, identify and make recommendations to address particular concerns regarding elders. The task force consisted of 38 issue experts including jurists, elder advocates, attorneys, Orphans' Court clerks, prosecutors, educators and representatives of the financial industry. The task force was charged with creating a foundation for substantive improvements in the way elders in Pennsylvania interact with the court system, and to develop a blueprint to address those challenges.

Baker Tilly recognizes that guardianship falls outside of the influence of the DHS. However, it is an issue that is impacting the transfer of LTC patients in the provider community. The process of guardianship was mentioned in nearly every interview conducted by the Baker Tilly team with healthcare associations, health systems and post-acute care providers. The challenge is pervasive and creates some of the costliest patient challenges in the LTC patient population.

The perception of the health systems and long-term care providers is that the guardianship process is complex and lengthy. When a patient awaiting discharge starts the guardianship process, most health systems assume they will be housing the patients for 60-90 days prior to placement. The study did not include a formal review of the guardianship process, however the universal note of the challenge in our interviews highlights an issue. Whether this is an issue of fact or provider perception, it should be studied further by working with the health care providers to define and provide quantitative data to measure the impact of the perceived challenge,

Key challenges identified with guardianship in our interview process include:

- The process is complicated, and the average family/caregiver does not have the understanding or ability to complete the application correctly without help. This places a burden on the health system or the LTC facility to support the process. In many cases where the support is not available, errors in the application create the need to restart the process, keeping the patient in the hospital longer.
- Financial literacy and/or accurate knowledge of the patient's finances is a particularly challenging part of the process and impacts many applications.
- The approach to guardianship is antiquated and not streamlined from both a process and technology standpoint.
- The providers we have interviewed to date have expressed a concern that the state's approach to guardianship could be more collaborative. The application review is subjective and depends on the relationship with regional resources and the quality and interest of those resources in advancing the process.

These challenges have resulted not only in the continued stay of these individuals in a hospital, but the providers expending non-budgeted resources to support this process. In many cases, the providers are completing the application process with/for the families and in some cases feeling the need to pay for attorneys as a health system expense to expedite the transfer of patients from the facility.

5. Planning for Complex Patient Populations

(A detailed analysis of these patients can be found in our Retrospective (page 32) and Prospective Analysis (page 61) and related studies and supporting materials for complex patients can be found in Appendix L.)

Baker Tilly believes there will be future capacity challenges to serve complex patient populations, especially when it comes consumer preference for home and community-based services. Specific patient categories are expected to have a disproportionate impact on the future of long-term care. These populations include mental health, dementia, obesity/bariatric, unmanaged chronic conditions, and patients requiring ventilation. Baker Tilly believes these patients create the largest area of concern for the future delivery of long-term care in the state of Wisconsin, as well as nationally.

Baker Tilly recommends the following actions to address the challenges associated with providing care for complex patient populations:

- Review the current licensing and utilization of tele-psych service providers to extend the coverage of care for these patients. Part of this process should be an analysis of the coverage and cost of these services and how LTC providers may be reimbursed for utilization. The cost of supporting these services should be less in total than the cost of this population's extended hospital stays.
- Consider support for grants, funding, and programs for psychosocial services.
- Perform a cost-benefit analysis of funding obesity surgical and pharmaceutical treatments against the cost of care for Medicaid patients. Should the numbers prove effective, apply for Medicare/Medicaid Innovation grant to support pilot with qualified provider.
- Explore telemedicine and support programs to extend access for lifestyle management programs and professionals.
- As detailed in our Prospective Analysis on page 61 regarding shifts in patterns of care, management of LTC populations is undergoing a change. Develop proactive pilot programs to manage patients earlier in the disease cycle to effectively supporting complex patients as well as integrated solutions.
- Explore programs to support private sector expansion of CBRF for dementia care

Baker Tilly has not specifically addressed chronic conditions which are large segments of the population and are rising proportionately to the population. Diseases such as cardiovascular, cancer, and COPD are well supported and have a support system in place.

National, regional, and state trends in workforce, patient acuity, consumer expectations and funding all influence the availability and capacity to meet anticipated demand. The Baker Tilly team has identified the following areas as high priority for Wisconsin, and we recommend the state and private sector to create action plans around the current state of these populations to meet future demands:

Behavioral Health and Dementia Patients

Approximately 75 million Americans will be over age 65 by 2030. Additionally, a 2012 study from the Institute on Medicine found that approximately one in five older adults in the U.S. experience a mental illness, substance use disorder, or both. That ratio, should it still exist in 2030, equates to approximately 15 million people. This equates to approximately 267,200 elderly Wisconsin residents by 2030 who will require some form of Behavioral Health support service or memory care services.

According to the Population Review Board, the proportion of adults ages 70 and older with dementia declined from 13% in 2011 to 10% in 2019. The share of older people with dementia is decreasing 1% to 2.5% per year, depending on the period and age group examined. In effect, the percentage of the population with dementia is decreasing, but the total number is increasing due to population growth. Despite the decline in new cases of dementia, as the large baby boomer population ages, the total number of people with dementia will rise. Estimates vary, but experts report more than 7 million people ages 65 or older had dementia in 2020. If current demographic and health trends continue, more than 9 million Americans could have dementia by 2030 and in Wisconsin the total could be as high as 185,000 by 2030.

Despite the decline in new cases of dementia, as the large baby boomer population ages, the total number of people with dementia will rise. Estimates vary, but experts report more than 7 million people ages 65 or older had dementia in 2020. If current demographic and health trends continue, more than 9 million Americans could have dementia by 2030 and in Wisconsin the total could be as high as 185,000 by 2030. This equates to approximately 267,200 elderly Wisconsin residents by 2030 who will require some form of support service or memory care services.

Those that suffer from dementia are more likely to suffer from five or more physical comorbid conditions and polypharmacy relative to those that do not suffer from dementia. Polypharmacy is defined as the simultaneous use of several drugs to treat a single or several conditions. It is often associated with adverse outcomes which include mortality, adverse drug reactions, increased length of stay in the hospital, readmission to the hospital after discharge, and increased frequency of falls. The three most common diseases which are found in those that suffer from dementia include hypertension (34.5%), diabetes (16.3%), and cardiac arrhythmia (7.3%). The prevalence of cardiometabolic conditions is increased for those who have more severe dementia. In addition, comorbidities are considered a risk factor for poor physical and mental health in those that suffer from dementia.

Bariatric/Obese Patients

Current projections are that national prevalence of adult obesity and severe obesity will rise to 48.9% and 24.2%, respectively, by 2030. This means that approximately 2,156,000 adults in Wisconsin will create a greater strain on the LTC system earlier in their lifespan than healthy patients.

The National Institute of Health conducted a study on the impact of obesity on LTC in the United States. Obesity and related chronic diseases lead to higher probability to enter a LTC facility at a younger age, incur more LTC days before death, and result in higher lifetime LTC costs reimbursed by Medicaid. However, such effect is only statistically significant among women, not significant among men. At the population level, we project that overweight and obesity diagnoses will induce 1.3 billion or more LTC patient days and $68 billion or more Medicaid costs (in 2012 value) among baby boomers annually on a national basis. This translates to 25,350,000 patient day and $1.3 billion annually for Wisconsin in 2030 forward.

Obesity presents a myriad of challenges beyond the tactical management of bariatric patients. Excess weight is a threat to health. It is associated with an increase in the Metabolic Syndrome, osteoarthritis, cardiovascular disease, respiratory compromise, intra-abdominal pressure, skin conditions, and mental illness.

This patient population also represents additional strain on staffing at all provider levels as more human resources are needed to manage obese patients. This is coupled with the additional financial and safety risk (e.g., workers' compensation claims) to organizations of having their staff care for the rising prevalence of obese patients.

Patients with Unmanaged Chronic or Multiple Chronic Conditions

Currently, approximately 50% of the US population has a chronic disease, creating an epidemic, and 86% of health care costs are attributable to chronic disease. The number of people with chronic conditions is rising rapidly and as of 2018 over 27% of the adult population had two or more chronic conditions.

The rise in volume of these patients presents a unique challenge to the LTC industry in terms of both staffing for the need and cost of care for this population. CMS recently cited a study by the American Journal of Managed Care that managing the complex needs of patients with diabetes, heart failure, asthma, COPD, kidney disease, and other long-term conditions can cost up to seventeen times more than other patients, which can add up to almost $40,000 per beneficiary per year.

The team's greatest concern for these patient populations is the current reliance on unpaid or family care to manage non-skilled LTC needs in the United States. This is detailed in the Prospective analysis and mentioned in the Workforce section of our report on page 57. The nature of these populations will be beyond both the ability of care for most families and will be financially unsustainable as a healthcare ecosystem.

Other significant considerations for the action plans for these populations include reimbursement and workforce challenges.

Reimbursement is often a significant factor in a LTC provider's decision to accept a patient with complex needs. Payors and providers have adopted strategies to help ensure the provision of services and manage clinical and financial outcomes. The decision to carve-in or carve-out the provision of services is a foundational decision. From a service provision and care delivery perspective, the carve-in approach convenes all services under the direction and provision of one provider or plan. Carve-out practices leverage third party providers to manage specific components of service (e.g., transportation), areas of care (e.g., palliative care) or plan elements (e.g., pharmacy and risk programs). This same concept is routinely applied in the provider contracting realm, as well as rates may carve-in comprehensive care components (e.g., care, supplies, room, and board) under per diem, RUG or episodic rates or carve-out specific treatments, such as pharmacy, specialty beds or supplies.

There are two large workforce challenges attributed to these populations, which should be addressed to effectively manage these patients in the future. These are the number of skilled workers for HCBS services, and the future volume and availability of unpaid/family personal care workers. Both issues are addressed in our Workforce section on page 57 and detailed in our Retrospective and Prospective workforce assessments on pages 32 and 61 respectively.

6. Workforce Considerations to Address Challenges

(Workforce references can be found in Appendix K.)

Baker Tilly has provided a summary analysis of the workforce issues in our Retrospective and Prospective Analysis on pages 32 and 61, respectively. Baker Tilly is aware that the state has significant resources allocated in the budget request to address the healthcare workforce issues in the state through the introduction of 2023 Assembly Bill 43. At the time of this report, the budget process was not complete, and it was not known whether the budget approved by the legislature would include the budget requests. There is a general understanding of the scope of workforce challenges across the nation which we have not restated in this report. We have focused our attention on recommended shifts in workforce practices, and specific examples which we believe will allow Wisconsin and its providers to meet the future demand.

Traditionally, the health care provider community has looked to the public sector and health systems to drive workforce innovation. These sectors are currently working to address workforce shortages through new labor approaches, implementation of labor-saving technologies, education support, and community outreach. Health systems have been able to implement initiatives which place them as employers of choice for many skilled workers. These programs include market leading compensation, shift flexibility and work/life balance programs, tuition assistance and reimbursement, childcare assistance programs, and staffing agency utilization to reduce gaps and lower burnout Wisconsin represents the nation at large in these categories, and Baker Tilly is confident these sectors will continue advancements in this arena.

The team’s primary concern is the changing paradigm in which the growth of the LTC population and the drive toward HCBS leaves the burden of innovation on the post-acute and LTC sectors for workforce solutions. The solutions typically utilized by health systems to address work force challenges fall beyond the financial and operational abilities of most post-acute providers to implement.

There have been several previous studies and focus groups on how state funding can address the workforce challenges in Wisconsin.

Provider Community Considerations

A substantial portion of meeting the workforce challenge falls on the provider community to expand the approach to talent and break away from traditional models. Overall, the provider community needs to change the workforce paradigm and mindset shifting away from attraction and compensation as the primary tools of workforce solutions.

Areas of particular focus for the provider community should be:

- While compensation will always be a factor, there is a practical limit to how much of a role compensation can play in building a workforce. Providers need to focus on the development of retention, engagement and non-compensation driven incentives to retain and upgrade existing talent pools.
- Extending the practice of 'staff pooling' beyond intercompany to intercommunity.
- Expanding the use of tele-health services to extend workforce utilization and reach, especially to support rural health.
- Greater adoption of labor-saving technologies across the spectrum to extend workforce effectiveness and reach.
- Proactively build programs to address anticipated shortage of unpaid caregivers.

State of Wisconsin Considerations

Professional Licensing Wisconsin has been an Interstate Medical Licensure Compact state since 2015, an Interstate Nursing Licensure Compact state since 2000, The Physical Therapy Compact in 2020 and recently joined Psychology Interjurisdictional Compact (PSYPACT) in 2022. The state acknowledges the value and strategic importance of expanding access and quality of care through participation in these relationships.

Understanding that this is outside of the jurisdiction of DHS (the Department of Safety and Professional Services handles licensing), however, it is important to note that the state is not currently a part of the Counseling Compact, nor does it have legislation pending to join; 18 states voted to participate. Like the aforementioned Compacts, the Counseling Compact is an interstate compact, allowing professional counselors licensed *and* residing in a compact member state to practice in other compact member states without need for multiple licenses.

For example, New York and Kansas changed their state laws in 2022 to allow nurse practitioners to diagnose, order tests and treatment for patients under the supervision of the respective state's nursing boards, not a contracted collaboration physician. Twenty-two states and 2 US Territories have full practice authority, including Minnesota and Iowa. An additional 11 states do not allow full practice authority but are not as restrictive as Wisconsin.

Research suggests that in appropriate circumstances, removing practice restrictions on certain healthcare occupations and granting full practice authority can improve access to care without compromising quality or increasing costs. Expanding scope of practice can ease pressure on the healthcare workforce in two primary areas:

- Allowing certain workers to independently operate under their own licenses without additional clinical supervision, freeing time of the supervisory workers.
- Allowing certain workers to perform more advanced work in healthcare settings could decrease work burden on other clinical providers.

Proprietary examples and research:

- Multistate Home Health/Hospice Early Educational Raise Program
    - A multistate home health and hospice agency has developed a retention program focused on keeping its nursing staff by recognizing individuals seeking to attain a higher level of education. The foundation of the program is to compensate nurses in their final semester of education at the rate of the level to be attained (i.e., CNA at LPN rate, LPN at RN rate, and certain higher rates for RNs where applicable.
        - The program was designed to show company commitment and reward nurses who showed initiative toward growth.
        - Internal assessments have shown a positive correlation in retention.
        - Internal assessments have shown a neutral to positive cost correlation regarding compensation increase and reduction in turnover/recruitment/staffing savings.

- Health System Talent Pool Pilot
    - A southern US based health system is piloting an expanded talent pooling program. The system is in an area faced with a critical nursing shortage and developed an internal talent/float pool which allowed them to offer its nurses opportunities to pick up shifts in other service lines to earn extra income. This program had the effect of increasing nurse engagement and lowering spending on agency staffing.
    - The health system analyzed the pool of available nurses in the market at large and recognized that the region was several thousand licensed nurses short of current open positions. Even with education, grants and positive immigration statistics the area is years away from meeting nursing needs.
    - The system recognized that its talent pooling program could alleviate some of this burden by extending a companywide initiative to a community wide initiative and had created a pilot to:
        - Extend the talent pool to its preferred provider network (skilled nursing, home health and hospice) partners to offer extended opportunities to nurses in participating programs.
        - Entered in discussions with the other major health system in the region to participate in the program.

- Personal Care Agency Scholarship Program
    - A Northeastern Personal Care Agency (called Private Duty in their geography) offers scholarships to college bound students in exchange for a contract for a stated period of work during or upon completion of their education.
        - The agency analyzed lost revenue due to worker shortages and developed a scholarship fund which would be offset by increased revenues per worker.

- California Health Workforce Pilot Project Program (HWPP)
    - HWPP is a program that supports the piloting of healthcare delivery concepts. It provides the opportunity for healthcare related organizations to demonstrate, test, and evaluate new or expanded roles for healthcare professionals. by providing the legal framework for the demonstration of new ideas.
    - The pilot project may involve teaching new skills to existing categories of health care personnel, developing new categories of health care personnel, accelerating the training of existing categories of health care personnel, and teaching new health care roles to previously untrained persons.

  - The HWPP program monitors the program in progress, collects and analyzes data generated by pilot projects, and develops a report with conclusions and sometimes recommendations regarding changing the laws that affect the specific health profession to reflect the pilot project concept. A closing report is provided to the Legislature upon request.
- Technology
  - The available technologies are too numerous to list in this study; however, in Appendix K there is a list of studies which outline the relevant types of technology and the associated benefits. We have chosen a few specific programs to highlight to show the possibilities in this arena.
    - Christianacare "Moxi Robot Pilot"
      - ChristianaCare is the first health system in the Philadelphia, Pennsylvania region piloting an innovative tool called Moxi, a collaborative robot — or "cobot"— that can assist in the hospital by making deliveries and performing other non-clinical tasks so that nurses and other clinical staff can spend more time focused on what they do best — caring for patients.
    - UPMC AnywhereCare
      - UPMC Health Plan, headquartered in Pittsburgh, Pennsylvania, partnered with UPMC Passavant Hospital on a virtual discharge pilot to help combat nurse burnout and mitigate the ongoing shortage. The pilot focused on a 30-bed inpatient unit specialized in orthopedics and urology. Because of its high throughput of patients, the unit made the perfect environment to test the effectiveness of a virtual discharge pilot.

        The unit nurses use a laptop to connect patients with UPMC Health Plan nurses through the UPMC Health Plan digital healthcare platform, AnywhereCare. The virtual program also allows the patient's family or caregiver to join the virtual discharge remotely. The health plan nurses are all trained in the discharge process, including provider preferences based on surgery type and physician.

        After six months of the virtual discharge pilot, inpatient nurses saved over four days of time while patient satisfaction scores for remote nurses were a 4.9 out of 5 and patient satisfaction with online care was 4.8. UPMC Health Plan's HCAHPS score rose from the 17th percentile before the pilot to the 94th percentile after the pilot.
- Nebraska Lifespan Respite
  - Lifespan Respite Program is a service designed to give caregivers a break from the demands of providing ongoing care for recipients with special needs unable to care for themselves. The Lifespan Respite Program provides funding for eligible unpaid primary family caregivers to purchase respite services.

    To be eligible, caregivers must:
    - Be providing care or supervision of applicant or recipient with special needs without reimbursement or payment;
    - Need respite services;
    - Reside in the same home as the person with special needs or be providing care to the recipient in the recipient's home for a minimum of 4 hours per day Sunday through Saturday; and
    - Caregivers may not use respite services while engaging in employment activities.

- California Paid Family Leave
  - Paid Family Leave (PFL) provides benefit payments to people who need to take time off work to:
    - Care for a seriously ill family member.
    - Bond with a new child.
    - Participate in a qualifying event because of a family member's military deployment.
  - If eligible, members receive benefit payments for up to eight weeks. Payments are about 60 to 70 percent of weekly wages earned 5 to 18 months before claim start date.

7. HCBS Initiatives

(See the Prospective Analysis section on page 61 and Appendix I.)

Wisconsin's care climate, DHS programming and consumer preferences have supported residents in their decision to receive care via home and community-based services. The current utilization exceeds current national trends and is on pace to continue through 2030 and beyond assuming regulations, funding and service definitions remain consistent. The following are recommendations for the private sector and providers to meet future LTC needs in Wisconsin leveraging HCBS. Some of these areas will also require the support of the state to be successful.

- Private Sector Medicare Certified Home Health Providers will need to expand in number and geographic coverage. The home health sector should also expand tele-health and Remote Patient Monitoring (RPM) to support rising acuity of patient population and leverage healthcare workers.
- The hospice sector and the state should stay abreast of the CMS Palliative Care Benefit discussions, projects, and changes.
- Private Sector Personal Care Agencies will need to expand in number and geographic coverage. The state will need to support the PCA sector in proactive planning for projected caregiver shortfalls. The PCA sector will also require state support in addressing caregiver training.
  - Sixty-two (62) percent of unpaid family caregivers identified are needing help or information on caregiving topics (source: Caregiving in the US 2020).
  - Specific areas of focus identified in the survey include: keeping the recipient of care safe at home, managing emotional stress of caregiver; assistance filling out forms, and paperwork and eligibility for services.

8. Managed Care Organization (MCO) Discharge Authorization Process

Baker Tilly recommends the following actions to address identified challenge in the MCO discharge Authorization Process:

- Wisconsin DHS audits the MCO authorization process and discharge timing for admitted MCO patients. Determine if appropriate standards exist for response to hospital requests and discharge needs. If yes, ensure accountability; if not, create standards by which each party must acknowledge and respond to the other to facilitate appropriate discharge. This assumes that DHS has the authority to evaluate and monitor the MCO's processes.

Interviews have brought attention to the timing/timeliness of obtaining discharge authorizations for MCO patients who need to be discharged to a different level of care for which they are currently approved. Multiple health systems also reported contention when they arranged discharges to a site with which the MCO did not currently contract or did not want to approve for other reasons (quality, distance, etc.), thereby delaying discharge. Providers also noted challenges getting timely responses back from MCO case managers to promote safe discharges with coordinated home and community-based services.

Health systems also noted that not all MCO's offer different levels of care in all settings. For instance, there are several potential levels of care in assisted living facilities. The plans which do not offer rates for different levels creates a financial and care challenge, as acuity rises and falls within this population regularly.

9. Other Areas for Consideration

Baker Tilly has identified additional areas of consideration for the State of Wisconsin to explore, possibly with the private sector or in support of the private sector's implementation, and to support the framework of future LTC services. The following additional items should be explored based on our evaluation of programs and practices which have merit, but do not have long-term outcomes at this time to implement without further study.

- Data collection and sharing models.
- Alternative funding models.
- Collaboration/innovation models.

Data Collection and Sharing Models

We recommend the state collaborates with the provider community to pull key metrics into the Health Information Exchange. During our interviews with the provider community, especially engaged health systems, we identified several key metrics which could provide current and leading indicators for the state of long-term care accessibility.

During the Public Health Emergency, the state worked with providers to identify and report how many patients were awaiting skilled nursing beds on any given day. This is a solid first step, but the practice can be expanded to a larger variety of metrics which will allow insight to the LTC trends in Wisconsin, including access to nursing beds, HCBS placements, key target populations, placement barriers, and other systemic challenges.

The health systems Baker Tilly interviewed during this study were able identify key areas for improvement or partnership. The team has worked with these providers to identify key metrics which will help support comprehensive discussion of these issues.

(Key metrics are identified in Appendix M.)

Alternative Funding Models

Long-term care is one of the largest under or uninsured risks facing families in the United States. Reliance on publicly funded programs to support LTC is overwhelming, and leaves many gaps in non-covered services, such as personal care. In addition, reliance on Medicaid forces a sizable portion of the population to "spend down" their resources to qualify for coverage. This practice exhausts personal resources and creates long-term reliance on publicly funded programs. As our population is both aging, and living longer, many states are exploring alternative methods of funding LTC services in order to increase coverage and reduce the long-term burden.

Baker Tilly suggests that the state of Wisconsin examine alternative funding models and create a team to explore future funding for LTC in Wisconsin.

Examples of Alternative Funding models include:

- Hawaii Alohacare & Kapuna Caregivers Programs
  - The State of Hawaii has created and manages a health plan called Alohacare for Medicare beneficiaries with an adjunct plan called Quest Integration for Medicaid beneficiaries in Hawaii. QUEST Integration provides Medicaid State Plan benefits and additional benefits (including institutional and home and community-based long-term-services and supports) based on medical necessity and clinical criteria to beneficiaries eligible under the state plan and to the demonstration populations. Hawaii Medicaid combined QUEST (families and children) with QUEST Expanded Access (QExA - aged, blind, and disabled) and implemented as QUEST Integration in Jan 2015.

- The structure of Quest Integration allows the State of Hawaii to bring all Medicaid plans under one roof and allows residents to compare plan costs and choices on an equal footing. The transparency allows Hawaiian consumers to make more educated choices around their costs and associated benefits. It also allows the state clear visibility to the choices offered to their residents and the ability to review the effectiveness of their plan partners.
- Hawaii has also created a specific program to support unpaid caregivers through its "Kapuna Caregivers Program." Launched as a small pilot with $600,000 from the state budget, it provided family caregivers employed at least 30 hours a week with up to $70 per day to cover costs for in-kind support, including adult day care, chore services, home-delivered meals, homemaker services, personal care, respite care, or transportation. The funds (subject to availability) are paid directly to contracted service providers, not the caregiver. In FY 2019, the program served 110 caregivers. Subsequently, Hawaii amended the program to try to maximize its reach to the estimated 154,000 eligible caregivers.

- Washington State: Public long-term care insurance program
  - In 2019, Washington became the first state to establish a public long-term care insurance program. Starting in 2025, eligible residents can receive an allowance of up to $100 per day, for help with activities of daily living and related services, with a lifetime cap of $36,500 (indexed to inflation). This benefit will be funded through a payroll tax of .58% that begins in 2022, which will generate about $1 billion per year. Self-employed people can opt in, and those with private LTC insurance can opt out. Eligible residents must have paid the tax for three consecutive years out of six, (or five consecutive years out of ten), and work at least 500 hours a year. Benefits are broadly defined: residents can use the money toward nursing home stays, but also in home meals, home equipment, and more. Notably, benefits can also be paid to family caregivers, as long as they receive minimum levels of training. While the daily allowance and cap are insufficient to fund full-time LTC, legislators expect that it is enough for up to five years of respite care, one year of a part-time in-home care provider, 8-12 months of assisted living care, 6-8 months of adult family home care, and 4-6 months of care in a nursing facility. The program is expected to generate saving in Medicaid long-term care spending, but figures are not available at this time to validate.

Collaboration/Innovation Models

As noted herein, growth in both the number of elderly citizens along with the rising acuity of this population will create additional stress on our long-term care systems. The development of these programs and practices relies on the resources, culture and preferences of each geography. Baker Tilly has identified a number of programs which provide the State of Wisconsin examples to use as it considers the appropriate steps for the future of long-term care.

- Washington State Innovation Model
  - Washington State has moved forward to the testing phase of the State Innovation Partnership with CMS. This model is supported by grant money from CMS to find the design, testing and measurement of new delivery and support initiatives aimed at improving financial and care outcomes for Medicaid beneficiaries. Although many states, including Wisconsin, have partnered with CMS for the Design phase of this initiative, testing is still rare. There are very structured criteria for the testing phase of the CMS initiative which have reduced the number of states who have moved forward. However, the thought process and design of the program itself is appealing and makes sense in approaching the award and measurement of state grant money. The conversations with health departments across the country have shown that several states are considering modeling their own grant and investment programs similarly to find and test new approaches that mean their own criteria. We would suggest that the Wisconsin Department of Health explore the structure of this program and design grant applications and their measurement tailored to the challenges facing the state in the future.

- Oregon Health Authority Transformation Center
  - The Centers for Medicare and Medicaid Innovation awarded a State Innovation Model (S) grant to Oregon in September 2012 for up to $45 million through September 30, 2016. Oregon was one of six states to receive the grant for testing innovative approaches to improving health and lowering costs across the health delivery system, including Medicaid, Medicare, and the private sector.
  - The grant supported the state's ongoing health system transformation and provided opportunities for Oregon to share what it learned with other states. Oregon's health reform to its Medicaid program started with the creation of coordinated care organizations (CCOs) in 2013. The SIM grant was an opportunity for Oregon to strengthen and support the coordinated care model and to begin to make its key elements, such as best practices to manage and coordinate care, available to others such as PEBB, OEBB, and Medicare beneficiaries.

    The SIM grant focused on innovation in three areas:
    - Innovation and rapid learning, which provided:
      - Resources and technical assistance to Oregon's CCOs
      - Facilitated learning collaboratives and rapid improvement cycles.
      - Promotion of health equity across sectors and payers including private payers, long-term care, community health, and education systems.
    - Delivery models
      - Evaluation of methods for integrating and coordinating between primary, specialty, behavioral and/oral health.
      - Improvement of community health through promotion and prevention activities.
      - Supported CCOs collaborations with long-term care, community health and social services.
    - Payment models, tested at two levels:
      - Global budget for CCOs
      - A "starter set" of promising alternative models for provider payment and models that focused on the value, rather than the volume, of services provided.
- Tennessee Healthcare Innovation Initiative
  - Tennessee's Health Care Innovation Initiative is changing the way health care is paid for in Tennessee, moving from paying for volume to paying for value. Its mission is to reward health care providers for high quality and efficient treatment of medical conditions and help maintain people's health over time.
  - The Tennessee Health Care Innovation Initiative's three strategies - primary care transformation, episodes of care, and long-term services and supports - are bringing together health care providers and clinicians, employers, major insurance companies, and patients and family members to reform the health care payment and delivery system in our state.
  - Tennessee is leading by example with the TennCare program and the state employee's benefits administration, with intentions to invite other stakeholders to join in the state-wide payment and delivery system.

State Nursing Home License Bed Moratorium

We suggest the state consider the following revisions/changes to current nursing home bed moratorium statute:

- Allow nursing homes to sell a portion of their licensed beds, or individual beds to another provider, and
- Allow a nursing home to sell a portion of their licensed beds or individual beds to another provider to anywhere in the state, whether the full license or a partial license, assuming demonstrated demand at the county or some other geographic service area level.

We do not recommend that the state completely stop the bed moratorium.

We recommend the state consider these changes to the statute to allow for redistribution of beds to areas of the state that have bed shortages for underserved populations later discussed in this report (herein called, “barrier populations”) whether now or in the future and to a health care entity or operator that has excess demand for nursing home beds for these populations in that area.

In addition, creating flexibility with the bed moratorium could be one preparatory action the state could take for the potential for future bed shortages if they occur after 2030.

MCO Discharge Escalation Review

Wisconsin DHS collaborates with the MCOs and health systems to review escalation and review process in cases where recommended discharge plan/disposition by the hospital is not approved or authorized by the MCO, delaying discharge.

However, our health system interviews have all expressed concern with the process as it exists. Six of the health systems interviewed specifically stated that the MCO case managers are creating a material barrier to their discharge process. Baker Tilly requested reporting from the Electronic Medical Record Systems (EMRs) to validate this information. This data was not available at the time of this report, but we encourage Wisconsin DHS to follow up on this request to validate or invalidate this concern.

Retrospective Analysis

The retrospective analysis includes assessments of multiple data sets collected by Baker Tilly related to the LTC sector in Wisconsin including the following:

- Demographics and Population Trends – 2010 to 2020
- National Trends Comparison – Nursing Homes
- Provider Utilization Trends
- Hospital Referrals to LTC Providers
- Workforce Challenges

Demographics and Population Trends – 2010 to 2020

Wisconsin's population has grown for the period 2010 to 2020, by approximately 318,000 persons (all ages). The total 65+ populations increased for that period by approximately 39% (approximately 305,000 persons aged 65+) and the total persons under 65, for comparison, increased by only 31,500 for the same period. The age 18-64 populations in Wisconsin increased under 1% for the same period. This suggested the greatest population growth in the state is of persons over the age of 65.

(See the Prospective Analysis section of this report starting on page 61 for projections of population.)

National Trends Comparison – Nursing Homes

Nursing home statistics for all Medicare and Medicaid certified nursing homes in Wisconsin (351 in the dataset) and nationally (14,533 in the data set) were collected from the 2021 Medicare cost reports, which was the most current period available at the time of reporting. The Wisconsin statewide medians (shown in the tables as, State Medians) are compared to the national medians for several categories, all summarized in the tables below.

Capacity and Occupancy

Although nursing homes are smaller in Wisconsin than nationally, the statistics suggest that Medicaid and Medicare trends are very similar in Wisconsin to the national trends. The median size of nursing homes in Wisconsin is 78 beds, compared to 100 beds nationally. The median Medicaid days for nursing homes was 9,685 Medicaid days, which was lower than the median for nationally (13,904) which is due to the of the smaller median size in Wisconsin. The Medicaid median occupancy was the same as the national median (57.1%). The median occupancy for Wisconsin nursing homes was 63.8% in 2021, lower than the national median (67.4%). The Medicare (MC) median occupancy in the state was 11.6%, which was slightly higher than the national median (10%) and the Medicare average length of stay was about the same (40 for Wisconsin and 41 nationally).

State Medians	
Beds	78
Days Available	27,084
Medicare Days	2,010
Medicaid Days	9,865
Other Days	5,901
Total Days	17,287
Total Occupancy %	63.83%
Medicare Occupancy %	11.63%
Medicaid Occupancy %	57.06%
Other Occupancy %	34.14%
Medicare Average Los	40

National Medians	
Beds	100
Days Available	36,135
Medicare Days	2,503
Medicaid Days	13,904
Other Days	5,481
Total Days	24,347
Total Occupancy %	67.38%
Medicare Occupancy %	10.28%
Medicaid Occupancy %	57.11%
Other Occupancy %	22.51%
Medicare Average Los	41

Source: Skilled Nursing Facility Cost Reports - HCRIS SNF CMS 2540-10

Medicare Profitability

The state median per diem reimbursement for Medicare in Wisconsin was higher than the national median ($577 vs $523), for 2021 while the per diem costs for Medicare were higher in WI ($431) versus nationally ($374).

State Medians	
Total Medicare Per Diem Reimbursement	$577.94
Total Medicare Per Diem Cost	$431.50
Total Medicare Per Diem Profit or (Loss)	$146.44
Profit (loss) as a % of Per Diem	25.34%

National Medians	
Total Medicare Per Diem Reimbursement	$523.22
Total Medicare Per Diem Cost	$374.95
Total Medicare Per Diem Profit or (Loss)	$148.27
Profit (loss) as a % of Per Diem	28.34%

Source: Skilled Nursing Facility Cost Reports - HCRIS SNF CMS 2540-10

Average Hourly Rates

The median average hourly rate for nursing homes in Wisconsin was $22.03 which was slightly lower than the national median ($22.19). Direct RN, LPN, and CNA median hourly rates are summarized below.

State Medians	
Total Entity	$22.03
Employee Benefits	$24.34
Administration	$29.81
Plant	$21.60
Laundry	$13.13
Housekeeping	$13.40
Dietary	$15.15
Nursing Admin	$42.35
Central Services	$17.50
Medical Records	$18.58
Social Services	$23.16
Activites	$16.76
Direct RN per Hr	$35.27
Direct LPN per Hr	$25.33
Direct Aide per Hr	$16.96
Total Direct Nursing w Benefits per Hr	$26.29
Total Contract Nursing per Hr	$42.26

National Medians	
Total Entity	$22.19
Employee Benefits	$0.00
Administration	$30.56
Plant	$21.31
Laundry	$11.02
Housekeeping	$12.52
Dietary	$14.66
Nursing Admin	$38.62
Central Services	$0.00
Medical Records	$17.10
Social Services	$22.69
Activites	$11.47
Direct RN per Hr	$36.37
Direct LPN per Hr	$27.87
Direct Aide per Hr	$16.73
Total Direct Nursing w Benefits per Hr	$24.96
Total Contract Nursing per Hr	$44.51

Source: Skilled Nursing Facility Cost Reports - HCRIS SNF CMS 2540-10

Benefits

The median total benefits to salary for Wisconsin were 17.4%, which was slightly higher than the national median (16.6%) in 2021. Other benefit costs are shown below.

State Benefits	
Retirement	$38,735.00
Health/Dental/Vision Insurance	$194,016.00
Life Insurance/Disability	$8,175.00
Worker's Compensation	$48,601.00
Payroll Taxes	$211,937.50
Unemployment Benefits	$14,943.50
Other Benefits	$8,267.00
Total Salary	$2,860,799.00
Total Benefits to Salary	17.35%

National Benefits	
Retirement	$502.00
Health/Dental/Vision Insurance	$195,381.00
Life Insurance/Disability	$0.00
Worker's Compensation	$55,178.00
Payroll Taxes	$258,237.50
Unemployment Benefits	$3,108.50
Other Benefits	$0.00
Total Salary	$3,526,043.00
Total Benefits to Salary	16.59%

Source: C Skilled Nursing Facility Cost Reports - HCRIS SNF CMS 2540-10

Per Patient Day Ratios

As indicated below, total nursing and RN and CNA per patient day ratios are all higher than the national medians, for 2021. The LPN per patient day median for Wisconsin was lower than the national median.

State Medians	
Total benefits to salary	17.35%
Nursing hours PPd	4.46
RN nursing hours PPd	1.05
LPN nursing hours PPd	0.68
Aide nursing hours PPd	2.72

National Medians	
Total benefits to salary	16.59%
Nursing hours PPd	4.00
RN nursing hours PPd	0.48
LPN nursing hours PPd	0.86
Aide nursing hours PPd	2.26

Source: Skilled Nursing Facility Cost Reports - HCRIS SNF CMS 2540-10

Per Diem Costs Routine

Below summarizes the per diem routine median costs for Wisconsin and the national medians, for 2021. The total routine costs for Wisconsin were higher ($272) than the national median ($261). Other routine per diem costs is shown in the table.

State Medians	
SNF	$129.81
SNF Capital Bldgs & Fixtures	$12.52
SNF Capital Movable Equip.	$1.20
SNF Admin & Gen.	$27.34
SNF Plant Oper.	$13.55
SNF Laundry & Linen	$6.57
SNF Housekeeping	$7.60
SNF Dietary	$37.59
SNF Nursing Admin.	$17.54
SNF Central Services	$1.16
SNF Pharmacy	$1.28
SNF Medical Records Lib	$3.03
SNF Social Service	$5.56
SNF Recreational Therapy	$7.43
SNF Total Routine Cost	$272.22

National Medians	
SNF	$112.98
SNF Capital Bldgs & Fixtures	$13.43
SNF Capital Movable Equip.	$0.46
SNF Admin & Gen.	$27.57
SNF Plant Oper.	$12.41
SNF Laundry & Linen	$5.30
SNF Housekeeping	$7.49
SNF Dietary	$35.05
SNF Nursing Admin.	$14.46
SNF Central Services	$0.61
SNF Pharmacy	$0.00
SNF Medical Records Lib	$2.03
SNF Social Service	$6.29
SNF Recreational Therapy	$1.44
SNF Total Routine Cost	$261.44

Source: Skilled Nursing Facility Cost Reports - HCRIS SNF CMS 2540-10

Ancillary Costs Per Diem

The table below summarizes per diem ancillary costs, for 2021. The total ancillary per diem costs (median) in 2021 were higher for Wisconsin ($163) than nationally ($152).

State Medians	
Radiology	$1.73
Laboratory	$3.35
Intravenous Therapy	$2.18
Oxygen Therapy	$1.60
Physical Therapy	$47.65
Occupational Therapy	$42.29
Speech Therapy	$14.15
Medical Supplies Charged to Patient	$1.58
Drugs Charged to Patient	$37.61
Total Ancillary	$162.55

National Medians	
Radiology	$1.09
Laboratory	$2.33
Intravenous Therapy	$0.00
Oxygen Therapy	$0.00
Physical Therapy	$47.76
Occupational Therapy	$39.96
Speech Therapy	$14.71
Medical Supplies Charged to Patient	$0.00
Drugs Charged to Patient	$33.13
Total Ancillary	$151.75

Source: Skilled Nursing Facility Cost Reports - HCRIS SNF CMS 2540-10

Provider Service Utilization Trends

The Baker Tilly team collected, reviewed, and assessed service utilization data and information to gain an understanding of the LTC sector in Wisconsin. This data assessment was supportive to the following specific observations and conclusions for the nursing home sector.

Key findings of the assessment of the multiple data sources on utilization of LTC services are summarized below. Additional details follow.

- Nursing home occupancy in Wisconsin has declined since the beginning of the COVID-19 pandemic.
- Wisconsin data from the Minimum Data Set (MDS) suggests acuity in Wisconsin nursing homes is increasing, following the national trend.
- Environmental and design elements have the potential to contribute to reduced census in multiple ways. One of the limitations impacting the ability of nursing homes to admit individuals is the desire or need to be housed in a private room.
- Currently, to accommodate the newly implemented Infection Control measures and consumer expectation, rooms designed to house two individuals are frequently being used by one individual and rooms that were designed to accommodate four individuals house two.
- Further analysis allowed for comparison of the number of assessments completed for individuals who require little to no assistance with key ADLs with a diagnosis of schizophrenia or manic depression, two key psychiatric illnesses that are rising in prevalence nationally.
- The prevalence of dementia is rising in Wisconsin and nationally. Sometimes residents with dementia who currently reside in Wisconsin nursing homes could have their needs met at an alternative lower-level setting or within the community.
- Assessments for people residing in Wisconsin nursing homes indicate that there are other individuals who require little to no assistance with ADLs, bringing to question whether their care could be provided in other lower-level settings or the community. These individuals require little to no assistance with ADLs and do not have diagnoses of schizophrenia, manic depression, or dementia. Review of their MDS data is indicative of the possibility that they could successfully receive care in settings outside of a nursing home if they have proper monitoring and other support services that may include meal preparation or service, medication assistance, and other non-ADL related care.

<u>Nursing Home Occupancy and Payor Mix</u>

Nursing home occupancy in Wisconsin has declined since the beginning of the COVID-19 pandemic. This is in line with the national trends. There are several factors currently influencing a lower occupancy rate, including:

- Lack of adequately trained and credentialed staff to provide care and services forcing management of admissions.
- Rejection of referrals for individuals who do not have a payor source.
- Rejection of referrals for individuals who have complex needs that cannot currently be met in the nursing home.
- Rejection of referrals for individuals who are identified as not appropriate for the setting.
- Restricted use of multi-person rooms, including group dining, due to Infection Control measures implemented during the pandemic.
- Recovering public fear of residing in congregate settings due to national news focused on negative nursing home outcomes during the pandemic. This has promoted a lower admission rate of traditional long-term residents, especially with the shift in workforce allowing more individuals to work from home and provide support to aging parents.
- Referrals to HCBS in lieu of discharges to nursing homes.
- Slow recovery in number of voluntary surgeries that would have previously recovered in nursing home setting.
- Lack of private rooms available.

Environmental and design elements have the potential to contribute to reduced census in multiple ways. One of the limitations impacting the ability of nursing homes to admit individuals is the desire or need for being housed in a private room with private shower and toilet. This is an expectation held by many of today's population, especially of individuals who are below the age of 65. Many nursing homes were designed and built between the late 1970s through the early 1990s. At that time, the general population typically were active in large gatherings and congregations and were used to shared spaces including housing and more shared services with less privacy. The typical nursing home design reflects those social factors with a limited number of private rooms that averaged only one private room for every 15-30 beds. Some nursing homes were also designed with ward-style resident rooms that housed four individuals. The age of the buildings also requires increased levels of capital reinvestment to meet and maintain life safety conditions and to maintain marketability to consumers.

Currently, to accommodate the newly implemented Infection Control measures and consumer expectations for person-centered care and dignity, rooms designed to house two individuals are frequently being used by one individual and rooms that were designed to accommodate four individuals house two. Nursing homes nationwide are struggling to evaluate the best approach to meet both regulatory and consumer expectations. These changes, along with an increased focus on the rehab-to-home model, therefore, bypassing the nursing home admission, and the staffing shortages have all contributed to the declines in nursing home occupancies that in extreme cases have resulted in closures.

Nursing Home Acuity and Unmet Needs

Acuity in Wisconsin nursing homes is increasing, following national trends. In addition to the complexity of comorbid conditions, individuals with psychiatric conditions and dementia increase the need for specialized knowledge and programming that was not considered traditional in the past. The number of individuals being referred with conditions that are challenging to meet under the current regulatory structure and to co-mingle with the traditional nursing home resident has increased drastically nationwide. These barrier conditions oftentimes impact the acuity in ways that are not measured by assistance required with ADLs and affect the culture within nursing homes as well.

When considering acuity, one of the factors studied was that of individuals who have diseases and conditions requiring highly involved care requiring specialized training, but not requiring assistance with ADLs beyond supervision. An example of which is those having serious mental illness.

Review of the MDS assessments for the period of 2018 through 2021 indicated of the number of individuals who were identified as having serious mental illness by HERC region.

Wisconsin Nursing Home Residents
Diagnosis of Serious Mental Illness per 1,000 Persons Served

Fox Valley	North Central	Northeast	Northwest	South Central	Southeast	Western	Total Wisconsin
26	27	19	27	52	117	15	283

Source: WI MDS Data

Further analysis allowed for comparison of the number of assessments completed each year for individuals who require little to no assistance with key ADLs with a diagnosis of schizophrenia or manic depression, two key psychiatric illnesses that are rising in prevalence nationally. As noted in the table below, prior to the pandemic (2017-2019), there was an increase in these diagnoses. Both conditions require ongoing medical treatment and support. The need for specialized training and psychiatric support oftentimes presents challenges. Behaviors associated with these diagnoses present challenges in both protecting the rest of the residents and effectively responding within the limitations of the federal regulations.

Review of the MDS assessments for the period of 2018 through 2021 allowed for identification of the number of individuals who were identified as having serious mental illness by HERC region.

Wisconsin Nursing Home Residents
Diagnosis of Schizophrenia and/or Manic Depression and No or Minimal ADL Assistance
per 1,000 Persons Served

HERC Region	2017	2018	2019	2020	2021
Fox Valley	1	3	2	2	1
North Central	2	2	2	1	1
Northeast	1	2	2	1	1
Northwest	2	1	1	1	2
South Central	2	3	3	4	2
Southeast	11	8	10	7	8
Western	0	0	0	1	1
Total Wisconsin	18	18	20	16	15

Source: WI MDS Data

It is important to note that the Wisconsin Nursing Home Administrative Rule DHS 132, page 177, allows for conversion of all or some beds within a facility to become licensed as an institution for mental diseases (IMD). Requirements for licensure are provided and not every nursing home would qualify. The number of facilities who have been able to take advantage of this licensure was not able to be identified, but anecdotally is not expected to be prevalent. This specialty licensure would need to be further explored in order to make specific recommendations.

The prevalence of dementia is rising in Wisconsin and nationally. Sometimes residents with dementia who currently reside in Wisconsin nursing homes could have their needs met at an alternative lower-level setting or within the community, supported by family. Wisconsin has recognized the future population needs in the "Wisconsin State Dementia Plan: 2019-2023." The innovative plan created a work plan with goals and strategies to allow for better support of individuals with dementia. While vast strides have been made nationally over the past two decades in the provision of services for individuals with dementia in the nursing home setting, there are often challenges with ensuring specially trained staff are consistently assigned to care for these residents. Oftentimes, programming and support at a lower level either in Assisted Living or other community settings could be achieved for this population, especially during the earlier stages of the disease process; however, adequate funding is not always available. We identified the number of assessments completed for individuals with the diagnoses of Alzheimer's Disease or generalized dementia who required little to no help with key ADLs in the following table. While the population represented within the MDS data accounts for less than 1% of the nursing home population, the likelihood of additional individuals being able to successfully receive care in a different setting when safety needs are met is high. Other residents who require moderate care with ADLs should also be considered.

Review of the MDS assessments for the period of 2018 through 2021 allowed for identification of the number of individuals who were identified as having a diagnosis of Alzheimer's Disease or other dementias yet required no or minimal ADL assistance by HERC region. The number of individuals by year is provided below.

Wisconsin Nursing Home Residents
Diagnosis of Alzheimer's and/or Dementia and No or Minimal ADL Assistance
per 1,000 Persons Served

HERC Region	2017	2018	2019	2020	2021
Fox Valley	0	1	1	1	0
North Central	3	1	2	1	1
Northeast	2	1	1	1	0
Northwest	1	1	0	2	0
South Central	3	1	2	1	1
Southeast	7	5	5	4	3
Western	0	0	0	0	0
Total Wisconsin	16	11	12	11	6

Source: WI MDS Data

Assessments reported for people residing in Wisconsin nursing homes indicate that there are also individuals who do not have diagnoses of schizophrenia, manic depression, Alzheimer's Disease, or dementia who require little to no assistance with ADLs, bringing to question whether their care could be provided in other lower-level settings or the community. MDS data provided indicates that there was a total of 6,496 assessments completed for individuals who were either totally independent or required supervision only to complete late loss ADLs. This number includes all diagnoses and represents 3% of the total number of assessments provided in the sample. The numbers provided below are displayed by HERC region and represent the total number of individuals for the period of 2018 through 2021, based on the assessment information provided.

Wisconsin Nursing Home Residents
Totally Independent or Require Supervision Only per 1,000 Persons Served

Fox Valley	North Central	Northeast	Northwest	South Central	Southeast	Western	Total Wisconsin
12	11	9	10	20	58	6	126

Source: WI MDS Data

Nursing Home Medicaid Funding and Case Mix Comparison

The number of individuals in Wisconsin who resided in nursing homes and were dependent on Medicaid as their primary payor source decreased between the years of 2015 and 2020. This reduction is consistent with the reduction in census following national trends. A comparison of Wisconsin and contiguous states supports that the number of licensed facilities in four of the five states has declined between 2015 and 2020, with Michigan being the exception. The same states were reviewed to identify the percentage of residents who had Medicaid as their primary payor source. The percentages in 2020 spanned between 47% in Iowa to 62% in Illinois. Wisconsin's Medicaid dependent nursing home population was reduced from 15,389 residents or 56.9% in 2015 to 11,875 residents or 55% in 2020. Nationally, census has declined in nursing homes beds over the past three years, reaching an average low in 2020 of 66%. In Wisconsin, occupancy has declined in every HERC region by at least 10% between the years of 2015 and 2021.

Wisconsin's ADL scores rose from 4.04 in 2016 to 4.10 in 2018, below the national average at 4.27 for the same period. ADL scores are used to reflect the level of an individual's dependency on others to provide care in relation to daily activities, and include bed mobility, eating, transfer assistance, and toileting. Comparison between the contiguous states to identify shifts in acuity included a review of the average ADL scores for the same years. National trends indicate that acuity is rising and of the comparison group which includes Michigan, ADL scores rose in three of the five states.

The following table summarizes the comparative number of facilities, percentage of Medicaid residents and the average ADL scores for the five contiguous states.

Wisconsin Facilities, Medicaid Residents, and Average Activity of Daily Living (ADL) Scores For 2015 and 2020

State	2015 # Facilities	2020 # Facilities	2015 # and % Medicaid Residents		2020 # and % Medicaid Residents		2015 Average ADL	2020 Average ADL
Wisconsin	387	355	15,389	56.9%	11,875	55%	4.04	4.10
Illinois	762	721	42,704	58.9%	40,358	62%	4.03	4.20
Iowa	442	434	11,832	47.9%	10,639	47%	3.83	3.76
Michigan	436	440	24,036	60.8%	23,052	54%	4.23	4.28
Minnesota	377	367	13,847	53.1%	12,708	54%	3.99	3.91

Source: American Health Care Association and National Center for Assisted Living (AHCA/NCAL) Research Division: Summary of Number of Patients and Payor for the Nation and by State. Certification and Survey Provider Enhanced Reports (CASPER), July 1, 2019 – July 30, 2020.

Facility Quality, Ratings and Compliance Summary

CMS created the Five-Star Rating System to help consumers compare nursing homes. There are three components: health inspections (e.g., surveys), staffing, and quality measures (QMs). Significant findings of our assessment of the Five Star data provided by the State in the CMS data files are as follows:

- Wisconsin has a proportionately higher number of nursing homes with a CMS Five Star Quality rating of 5 in comparison to National averages. The overall star ratings for Wisconsin's nursing homes are disproportionate to many states as 47% fall within 4- and 5-star ratings, typically lower for the two combined in other states and only 15% falling within the 3-star rating which typically has a higher percentage as the "average".
- The Northwest region has a significantly higher number of facilities with an overall rating of five and the Southeast region has the highest percentage of one-star performers.
- Only 3% of facilities in the Northeast and Southeast regions received 5 stars in the health inspection component of the Five Star rating.
- Wisconsin nursing homes have consistently outperformed the National averages for total number of health inspection deficiencies per survey cycle according to CMS September 2022 data.
- Ratings for Quality Measures, the third component, used to derive the overall five-star rating is more reflective of national trends across the Wisconsin HERC regions.
- Wisconsin Division of Quality Assurance has developed a nice Survey Guide for nursing homes, and should promote this while continuing to build collaborative relationships with providers and other stakeholders.
- Comparison and trending for Assisted Living settings is difficult to achieve due to a lack of reporting mechanisms and the variances in requirements across the states.
- There is an opportunity for increased use of CMP funds in Wisconsin. Wisconsin DHS may want to consider a review of Oklahoma's approach to promote use of CMP funds.

Quality and Staffing Levels in Nursing Homes

Wisconsin has a proportionately higher number of nursing homes with a CMS Five Star Quality overall rating of 5 in comparison to National averages. CMS data from September of 2022 was evaluated as it relates to the Five Star Quality Rating System, a system designed to inform the public about standardized data elements gathered from each resident's MDS, claims-based measures, survey results, and levels of nursing staffing. Developed to represent a bell curve, changes in cut-points and measures since introduction in 2008 has allowed for changes in the numbers of nursing homes falling within rating categories of one 1 through 5. Wisconsin has a proportionately higher number of facilities in the 1-, 2-, and 5-star categories; with a 1 being the lowest rating and 5 the highest. The other metrics were also reviewed across HERC regions.

Wisconsin Nursing Homes
by Overall CMS Five-Star Quality Rating

Overall Rating	Fox Valley	North Central	Northeast	Northwest	South Central	Southeast	Western	Total Wisconsin
1	3	2	6	7	18	37	4	77
2	4	4	4	9	14	17	-	52
3	3	5	6	6	13	13	3	49
4	10	10	6	12	13	11	9	71
5	12	11	7	23	15	15	6	89
HERC Total	32	32	29	57	73	93	22	338

Source: CMS Dataset

The Northwest region has a significantly higher number of facilities with an overall rating of five and the Southeast region has the highest percentage of one-star performers. The South-Central region presents closest to the traditional bell curve and is proportionate in star assignment. One-star ratings have increased nationally since inception and typically account for 15-20% of the facilities within a state. If you remove the Southeast region from the calculation, the sum of the other regions falls in line with the national average at 16% for one-star performers. However, 40% of the facilities located in the Southeast region achieved an overall rating of one, which could be indicative of either the need for additional provider education or further evaluation of the components and practices. The opposite is true for the Northwest HERC region, which is reflective of 40% of the facilities achieving the esteemed rating of 5 stars.

Further analysis of the metrics impacting the overall star rating and each component by region included the Health Inspection rating component. Health Inspections (HI) scores are derived from three cycles of certification surveys using a point system that weights deficiencies identified by surveyors that are more severe in scope and severity higher than those with the potential to have a lessor impact and affect fewer residents. The higher a facility scores, the lower their HI rating. The Northwest region takes the lead with over 19% of the facilities achieving a five-star rating in HI. The Northeast and Southeast regions both are represented by only 3% of the facilities achieving 5 stars in HI. It is important to note that provider feedback in Wisconsin is not unlike that in several other states supporting the belief that the HI component of the quality rating is the most volatile and difficult to control due to the subjective nature of some components of the survey process.

Wisconsin nursing homes have consistently outperformed the National averages for total number of health inspection deficiencies per survey cycle according to CMS September 2022 data. In short, this means that Wisconsin outperforms the national average for nursing home citations and is a positive indicator of quality for the state.

Wisconsin Division of Quality Assurance has developed a nice Survey Guide for nursing homes, skilled nursing facilities and nursing facilities and should promote this while continuing to build collaborative relationships with providers and other stakeholders. The 18-page document is available to providers and provides a condensed explanation of some of the things that is to be expected during a survey as well as how to apply for waivers, how to address deficiencies found during surveys, and other pertinent information. The document would be a good resource for all providers, but particularly those administrators and other leaders who are newer to the business or need a refresher. Promoting this tool, along with other training opportunities for providers to aid them in achieving successful survey outcomes should be considered to continue building collaborative relationships.

The following summarizes the number of providers that were reported for the QM component by rating and by HERC for each of the long-stay and short-stay.

Number of Providers by HERC
By Long-Stay QM Rating

Long-Stay QM Rating	Fox Valley	North Central	Northeast	Northwest	South Central	Southeast	Western	Grand Total
1	1	1	2	6	9	8	1	28
2	1	1	2	9	15	20	3	51
3	8	12	13	13	13	18	4	81
4	8	3	5	11	13	19	4	63
5	13	14	7	18	19	24	10	105
Grand Total	31	31	29	57	69	89	22	328

Source: CMS, September 2022.

Number of Providers by HERC
By Short-Stay QM Rating

Short-Stay QM Rating	Fox Valley	North Central	Northeast	Northwest	South Central	Southeast	Western	Grand Total
1	0	0	0	4	3	6	0	13
2	2	1	2	3	6	16	1	31
3	2	7	3	9	10	20	3	54
4	8	8	5	8	17	19	3	68
5	10	12	14	20	25	27	7	115
(blank)	10	4	5	13	12	6	9	59
Grand Total	32	32	29	57	73	94	23	340

Source: CMS, September 2022.

Not every nursing home meets the criteria for both long-stay and short-stay measures and a high number, or 17%, of Wisconsin facilities did not have enough volume of completed MDS for short-stay residents to be assigned scores. Based on the distribution, it is evident that smaller facilities with lower resident turnover or facilities who do not have a high number of skilled residents did not meet the volume requirement for short stay measures as indicated by the “blank” column. The numbers assigned for rating across both sets of QMs is a more consistent representation. However, there are still outliers. Providers should be directed towards additional education and training in how to successfully affect systematic change for specific measures.

Wisconsin has a high number of facilities achieving a five-star rating in the staffing component of the rating score, which is the third metric, used in calculating the overall Five Star Rating. RN, LPN, and CNA hours are applied to a formula that takes multiple factors into consideration, including resident acuity. This measure, the last to be developed, has caused challenges for both regulators and providers due to difficulty in understanding the instructions and inconsistency in submitting accurate data. As further clarity and directions are provided by CMS, this measure will merit more focus in the future. There are opportunities for improvement and additional focus and review of the metric by providers should be considered.

Number of Providers by HERC By Staffing Rating								
Staffing Rating	Fox Valley	North Central	Northeast	Northwest	South Central	Southeast	Western	Grand Total
1	4	6	8	6	13	25	3	65
2	3	2	0	4	10	16	0	35
3	6	7	8	8	5	14	4	52
4	8	10	6	24	23	23	8	102
5	11	7	6	15	21	15	7	82
Grand Total	32	32	28	57	72	93	22	336

Source: CMS, September 2022.

Utilization Findings from the Provider Survey

(See Appendix B for all provider surveys.)

In lieu of available data, Baker Tilly initiated a survey in conjunction with the DHS to solicit certain data points directly from the providers. The survey requested occupancy data for the assisted living providers because occupancy datasets are not publicly available for these provider types. This table summarizes the data provided.

Occupancy	
CBRF	88.6% (n=154)
RCAC	78.8% (n=36)
1-2 Bed AFH	90.4% (n=469)
3-4 Bed AFH	86.1% (n=319)

Source: Provider survey, 2022.
Note: Survey results for respondents only.

The table below summarizes the provider responses regarding challenges to accepting Medicaid-waiver referrals (from all sources).

Which areas are challenges to accepting Medicaid-waiver referrals?					
	Nursing Home	CBRF	RCAC	1-2 Bed AFH	3-4 Bed AFH
Lack of open beds	26.0%	40.8%	25.8%	46.5%	50.4%
Referral is not appropriate for our setting	64.4%	66.4%	64.5%	36.9%	45.8%
Staffing shortages	68.3%	32.0%	29.0%	28.0%	43.6%
Behavioral health needs	67.3%	57.6%	48.4%	24.5%	35.2%
Payor authorization	17.3%	30.4%	38.7%	22.7%	27.1%
Resident condition at time of referral	35.6%	40.0%	41.9%	18.4%	28.4%
Urgency/timing of the referral	12.5%	16.8%	22.6%	16.0%	17.4%
Other	14.4%	21.6%	45.2%	16.0%	11.4%
Complexity of acuity	51.9%	48.0%	41.9%	14.5%	17.0%
Covid outbreaks	20.2%	8.8%	9.7%	8.5%	305.0%
Distance of the referral from the facility/family	15.4%	10.4%	6.5%	7.1%	5.1%
Cost of treatment/medications	37.5%	9.6%	22.6%	5.7%	6.8%
Pharmacy coverage	3.9%	0.8%	3.2%	3.6%	1.3%

Source: Provider survey, 2022.
Note: Results for survey respondents only.

The respondents (all provider types responding to the survey question) indicated whether they anticipate participation in the Medicaid-waiver program in the next 12 months. See below for answers to the specific question choices. (Nursing homes were not asked these questions.)

Anticipated Medicaid-waiver program participation in the next 12 months				
	CBRF	RCAC	1-2 Bed AFH	3-4 Bed AFH
Anticipate participating in the Medicaid-waiver program	75.6% (n=99)	60.0% (n=21)	48.0% (n=152)	75.0% (n=189)
Anticipate participating in the program and accepting/keeping residents on Medicaid-waiver in the facility for the next 5 years	67.2% (n=88)	42.9% (n=15)	NA	NA
Anticipate increasing Medicaid-waiver capacity (percent of admissions; percent of total beds)	22.1% (n=29)	8.9% (n=3)	11.2% (n=35)	26.3% (n=66)
Anticipate accepting Medicaid-waiver admissions directly at the facility	50.0% (n=64)	34.3% (n=12)	NA	NA
Anticipate accepting high acuity resident referrals on Medicaid-waiver	NA	28.8% (n=36)	25.3% (n=72)	38.6% (n=93)
Anticipate accepting referrals for residents with complex behaviors and are on Medicaid-waiver	NA	27.0% (n=34)	29.8% (n=87)	43.2% (n=104)

Source: Provider survey, 2022.
Note: Survey results for respondents only.

As noted below, there is a lower to moderate expectation for high acuity or complex admissions in to the AFH or RCAC. There are also only a portion of the respondents that routinely serve residents with complex behavioral conditions. Anecdotally, these expectations may be a result of the provider's confidence to safely manage high acuity referrals and complex behaviors.

Provider Survey Results

				Facility Type	
	SNF	CBRF	RCAC	1-2 bed AFH	3-4 bed AFH
Anticipate accepting high acuity resident referrals on Medicaid-waiver	-	-	28.8%	25.3%	38.6%
n=	-	-	36	72	93
Anticipate accepting complex admissions on Medicaid-waiver in next 12 Months	-	-	27.0%	29.8%	43.2%
n=	-	-	34	87	104

Source: Provider Survey, 2022.
Note: Results for survey respondents only.

Routinely Serve Residents with Complex Behavioral Conditions

	# Facilities	% of total
CBRF	30	16.5%
3-4 bed AFH	142	35.2%
1-2 bed AFH	153	26.6%

Source: Provider survey, 2022.
Note: Results for survey respondents only.

The respondents noted that only a portion of the nursing home beds have been designated for complex behaviors. Anecdotally, this is often reflective of dedicated memory support units.

Nursing Home Beds Designated for Complex Behavior Residents

	%	n=
Less than 20%	51%	70
20-79%	13%	18
80%+	4%	5
Not Applicable/Do not serve	32%	43

Source: Provider survey, 2022.
Note: Results for survey respondents only.

As reported in the publication, State of Senior Housing, 2021, over 48% of nursing homes (n=2,259) nationally were over 41 years old as of 2021. Age of the buildings and condition of the physical plant can and often does impact consumer utilization. The provider survey conducted by Baker Tilly has limited responses regarding the condition of the nursing home buildings. Other providers surveyed did not provide enough data points to present or conclude on responses. The survey suggested that the average age of nursing homes of the providers participating in the survey was 62 years old, suggesting that most of the nursing homes will need capital improvements to bring them current to today's standards of physical plant, save for those nursing homes that have already invested in improvements.

Condition of Building
For Nursing Homes Only

	%	n=
Poor	5.0%	5
Moderate	20.8%	21
Good	44.6%	45
Excellent	29.7%	30
Average Age	62 years	n=91

Source: Provider Survey, 2022.
Note: Results for survey respondents only.

Anecdotally, this will continue to be a challenge that will need to be addressed by providers to ensure they are meeting life safety considerations and remaining competitive.

Assisted Living or Licensed Adult Family Homes Quality and Ratings

Comparison and trending of survey and quality measures for Assisted Living settings is difficult to achieve due to a lack of reporting mechanisms and the variances in requirements across the states. Based on information obtained throughout the study, there are individuals residing in nursing homes who could be served in these lower-level settings.

Home and Community Based Services Utilization Trends

Home health, hospice and personal care services make up the HCBS services included in this review of Wisconsin's LTC continuum. All three levels of service were available in the seven (7) Wisconsin HERC Regions and were provided in private homes, assisted living, and adult family homes. Additionally, hospice services were also provided in the nursing home setting; data from annual provider surveys conducted from 2017 - September 2022 indicate approximately 14% of hospice patients were served in this setting.

Review of Home Health Medicare Cost Report data demonstrates a clear increase in the use of services across Wisconsin from 2017 through 2021. The sole exception is the South Central HERC with a slight decrease of utilization.

Home Health Agency Unduplicated Census

	2017	2021	% Change
Wisconsin HHA Utilization Trend	72,268	92,319	27.7%
Fox Valley HERC	7,055	9,955	41.1%
North Central HERC	3,332	9,532	186.0%
Northeast HERC	8,950	11,953	33.5%
Northwest HERC	3,621	4,797	32.4%
South Central HERC	12,282	12,154	-1.04%
Southeast HERC	42,471	45,784	7.24%
Western HERC	557	1,144	105.3%

Source: Wisconsin HHA Cost Reports 2017-2021

National Home Health Medicare Cost Report data illustrates that the trend towards enrollment in Medicare Advantage Plans has impacted the payor mix of home health recipients. Traditional Medicare decreased between 2017- 2021, almost directly proportional to the increase in the Other payor category (Medicare Advantage, Commercial, etc). Medicaid recipient use increased significantly, over the same period of time, aligning with the notable increase in enrollment during the pandemic years of 2020 and 2021.

National Home Health Payor Mix			
	2017	2021	% Change
Medicare %	55.0%	47.6%	-13.4%
Medicaid %	0.6%	3.1%	460.7%
Title V%	0.1%	0.0%	-71.4%
Other %	44.3%	49.2%	11.0%

Source: CMS HHA Cost Reports 2017-2021

Wisconsin Home Health Cost Report data for the same period reveals a similar decrease in Traditional Medicare's percent of the payor mix from 2017-2021, but the decrease was offset by an increase in Medicaid recipient use of the home health benefit. Wisconsin's Other payor category is already higher than the national average and demonstrated minimal increase.

Wisconsin Home Health Payor Mix			
	2017	2021	% Change
Medicare %	42.8%	38.6%	-9.7%
Medicaid %	1.1%	4.3%	305.6%
Title V%	0.0%	0.0%	0.0%
Other %	56.1%	57.0%	1.6%

Source: Wisconsin HHA Cost Reports 2017-2021

From a national trend perspective, data from the Centers for Disease Control and Prevention (CDC) demonstrates that in 2018, 1.5% of the total population, across all payors, used home health services. Comparatively, Wisconsin's home health use represented 1.43% of the state's population in 2018. Looking further, the state experienced growth of home health services in 2019 and 2020, where home health use represented 1.57% of the stated population each year, and 2021 is projected to be 1.64%.

The following summarizes the national LTC Home Health and Hospice utilization based on 2018 experience as reported by the CDC.

	Population Counts	
2018 National Census	328,239,523	
2018 LTC Utilization	Number of people using LTC service	Percent of national census
Home health	4,940,300	1.5%
Hospice	1,552,500	0.5%

As noted in CMS's Medicare Home Health Proposed Rule for CY 2023, which generally speaks to the current state of the home health utilization and reimbursement considerations, the average number of visits per beneficiary, based on 2021 claims data is 8.8 visits per 30-day payment episode. Also, the average patient is currently on service for 3.04 episodes. This equates to the average national total of 27.75 visits per home health beneficiary annually. It should be noted that this number is impacted by the change to the Patient Driven Grouping Model (PDGM) and the Covid 19 Pandemic.

At the time of this writing, OASIS data was not available to describe the case mix and clinical acuity of Wisconsin's home health patients, but it is reasonable to assume these patients align with the national trends.

This is reinforced by the comparative Wisconsin specific nursing facility data. MedPac's March 2022 Report to Congress contained aggregated home health data reflecting the distribution of services across the 12 Clinical Groupings defined in the Patient Driven Groupings Model (PDGM). The primary diagnoses serviced by home health providers in 2019 and 2020 align with the rising comorbidities impacting long-term care, including: heart disease, hypertension, respiratory disease, cerebrovascular disease, diabetes, joint disease, sensory impairment, and mental health diagnoses. While there was little change in distribution of patients across clinical categories between 2019 and 2020, there was a shift in acuity. 2020 data in table 8-5 demonstrates an increase in greater functional debility and high-comorbidity payment groups, translating into sicker, less conditioned patients receiving services at home.

TABLE 8–4

Distribution of 30-day periods by clinical category in 2019 and 2020

	Share of 30-day periods		Percentage point difference
	2019	2020	
Categories other than MMTA:			
Musculoskeletal rehabilitation	19.4%	19.5%	0.1
Wounds	12.3	14.2	1.9
Neurological rehabilitation	10.3	10.6	0.3
Complex nursing interventions	4.5	3.1	–1.4
Behavioral health	2.7	2.3	–0.4
MMTA categories:			
Cardiac and circulatory	21.6	19.3	–2.3
Respiratory	7.9	7.8	–0.1
Endocrine	6.8	7.3	0.5
Gastroenterology/genitourinary	4.3	4.6	0.3
Infectious disease	3.8	4.7	0.9
Surgical aftercare	3.4	3.5	0.1
Other	2.9	3.2	0.3

Note: MMTA (medication management, teaching, and assessment). Home health services initiated in 2019 were paid under 60-day episodes. For this table, home health care services initiated in 2019 were recalculated as 30-day periods to provide comparable units of service in the two years. Thirty-day periods are included in the month and year that the period ended. Components may not sum to totals due to rounding.

Source: MedPAC analysis of 2019 home health Limited Data Set file and 2020 home health standard analytic file.

Source: MedPac March 2022 Report to Congress Table 8-4

TABLE 8–5

In 2020, more periods were reported in greater functional-debility and high-comorbidity payment groups

	Share of 30-day periods	
	2019	**2020**
Reported functional status (high = greater debility)		
Low	33.0%	25.7%
Medium	34.0	32.7
High	33.0	41.6
Comorbidity group (high = more/more severe comorbidities)		
None	54.3	49.1
Low	37.2	37.0
High	8.5	13.9

Note: Home health services initiated in 2019 were paid under 60-day episodes. For this table, home health care services initiated in 2019 were recalculated as 30-day periods to provide comparable units of service in the two years. Thirty-day periods are included in the year that the period ended.

Source: MedPAC analysis of 2019 home health Limited Data Set file and 2020 home health standard analytic file.

Source: MedPac March 2022 Report to Congress Table 8-5

Additionally, some acuity information can be inferred by the Hierarchical Condition Categories (HCC) score. Each HCC represents diagnoses with similar clinical complexity and expected annual care costs. It should be noted that the CMS HCC score differs from the HHS HCC in that it was developed for Medicare and Medicaid enrollee over the age of 65 and those with disabilities; the HHS HCC covers all patients on Affordable Care Act (ACA) plans and covers a much broader diagnosis list. The CMS-HCC risk score for a beneficiary is the sum of the score or weight attributed to each of the demographic factors and HCCs within the model. The CMS-HCC model is normalized to 1.0. Beneficiaries would be considered healthy, and therefore less costly, with a risk score less than 1.0. As seen in the attached table, both 2019's and 2020's annual averages were above 1.0, at 2.05 and 2.0, respectively, indicating they are less healthy and potentially more costly than other beneficiaries. This also reveals little change in the case mix between 2019 and 2020, translating to little change in acuity. Both years trended in a similar fashion as well, with the more severe patients receiving care Q1 of each year and then decreasing in Q4.

TABLE 8–6

Mean CMS–HCC score for home health beneficiaries by quarter of use, 2019 and 2020

	Quarter				
	1	**2**	**3**	**4**	**Annual average**
2019	2.54	2.24	2.12	2.02	2.05
2020	2.44	2.28	2.09	1.99	2.00

Note: CMS–HCC (CMS hierarchical condition category). Home health services initiated in 2019 were paid under 60-day episodes. For this table, home health care services initiated in 2019 were recalculated as 30-day periods to provide comparable units of service in the two years. Thirty-day periods are included in the quarter that the period ended.

Source: MedPAC analysis of data from the 2019 and 2020 Medicare CMS–HCC files.

Source: MedPac March 2022 Report to Congress Table 8-6

Lastly, a state-by-state comparison of the number of Medicare Home Health users who have 3 or more chronic conditions, as compared to all Medicare beneficiaries, demonstrates that Wisconsin had the 7th highest percent in the country. According to a study by the Alliance for Home Health Quality and Innovation, (page 37), 93.28% of Wisconsin home health users had 3 or more chronic conditions, as compared to 19.96% of all beneficiaries in the state. This is comparable to the regional states of Illinois, Indiana, and Iowa. Nevada demonstrates the lowest percent of these patients while North Dakota represented the highest percent of home health users with 3 or more chronic conditions. This reinforces the increasing acuity of the average home health patient across the country and in Wisconsin.

From a quality perspective, Wisconsin Home Health quality is at or above the national averages for how often the home health team met measures related to patient care in 2020. However, the averages for patient outcomes while patients were on home health service in 2020 were slightly below national standards for 2020. The higher Wisconsin averages for hospital admission and unplanned emergency care are considered a lower performance in these metrics.

Averages for How Often Home Health Team Met Quality Measures Related to Patient Care, 2020

Measure	National	Wisconsin
Checked patients for depression	97%	98%
Checked patients' risk of falling	100%	100%
For diabetic patients, got doctor's orders, gave, and educated about foot care	96%	96%
Taught patients (or their family caregivers) about their drugs	99%	99%
Began care in timely manner	96%	95%
Determined whether patients received a flu shot for the current flu season	79%	82%
Determined whether patients received a pneumococcal vaccine	82%	91%

Source: Centers for Medicare and Medicaid Services, Medicare Home Health Compare.

Averages for Patient Outcomes while in Home Health Care 2020

Measure	National	Wisconsin
Wounds improved or healed after operation	92%	90%
Got better at bathing	82%	80%
Breathing improved	83%	82.00%
Got better at walking or moving around	80%	79%
Got better at getting in and out of bed	81%	82%
Got better at taking drugs correctly by mouth	75%	71%
Had to be admitted to hospital	15%	16%
Needed any urgent, unplanned care in the hospital emergency room – without being admitted to the hospital	13%	16%

Source: Centers for Medicare and Medicaid Services, Medicare Home Health Compare.

Analysis of the county coverage information in the 1572A Home Health data from 2017-2021 demonstrates dramatic disparity in the concentration of home health providers across counties and HERC, with multiple rural counties having only 3-5 providers, while counties like Jefferson and Dodge had over 20 and Milwaukee had almost 40 providers. The Western and Northeast HERCs had lower provider numbers across their counties, while the South Central and Southeast HERCs had the greatest numbers of providers. Appendix F contains tables for number of providers, by county, by HERC.

Like home health, hospice care is firmly established as part of the long-term care continuum in Wisconsin. The state has followed national trends in both the increase in the number of hospice agencies, as well as the percentage of descendants who use hospice services at the end of life. Nationally, from 2000 to 2019, hospice use rates among decedents more than doubled, increasing from less than 25 percent to more than 50 percent of decedents. In more recent years, the share of decedents who leveraged hospice has maintained growth, at a rate of 0.9% annually. 2020 was an exception; the growth of deaths outpaced hospice growth due to the public health emergency (Covid-19), resulting in a decline of 3.8%. This is widely accepted as an outlier year and will not be included in the trend data in the prospective section of this report.

The National Hospice and Palliative Care Organization (NHPCO) Facts and Figures Report, 2017 Edition, identified that 51-55% of eligible Wisconsin decedents received hospice services in 2016. This was regionally comparable to Minnesota and Michigan, and a higher ratio than Indiana and Illinois. Iowa was the lone state in the region, and one of only four states in the nation to exceed that range. 2018 patient data, as indicated in NHPCO Facts and Figures, 2020 Edition, places Wisconsin 8th in the nation for eligible decedents using hospice care at 55.7%. The trend for use continued in the 2022 Edition, where Wisconsin rose to be the 4th highest state for utilization by eligible decedents, at 54.7%. The decrease from the previous measure aligns with the 2020 death/hospice metrics discussed above.

The payor mix for hospice is simpler than Home Health, as is does not include Title V and has not yet been impacted by Medicare Advantage Plans to the same level that Home Health has. Medicare Advantage Enrollment is a near future consideration for hospice, as plans are now available in 13 states and Puerto Rico. Wisconsin providers will need to consider how to navigate the change in contracting, revenue flow and case mix. Cost report data from 2017-2021 shows that Traditional Medicare remains by far the largest payor for hospice services, with a slight increase over the course of the period. Medicaid utilization remained about the same.

National Hospice Payor Mix

	2017	2021	% Change
Medicare %	89.5%	91.7%	2.5%
Medicaid %	3.2%	3.1%	-3.1%
Other %	7.3%	5.2%	-28.8%

Source: CMS Hospice Agency Cost Reports 2017-2021

Wisconsin's payor mix followed the national trends, albeit with less overall change in utilization percents. It should be noted that Wisconsin's percent of Medicaid use is less than the national average, and the Medicare slightly higher.

Wisconsin Hospice Payor Mix

	2017	2021	% Change
Medicare %	94.2%	94.6%	0.4%
Medicaid %	1.6%	1.7%	6.3%
Other %	4.1%	3.7%	-9.8%

Source: Wisconsin Hospice Agency Cost Reports 2017-2021

Hospice quality measures are evolving, and several claims-based elements added in recent years to provide additional insight to end of life care provision. One element has been the addition of the Hospice Care Index (HCI). Introduced in FY 2022, the HCI is a composite score of ten indicators which reflect care throughout the hospice stay and by the care team. As highlighted below in the Patient Care Data, Wisconsin has a composite score of 9.5 out of 10, above the national average of 9.8. Wisconsin Patient Care Measures are at or above national averages, indicating a good quality of care. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures are also at or above national standards, indicating a good patient experience with the care. See next page for data. https://data.cms.gov/provider-data/search?theme=Hospice%20care

Hospice Data-Patient Care Measures		
Measure Name	National	Wisconsin
Hospice and Palliative Care Treatment Preferences	99.5	99.8
Beliefs & Values Addressed (if desired by the patient)	98.1	98.9
Hospice and Palliative Care Pain Screening	97.9	98.5
Hospice and Palliative Care Pain Assessment	94.1	96
Hospice and Palliative Care Dyspnea Screening	98.9	98.5
Hospice and Palliative Care Dyspnea Treatment	97.4	96.5
Patient Treated with an Opioid Who Are Given a Bowel Regimen	93.5	98.4
Hospice and Palliative Care Composite Process Measure	90.9	93.5
Hospice Visits in the Last Days of Life	49.2	71
Hospice Care Index Overall Score	8.8	9.5
CHC/GIP provided (%days)	0.7	0.7
Gaps in nursing visits (% elections)	51.2	47.9
Early live discharges (% live discharges)	7.8	6.8
Late live discharges (% live discharges)	34.4	35.6
Burdensome transitions, Type 1 (% live discharges)	8.2	5.6
Burdensome transitions, Type 2 (% live discharges)	2.3	1.4
Per-beneficiary spending (U.S. dollars $)	15,207	13111
Nurse care minutes per routine home care days (minutes)	13.9	16.1
Skilled nursing minutes on weekends (% minutes)	9.3	9.3
Visits near death (% decedents)	90	95.3

Source: CMS, released February 15, 2023

Hospice care - National CAHPS Hospice Survey Data		
Measure Name	National	Wisconsin
The hospice team did |not| provide the right amount of emotional and spiritual support	10	8
The hospice team provided the right amount of emotional and spiritual support	90	92
Caregivers rated the hospice agency a 6 or lower	5	4
Caregivers rated the hospice agency a 7 or 8	14	15
Caregivers rated the hospice agency a 9 or 10	81	81
NO, they would probably not or definitely not recommend the hospice	5	4
YES, they would probably recommend the hospice	11	12
YES, they would definitely recommend the hospice	84	84
The hospice team sometimes or never treated the patient with respect	2	2
The hospice team usually treated the patient with respect	8	7
The hospice team always treated the patient with respect	90	91
The patient sometimes or never got the help they needed for pain and symptoms	10	9
The patient usually got the help they needed for pain and symptoms	15	18
The patient always got the help they needed for pain and symptoms	75	73
The hospice team sometimes or never communicated well	7	6
The hospice team usually communicated well	12	13
The hospice team always communicated well	81	81
The hospice team sometimes or never provided timely help	10	10
The hospice team usually provided timely help	13	13
The hospice team always provided timely help	77	77
They did not receive the training they needed	9	11
They somewhat received the training they needed	15	18
They definitely received the training they needed	76	71

Source: CMS, released February 15, 2023

It is important to note that the trend in the state from 2017 to September 2022 is a decrease in the total numbers of hospice patients served in nursing homes, declining from 23% to 15%. This trend was evident in all HERCs, except the Southeast and South Central HERCs, which demonstrated increases of nursing home-based hospice patients of 2% and 9%, respectively. The Northcentral HERC remained relatively constant, with a decline of only 1%. Like the increase in home health numbers, this trend reinforces the rising consumer preference to receive services in a home setting.

As in Home Health, access to Hospice services was impacted by available providers. Review of the Hospice providers by county, informed by the Wisconsin DHS 643 data from 2017 to September 2022, revealed that multiple counties and HERCs have limited numbers of providers, impacting access and choice for residents. The Northwest HERC demonstrated the state's most limited access, with three counties having only one hospice provider and three additional counties having only two. The Northeast and North Central HERCs also illustrate counties with fewer providers, especially in the northern tiers of the HERCS. The South Central and Southeast HERCS had the greatest number of providers, although notably less saturated with Hospice than they were with Home Health providers. The Southeast HERC was the most evenly distributed among the counties, offering the residents the most consistent access to care across any one HERC.

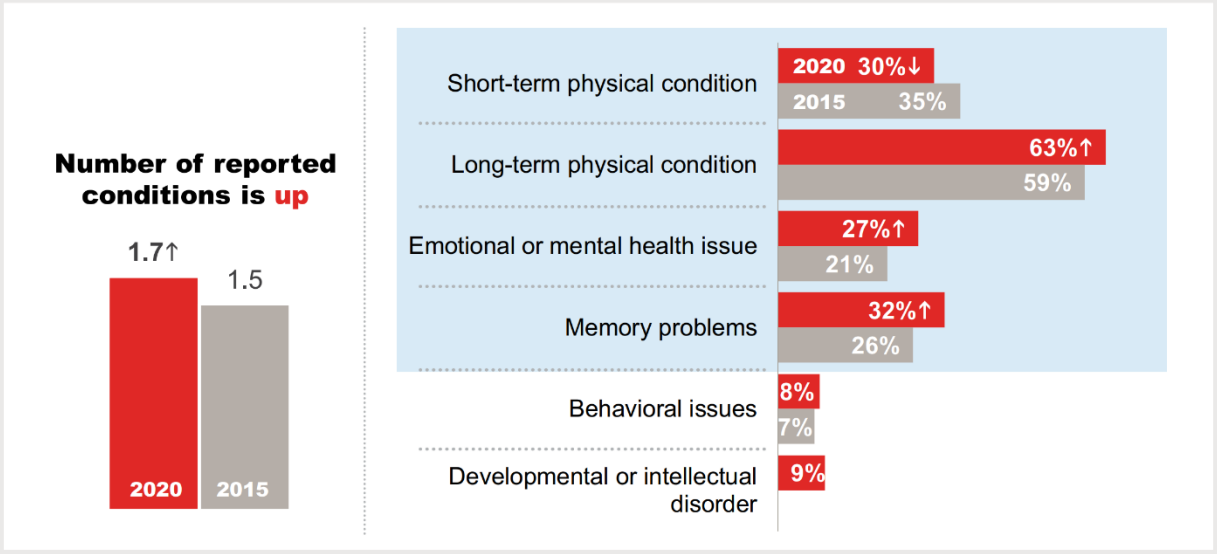
Personal care services are a critical component in the success of chronic disease management in long-term care, especially for those members residing at home and in facilities that have minimal medical support available. Personal care services include support with Activities of Daily Living (ADL) like bathing and grooming, and Instrumental Activities of Daily Living (IADL) such as cooking and cleaning. Recipients of personal care support receive it via caregiver relationships and PCA with programmatic support from the Medicaid Home and Community Based Waiver programs. Wisconsin’s Family Care, Family Care Partnership and the Include, Respect, I Self-Direct (IRIS) programs support the elderly, blind and disabled who wish to remain in their home or community, instead of a state medical facility or nursing home.

It is difficult to assess the amount of personal care provided to Wisconsin residents during the retrospective period because of the high prevalence of services being provided by unpaid caregivers, and because the segment of professional services provided under private pay arrangements with PCAs are not reported in any centralized or regulated manner. There was also a challenge with some values in the encounter data provided in response to Baker Tilly’s data request. In many cases fields such as ‘Location of service” were left blank, rendering calculation of Medicaid funded care unreliable.

Understanding the total number of hours and scale of services is important for understanding how foundational the provision of personal care services is to the success of long-term patients. According to Caregiving in the US 2020 report, published by the National Alliance for Caregiving and the AARP Public Policy Institute, the average recipient who received personal care from 2015-2020 was 68.9 years old and received 24 hours of care per week. This differs slightly from Genworth’s 2021 Report, which indicates a baseline average of 44 hours a week but includes a financial planning perspective. Eighty-eight percent (88%) of the people receiving care lived in a personal home in 2020, versus 89% in 2015, with the largest area of note being a 5% change from residing in their own home to residing in a caregiver’s home in the 2020 data.

As would be expected for a population increasing in ADL and IADLS needs, most recipients of personal care services were receiving support for long-term physical conditions (see figure below). This mirrors identified trends in CDC comorbidity trends, Nursing Facility MDS and Home Health acuity data. About 45% of those caring for someone age 50 or older report the presence of two or more conditions, up from 38% in 2015, with noted increases in reported conditions, emotional or mental health issues, behavioral issues, and memory problems.

Figure 22. Types of Care Recipient Conditions



Q17. Does/Did your [relation] need care because of a …?

2020 Base: Caregivers of Recipient Age 18+ (n=1,392)
2015 Base: Caregivers of Recipient Age 18+ (n=1,248)

Note: Respondents may select more than one response; results add to greater than 100 percent.

Source: National Alliance for Caregiving and AARP Public Policy Institute, Caregiving in the US 2020

Twelve percent of Americans provide ongoing living assistance to a friend or family member right now, and 6% of Americans aged 40 and older are receiving ongoing living assistance. Those providing care rank Wisconsin in the top quartile overall on measures of long-term services and supports according to the Long-Term Services and Supports State Scorecard. These measures include Choice of Setting, Quality of Life, Support of Family Caregivers, Effective Transitions and Affordability. Wisconsin aligned consistently with Minnesota regionally, but there was high variance among the other neighboring states, especially in Effective Transitions and Quality of Life.

Hospital Referrals to LTC Providers

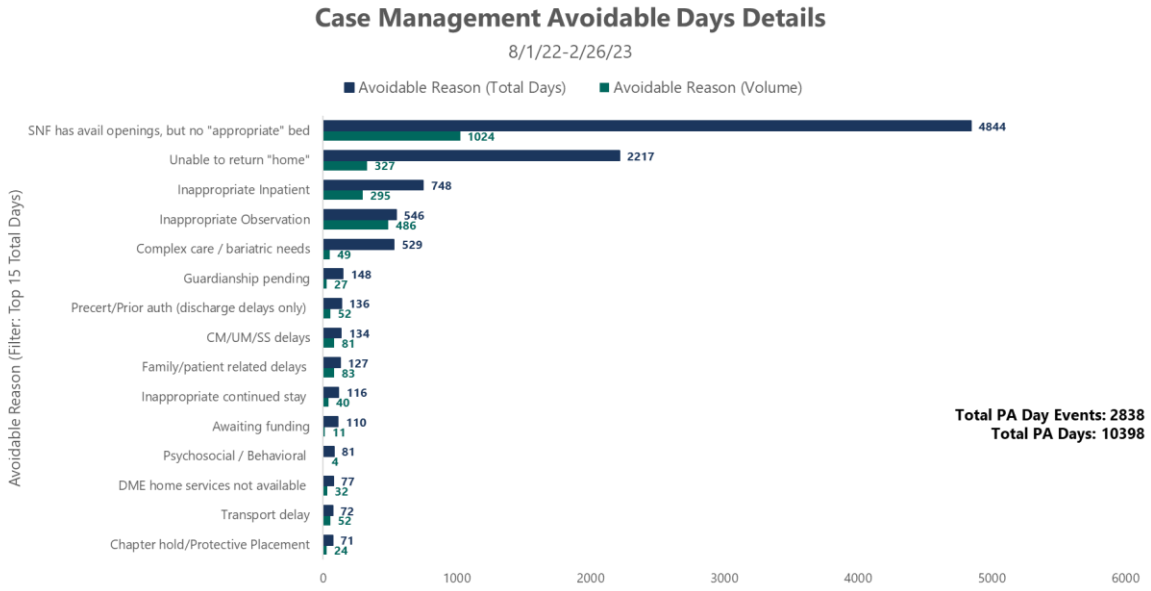
DHS specifically requested that Baker Tilly assess the relationship between LTC and referral sources to assess challenges, barriers to effective management, communication improvement needs, systems issues, and other matters effecting the referral process. This assessment included interviews with providers of all types and referral sources, such as hospitals. In addition, the providers (all types) were given the opportunity to respond to questions about the referral process in the provider survey. See Appendix B for the survey results.

Community Health Impact Statement - Financial Impact of Medicaid LTC Patients

The financial impact of Medicaid LTC patients on acute and LTC providers is difficult to quantify. Due to the challenge in discharging the LTC population to safe and appropriate destinations, the acute care hospitals have become a de facto part *of* the LTC industry due to their management of these patients to the tune of thousands bed days per year.

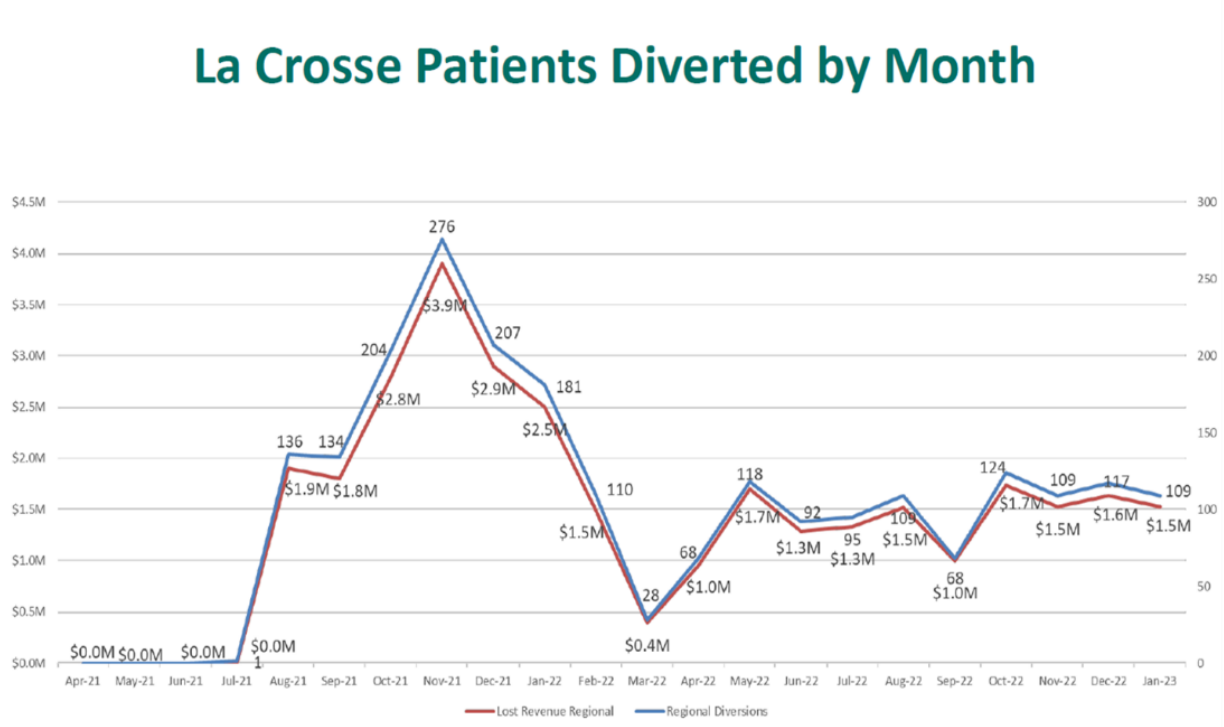
The financial burden is not the only impact of the inability to place this population effectively, as noted earlier. There is an additional burden of care not being met in the general population due to hospital beds being taken by the LTC population. The reality of this challenge is seen in deferred surgeries, resources diverted away from staff and other operations, and the inability to admit acuity patients from the overall community due to bed capacity.

An example from one health system in the Western HERC, is indicative of the challenges faced by health systems across the state:



The result of the delayed discharges and admission limitations has a collective long-term impact on the community including a rise of acuity in the patients which can't be admitted to traditional LTC services, ultimately resulting in an increased total cost of care over the long-term, increased stress on emergency departments which are forced to constantly stabilize or board these patients due to lack of beds, increased cost and destabilization of families ill equipped to care for advanced conditions but who have no alternative without hospital beds, among other impacts.

This is again illustrated by the number of patients diverted by month. Diverted in this example refers to patients who were sent to other health care facilities due to lack of capacity. While these denied patients have dropped since the peak of COVID-19, they have not returned to pre-pandemic level:



We have noted several key challenges in the following sections which have critical impact on the ability of health systems to discharge, and LTC providers to admit, the patient population most impacting the State's hospitals.

The LTC patient population has a cascading impact on the general health system in Wisconsin and must be considered from this perspective. There is both a substantial cost that is being borne by the hospitals to support this patient population along with a significant impact on the ability to effectively meet the needs of the rest of Wisconsin's residents.

To put the scope of this challenge in perspective, our team estimates the following impacts on the health care ecosystem in Wisconsin for 2022:

- 177,390: The number of excess hospital days for patients waiting for LTC placement.
- 177,390: The number of bed days unavailable for other patients in acute care hospitals.
- $484,629,480: The approximate cost of these excess days in hospital operating expenses.

[These figures were developed using the DHS reported data for patients awaiting placement in the Wisconsin EMResources tool and the Kaiser Family Foundation reported rate of $2,732 per inpatient day of hospital operating expenses for Wisconsin. The figure represents approximately 5-7% of all patient days for the year. Exact patient days for 2022 are not yet available.]

In contrast, the LTC providers appear to have differing motivators regarding their role in participating in this ecosystem. Many reasons of which are noted in this report, including staffing constraints, financial impact, regulatory impacts, etc. This is further demonstrated by the provider survey responses regarding the perceived importance regarding initiatives with referral sources.

Percentage of respondents ranking initiatives as the most impactful to their organization "(1) most important" by Health Service Area

	1-2 Bed AFH	3-4 Bed AFH	CBRF	RCAC	Nursing Home
Initiatives to improve relationships between long-term care and referral sources such as hospitals, managed care organizations and others	8.3%	12.8%	4.3%	5.7%	1.8%

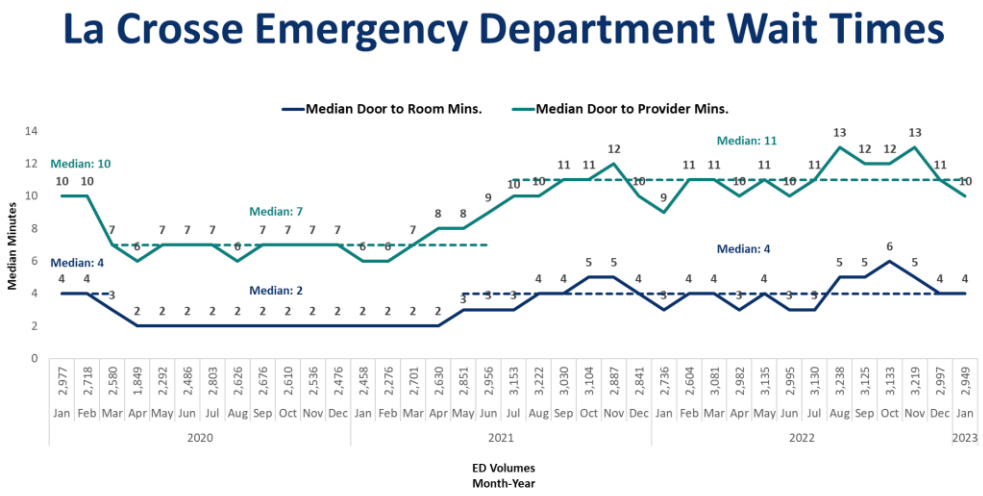
Source: Provider Surveys, 2022
Note: Data for respondents only.

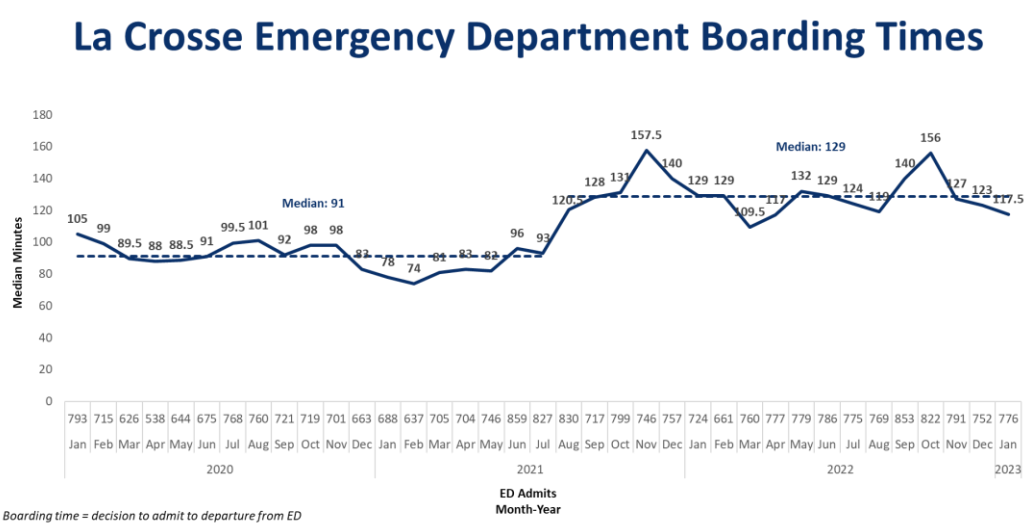
Impacts Beyond Financial

The challenges of this patient population are being felt by both the hospitals serving this population and by the community members who are unable to obtain services due to lack of acute care beds. Some examples of this include:

- Deferred Surgeries: Health systems have been deferring non-critical surgeries due to their inability to admit additional patients. The deferral of these procedures leads to a decline in the health, lifestyle, and satisfaction of these patients.
- Increased pressure on emergency departments: The lack of beds also causes a backlog in emergency departments. Hospitals are boarding patients in the emergency departments who either cannot be admitted due to lack of acute beds, or boarding patients who are LTC appropriate due to a lack of LTC beds. In addition, patients who would normally be admitted if a bed were available are stabilized and sent back to a home setting. This approach leads to a cyclical return to the emergency department until the patient's condition is treated appropriately.
- Increased staff pressure and burn out: The deferred discharge of the LTC patient population adds to the increase in hospital census and the patient to staff ratios. This increased pressure is particularly felt in the nursing and case management populations. The situation in the emergency departments is even more intense as utilization and boarding pressure an already stretched team.

An example of these issues includes the impact on Emergency Department Wait times, and the number of Emergency Department Boarding patients. These graphs are from a Western HERC health system but represent the challenges faced by health systems across the state.





[We have requested validating data from the Provider EMR system. At the time of this writing two health systems were able to provide data.]

Workforce In Wisconsin Challenges

DHS representatives indicated a strong understanding of the current state of the workforce. There are multiple ongoing statewide initiatives to address these challenges. Baker Tilly was directed to focus our study on innovative approaches to upcoming challenges and identify any gaps in workforce that should be a particular focus. The workforce shortage being experienced by Wisconsin is a theme that runs throughout our report. The staffing challenges create a ripple effect that increases the cost and timeliness of care, which are also noted throughout our report.

Workforce Crisis in Healthcare/LTC

The State of Wisconsin is experiencing the same shortage in the LTC workforce as the rest of the country. The Bureau of Labor Statistics estimates the nation has lost over 400,000 long-term care employees since the start of the Covid-19 pandemic. The cause of this workforce challenge is multi-faceted and includes factors such as burnout, equal or better compensation from lower stress jobs, and increased need/competition from health systems for the same workforce.

The strain of the pandemic has accelerated people leaving the healthcare workforce especially in nursing which already had an aging employment grouping prior to the pandemic. Additionally, the workforce issue has been a prevalent issue for years as enrollment and number of graduates in nursing programs has steadily declined.

While these challenges are not unique to Wisconsin, this workforce challenge comes at a time when the State is already straining to provide enough care for the Medicaid population. Total workforce numbers do not meet demand and demographic changes are expected to exacerbate this issue over the next 5 years and potentially longer. The impact of staffing disproportionately impacts the LTC Medicaid population as providers in all LTC settings struggle under the burden of operational and care concerns.

As staff to patient ratios continue to be impacted by available workforce and patient acuity, the facilities are accepting fewer admissions to concentrate on providing care for existing patient populations. The cost of care has increased for these facilities due to supply chain increases, workforce and labor increases and other rising costs due to inflation experienced by all businesses. Facilities are choosing to accept patients with higher daily reimbursements in their limited intake to stay in business, and the Medicaid population falls on the lower side of reimbursement as compared to other payors.

The workforce challenge extends beyond financial considerations and has implications for a provider's ability to care for the patient population. The patients in Wisconsin's Medicaid LTC population have a higher average acuity than other patient populations and this further stretches an understaffed team as these complex patients take much more time and focus. In addition, as teams are stretched, less experienced team members are taking care of patients (e.g., an LPN covering former RN responsibilities). When this occurs, it limits the complexity of patients that a provider can accept to stay within the capabilities of the available care givers.

There are many other complicating factors which impact the workforce challenges such as the Covid-19 vaccine mandate, the lack of access to qualified international legal immigrants, the time of approval for professional licenses, and the lack of supporting programs such as affordable housing, childcare, and tax credits.

Provider Survey Findings – Workforce

Interviews with providers, LTC associations, and healthcare associations all suggested that workforce shortages are creating access issues, open beds and units, lack of development of new beds, access issues to home care visits, etc., across the entire spectrum of LTC providers (ALF, SNF, HHA, AFH). Provider surveys support these interview findings. See the findings of the provider survey below, and full survey results in Appendix B.

The general themes of the provider survey responses align with other points raised throughout the report, including:

- Recruiting and retaining staffing by the LTC providers is impacting the ability to accept admissions.
- Competitive wages and benefits and the availability of interested workforce are noted impacts on recruiting efforts.
- Nursing homes have resorted to agency staffing to support staffing needs.

Percentage of respondents who are experiencing challenges in their labor pool that impact their ability to take referrals.	
1-2 Bed AFH	33.9%
3-4 Bed AFH	46.9%
CBRF	57.0%
RCAC	52.8%
Nursing Home	86.4%

Source: Provider survey, 2022
Note: Survey results for respondents only.

Percentage of respondents that have open beds, limited admissions, and limiting visits, due to staffing limitations.		
	%	n=
1-2 bed AFH	20.3%	63
3-4 bed AFH	34.4%	86
CBRF	38.9%	51
RCAC	28.6%	10
SNF	86.5%	96
Hospice	75.0%	12
HHA	77.8%	7
Personal Care	82.6%	38

Source: Provider survey, 2022.
Note: Results for survey respondents only.

Challenges in workforce					
	1-2 Bed AFH	3-4 Bed AFH	CBRF	RCAC	Nursing Home
Competitive rates/wages	75.5%	88.1%	89.0%	88.6%	91.6%
Non-compensated benefits	35.7%	48.6%	36.8%	40.0%	30.8%
Retention	28.9%	48.2%	58.8%	60.0%	66.4%
Initial and ongoing training requirements	26.7%	32.3%	36.0%	20.0%	27.1%
Recruitment	25.3%	45.4%	61.0%	57.1%	75.7%
Labor pool experience level	21.3%	26.7%	48.5%	45.7%	43.9%
Staff attrition	17.7%	29.5%	40.4%	20.0%	47.7%
Other	16.6%	9.2%	8.1%	8.6%	13.1%
Geography/travel distance	14.1%	11.6%	18.4%	20.0%	23.4%

Source: Provider survey, 2022.
Note: Survey results for respondents only.

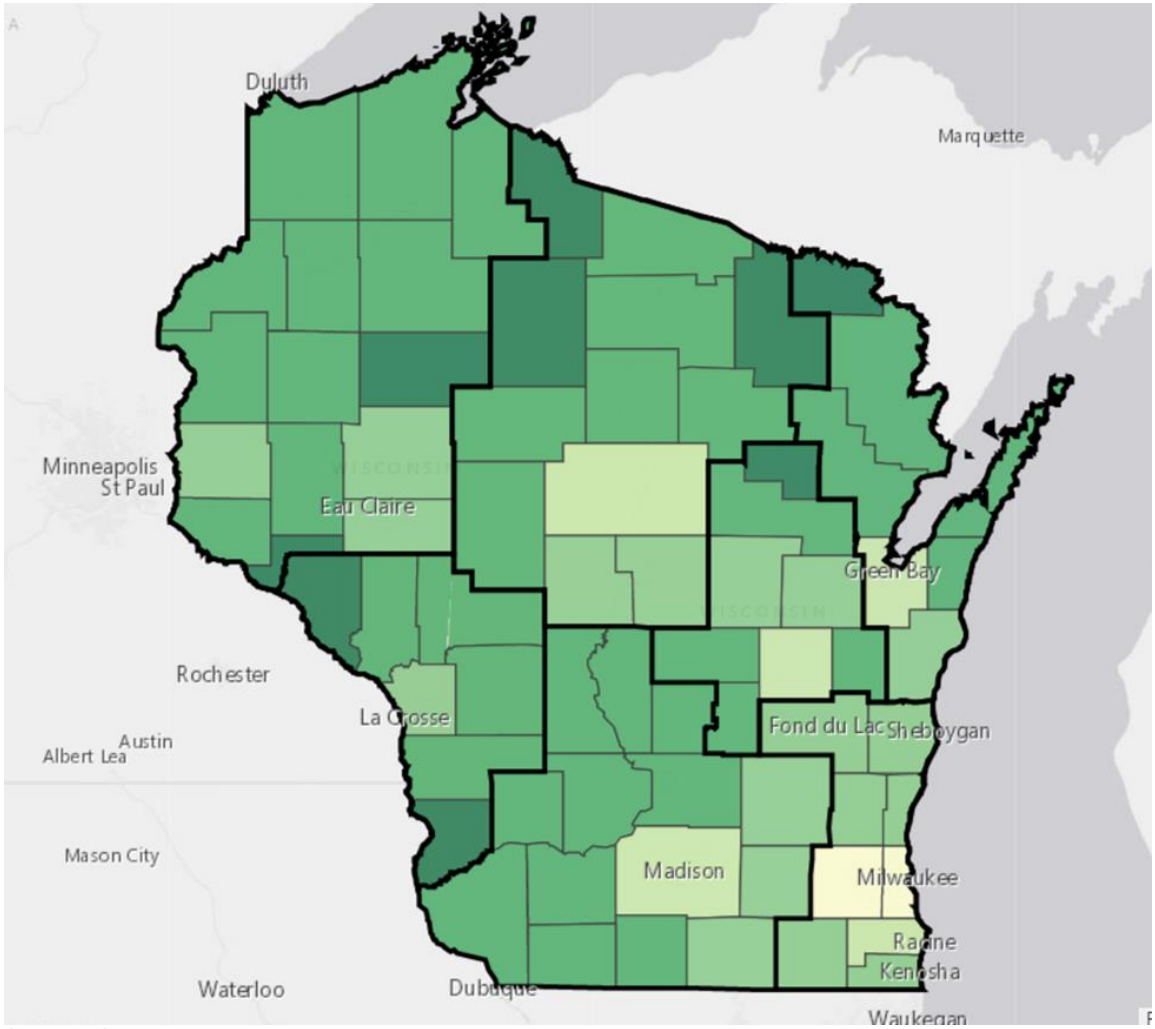
Challenges with attracting and retaining staff					
	1-2 Bed AFH	3-4 Bed AFH	CBRF	RCAC	Nursing Home
Competitive rates/wages	70.3%	86.6%	83.0%	88.6%	83.2%
Staff availability	47.0%	61.0%	61.5%	68.6%	76.6%
Non-Compensated benefits	30.8%	46.8%	34.8%	37.1%	29.9%
Other	22.6%	8.5%	11.9%	8.6%	5.6%
Staff attrition	15.0%	15.9%	29.6%	22.9%	29.9%
Physical plant/environment	3.4%	2.9%	2.2%	2.9%	6.5%
Complex needs of the resident population (e.g., behavioral health, dementia, very high acuity)	NA	NA	43.7%	NA	38.3%
Corporate culture	NA	NA	3.0%	2.9%	13.1%

Source: Provider survey, 2022.
Note: Survey results for respondents only.

Percentage of respondents who needed to use agency/contracted staff to provide patient care in the past 12 months	
1-2 Bed AFH	7.5% (n=24)
3-4 Bed AFH	11.7% (n=30)
CBRF	38.5% (n=52)
RCAC	33.3% (n=12)
Nursing Home	88.0% (n=95)

Source: Provider survey, 2022.
Note: Survey results for respondents only.

Baker Tilly has analyzed the future demographics for the workforce in the state to highlight counties which will face the greatest future workforce gaps. The heat map below represents the difference in growth between the 20-64 working age population and the 65+ population by 2030. The data source for demographics shown on the map is ESRI.



Source: ESRI

Map Key:

- Less than 1,000
- 1,001 – 3,000
- 3,001 – 7,000
- 7,001 – 15,000
- Greater than 15,001

Prospective Analysis

Baker Tilly has conducted a study of the future needs of Long-Term Care in the State of Wisconsin. The team analyzed trends in current capacity, care, and programs in Wisconsin, and benchmarked these against national trends and our team's knowledge and expertise in these areas.

The prospective analysis includes:

- Demographics and Population Projections – 2022-2027
- LTC Demand Projections by Provider Type
- Other Factors and Considerations

Demographics and Population Projections – 2022 to 2027

(See Appendix C for the HERC map and definitions and see Appendix D and E for the demographic data tables for each HERC region.)

The demographics assessed are for the period 2022 to 2027, which is the most current period available by the demographic resource center, ESRI. The corresponding demand projections are for the same period. Projections beyond 2027 are not available by ESRI.

Wisconsin Population Trend Comparison to National

Demographics for each HERC region, the state, and the United States are summarized in the table for comparison. The State of Wisconsin is projected to grow 0.5% for the period 2022 to 2027, which is slightly slower than the projected national growth rate. The fastest growing HERC region is the South Central region of Wisconsin, while the North Central and Southeast regions are shrinking slightly for the period.

Total Population, by HERC, Wisconsin, and the United States

	2010 Totals	2022 Estimated Totals	2027 Estimated Totals	Percent Increase/Decrease 2010 to 2022	Percent Increase/Decrease 2022 to 2027
HERC Regions					
Fox Valley Area	534,798	558,895	562,455	4.5%	0.6%
Northeast	461,640	490,457	495,246	6.2%	1.0%
Northwest	565,926	599,285	606,273	5.9%	1.2%
Western	268,580	280,825	281,913	4.6%	0.4%
Southeast	2,237,110	2,275,570	2,270,204	1.7%	-0.2%
South Central	1,149,195	1,251,066	1,270,797	8.9%	1.6%
North Central	469,737	475,275	474,911	1.2%	-0.1%
Wisconsin	5,686,986	5,931,373	5,961,799	4.3%	0.5%
United States	308,745,531	335,707,897	339,902,796	8.7%	1.2%

Source: ESRI 2022

The demographics projections for populations aged 65+ for each HERC region in Wisconsin are summarized in the following table for the period 2022 to 2027, as well as the aged 65+ trends for Wisconsin and for the United States. The state's aged 65+ population is growing faster than the United States, for the period assessed. The HERC with the fastest growing aged 65+ population is Northwest followed closely by South Central. It should be noted that the Northwest HERC is a large, primarily rural geographic area with few LTC providers.

Population by Senior (65+), by HERC, Wisconsin, and the United States

	Census 2010		Estimated 2022			Projected 2027		
	Total Population	Percent of Total Population	Total Population	Percent of Total Population	Percent Increase/Decrease from 2010	Total Population	Percent of Total Population	Percent Increase/Decrease from 2022
HERC Regions								
Fox Valley Area	74,954	14.0%	101,809	18.2%	35.8%	116,328	20.7%	14.3%
Northeast	67,348	14.6%	93,482	19.1%	38.8%	106,790	21.6%	14.2%
Northwest	81,575	14.4%	116,849	19.5%	43.2%	134,008	22.1%	14.7%
Western	39,777	14.8%	54,367	19.4%	36.7%	61,352	21.8%	12.8%
Southeast	286,053	12.8%	397,717	17.5%	39.0%	452,717	19.9%	13.8%
South Central	149,186	13.0%	216,391	17.3%	45.0%	247,910	19.5%	14.6%
North Central	78,421	16.7%	102,257	21.5%	30.4%	115,307	24.3%	12.8%
Wisconsin	777,314	13.7%	1,082,872	18.3%	39.3%	1,234,412	20.7%	14.0%
United States	40,267,984	13.0%	58,569,38	17.4%	45.4%	66,046,169	19.4%	12.8%

Source: ESRI 2022

LTC Demand Projections, by Provider Type

Accessibility to LTC beds and services is a critical issue that has significant barriers. Regulators, providers, and consumers in Wisconsin will need strategies to ensure that there are enough beds and services for persons that require long-term and short-term care, whether in a facility (e.g., nursing home, assisted living) or at home with support services.

Nursing Home Bed Demand vs. Operational Supply

(See the Executive Summary for additional details.)

The State has a robust LTC system that includes nursing homes, assisted living, including AFH, and home care services that are supported by Medicaid and the Medicaid-waiver programs (e.g., Family Care, IRIS).

The implementation of Family Care and other HCBS programs has reduced the need for nursing home beds and increased the supply of assisted living and other home care services. The trend of decreasing utilization of nursing homes will persist due to these alternative settings supported by Medicaid-waivers as well as the impact of continuing workforce shortages in LTC and changing consumer preferences to remain in a home setting. All these matters are documented herein.

The findings suggest that there are enough nursing home beds in Wisconsin to meet current demand, and most likely future demand for the foreseeable future. The assessment found significant excess supply in most of the regions of the state suggesting underutilization of beds and lack of demand from consumers. Interviews and surveys provided perspective on bed demand. As noted throughout this report, the most significant factor impacting the nursing home segment is workforce shortage. Nursing homes are unable to fill licensed beds primarily due to a lack of licensed and certified workforce. The workforce shortage issue is likely to persist statewide and nationally, suggesting that there will continue for the foreseeable future to be excess supply in nursing homes that could be utilized only if the workforce shortage is resolved.

The bed demand assessments suggest, however, there is a shortage of supply of beds for special needs populations, regardless of care setting, with high acuity and severe dementia/behavioral issues whether caused by dementia or mental health conditions and/or other cognitive related issues. Many of these persons are also lacking payment source and most of the persons with payment are on Medicaid. Data and qualitative assessments suggest that nursing homes are not accepting these resident referrals for several key reasons:

- Lack of workforce to provide the required care for these resident acuity and behavior issues.
- Not properly set up to provide the specific care the resident requires including equipment, physical plant configuration, and other.
- Lack of qualified workforce on staff (not specifically trained for the resident conditions and needs).
- Lack of payment/no payment source.
- Guardianship barriers.
- Lack of presumptive eligibility.

The Baker Tilly team conducted projections of current and future demand and supply of nursing home beds based on utilization trends and demographic shifts in each region of the state. The purpose of the assessment was to identify areas that are over/under-bedded currently, and which may be under or over bedded in 2030. Four scenarios were assessed with different assumptions as follows:

1. Utilization rates will decline consistent with the past five years, and supply will decline consistent with the past five-year rate of decline (five-year trend).
2. Utilization rates will stabilize, and supply will decline consistent with the past five-year rate of decline.
3. Utilization will stabilize (remain at current rates), and supply will not decline or increase from current supply.
4. Utilization rates will continue to decline consistent with the past five years and supply will not decline or increase from current supply.

The results of the scenarios suggest the highest risk of under supply of nursing beds in Scenario 2 above. If utilization remains stable at estimated 2022 use rates, and the supply continues to decline, there is an expected 7,300+ nursing bed shortage by 2030. However, it is important to note that the bed utilization methodology does not account for the delivery of services in alternative settings and several other factors, such as the future impact on utilization of the reimbursement increases in current budget.

The table below summarizes the projected nursing home bed demand model for each of the scenarios defined, based on the defined HERC regions with the data available. The 2030 projected bed need under scenario 1 & 2 is approximately 19,700 beds and for scenario 3 & 4, the projected supply is approximately 26,400. For each of the scenarios below, the utilization rate is assumed to decrease or remain stable, noted accordingly. See the table for each scenario's assumptions.

Bed Utilization Projections

HERC and Wisconsin Summary

2020 to 2030

	2022 Supply, Utilization and Bed Demand Estimates, based on Projected Utilization Rates			2022 Bed Excess/ (Under) Supply Projection	2030 Projected Bed Excess/(Under) Supply, by HERC [3]			
Region	2022 Supply [1]	2022 Projected NH Utilization Rate [2]	2022 Bed Demand [2]		Scenario 1	Scenario 2	Scenario 3	Scenario 4
					Utilization decreases and reduction of NH supply based on past downsizing trends.	Utilization remains stable (2022 rate), reduction in NH supply based on past downsizing trends.	Utilization remains stable (2022 rate) and no reduction in NH supply from 2022.	Utilization decreases and no reduction in supply from 2022.
Northwest	3,194	1.88	2,170	1,024	598	(490)	301	1,390
Western	1,477	2.20	1,219	258	177	(537)	(126)	587
North Central	2,574	1.99	2,031	543	(195)	(895)	(106)	595
South Central	5,382	1.86	3,929	1,453	1,326	(660)	72	2,058
Northeast	2,405	1.75	1,612	793	657	(406)	201	1,264
Southeastern	8,677	2.12	8,151	526	622	(4,197)	(2,106)	2,713
Fox Valley	2,745	1.12	1,162	1,583	994	159	1,136	1,971
Wisconsin	26,454	1.91	20,274	6,180	4,916	(7,353)	(688)	11,581

HERC regions: Healthcare Emergency Readiness Coalition. See map in report Appendix C.

[1] Nursing home licensed bed capacity and utilization data as of October 2022.

[2] 2022 utilization rate and 2022 bed demand projected by Baker Tilly.

[3] 2030 bed demand projections estimated by Baker Tilly.

Data sources: Division of Quality Assurance, MDS, CMS iQIES, October 2022; Department of Administration, Demographic Services Center

Projected Balance of Short-term and Long-term Residential Services

The nursing home bed demand for 2030 is projected to be just over 19,700 beds. Assuming 15% of the beds will be occupied by persons requiring a short-term rehabilitation stay, of this total, it is estimated that there will be a need for approximately 2,955 beds for short-term rehabilitation services (Medicare-certified) and the balance of the beds for long-term custodial care (no matter the resident acuity or condition and care level needs).

This assumes the payor mix (summarized below) remains stable regardless of the number of beds needed and that about 15% of all nursing home beds will be needed for Medicare covered rehabilitation services. Unforeseen and future changes to the Medicare program/regulations such as funding and eligibility criteria by CMS could impact the use of nursing homes for rehabilitation services and could decrease or increase the bed need for these services. Nationally, the median Medicare occupancy rate in 2021 was 10.3%.

See below for the trends in Medicare payor mix.

Trends in Percentage of Medicare Patient Days (as % of Total Days)
2015-2021

Year	Total Number of Providers	Total Licensed Beds	Total Occupancy	Total Medicare
2015	373	33,798	78%	14%
2016	365	32,414	78%	14%
2017	362	32,214	74%	14%
2018	351	30,577	75%	15%
2019	335	27,497	75%	16%
2020	325	26,832	71%	15%
2021	321	25,752	67%	Approx. 15%

Source: Wisconsin Medicaid Cost Reports, Wisconsin Department of Health Services

Planned Closures and Consolidations

Provider survey results regarding planned closures and consolidations were inclusive and specific data for each region of the state, by provider type, was not available.

The survey results for nursing homes only suggest that of the respondents 48.1% (n=50) plan to delicense beds in the next 12-24 months and 41.9% (n=44) plan to downsize capacity.

Conclusions about closures and/or consolidations for all nursing homes in the state cannot be drawn from this dataset; however, conclusions about the nursing homes that responded are as stated. However, anecdotally, on a national basis the consultants are in strategic discussions regarding the downsizing of nursing homes and delicensing of nursing homes for several reasons, including short-term financial sustainability, staffing pressures, and providing private room accommodations, among others.

Most of the nursing home respondents to the provider survey (57.7%, n=60) were not planning to decertify in the next 12-24 months. However, general conclusions about the industry in Wisconsin cannot be drawn from this data set because fewer 17% of the nursing homes responded to the question, and as the table below shows, only a fraction of the industry responded to the other questions asked about closures, certification, and transition of space.

Survey Results Nursing Home Respondents Only				
		Yes	Do not know	No
Planning to delicense beds		48.1%	43.2%	8.7%
	n=	50	45	9
Planning to downsize capacity		41.9%	47.7%	13.3%
	n=	44	47	14
Planning to decertify Medicaid or Medicare in next 12-24 months?		6.7%	35.6%	57.7%
	n=	7	37	60
Planning to delicense beds and transition space to alternative use in next 12-24 months		8.7%	43.3%	48.1%
	n=	9	45	50

Source: Provider Survey, 2022.
Note: Results for survey respondents only.

Assisted Living and Adult Family Home Bed Supply and Projected Demand

The assisted living (frail elderly and people with physical disabilities or intellectual disabilities) and memory care-specific bed supply will not meet the demand by consumers in the foreseeable future in each region of the state. This finding is true for persons with means and income to pay privately for these services (defined as households with more than $25,000 annual income) as well as for persons without means (potentially, Medicaid and Family Care eligible persons).

- ALF beds will have the highest future needs in the southeast, south central, northwest and north central regions for private pay.
- The southeast, northwest and north central will have the highest needs for low income/Medicaid ALF beds.
- Deficit for memory care beds is the greatest in the southeast and south central for private pay.
- Deficit for memory care beds is the greatest in the southeast, northwest and north central for low income/Medicaid.
- The AFH projections suggest the potential need for further development of these options throughout the state.

To assess demand, current supply and population and income estimates for 2022 and 2027 were assessed, as well as percentages of the populations estimated to have impairments in Activities of Daily Living (ADLs), cognitive impairments due to Alzheimer's/dementia. Additional considerations such as percentage of persons living alone were factored into the models to estimate need for assisted living beds.

The following tables summarize the 2022 assisted living facilities and beds/units by HERC (at 100% of licensed capacity, not operating capacity). Further, the assisted living supply estimates for 2022 are summarized for the total (all provider types) and for memory care specific assisted living providers (at 100% licensed capacity). In addition, for purposes of assessing demand and excess or deficit supply by 2027, the demand model assumes an operating occupancy rate of 90% (10% vacancy rate). Therefore, in the demand model summary on the next page, the totals included in the demand model do not add up to 100% of the licensed capacity. This is not an error and is the standard practice in demand modeling for assisted living for elderly (65+ populations).

Assisted Living Supply
For 2022

	Wisconsin	
	Facilities	Beds/Units
Adult Family Homes	2,042	7,890
Community Based Residential Facilities	1,605	34,439
Residential Care Apartment Complexes	355	16,910
Total	4,002	59,239

Source: Department of Health Services, Directories of Assisted Living Facilities
*AFH listed are for 3-4 bed only. 1-2 bed AFHs are regulated by each county's Human Services department.
Note: 100% of licensed capacity shown.

Assisted Living Supply, by Provider Type
For 2022

	Facilities	Beds/Units	Facilities	Beds/Units	Facilities	Beds/Units	Facilities	Beds/Units
	Fox Valley		North Central		Northeast		Northwest	
AL AFH	97	375	117	463	103	406	252	990
AL CBRF	183	4,050	138	2,480	139	2,989	159	3,078
AL RCAC	31	1,646	31	1,202	25	1,234	39	1,245
Total	311	6,071	286	4,145	267	4,629	450	5,313
	South Central		Southeast		Western		Wisconsin Totals	
AL AFH	286	1,106	1,082	4,132	105	418	2,042	7,890
AL CBRF	332	6,712	587	13,826	67	1,304	1,605	34,439
AL RCAC	71	3,621	125	6,839	33	1,123	355	16,910
Total	689	11,439	1,794	24,797	205	2,845	4,002	59,239

Source: Department of Health Services, Directories of Assisted Living Facilities
Note: 100% of licensed capacity shown.

The deficits identified by the demand model, by HERC, are summarized in the table below, for elderly (65+) assisted living and segmented for memory-care specific beds and estimated for 2027. Estimates for under 65 follow this analysis. The estimates are based on future demographic trends of the target populations (as described in the opening statement above), current supply (summarized above) and by applying a Baker Tilly methodology to determine potential demand. See Appendix O for the demand tables for the elderly, 65+ assisted living demand assessment.

The deficits estimated in the table below represent the potential assisted living and memory care supply in excess of current supply for each HERC assuming no further development occurs for the period and assuming an occupancy rate of 90% (10% vacancy rate), which is standard in the industry. No facility operates 100% occupied 100% of the time. It is a standard practice to include a vacancy rate in the demand models when assessing deficit of beds or excess supply of beds in a geographic area.

The 2022 estimates in the table are provided for context. Projected supply excess and or (deficit) for 2027 indicates the number of beds that are needed in excess of the current supply (shown in negative numbers, to indicate deficit of beds if not developed by 2027). If the assisted living industry does not increase supply by at least the deficit number of beds, there will be an under supply of assisted living in these areas. See Appendix O for the demand models by HERC.

Assisted Living Demand Estimates for Elderly 65+ Populations
Total Bed Need, Existing Supply and Projected Supply Excess or Deficit
For 2022 and 2027

	Total Bed Demand, for Elderly 65+				Existing Supply of Beds Included in the Model [3]		Projected Supply Excess and/or (Deficit), for 2027			
HERC Region	Private Pay [1]		Lower Income & Medicaid [2]		Private Pay [1]	Lower Income & Medicaid [2]	Private Pay [1]		Lower Income & Medicaid [2]	
	2022	2027	2022	2027	2022	2022	2022	2027	2022	2027
Assisted Living (non-Memory Care) Totals										
Fox Valley	2,926	3,304	964	910	3,051	686	125	(253)	(278)	(224)
North Central	2,427	2,774	855	810	2,085	481	(342)	(689)	(374)	(329)
Northeast	2,447	2,807	807	763	2,269	496	(178)	(538)	(311)	(267)
Western	1,454	1,674	497	477	1,404	280	(50)	(270)	(217)	(197)
Southeast	11,492	13,140	3,460	3,190	11,360	2,538	(132)	(1,780)	(922)	(652)
South Central	6,218	7,139	1,641	1,549	6,147	1,282	(71)	(992)	(359)	(267)
Northwest	2,796	3,276	953	925	2,526	575	(270)	(750)	(378)	(350)
Sub-totals	29,760	34,114	9,177	8,624	28,843	6,336	(917)	(5,271)	(2,841)	(2,288)
Memory Care Assisted Living Totals										
Fox Valley	958	1,070	549	499	947	238	(11)	(123)	(311)	(261)
North Central	783	883	499	455	619	156	(164)	(264)	(343)	(299)
Northeast	763	868	462	420	628	156	(135)	(240)	(306)	(264)
Western	427	492	288	267	335	84	(92)	(157)	(204)	(183)
Southeast	3,711	4,182	1,961	1,716	3,336	843	(375)	(846)	(1,118)	(873)
South Central	1,977	2,242	912	826	1,802	454	(175)	(440)	(458)	(372)
Northwest	923	1,058	556	518	796	200	(127)	(262)	(356)	(318)
Sub-totals	9,542	10,795	5,227	4,701	8,464	2,131	(1,078)	(2,331)	(3,096)	(2,570)
Totals	39,302	44,909	14,404	13,325	37,306	8,467	(1,996)	(7,603)	(5,937)	(4,858)

Source: ESRI, Baker Tilly proprietary demand models

[1] Private pay defined as households with more than $25,000 annual household income for non-memory care assisted living and $50,000 annual income for memory care assisted living.

[2] Lower income & Medicaid income defined as households with less than $25,000 annual household income.

[3] The demand model assumes that occupancy capacity reflects a 10% vacancy rate. Actual licensed capacity is higher than these totals, as a result. Only 5% of the AFH bed capacity is included in this demand model. See the next section for the AFH demand assessment.

The projected market penetration in the table below is the percentage of the available AFH supply occupied by persons from the target population in each HERC. The lower the penetration, the more supply that could be developed to meet the potential demand in each area. Below 5% suggests there is significant room for additional supply development to meet the potential demand by the target population, which in this case is the under 65 adult populations.

The statewide market penetration rate for AFHs is 4.2%. This benchmark finding is quite low suggesting possible room for additional capacity in the AFH bed supply. Using this benchmark, the northeast, Fox Valley, and South-Central regions may be lacking supply (significantly below the statewide benchmark) to meet the needs of this population. However, all the HERC areas have low penetration rates based on the assumption of a "high" penetration rate benchmark of 20%. The penetration rate is an indicator of how many beds a market can absorb. In this case, the market supply is absorbing only 4.2% of the potential available market or eligible lives/population. The lower the benchmark, the greater the potential for absorption of additional supply.

Adult Family Home Market Penetration Rates (Demand Table)

2027 Projections	Wisconsin	Northwest	North Central	Northeast	Fox Valley Area	Southeast	South Central	Western
Age Eligible Population Estimates								
Population aged 20-64 (Age-eligible) (a)	3,336,186	331,752	253,605	274,173	315,604	1,274,638	733,833	152,581
Assumed percentage of individuals requiring assistance* (b)	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%
Estimated age-eligible individuals (a)*(b)	110,094	10,948	8,369	9,048	10,415	42,063	24,216	5,035
Estimated Market Penetration								
Total AFH supply for individuals with a developmental disability	7,639	962	451	402	367	3,995	1,056	406
Assumption: 75% AFH serve adults aged 20-64 (c)	5,729	722	338	302	275	2,996	792	305
Assumption: AFH operate at 90% occupancy, 95% filled by people within region (c)	4,898	617	289	258	235	2562	677	261
Total age-eligible individuals (d)	115,823	11,670	8,707	9,350	10,690	45,059	25,008	5,340
Market Penetration Rate (c)/(d)	4.2%	5.3%	3.3%	2.8%	2.2%	5.7%	2.7%	4.9%

Source: ESRI®, Wisconsin Department of Health Services, US Census Bureau American Community Survey, 2017-2021 estimates, Baker Tilly proprietary demand models.
*Reflects statewide average of the proportion of individuals aged 18-64 with cognitive (4.4%), ambulatory (3.8%), self-care (1.7%), and/or independent living (3.4%) disability.

Home and Community-Based Services Projected Eligible Lives

The assessment above estimated the need and numbers of beds to meet the potential demand. The below tables represent the number or individuals projected to be eligible for Home Health and Hospice services. The tables reflect national, state and HERC trends, informed by CDC data and Wisconsin provider reporting. As noted, CDC does provide projections for 2030; however, the methodology may differ from that used by ESRI (other census data) provided herein. Home Health and Hospice modeling leveraged Wisconsin utilization data extrapolated from MDS, Cost Report and Department of Health Survey results. Data source for each of these tables is the CDC.

2030 National Census Projection	US TOTAL: 359,402,194
2030 Projected Eligible Lives:	Number of people
Home Health	5,409,326
Hospice	1,699,893

Wisconsin Projections by Year - Total Population	2025	2030
Projected Total Population	6,203,850	6,375,910
Projected Eligible Lives:		
Home Health	101,743	104,565
Hospice	55,835	57,383

Wisconsin Projections by Year - Population 65+	2025	2030
Projected Population Aged 65+	1,257,515	1,424,320
Projected Eligible Lives:		
Home Health	69,163	78,338
Hospice	30,060	34,047

The following tables summarize the utilization projections for 2025 to 2030 for each HERC.

Projections by Year - Total Population	2025	2030
Projected Total Population Fox Valley HERC	594,600	615,215
Projected Eligible Lives:		
Home Health	9,751	10,090
Hospice	5,351	5,537

Projections by Year - Population 65+	2025	2030
Projected Population Aged 65+ Fox Valley HERC	123,595	143,125
Projected Eligible Lives:		
Home Health	6,798	7,872
Hospice	2,954	3,421

Projections by Year - Total Population	2025	2030
Projected Total Population North Central HERC	499,315	508,280
Projected Eligible Lives:		
Home Health	8,189	8,336
Hospice	4,494	4,575

Projections by Year - Population 65+	2025	2030
Projected Population Aged 65+ North Central HERC	119,930	134,760
Projected Eligible Lives:		
Home Health	6,596	7,412
Hospice	2,867	3,221

Projections by Year - Total Population	2025	2030
Projected Total Population Northeast HERC	507,870	524,780
Projected Eligible Lives:		
Home Health	8,329	8,606
Hospice	4,571	4,723

Projections by Year - Population 65+	2025	2030
Projected Population Aged 65+ Northeast HERC	110,275	126,160
Projected Eligible Lives:		
Home Health	6,065	6,939
Hospice	2,636	3,016

Projections by Year - Total Population	2025	2030
Projected Total Population Northwest HERC	624,100	641,725
Projected Eligible Lives:		
Home Health	10,235	10,524
Hospice	5,617	5,776

Projections by Year - Population 65+	2025	2030
Projected Population Aged 65+ Northwest HERC	136,375	153,540
Projected Eligible Lives:		
Home Health	7,501	8,445
Hospice	3,260	3,670

Projections by Year – Total Population	2025	2030
Projected Total Population South Central HERC	1,280,165	1,323,530
Projected Eligible Lives:		
Home Health	20,995	21,706
Hospice	11,521	11,912

Projections by Year - Population 65+	2025	2030
Projected Population Aged 65+ South Central HERC	251,260	285,610
Projected Eligible Lives:		
Home Health	13,819	15,709
Hospice	6,006	6,827

Projections by Year - Total Population	2025	2030
Projected Total Population Southeast HERC	2,402,540	2,459,100
Projected Eligible Lives:		
Home Health	39,402	40,329
Hospice	21,623	22,132

Projections by Year - Population 65+	2025	2030
Projected Population Aged 65+ Southeast HERC	450,880	508,280
Projected Eligible Lives:		
Home Health	24,798	27,955
Hospice	10,778	12,150

Projections by Year - Total Population	2025	2030
Projected Total Population Western HERC	295,260	303,280
Projected Eligible Lives:		
Home Health	4,842	4,974
Hospice	2,657	2,730

Projections by Year - Population 65+	2025	2030
Projected Population Aged 65+ Western HERC	65,200	72,845
Projected Eligible Lives:		
Home Health	3,586	4,006
Hospice	1,559	1,741

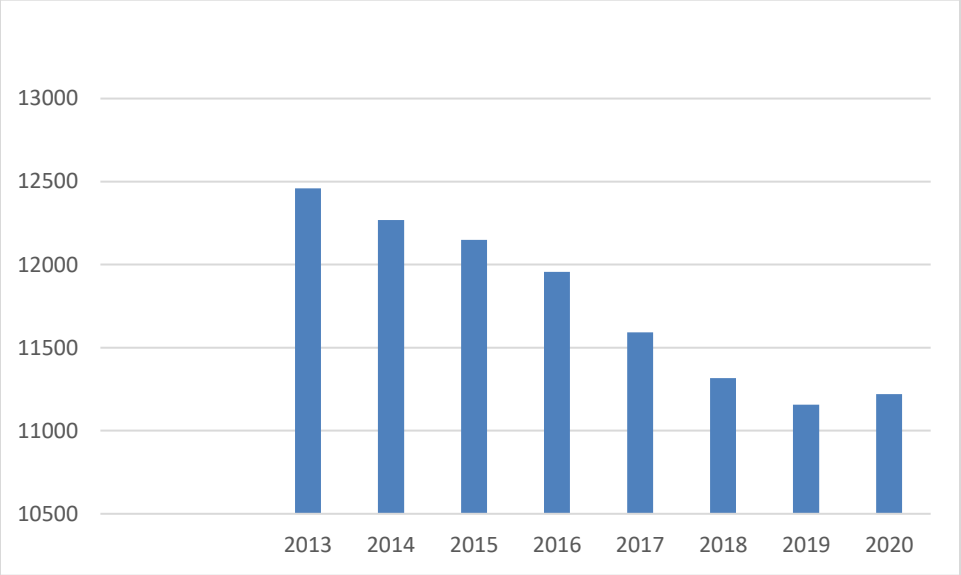
Home Health Projections

HCBS are being utilized in increasing numbers across the state and nationally; however, our provider surveys of the top 10 health systems in the state have defined availability as a concern for patient discharges. As discussed previously, this includes placement in facility-based locations in addition to HCBS.

An estimated 70% of seniors turning age 65 will require LTC services during their lifetime, and they will receive care for an average of 3 years. Given that the stated preference among those aged 65+ and those aged 40+ years is to receive services in a personal home (theirs or a caregivers), it is critical to understand the needs and capacity for the home and community-based provider types.

As identified by the Retrospective Analysis on page 32, the utilization of home health services has seen a steady increase on a state, regional and national level. Additionally, the number of those receiving services continues to increase due to consumer preferences and deliberate direction of referrals to HCBS. Wisconsin's Home Health utilization across all payors is currently trending at 1.64% of the total population, but that metric alone will not assist DHS in anticipating future home health needs. As the population of seniors is set to reach or exceed 20% in every HERC by 2030, and as the number of Medicare Certified Home Health providers continues to decline ensuring provider capacity and patient access is vitally important. Nationally, there has been about a 10% decrease in the number of Medicare certified Home Health Agencies since 2013.

Number of Medicare Certified Home Health Agencies in the U.S. 2013-2020



Source: data.cms.gov February 2022

Medicare recipient utilization of home health is much higher than the total population, at 5.5%. As of February 2023, 133 licensed Home Health Agencies serve Wisconsin residents, and as of today, as identified in the Retrospective Analysis, there are already gaps in geographical availability for this type of care (Appendix F). As the population expands and needs increase, assuming that the consumer preference is consistent with the identified trends, the state does not have enough provider capacity in the majority of 5 HERCs. The South Central and Southeast HERCs are positioned to meet demand, assuming staffing levels can be maintained in the appropriate ratios for care. Unlike facility-based care, field-based providers can expand to serve as many lives for which they have staffing and license. Caseloads are built on visits, not necessarily a specific patient total, and vary based on acuity and diagnosis mix. According to the National Healthcare at Home Best Practices and Future Insight Study, an FTE should make an average of 5.5 visits per day, or 27.5 visits per week. Additional factors, like type of visit, mileage driven and other requirements, like staff supervision, can impact on this number.

Leveraging the Wisconsin data and the projected eligible lives for the state, Home Health providers will need to perform an estimated 2,797,114 visits in 2030; 2,095,542 of those will be for patients over the age of 65. There is not a patient to license metric, nor is there a fixed ratio of nursing to therapy services, therefore, a specific number of providers cannot be indicated. However, the counties with minimal numbers of providers, especially those with 4 or fewer providers, present the greatest opportunity to increase the number and/or capacity of the home health providers. Prioritizing Home Health Agency applications for these counties is a measure that can help ensure that patient choice and access are maintained. Staffing concerns and strategies are addressed in the Workforce segment further in this section.

HERC Regions	Projected 2030 Age 65+ Census	Projected 2030 65+ HHA Utilization
Fox Valley Area	143,125	7,872
Northeast	126,160	6,939
Northwest	153,540	8,445
Western	72,845	4,006
Southeast	508,280	27,955
South Central	285,610	15,709
North Central	134,760	7,412
Wisconsin	1,424,320	78,338
United States	73,138,000	4,022,590

Source: CDC and Baker Tilly methodology.

Hospice Projections

As established in the Retrospective Analysis, Wisconsin is one of the nation's leaders in the percentage of Medicare-eligible recipients who leverage hospice services at end of life. However, hospice service availability is not currently equitable across all HERCs, and, as in home health, Wisconsin is not positioned to meet demand for services as the baby boomer generation ages further into long-term care services.

Two significant factors are impacting the anticipated deficit in hospice providers: the volume of the population as compared to the mortality rate, and the misalignment between the leading primary hospice diagnosis and the leading causes of death in the United States. According to the CDC, the current life expectancy in the US is 76.4 years, and the current mortality rate is 4.37% for this population. Projecting this against Wisconsin's current Hospice Utilization rate of 54.7%, the state can anticipate approximately 34,047 residents over the age of 65 receiving hospice services annually by 2030. This does not account for recipients under the age of 65 who may also require services. The other notable area is a disparity between primary hospice diagnosis (Alzheimer's Dementia) versus the top two leading causes of death (Heart Disease and Cancers for multiple consecutive years) raises the concerns about the depth of capacity and strain on professional trams as the increases in the number of dementia patients and the comorbid acuities overlap in end-of-life care.

As there are already multiple noted areas that are underserved across the state, it is imperative that provider capacity be improved to properly meet the end of life needs and expectations of Wisconsin's terminally ill and their families.

HERC Regions	Projected 2030 Age 65+ Census	Projected 2030 65+ Hospice Utilization
Fox Valley Area	143,125	3,421
Northeast	126,160	3.016
Northwest	153,540	3,670
Western	72,845	1,741
Southeast	508,280	12,150
South Central	285,610	6,827
North Central	134,760	3,221
Wisconsin	1,424,320	34,047
United States	73,138,000	1,699,893

Source: CDC and Baker Tilly methodology.

Personal Care Projections

Approximately 34% of unpaid caregivers in the US are Baby Boomers (birth years 1946 – 1964). Their transition to becoming the recipients of care will impact the caregiving landscape in a similar manner to their departure from the formal workforce. This is in addition to Generation X (birth years 1965 – 1980), with approximately 10,000,000 fewer members, not having the capacity to provide the same percentage of unpaid care.

Most Americans (88%) want to stay in their own home or the home of a loved one in the event they need ongoing living assistance as they age. Receiving care at their own home is the preferred option for 76%, and 11% would prefer a friend or family member's home. Just 10% would prefer a senior community, and 2% a nursing home. This remains unchanged from previous years. In 2020, 89% preferred to receive care at home or with friends or family. In a 2016 survey of Americans aged 40 and older, 81% said the same.

Approximately 70% of Americans aged 65 or older will require at least 2 years of supportive services in the home towards the end of their life. (LTC.gov https://acl.gov/ltc/basic-needs/how-much-care-will-you-need). Considering that the average life expectancy in the US is 76.4 years, it is difficult to predict precisely when these services will be leveraged. Americans use an average of 24 hours of personal care per week (AARP National Caregivers Study). Although specific "beds" or exact number of "people" cannot be estimated for personal care service, the number of hours can be approximated based on current market trends and projected demographics. If 70% of residents turning 65 in 2030 all needed caregiver services at the same time, Wisconsin will need approximately 1,244, 285,952 hours of personal care per year assuming financial resources are available to pay for the requested services. This number is based on WI DHS projection of 1,424,320 residents over the age of 65 by 2030. Seventy (70) percent equals 997,024 residents 65+, needing 24 hours of personal care per week. More realistically, those seniors who struggle with one of the functional domains (vision, hearing, ambulation, cognition, mobility, self-care) will leverage caregiver support. In 2020, 18% of adults aged 65 or older identified that they cannot function of need support with at least one functional domain. (2021 Profile of Older Americans, ACL 2022). This translates to 256,378 Wisconsin residents potentially needing 319,909,824 hours of personal care by 2030.

Other Factors and Considerations

Influencers of Financial Stability of LTC Providers

Long-term care services play a significant role in the delivery of services for our elderly and other vulnerable populations that require care and services. The recent years have accelerated several headwinds that have negatively impacted the financial stability of long-term care services (i.e., workforce issues at multiple department levels, increased wages, inflationary costs, supply constraints, declining third party reimbursement, decisions regarding institutional versus home based services), in addition to the more recent public perception of long-term care services resulting from the pandemic. The providers that have successfully navigated the headwinds have generally benefited from the following traits or characteristics (not intended to be all-inclusive):

- Geographically accessible to the workforce.
- Culture and competitive salary and benefits to attract and retain staff in the highly competitive market.
- Multiple levels of service to diversify the risks associated with long-term care services; for example, continuing care retirement communities that offer retirement living, assisted living, memory support and nursing services that benefit from a private payor, or providers offering housing options in addition to long-term care services.
- Innovative leadership teams that have actively solicited partners or alternative delivery models to meet the consumer's health needs.
- Proactive operators that have adjusted the delivery models to accommodate the higher cost of services while maintaining quality outcomes. This might have included managing the referral relationships to ensure a quality payor mix.
- Organizations that have developed an infrastructure with strong governance and leadership, timely reporting, and appropriate controls to allow for timely and innovative solutions as challenges are identified.
- Organizations that have maintained a healthy balance sheet reserves to weather the current challenges.

Across the country, providers are encountering the same issues. While there is an expectation for increased needs as the population ages over the next 10-20 years, there are still many risks that must be addressed and reconciled in today's health care environment. A provider's response to these risks will depend on resiliency and/organizational strength. Risk factors, many of which have already been addressed with this report, include:

- Governmental funding for health care services – CMS and State governments have continued to assess funding requirements for Medicare and Medicaid qualifying services. This will continue to put pressure on those providers that are not able to manage the payor mix for services.
- Population wealth – the number of aging elders is expected to have less average wealth than the elders today. This will continue to put pressure on the Medicaid system for payment.

- Regulatory pressures – increased scrutiny of health care providers will require continued investment in training and education to ensure compliance and alignment with quality expectations. In addition, there is the potential for increased regulation in alternative service levels (e.g., assisted living, CBRF) as service providers expand the care into less regulated environments.
- Workforce – The workforce issue is not expected to be resolved within the next 36 months. This will present continued pressure for providers to remain competitive with wages and benefits not only against their peers, but with other industries as well. Further, there are studies that over the long-term there will be a dramatic shortage of caregivers to elders based solely on the population trends.
- Consumer preferences – Consumer expectations for services and location of services are expected to favor home-based settings. This will continue to put pressure on providers that will need to accommodate a frailer elderly person that may have spent down most of their resources while accommodating health preferences at home.
- Behavioral issues – Absent safe and affordable housing and services for those with behavioral health issues (and those most likely to not have an alternative payor source), provider groups – both health systems and nursing homes – will become the primary solution for providing services. This will create continued pressure to safely integrate populations with varying health needs and still maintaining currently defined quality outcomes.

Demographic and Consumer Preference Shifts

Demographic and consumer shifts have been and will be a significant factor affecting the demand for LTC services in Wisconsin. There has already been a significant shift in consumer definition of “retirement community” which began decades ago. We anticipate that the consumer preferences for how they receive care, whether for retirement or long-term maintenance will dictate how services are delivered in the foreseeable future.

Consumers demand a choice in how services are delivered and in what setting they receive services, which to a large extent determines whether they use a nursing home, assisted living, or at home care for long-term care services. Studies also show that the influence of adult children plays a role in consumer choice. As adult children encounter their own challenges in response to the economy, homeownership or other job situations, for example, they may influence decisions regarding available resources for aging services. For certain, consumers with resources will chose settings such as assisted living for services for their chronic, long-term conditions and for assistance with activities of daily living and for memory loss services.

These preference shifts have already impacted the nursing home and assisted living industries, driving down the demand for nursing home beds and settings and increasing the demand for at home services or homelike settings such as assisted living and even independent living settings with services. Memory care service delivery has also been impacted, shifting from the nursing home settings and others to assisted living memory care units. The demand for these alternatives to nursing homes will likely increase as baby boomers begin turning 80 and older, and the need for settings such as assisted living and more home care providers will increase in Wisconsin.

Shift in Service Delivery

Awareness has increased across the healthcare spectrum that the traditional methods of care will not be sustainable for the aging of the Baby Boom generation. Siloed approaches to patient data, services and payment create barriers to effectively managing the needs of an aging population. Collaboration between provider communities and collaboration between payors and providers will be critical to meet challenges facing the industry.

Historically, the public sector has led the way to shifts in care through regulation and funding of services. While public direction is and will remain a force in innovation, the private sector needs to become an equal partner in driving change. This is happening in pockets on a national basis driven by geographic needs or directed by leaders in the payor and provider sectors.

There is a wide variety of approaches which are being applied actively and through pilots to meet the changing dynamics of LTC services. While it is challenging to describe every attempt, they generally fall into three main categories:

- Provider Long-Term Care Integration
- Payor/Provider Collaborations
- Publicly Funded Innovation

Provider LTC Integration

The approach of integrating levels of care has been growing as a practice for the last decade in the United States. It is defined as a multi-disciplinary team of care givers working collaboratively to meet the entire spectrum of patient needs. This is especially challenging and important in long-term care where many aspects of a patient's outcome fall outside of traditional scope of clinical professionals. Issues such as a safe home environment, food security, transportation, family care, have tremendous impact on patient outcomes but have not historically been managed or coordinated by a clinical care team.

Providers, especially health systems, are increasingly aware and sophisticated in the ability to measure and quantify these factors in measuring clinical and financial outcomes. In response, the creation of Accountable Care Organizations (ACOs), preferred provider networks, care coordination departments and other practices have evolved. These practices break down the barriers that exist between disciplines, practices, and provider groups to view and manage patients as a whole.

The next step in provider evolution varies widely across spectrum of healthcare and requires building interconnected solutions that span the continuum of care to include patient access, care, management, and outcomes. This is a much more challenging step as the economic needs and targeted outcomes are quite different among the provider community. It is challenging enough when clinically similar entities such as health systems and long-term care facilities build partnerships. However, adding organizations such as emergent and non-emergent transportation providers, personal care providers, and mental health providers, adds partners who operate on a fundamentally different economic and outcome basis.

Solving these challenges will require a fundamental shift in how health care providers approach partnerships and the creation of new models. The current and future leadership of the provider community must broaden the mindset of 'best for the health of my organization' to 'best for the health of my ecosystem' and build programs which mutually benefit the entire partner community. This shift is challenging, and constantly evolving, especially as the economics of healthcare continuously shift.

Some examples of provider long-term care integration include:

- Encompass Health
  - Encompass Health in a Rehabilitative and Hospice organization integrated across the healthcare continuum.

- Johns Hopkins ElderPlus
  - Hopkins ElderPlus is a voluntary health program designed to provide and coordinate all needed preventive, primary, acute, and long-term care services so that older individuals can continue living in the community.

- Intermountain at Home
  - Intermountain Health is an integrated, non-profit health system based in Salt Lake City, with clinics, a medical group, affiliate networks, hospitals, homecare, telehealth, health insurance plans, and other services.

Payor/Provider Collaborations

Including the payor sector of healthcare in driving long-term care innovation is critical to solving industry challenges. Regardless of whether the funding source being public or private, the collection and analysis of data in the payor environment is different than the way providers have traditionally collected and used information. In addition, the provider community typically views patients from the perspective of a patient's episode of care, while the payor community has a much longer and broader term view of patient populations at a macro level.

The combination of the viewpoints offers an extremely powerful approach to migrate managing a patient's episode of care to a patient's lifecycle of care. By partnering to create payment models to match long-term outcomes these two sectors of healthcare can develop programs which cross traditional provider boundaries. By measuring the impact of areas such as social determinants of health, transportation, food security, personal care, etc., these partnerships can create integrated outcomes which enhance clinical outcomes while creating financial sustainability.

Some examples of these programs include:

- UnitedHealth Optum
  - UnitedHealth Optum is a health care and well-being company made up of a diverse team around the world dedicated to making health care work better through two distinct and complementary businesses: Optum and UnitedHealthcare.
  - UnitedHealth is one of the largest health care insurance companies in the United States. Optum Health provides care directly through local medical groups and ambulatory care systems, including primary, specialty, urgent and surgical care to 102 million consumers. This business also provides products and services that engage people in their health and help manage chronic, complex, and behavioral health needs. Customers include employers, health systems, government, and health plans.
  - By combining the two entities the organization is able to develop an integrated ecosystem which allows the development, piloting and implementation of programs which are financially sustainable over time while improving patient care and satisfaction.
- Highmark
  - Highmark is a blended health organization. The businesses include the Highmark Health Plan, one of America's largest Blue Cross Blue Shield insurers; a growing regional hospital and physician network; and leading companies that offer dental solutions, reinsurance solutions, population health management, and innovative, technology solutions.
  - Highmark is another organization that has created horizontal and vertical integration across the healthcare sectors to manage their members and patients across the continuum of coverage and care.
- CBC Landmark Partnership
  - Capital Blue Cross and Landmark Health have created a partnership which allows CBC plan members to access 24/7 in home services. This partnership allows CBC to manage patient care proactively in a home-based setting creating access to care in a manner which provides financial value to the health plan.

Publicly Funded Innovation

The role of public funding for new models of care will continue to play a critical role for the future of long-term care. Many aspects of long-term care rely on organizations who do not have the resources to fund the pilot programs which are necessary to evolve the long-term care community. By providing avenues to fund these programs federal and state entities are creating an arena to gather and share data across the healthcare ecosystem.

While the Center for Medicare & Medicaid Innovation will be a central force in the foreseeable future, state directed innovation should be an equal partner in these efforts. The number of unique regional challenges equals the national challenges facing long-term care. Structured environments which require data collection, sharing, and measurement are necessary to ensure that public money is funding the strongest outcomes for the community.

Wisconsin Examples of Partnerships to Meet LTC Needs

Some providers in Wisconsin have taken the initiative to try new solutions to meet the challenges in serving the LTC population.

Luther Manor / Froedtert

One such relationship, as created between Luther Manor and Froedtert, is designed to help facilitate some of the barrier-type discharges from the hospital to a LTC nursing bed under a contract arrangement. The program is designed to be a scalable, care-focused solution that values the strengths and business realities of each organization.

The organizations came together during the midst of the COVID-19 pandemic to develop a solution that would allow the Froedtert health system to safely discharge patients in order to relieve over-capacity. Luther Manor had the capability to manage the patients, however there were financial and staffing barriers which prevented their team from accepting the number of patients Froedtert needed to discharge.

The organizations built a ‘bed hold’ partnership in which Froedtert paid to reserve a certain number of beds in the Luther Manor facility for their patients each month. This additional income allowed Luther Manor to staff and service these additional patients safely in an economically viable way. In addition to financial concerns the teams developed a ‘playbook’ which outlined the program, the patients, and a check list for both parties in order to make the program operationally sound. Key portions of this program included strong clinical leadership for Luther Manor, and patient clinical transparency on behalf of Froedtert.

There were many clinical and operational lessons learned during this partnership which provided strong foundations for the future. However, the program’s financial model needs to be studied further to create a sustainable revenue and cost structure which does not rely on the health system funding an initiative to reduce costs to the health system.

Northeastern Wisconsin Health System and Skilled Nursing Partner

This model was developed to address the workforce shortage in the LTC partner facility which was limiting admissions. The health system is supporting the hourly cost difference between full-time staff and travel agency nurses to meet the staffing demand. This has allowed the LTC provider to increase admissions while improving the working conditions for existing staff who were stretched to the breaking point. At the time of this report, we do not have enough financial data to determine the sustainability of this program.

Appendices

Appendix A: Data Sources

- Definitive Healthcare
- Demographics Services Center, Division of Intergovernmental Relations, Department of Administration, State of Wisconsin
- ESRI®
- The Centers for Medicare & Medicaid Services (CMS.gov) HCRIS cost report form data utilized: Hospital Cost Report (CMS-2552-10), Skilled Nursing Facility Cost Report (CMS-2540-10), Home Health Agency Cost Report (CMS-1728-94 and CMS-1728-20), Hospice Cost Report (CMS-1984-14).
- 2021 Profile of Older Americans Published by the Association for Community Living, November 2022 https://acl.gov/aging-and-disability-in-america/data-and-research/profile-older-americans
- LongTermCare.gov. https://acl.gov/ltc/basic-needs/how-much-care-will-you-need
- 2022 National Investment Center for Seniors Housing & Care Inc., NIC MAP© Data Service
- Wisconsin Department of Health Services, Division of Quality Assurance Provider Directory
- Wisconsin Department of Health Services, Community Based Residential Facility Directory
- Wisconsin Department of Health Services, Residential Care Apartment Complex Directory
- Wisconsin Department of Health Services, Nursing Home Directory
- Wisconsin Department of Health Services, Adult Family Home Directory
- Wisconsin Department of Health Services, Wisconsin Home Health Agency Cost Reports, 2017-2021
- Wisconsin Department of Health Services, Wisconsin Hospice Agency Cost Reports, 2017-2021
- Wisconsin Department of Health Services, Home Health Agency 1572A Records 2017- July 2021
- Wisconsin Department of Health Services, Hospice Agency 643 Records 2017- September 2022
- Centers for Disease Control and Prevention (CDC)
- United States Census Bureau
- Wisconsin Department of Health Services WISH Population by Gender
- National Hospice and Palliative Care Association Annual Report 2022
- National Hospice and Palliative Care Association Annual Report 2020
- National Hospice and Palliative Care Association Annual Report 2017
- National Alliance for Caregiving and AARP Public Policy Institute, Caregiving in the US 2020
- MedPac March 2022 Report to Congress
- Genworth Cost of Care Survey 2004-2021, Conducted by CareScout®
- National Healthcare at Home Best Practices and Future Insight Study 2021-2022, Conducted by Berry Dunn
- Home Health Chartbook 2021: Prepared by the Alliance for Home Health Quality and Innovation (AHHQI) https://www.nahc.org/resources-services/2021-home-health-chartbook/
- Home Health Proposed Rule CY 2023 https://www.federalregister.gov/d/2022-13376
- Administration for Community Living
- Wisconsin Department of Health Services Life Expectancy Tables

- Wisconsin Department of Health Services, MDS Data.csv, 10/13/2022
- Wisconsin Department of Health Services, Wisconsin Nursing Home Cost Reports, 2015-2022
- Wisconsin Department of Health Services, Deidentified Encounter Extract, 2018-2021
- Wisconsin Department of Health Services, IRIS Encounter Data, 2021
- Wisconsin Department of Health Services, IRIS Claims Data, 2021
- Wisconsin Division of Quality Assurance, Citations, 2017-2022
- Wisconsin Division of Quality Assurance, Nursing Home Occupancy and Utilization by County, 2017-2022

Appendix B: Provider Opinion Survey Results

Providers were surveyed in October and November 2022 to collect opinion and factual data in support of the assessments and analysis of LTC system in Wisconsin. The providers chose whether to participate in the survey. Survey questions were developed for each provider type and DHS reviewed and approved the questions and format of each survey distributed. DHS was responsible for sending the survey, via Survey Monkey, to each provider from the DHS, email distribution list. Baker Tilly does not have access to the demographics of the providers that were sent the survey and/or those that chose to participate. The provider-types that were given the opportunity to participate in the surveyed included:

- 1-2 bed Adult Family Home (1-2 bed AFH)
- 3-4 bed Adult Family Home (3-4 bed AFHs)
- Community Based Residential Facility (CBRF)
- Skilled Nursing Facility/Nursing Home (SNF)
- Residential Care Apartment Complex (RCAC)
- Hospital(s)
- Home Health Agency(s)
- Hospice(s)
- Personal Care Agency(s)

Results were collected in early December 2022 after several attempts made to increase participation and to capture as many providers as possible. In some cases, results are summarized by HERC if there were enough responses from the region. Survey results for the participants of the survey are attached below and reflect those findings by provider type and HERC, if possible.

Summary Findings

The next several pages summarize the findings of common questions asked on the surveys of each provider type. The full results of the 1-2 bed AFH, 3-4 bed AFH, CBRF, RCAC, and SNF surveys follow.

Demographics

Current Occupancy, 2022 Year to Date	
1-2 Bed AFH	90.4% (n=469)
3-4 Bed AFH	86.1% (n=319)
CBRF	88.6% (n=154)
RCAC	78.8% (n=36)

Ownership Type		
	Free Standing or Private Ownership	Part of a Corporate Chain
1-2 Bed AFH	95.0%	5.0%
3-4 Bed AFH	95.2%	4.8%
CBRF	86.7%	13.3%
RCAC	77.5%	22.5%
Nursing home	57.5%	42.5%

Which groups do you routinely serve?			
	1-2 Bed AFH	3-4 Bed AFH	CBRF
Developmentally disabled	90.6%	92.6%	NA
Mental health conditions	51.2%	63.3%	38.5%
Physically disabled	38.7%	52.6%	45.1%
Advanced aged/frail elderly	32.8%	58.3%	75.3%
Complex behavioral conditions	26.7%	35.2%	16.5%
Dementia/Alzheimer's/ memory loss	25.8%	51.6%	68.1%
Traumatic brain injury	21.6%	49.6%	22.5%
Alcohol and drug dependence/abuse	12.5%	18.4%	14.8%
Other	5.6%	6.2%	11.5%

Characteristics of campus			
	CBRF	RCAC	Nursing Home
Listed facility (e.g., CBRF, RCAC, nursing) only	83.1%	85.0%	83.9%
Memory care Community Based Residential Facility	29.0%	35.0%	18.3%
Community Based Residential Facility	100%	32.5%	32.9%
Residential Care Apartment Complex	14.8%	100%	28.5%
Senior housing/homes (market rate)	4.4%	20.0%	13.9%
Affordable housing	0.6%	7.5%	2.2%
Home health agency	1.1%	7.5%	6.6%
Personal care agency/non-certified home care program	4.4%	12.5%	5.1%
Nursing home	9.8%	32.5%	100%
Adult day center	3.3%	5.0%	5.15%
Other	8.7%	15.0%	8.8%

Initiatives

Percentage of respondents ranking initiatives as the most impactful to their organization "(1) most important" by Health Service Area					
	1-2 Bed AFH	3-4 Bed AFH	CBRF	RCAC	Nursing Home
Workforce initiatives to attract workers to the industry	43.7%	60.3%	80.7%	68.6%	87.4%
Initiatives to improve the living environment such as physical plant renovations, creating homelike environments, and other physical plant improvements for life enrichment of the residents and staff.	29.5%	14.1%	7.4%	11.8%	4.5%
Initiatives to establish strategic options (e.g., affiliations, partnerships, and bed use agreements) with healthcare providers	12.2%	7.6%	5.6%	0.0%	1.8%
Initiatives to help improve the image and reputation of the long-term care industry	9.4%	9.7%	5.0%	14.3%	5.4%
Initiatives to improve relationships between long-term care and referral sources such as hospitals, managed care organizations and others	8.3%	12.8%	4.3%	5.7%	1.8%

Referral Patterns

From where do your referrals originate?					
	1-2 Bed AFH	3-4 Bed AFH	CBRF	RCAC	Nursing Home
Managed care organization	71.8%	89.0%	73.1%	74.3%	56.6%
County agency	24.1%	32.2%	41.1%	17.1%	17.7%
Family of resident	23.8%	36.9%	64.5%	94.3%	69.0%
Other	15.3%	11.4%	22.0%	14.3%	8.9%
Existing residents	13.2%	18.4%	51.8%	85.7%	37.2%
Aging and disability resource center	9.7%	23.1%	42.6%	62.9%	25.7%
Home health agency serving the area	9.7%	9.4%	25.5%	45.7%	37.2%
Assisted living facility in the area	7.7%	12.2%	30.5%	40.0%	62.0%
Doctor of resident	7.1%	7.1%	24.8%	60.0%	44.3%
Local hospital	5.9%	18.4%	61.0%	54.3%	100.0%
Nursing homes	5.3%	13.7%	48.9%	71.4%	57.5%

Percentage of respondents who accept Medicaid-waiver referrals as direct admissions	
3-4 Bed AFH	86.3%
CBRF	64.3%
RCAC	50.0%

Why do you choose not to accept Medicaid-waiver direct admissions?

	3-4 Bed AFH	CBRF	RCAC
We are not contracted with a Medicaid-waiver/Managed Care Organization.	43.8% (n=21)	20.4% (n=10)	27.8% (n=5)
Other	29.2% (n=14)	22.5% (n=11)	16.7% (n=3)
Medicaid-waiver rates do not cover our costs.	27.1% (n=13)	53.1% (n=26)	50.0% (n=9)
We allow current tenants to transition to Medicaid-waiver.	6.3% (n=3)	42.9% (n=21)	33.3% (n=6)
Other financial considerations	NA	6.1% (n=3)	11.1% (n=2)

Percentage of respondents who are limiting Medicaid-waiver admissions due to financial constraints	
3-4 Bed AFH	20.3%
CBRF	43.3%
RCAC	60.0%

How long (on average) do your private pay residents pay privately before they transition to Medicaid-waiver?

	3-4 Bed AFH	CBRF	RCAC
Not relevant, do not contract with Medicaid-waiver/Medicaid-managed care organization	20.2%	4.7%	13.9%
Less than 1 year	24.0%	14.7%	2.8%
1-2 years	5.9%	20.9%	22.2%
3-4 years	5.5%	20.9%	30.6%
5-6 years	0.0%	5.4%	8.3%
7-9 years	0.0%	0.8%	8.3%
10 years or more	0.4%	0.8%	2.8%
Do not know/do not track	44.1%	31.8%	11.1%

What percentage of your occupied beds are private pay, Medicaid-waiver, or other residents?

	Less than 20%	20-79%	80% or more
3-4 Bed AFH			
Private Pay	91.0%	7.4%	1.6%
Medicaid-waiver	11.3%	12.6%	76.1%
Other	58.0%	15.0%	27.0%
CBRF			
Private Pay	42.1%	41.3%	16.5%
Medicaid-waiver	24.1%	42.9%	33.1%
Other	76.3%	6.8%	17.0%
RCAC			
Private Pay	8.8%	44.1%	47.1%
Medicaid-waiver	29.6%	63.0%	7.4%
Other	100.0%	0.0%	0.0%

Which areas are challenges to accepting Medicaid-waiver referrals?

	1-2 Bed AFH	3-4 Bed AFH	CBRF	RCAC	Nursing Home
Lack of open beds	46.5%	50.4%	40.8%	25.8%	26.0%
Referral is not appropriate for our setting	36.9%	45.8%	66.4%	64.5%	64.4%
Staffing shortages	28.0%	43.6%	32.0%	29.0%	68.3%
Behavioral health needs	24.5%	35.2%	57.6%	48.4%	67.3%
Payor authorization	22.7%	27.1%	30.4%	38.7%	17.3%
Resident condition at time of referral	18.4%	28.4%	40.0%	41.9%	35.6%
Urgency/timing of the referral	16.0%	17.4%	16.8%	22.6%	12.5%
Other	16.0%	11.4%	21.6%	45.2%	14.4%
Complexity of acuity	14.5%	17.0%	48.0%	41.9%	51.9%
Covid outbreaks	8.5%	3.05	8.8%	9.7%	20.2%
Distance of the referral from the facility/family	7.1%	5.1%	10.4%	6.5%	15.4%
Cost of treatment/medications	5.7%	6.8%	9.6%	22.6%	37.5%
Pharmacy coverage	3.6%	1.3%	0.8%	3.2%	3.9%

Labor Pool

Percentage of respondents who are experiencing challenges in their labor pool that impact their ability to take referrals	
1-2 Bed AFH	33.9%
3-4 Bed AFH	46.9%
CBRF	57.0%
RCAC	52.8%
Nursing Home	86.4%

Please identify other challenges in workforce

	1-2 Bed AFH	3-4 Bed AFH	CBRF	RCAC	Nursing Home
Competitive rates/wages	75.5%	88.1%	89.0%	88.6%	91.6%
Non-compensated benefits	35.7%	48.6%	36.8%	40.0%	30.8%
Retention	28.9%	48.2%	58.8%	60.0%	66.4%
Initial and ongoing training requirements	26.7%	32.3%	36.0%	20.0%	27.1%
Recruitment	25.3%	45.4%	61.0%	57.1%	75.7%
Labor pool experience level	21.3%	26.7%	48.5%	45.7%	43.9%
Staff attrition	17.7%	29.5%	40.4%	20.0%	47.7%
Other	16.6%	9.2%	8.1%	8.6%	13.1%
Geography/travel distance	14.1%	11.6%	18.4%	20.0%	23.4%

Please identify the challenges with attracting and retaining staff

	1-2 Bed AFH	3-4 Bed AFH	CBRF	RCAC	Nursing Home
Competitive rates/wages	70.3%	86.6%	83.0%	88.6%	83.2%
Staff availability	47.0%	61.0%	61.5%	68.6%	76.6%
Non-Compensated benefits	30.8%	46.8%	34.8%	37.1%	29.9%
Other	22.6%	8.5%	11.9%	8.6%	5.6%
Staff attrition	15.0%	15.9%	29.6%	22.9%	29.9%
Physical plant/environment	3.4%	2.9%	2.2%	2.9%	6.5%
Complex needs of the resident population (e.g., behavioral health, dementia, very high acuity)	NA	NA	43.7%	NA	38.3%
Corporate culture	NA	NA	3.0%	2.9%	13.1%

Percentage of respondents who participate in any collaborative initiatives to solve labor challenges	
1-2 Bed AFH	15.4% (n=47)
3-4 Bed AFH	22.9% (n=58)
CBRF	50.4% (n=68)
RCAC	52.8% (n=19)
Nursing Home	63.1% (n=67)

Percentage of respondents who needed to use agency/contracted staff to provide patient care in the past 12 months	
1-2 Bed AFH	7.5% (n=24)
3-4 Bed AFH	11.7% (n=30)
CBRF	38.5% (n=52)
RCAC	33.3% (n=12)
Nursing Home	88.0% (n=95)

Benefits offered to direct care staff

	1-2 Bed AFH	3-4 Bed AFH	CBRF	RCAC	Nursing Home
We do not/cannot offer benefits	67.6%	45.9%	NA	NA	NA
Training	29.1%	57.7%	88.6%	88.6%	82.9%
Flexible schedule	23.6%	47.4%	79.4%	88.6%	83.8%
Paid time off	20.4%	35.6%	90.8%	88.6%	99.1%
Bonus/reward system (incremental)	18.2%	44.3%	70.2%	68.6%	75.2%
Other	18.2%	11.1%	13.7%	14.35	10.5%
Retention bonus	12.7%	36.0%	38.9%	37.1%	51.4%
Sign on bonus	10.6%	19.4%	42.0%	62.9%	75.2%
Health insurance	10.2%	12.7%	59.5%	77.1%	99.1%
Opportunities for paid continued education	9.1%	24.9%	50.4%	45.7%	65.7%
Retirement plan	6.9%	14.2%	58.0%	71.4%	90.5%
Travel assistance (e.g., reduced bus pass)	5.5%	7.1%	9.2%	2.9%	2.9%
Workforce housing	4.0%	4.7%	2.3%	2.9%	1.9%
Childcare assistance	2.2%	6.3%	1.5%	2.9%	5.7%

Percentage of respondents who had open beds for admission from referral sources but had to limit admissions due to staffing limitations in the past year	
1-2 Bed AFH	20.3% (n=63)
3-4 Bed AFH	34.4% (n=86)
CBRF	38.9% (n=51)
RCAC	28.6% (n=10)
Nursing Home	86.5% (n=96)

Percentage of respondents who had open beds for Medicaid-waiver admission from referral sources but had to limit admissions due to staffing limitations in the past year	
CBRF	37.1% (n=49)
RCAC	22.9% (n=8)

Bed Capacity Needs/Future/Prospective

Anticipated Medicaid-waiver program participation in the next 12 months				
	1-2 Bed AFH	3-4 Bed AFH	CBRF	RCAC
Anticipate participating in the Medicaid-waiver program	48.0% (n=152)	75.0% (n=189)	75.6% (n=99)	60.0% (n=21)
Anticipate participating in the program and accepting/keeping residents on Medicaid-waiver in the facility for the next 5 years	NA	NA	67.2% (n=88)	42.9% (n=15)
Anticipate increasing Medicaid-waiver capacity (percent of admissions; percent of total beds)	11.2% (n=35)	26.3% (n=66)	22.1% (n=29)	8.9% (n=3)
Anticipate accepting Medicaid-waiver admissions directly at the facility	NA	NA	50.0% (n=64)	34.3% (n=12)
Anticipate accepting high acuity resident referrals on Medicaid-waiver	25.3% (n=72)	38.6% (n=93)	NA	28.8% (n=36)
Anticipate accepting referrals for residents with complex behaviors and are on Medicaid-waiver	29.8% (n=87)	43.2% (n=104)	NA	27.0% (n=34)

If the Department of Health Services increases Medicaid/Medicaid-waiver rates, what would you do with the money specifically?					
	1-2 Bed AFH	3-4 Bed AFH	CBRF	RCAC	Nursing Home
Increase wages for current staff	69.5%	93.8%	88.5%	89.7%	91.3%
Increase staff to resident ratio	21.0%	45.2%	47.5%	55.2%	49.5%
Save any excess funds	27.1%	14.1%	13.1%	6.9%	6.8%
Invest in physical plant/infrastructure	28.1%	38.2%	41.8%	58.6%	52.4%
Expand services (evaluate new services, add capacity, etc.)	33.9%	42.3%	31.2%	34.5%	19.4%
Accept more Medicaid-waiver referrals	22.4%	39.4%	50.0%	65.5%	47.6%
Accept higher acuity referrals from sources	17.0%	32.4%	26.2%	34.5%	33.0%
Other	13.9%	10.0%	8.2%	6.9%	7.8%
Reopen closed wings	NA	NA	9.8%	6.9%	27.2%

The results of the surveys of the 1-2 bed AFH, 3-4 bed AFH, CBRF, RCAC, and SNF providers are attached below.

1-2 Bed AFH Provider Survey Results

Demographics

Which Health Services Area(s) are you located in?		
Health Service Areas	**Percentage of Respondents**	**Respondents**
Area 1: Northwest (Douglas, Bayfield, Ashland, Burnett, Washburn, Sawyer, Polk, Barron, Rusk, Saint Croix, Dunn, Chippewa, Pierce, Pepin, Eau Claire Counties)	13.6%	78
Area 2: North Central (Iron, Vilas, Price, Oneida, Forest, Taylor, Lincoln, Langlade, Clark, Marathon, Wood, Portage Counties)	13.6%	78
Area 3: Northeast (Florence, Marinette, Oconto, Door, Kewaunee, Brown, Manitowoc Counties)	9.4%	54
Area 4: Fox Valley Area (Menominee, Shawano, Waupaca, Outagamie, Waushara, Winnebago, Calumet, Green Lake Counties)	7.1%	41
Area 5: Southeast (Fond du Lac, Sheboygan, Ozaukee, Washington, Milwaukee, Waukesha, Racine, Walworth, Kenosha Counties)	22.4%	129
Area 6: South Central (Juneau, Adams, Marquette, Richland, Sauk, Columbia, Dodge, Grant, Iowa, Dane, Jefferson, Lafayette, Green, Rock Counties)	20.2%	116
Area 7: Western (Buffalo, Trempealeau, Jackson, La Crosse, Monroe, Vernon, Crawford Counties)	15.7%	90
Total Respondents*	**583**	

*Respondents may serve more than one Health Service Area. Percentages do not equal 100%.

Current Occupancy, 2022 Year to Date	
Average statewide	90.4% (n=469)
Area 1: Northwest	85.2% (n=68)
Area 2: North Central	89.7% (n=63)
Area 3: Northeast	98.2% (n=51)
Area 4: Fox Valley Area	90.4% (n=33)
Area 5: Southeast	87.7% (n=90)
Area 6: South Central	93.8% (n=98)
Area 7: Western	89.3% (n=72)

Ownership Type		
	Free Standing or Private Ownership	Part of a Corporate Chain
Average statewide	95.0%	5.0%
Area 1: Northwest	97.4%	2.6%
Area 2: North Central	96.0%	4.0%
Area 3: Northeast	98.1%	1.9%
Area 4: Fox Valley Area	95.1%	4.9%
Area 5: Southeast	88.0%	12.0%
Area 6: South Central	97.4%	2.6%
Area 7: Western	96.5%	3.5%

Which groups do you routinely serve?								
	Statewide	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7
Developmentally disabled	90.6%	92.3%	92.1%	94.4%	97.6%	92.2%	91.3%	80.7%
Mental health conditions	51.2%	48.7%	46.1%	51.9%	53.7%	57.0%	47.8%	53.4%
Physically disabled	38.7%	35.9%	39.5%	35.2%	24.4%	43.0%	45.2%	31.8%
Advanced aged/frail elderly	32.8%	26.9%	38.2%	11.1%	14.6%	38.3%	45.2%	29.6%
Complex behavioral conditions	26.7%	23.1%	26.3%	27.8%	19.5%	38.3%	23.5%	23.9%
Dementia/Alzheimer's/ memory loss	25.8%	20.5%	27.6%	14.8%	9.8%	28.9%	37.4%	22.7%
Traumatic brain injury	21.6%	18.0%	19.7%	13.0%	22.0%	25.0%	27.8%	19.3%
Alcohol and drug dependence/abuse	12.5%	9.0%	14.5%	5.6%	14.6%	15.6%	15.7%	8.0%
Other	5.6%	2.6%	6.6%	7.4%	2.4%	5.5%	10.4%	2.3%

Percentage of respondents who offer rehabilitation services to people with intellectual or developmental disabilities	
Average statewide	44.3%
Area 1: Northwest	42.9%
Area 2: North Central	41.3%
Area 3: Northeast	45.3%
Area 4: Fox Valley Area	31.7%
Area 5: Southeast	37.0%
Area 6: South Central	49.1%
Area 7: Western	53.3%

Initiatives

Which initiatives would be the most impactful on your organization if implemented? Rank order from most important (1) to least important (5)
Statewide Results

	1	2	3	4	5
Workforce initiatives to attract workers to the industry	43.7%	12.9%	13.9%	13.9%	15.5%
Initiatives to improve the living environment such as physical plant renovations, creating homelike environments, and other physical plant improvements for life enrichment of the residents and staff.	29.5%	26.3%	20.5%	10.9%	12.8%
Initiatives to establish strategic options (e.g., affiliations, partnerships, and bed use agreements) with healthcare providers	12.2%	13.8%	12.2%	22.5%	39.4%
Initiatives to help improve the image and reputation of the long-term care industry	9.4%	25.5%	23.6%	24.2%	17.4%
Initiatives to improve relationships between long-term care and referral sources such as hospitals, managed care organizations and others	8.3%	21.4%	30.0%	26.5%	13.7%

Percentage of respondents ranking initiatives as the most impactful to their organization "(1) most important" by Health Service Area

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7
Workforce initiatives to attract workers to the industry	59.2%	61.5%	40.0%	37.5%	47.1%	22.4%	42.9%
Initiatives to improve the living environment such as physical plant renovations, creating homelike environments, and other physical plant improvements for life enrichment of the residents and staff.	20.4%	22.5%	38.7%	38.9%	26.5%	40.7%	22.5%
Initiatives to establish strategic options (e.g., affiliations, partnerships, and bed use agreements) with healthcare providers	11.8%	9.5%	6.9%	10.5%	16.9%	15.3%	9.6%
Initiatives to help improve the image and reputation of the long-term care industry	5.8%	2.6%	6.9%	20.0%	5.7%	18.6%	10.2%
Initiatives to improve relationships between long-term care and referral sources such as hospitals, managed care organizations and others	10.2%	5.0%	3.3%	5.9%	6.9%	5.3%	18.0%

Referral Patterns

From where do your referrals originate?

	Statewide (n=340)	Area 1 (n=51)	Area 2 (n=44)	Area 3 (n=32)	Area 4 (n=23)	Area 5 (n=74)	Area 6 (n=63)	Area 7 (n=55)
Managed care organization	71.8%	70.6%	77.3%	68.8%	69.6%	83.8%	69.8%	60.0%
County agency	24.1%	21.6%	27.3%	31.3%	21.7%	17.6%	28.6%	27.3%
Family of resident	23.8%	13.7%	20.5%	40.6%	8.7%	28.4%	28.6%	23.6%
Other	15.3%	11.8%	11.4%	18.8%	26.1%	14.9%	19.1%	9.1%
Existing residents	13.2%	17.7%	13.6%	9.4%	0.0%	12.2%	19.1%	10.9%
Aging and disability resource center	9.7%	9.8%	4.6%	6.3%	0.0%	9.5%	17.5%	10.9%
Home health agency serving the area	9.7%	13.7%	11.4%	0.0%	4.4%	6.8%	6.4%	20.0%
Assisted living facility in the area	7.7%	7.8%	9.1%	15.6%	0.0%	9.5%	7.9%	5.5%
Doctor of resident	7.1%	3.9%	4.6%	9.4%	0.0%	8.1%	7.9%	10.9%
Local hospital	5.9%	3.9%	2.3%	3.1%	0.0%	12.2%	6.4%	5.5%
Nursing homes	5.3%	3.9%	0.0%	3.1%	0.0%	10.8%	9.5%	1.8%

What are significant barriers to taking referrals in general?

	Statewide (n=323)	Area 1 (n=48)	Area 2 (n=40)	Area 3 (n=31)	Area 4 (n=22)	Area 5 (n=73)	Area 6 (n=63)	Area 7 (n=48)
Lack of open beds	54.5%	37.5%	60.0%	58.1%	45.5%	42.5%	63.5%	72.9%
Referral is not appropriate for our setting	48.6%	56.3%	47.5%	51.6%	50.0%	31.5%	54.0%	54.2%
Staffing shortages	30.3%	27.1%	30.0%	29.0%	31.8%	42.5%	31.8%	22.9%
Resident condition at time of referral	29.7%	20.8%	35.0%	16.1%	22.7%	31.5%	34.9%	37.5%
Payment source of resident	28.8%	27.1%	35.0%	32.3%	18.2%	37.0%	28.6%	22.9%
Behavioral health needs	27.6%	22.9%	35.0%	25.8%	18.2%	26.0%	34.9%	27.1%
Complexity of acuity of resident	19.8%	14.6%	20.0%	19.4%	22.7%	19.2%	25.4%	20.8%
Urgency/timing of the referral	15.8%	8.3%	22.5%	9.7%	4.6%	20.6%	22.2%	14.6%
Other	15.8%	22.9%	15.0%	9.7%	18.2%	23.3%	11.1%	6.3%
Lack of private rooms at the facility	8.1%	2.1%	12.5%	12.9%	0.0%	2.7%	9.5%	16.7%

Which areas are challenges to accepting Medicaid-waiver referrals? ***Statewide Results (n=282)***	
Lack of open beds	46.5%
Referral is not appropriate for our setting	36.9%
Staffing shortages	28.0%
Behavioral health needs	24.5%
Payor authorization	22.7%
Resident condition at time of referral	18.4%
Urgency/timing of the referral	16.0%
Other	16.0%
Complexity of acuity	14.5%
Covid outbreaks	8.5%
Distance of the referral from the facility/family	7.1%
Cost of treatment/medications	5.7%
Pharmacy coverage	3.6%

What barriers, if any, are you experiencing with contracting with Managed Care Organizations, other than financial/rates? ***Statewide Results (n=225)***	
Communication	45.8%
Other	36.9%
Resident assessment process	36.4%
Referral and admission process	25.8%
Clinical team (external)	8.0%
Coordinating with the Aging and Disability Resource Center	5.8%

Labor Pool

Percentage of respondents who are experiencing challenges in their labor pool that impact their ability to take referrals	
Average statewide	33.9% (n=110)
Area 1: Northwest	44.0% (n=22)
Area 2: North Central	25.0% (n=10)
Area 3: Northeast	25.0% (n=8)
Area 4: Fox Valley Area	28.6% (n=6)
Area 5: Southeast	39.2% (n=29)
Area 6: South Central	34.4% (n=21)
Area 7: Western	38.8% (n=19)

Regarding challenges in your labor pool that impact your ability to take referrals, please choose the affected disciplines ***Statewide Results (n=110)***	
Lack of caregivers	84.6%
Lack of available other direct care/support staff	53.6%
Lack of available housekeeping, other non-direct care support staff	20.0%
Other	14.6%
Lack of available Certified Nursing Assistants	11.8%
Lack of available Registered Nurses	7.3%
Lack of available intake staff	7.3%
Lack of available Licensed Practical Nurses	3.6%
Lack of available dietary staff	1.8%

Please identify other challenges in workforce ***Statewide Results (n=277)***	
Competitive rates/wages	75.5%
Non-compensated benefits	35.7%
Retention	28.9%
Initial and ongoing training requirements	26.7%
Recruitment	25.3%
Labor pool experience level	21.3%
Staff attrition	17.7%
Other	16.6%
Geography/travel distance	14.1%

Please identify the challenges with attracting and retaining staff ***Statewide Results (n=266)***	
Competitive rates/wages	70.3%
Staff availability	47.0%
Non-compensated benefits	30.8%
Other	22.6%
Staff attrition	15.0%
Physical plant/environment	3.4%

Percentage of respondents who participate in any collaborative initiatives to solve labor challenges	
Average statewide	15.4% (n=47)
Area 1: Northwest	6.1% (n=3)
Area 2: North Central	15.4% (n=6)
Area 3: Northeast	16.7% (n=5)
Area 4: Fox Valley Area	5.0% (n=1)
Area 5: Southeast	21.7% (n=15)
Area 6: South Central	19.6% (n=11)
Area 7: Western	18.2% (n=8)

Percentage of respondents who needed to use agency/contracted staff to provide patient care in the past 12 months	
Average statewide	7.5% (n=24)
Area 1: Northwest	0.0% (n=0)
Area 2: North Central	12.5% (n=5)
Area 3: Northeast	3.1% (n=1)
Area 4: Fox Valley Area	9.1% (n=2)
Area 5: Southeast	12.5% (n=9)
Area 6: South Central	5.1% (n=3)
Area 7: Western	8.5% (n=4)

Benefits offered to direct care staff ***Statewide Results (n=275)***	
We do not/cannot offer benefits	67.6%
Training	29.1%
Flexible schedule	23.6%
Paid time off	20.4%
Bonus/reward system (incremental)	18.2%
Other	18.2%
Retention bonus	12.7%
Sign on bonus	10.6%
Health insurance	10.2%
Opportunities for paid continued education	9.1%
Retirement plan	6.9%
Travel assistance (e.g., reduced bus pass)	5.5%
Workforce housing	4.0%
Childcare assistance	2.2%

Percentage of respondents who had open beds for admission from referral sources but had to limit admissions due to staffing limitations in the past year	
Average statewide	20.3% (n=63)
Area 1: Northwest	27.1% (n=13)
Area 2: North Central	7.7% (n=3)
Area 3: Northeast	12.5% (n=4)
Area 4: Fox Valley Area	31.6% (n=6)
Area 5: Southeast	35.7% (n=25)
Area 6: South Central	19.0% (n=11)
Area 7: Western	10.9% (n=5)

Financial

How many beds are typically occupied daily by persons on Medicaid-waiver sources?			
	0%	50%	100%
Average statewide (n=294)	15.3%	13.6%	71.1%
Area 1: Northwest (n=46)	15.2%	15.2%	69.6%
Area 2: North Central (n=34)	17.7%	8.8%	73.5%
Area 3: Northeast (n=32)	6.3%	3.1%	90.6%
Area 4: Fox Valley Area (n=21)	9.5%	19.1%	71.4%
Area 5: Southeast (n=67)	23.9%	13.4%	62.7%
Area 6: South Central (n=51)	9.8%	17.7%	72.6%
Area 7: Western (n=44)	18.2%	13.6%	68.2%

Percentage of respondents who are considering closure due to financial constraints	
Average statewide	21.3% (n=67)
Area 1: Northwest	12.2% (n=6)
Area 2: North Central	38.5% (n=15)
Area 3: Northeast	25.0% (n=8)
Area 4: Fox Valley Area	9.1% (n=2)
Area 5: Southeast	24.3% (n=17)
Area 6: South Central	15.8% (n=9)
Area 7: Western	25.5% (n=12)

Percentage of respondents who are considering closure for reasons other than financial	
Average statewide	18.4% (n=58)
Area 1: Northwest	18.8% (n=9)
Area 2: North Central	30% (n=12)
Area 3: Northeast	15.2% (n=5)
Area 4: Fox Valley Area	13.6% (n=3)
Area 5: Southeast	13.0% (n=9)
Area 6: South Central	14.0% (n=8)
Area 7: Western	25.5% (n=12)

Bed Capacity Needs/Future/Prospective

Percentage of respondents who anticipate participating in the Medicaid-waiver program for the next 12 months	
Average statewide	48.0% (n=152)
Area 1: Northwest	42.9% (n=21)
Area 2: North Central	45.0% (n=18)
Area 3: Northeast	46.9% (n=15)
Area 4: Fox Valley Area	33.3% (n=7)
Area 5: Southeast	59.4% (n=41)
Area 6: South Central	50.9% (n=30)
Area 7: Western	43.8% (n=21)

Percentage of respondents who anticipate increasing Medicaid-waiver capacity in the next 12 months	
Average statewide	11.2% (n=35)
Area 1: Northwest	4.2% (n=2)
Area 2: North Central	5.0% (n=2)
Area 3: Northeast	6.1% (n=2)
Area 4: Fox Valley Area	4.8% (n=1)
Area 5: Southeast	19.4% (n=13)
Area 6: South Central	17.0% (n=10)
Area 7: Western	12.8% (n=6)

Do you anticipate accepting high acuity resident referrals on Medicaid-waiver in the next 12 months? ***Statewide Results (n=285)***	
Yes, we provide high acuity services for Medicaid-waiver residents and will continue to do so for the next 12 months or longer.	25.3% (n=72)
No, we provide high acuity services for only private pay.	0.7% (n=2)
No, we do not provide high acuity services.	24.9% (n=71)
We are unsure whether we will provide high acuity services for persons on Medicaid-waiver in the next 12 months.	49.1% (n=140)

Do you anticipate accepting referrals for residents with complex behaviors and are on Medicaid-waiver in the next 12 months? ***Statewide Results (n=292)***	
Yes, we provide these services for Medicaid-waiver residents and will continue to do so for the next 12 months or longer.	29.8% (n=87)
No, we serve residents with complex behaviors that pay privately only.	1.4% (n=4)
No, we do not serve residents with complex behaviors.	23.6% (n=69)
We are unsure whether we will provide these services for persons on Medicaid-waiver in the next 12 months.	45.2% (n=132)

If the Department of Health Services increases Medicaid/Medicaid-waiver rates, what would you do with the money specifically?

	Statewide (n=295)	Area 1 (n=45)	Area 2 (n=37)	Area 3 (n=29)	Area 4 (n=20)	Area 5 (n=68)	Area 6 (n=55)	Area 7 (n=42)
Increase wages for current staff	69.5%	68.9%	64.9%	79.3%	50.0%	77.9%	63.6%	76.2%
Increase staff to resident ratio	21.0%	22.2%	18.9%	17.2%	15.0%	25.0%	29.1%	14.3%
Save any excess funds	27.1%	35.6%	21.6%	24.1%	35.0%	20.6%	27.3%	28.6%
Invest in physical plant/infrastructure	28.1%	31.1%	24.3%	34.5%	20.0%	20.6%	32.7%	28.6%
Expand services (evaluate new services, add capacity, etc.)	33.9%	40.0%	37.8%	37.9%	35.0%	35.3%	32.7%	26.2%
Accept more Medicaid-waiver referrals	22.4%	15.6%	24.3%	17.2%	25.0%	26.5%	25.5%	26.2%
Accept higher acuity referrals from sources	17.0%	4.4%	27.0%	10.3%	15.0%	19.1%	21.8%	21.4%
Other	13.9%	6.7%	21.6%	24.1%	15.0%	14.7%	7.3%	7.1%

3-4 Bed AFH Provider Survey Results

Demographics

Which Health Services Area(s) are you located in?		
Health Service Areas	**Percentage of Respondents**	**Respondents**
Area 1: Northwest (Douglas, Bayfield, Ashland, Burnett, Washburn, Sawyer, Polk, Barron, Rusk, Saint Croix, Dunn, Chippewa, Pierce, Pepin, Eau Claire Counties)	13.7%	55
Area 2: North Central (Iron, Vilas, Price, Oneida, Forest, Taylor, Lincoln, Langlade, Clark, Marathon, Wood, Portage Counties)	4.7%	19
Area 3: Northeast (Florence, Marinette, Oconto, Door, Kewaunee, Brown, Manitowoc Counties)	4.5%	18
Area 4: Fox Valley Area (Menominee, Shawano, Waupaca, Outagamie, Waushara, Winnebago, Calumet, Green Lake Counties)	4.7%	19
Area 5: Southeast (Fond du Lac, Sheboygan, Ozaukee, Washington, Milwaukee, Waukesha, Racine, Walworth, Kenosha Counties)	49.9%	201
Area 6: South Central (Juneau, Adams, Marquette, Richland, Sauk, Columbia, Dodge, Grant, Iowa, Dane, Jefferson, Lafayette, Green, Rock Counties)	20.1%	81
Area 7: Western (Buffalo, Trempealeau, Jackson, La Crosse, Monroe, Vernon, Crawford Counties)	5.0%	20
Total Respondents*		**409**

*Respondents may serve more than one Health Service Area. Percentages do not equal 100%.

Current Occupancy, 2022 Year to Date	
Average statewide	86.1% (n=319)
Area 1: Northwest	90.8% (n=48)
Area 5: Southeast	79.5% (n=142)
Area 6: South Central	88.8% (n=70)

Ownership Type		
	Free Standing or Private Ownership	Part of a Corporate Chain
Average statewide	95.2%	4.8%
Area 1: Northwest	90.9%	9.1%
Area 5: Southeast	96.9%	3.1%
Area 6: South Central	93.8%	6.2%

Which groups do you routinely serve?				
	Statewide	Area 1: Northwest	Area 5: Southeast	Area 6: South Central
Developmentally disabled	92.6%	98.2%	95.0%	88.9%
Mental health conditions	63.3%	52.7%	67.2%	60.5%
Advanced aged/frail elderly	58.3%	38.2%	73.7%	44.4%
Physically disabled	52.6%	56.4%	57.1%	45.7%
Dementia/Alzheimer's/memory loss	51.6%	23.6%	68.7%	45.7%
Traumatic brain injury	49.6%	45.5%	59.6%	35.8%
Complex behavioral conditions	35.2%	32.7%	41.4%	27.2%
Alcohol and drug dependence/abuse	18.4%	14.6%	23.7%	12.4%
Other	6.2%	5.5%	6.1%	6.2%

Initiatives

Which initiatives would be the most impactful on your organization if implemented? Rank order from most important (1) to least important (5) *Statewide Results*					
	1	2	3	4	5
Workforce initiatives to attract workers to the industry	60.3%	13.8%	10.5%	6.5%	8.9%
Initiatives to improve the living environment such as physical plant renovations, creating homelike environments, and other physical plant improvements for life enrichment of the residents and staff.	14.1%	20.6%	22.2%	23.8%	19.4%
Initiatives to improve relationships between long-term care and referral sources such as hospitals, managed care organizations and others	12.8%	27.2%	22.4%	26.0%	11.6%
Initiatives to help improve the image and reputation of the long-term care industry	9.7%	23.8%	24.6%	21.0%	21.0%
Initiatives to establish strategic options (e.g., affiliations, partnerships, and bed use agreements) with healthcare providers	7.6%	14.1%	20.2%	19.8%	38.4%

Percentage of respondents ranking initiatives as the most impactful to their organization "(1) most important" by Health Service Area			
	Area 1: Northwest	Area 5: Southeast	Area 6: South Central
Workforce initiatives to attract workers to the industry	74.3%	53.5%	54.0%
Initiatives to improve the living environment such as physical plant renovations, creating homelike environments, and other physical plant improvements for life enrichment of the residents and staff.	11.4%	16.4%	12.2%
Initiatives to improve relationships between long-term care and referral sources such as hospitals, managed care organizations and others	5.7%	20.0%	5.8%
Initiatives to help improve the image and reputation of the long-term care industry	2.9%	7.8%	25.5%
Initiatives to establish strategic options (e.g., affiliations, partnerships, and bed use agreements) with healthcare providers	8.3%	7.3%	7.4%

Referral Patterns

Percentage of respondents who accept Medicaid-waiver referrals as direct admissions	
Average statewide	86.3% (n=232)
Area 1: Northwest	78.4% (n=29)
Area 5: Southeast	87.4% (n=111)
Area 6: South Central	85.5% (n=47)

Why do you choose not to accept Medicaid-waiver direct admissions? ***Statewide Results***	
We allow current tenants to transition to Medicaid-waiver.	6.3% (n=3)
We are not contracted with a Medicaid-waiver/Managed Care Organization.	43.8% (n=21)
Medicaid-waiver rates do not cover our costs.	27.1% (n=13)
Other	29.2% (n=14)

What percentage of your occupied beds are private pay, Medicaid-waiver, or other residents?

	Less than 20%	20-79%	80% or more
Statewide (n=251)			
Private Pay	91.0%	7.4%	1.6%
Medicaid-waiver	11.3%	12.6%	76.1%
Other	58.0%	15.0%	27.0%
Area 1: Northwest (n=35)			
Private Pay	96.2%	3.8%	0.0%
Medicaid-waiver	13.8%	10.3%	75.9%
Other	59.1%	13.6%	27.3%
Area 5: Southeast (n=118)			
Private Pay	88.9%	10.0%	1.1%
Medicaid-waiver	12.8%	15.6%	71.6%
Other	52.3%	0.0%	27.3%
Area 6: South Central (n=49)			
Private Pay	94.6%	2.7%	2.7%
Medicaid-waiver	2.2%	13.0%	84.8%
Other	62.5%	18.8%	18.8%

How long (on average) do your private pay residents pay privately before they transition to Medicaid-waiver?

	Statewide (n=238)	Area 1: Northwest (n=32)	Area 5: Southeast (n=114)	Area 6: South Central (n=46)
Not relevant, do not contract with Medicaid-waiver/Medicaid-managed care organization	20.2%	28.1%	21.1%	15.2%
Less than 1 year	24.0%	28.1%	23.7%	17.4%
1-2 years	5.9%	3.1%	8.8%	6.5%
3-4 years	5.5%	3.1%	3.5%	6.5%
5-6 years	0.0%	0.0%	0.0%	0.0%
7-9 years	0.0%	0.0%	0.0%	0.0%
10 years or more	0.4%	0.0%	0.0%	2.2%
Do not know/do not track	44.1%	37.5%	43.0%	52.2%

From where do your referrals originate, regardless of payor source?

	Statewide (n=255)	Area 1: Northwest (n=37)	Area 5: Southeast (n=118)	Area 6: South Central (n=50)
Managed care organizations	89.0%	94.6%	88.1%	94.0%
Family of resident	36.9%	37.8%	33.9%	42.0%
County agency	32.2%	29.7%	25.4%	42.0%
Aging and disability resource center	23.1%	21.6%	24.6%	24.0%
Existing residents	18.4%	10.8%	21.2%	16.0%
Local hospital	18.4%	18.9%	17.8%	20.0%
Nursing homes	13.7%	21.6%	11.9%	14.0%
Assisted living facility in the area	12.2%	10.8%	14.4%	12.0%
Other	11.4%	18.9%	7.6%	14.0%
Home health agency serving the area	9.4%	13.5%	9.3%	12.0%
Doctor of resident	7.1%	10.8%	5.1%	8.0%

What are significant barriers to taking referrals in general?

	Statewide (n=249)	Area 1: Northwest (n=37)	Area 5: Southeast (n=113)	Area 6: South Central (n=49)
Referral is not appropriate for our setting	56.2%	54.1%	57.5%	61.2%
Lack of open beds	54.2%	54.1%	46.9%	59.2%
Staffing shortages	50.2%	51.4%	53.1%	38.8%
Behavioral health needs	41.8%	27.0%	43.4%	40.8%
Resident condition at time of referral	36.1%	18.9%	42.5%	38.8%
Payment source of resident	34.9%	29.7%	38.9%	30.6%
Urgency/timing of the referral	19.7%	24.3%	21.2%	16.3%
Payor authorization	18.1%	24.3%	20.4%	14.3%
Complexity of acuity	16.9%	16.2%	16.8%	14.3%
Other	11.2%	13.5%	8.0%	16.3%
Distance of the referral from the facility/family	8.0%	5.4%	8.0%	8.2%
Covid outbreaks	4.0%	0.0%	6.2%	6.1%
Cost of treatment/medications	4.0%	2.7%	4.4%	4.1%
Pharmacy coverage	1.2%	2.7%	0.9%	2.0%

Which areas are challenges to accepting Medicaid/Medicaid-waiver referrals?

	Statewide (n=236)	Area 1: Northwest (n=34)	Area 5: Southeast (n=107)	Area 6: South Central (n=47)
Lack of open beds	50.4%	52.9%	40.2%	51.1%
Referral is not appropriate for our setting	45.8%	52.9%	45.8%	46.8%
Staffing shortages	43.6%	50.0%	43.0%	36.2%
Behavioral health needs	35.2%	23.5%	36.5%	40.4%
Resident condition at time of referral	28.4%	20.6%	31.8%	21.3%
Payor authorization	27.1%	26.5%	28.0%	29.8%
Urgency/timing of the referral	17.4%	20.6%	16.8%	21.3%
Complexity of acuity	17.0%	11.8%	14.0%	21.3%
Other	11.4%	14.7%	8.4%	19.2%
Cost of treatment/medications	6.8%	5.9%	7.5%	6.4%
Distance of the referral from the facility/family	5.1%	8.8%	1.9%	6.4%
Covid outbreaks	3.0%	0.0%	2.8%	6.4%
Pharmacy coverage	1.3%	2.9%	1.9%	0.0%

What barriers exist to contracting with Medicaid-waiver/Managed Care Organizations, other than financial/rates?

	Statewide (n=208)	Area 1: Northwest (n=28)	Area 5: Southeast (n=104)	Area 6: South Central (n=39)
Not relevant, do not contract with Medicaid-waiver/Medicaid-Managed Care Organization	8.7%	7.1%	10.6%	5.1%
Resident assessment/functional screen process	41.8%	50.0%	34.6%	56.4%
Managed Care Organization issues	40.4%	35.7%	36.5%	46.2%
Contract issues	38.9%	28.6%	41.4%	51.3%
Communication	32.7%	46.4%	33.7%	25.6%
Referral and Admission Process	22.1%	10.7%	24.0%	23.1%
Other	11.5%	10.7%	9.6%	10.3%
Clinical team (external)	10.1%	3.6%	9.6%	12.8%
Aging and Disability Resource Center (ADRC)	5.3%	0.0%	6.7%	5.1%

Percentage of respondents who get direct referrals from hospitals

Average statewide	22.0% (n=56)
Area 1: Northwest	40.5% (n=15)
Area 5: Southeast	19.3% (n=23)
Area 6: South Central	8.2% (n=4)

What barriers, if any, are you experiencing with receiving referrals directly from hospitals? *Statewide Results*	
Lack of open beds	50.0% (n=28)
Referral is not appropriate for our setting	37.5% (n=21)
Payment source of resident	33.9% (n=19)
Resident condition at time of referral	32.1% (n=18)
Urgency/timing of the referral	30.4% (n=17)
Staffing shortages	28.6% (n=16)
Lack of private rooms	14.3% (n=8)
Not applicable	8.9% (n=5)
Other	7.1% (n=4)
Covid outbreaks	3.6% (n=2)

Labor Pool

Percentage of respondents who are experiencing challenges in their labor pool that impact their ability to take referrals	
Average statewide	46.9% (n=120)
Area 1: Northwest	54.1% (n=20)
Area 5: Southeast	44.2% (n=53)
Area 6: South Central	40.8% (n=20)

Regarding challenges in your labor pool that impact your ability to take referrals, please choose the affected disciplines *Statewide Results*	
Lack of caregivers	93.3% (n=111)
Lack of available other direct care/support staff	53.8% (n=64)
Lack of available Certified Nursing Assistants	24.4% (n=29)
Lack of available housekeeping, other non-direct care support staff	18.5% (n=22)
Lack of available intake staff	8.4% (n=10)
Lack of available Registered Nurses	7.6% (n=9)
Lack of available dietary staff	5.0% (n=6)
Other	5.0% (n=6)
Lack of Licensed Practical Nurses	3.4% (n=4)

Please identify other challenges in workforce

	Statewide (n=251)	Area 1: Northwest (n=36)	Area 5: Southeast (n=119)	Area 6: South Central (n=47)
Competitive rates/wages	88.1%	80.6%	86.6%	91.5%
Non-Compensated benefits	48.6%	44.4%	48.7%	44.7%
Retention	48.2%	50.0%	51.3%	42.6%
Recruitment	45.4%	50.0%	44.5%	51.1%
Initial and ongoing training requirements	32.3%	19.4%	38.7%	27.7%
Staff attrition	29.5%	19.4%	32.8%	29.8%
Labor pool experience level	26.7%	27.8%	27.7%	23.4%
Geography/travel distance	11.6%	13.9%	13.5%	12.8%
Other	9.2%	8.3%	10.1%	10.6%

Please identify the challenges with attracting and retaining staff

	Statewide (n=246)	Area 1: Northwest (n=35)	Area 5: Southeast (n=117)	Area 6: South Central (n=46)
Competitive rates/wages	86.6%	80.0%	86.3%	87.0%
Staff availability	61.0%	74.3%	54.7%	69.6%
Non-Compensated benefits	46.8%	42.9%	42.7%	52.2%
Staff attrition	15.9%	11.4%	18.0%	13.0%
Other	8.5%	8.6%	6.0%	15.2%
Physical plant/environment	2.9%	0.0%	5.1%	2.2%

Percentage of respondents who are involved in any collaborative initiatives to solve labor challenges	
Average statewide	22.9% (n=58)
Area 1: Northwest	16.2% (n=6)
Area 5: Southeast	23.9% (n=28)
Area 6: South Central	28.6% (n=14)

Percentage of respondents who needed to use agency/contracted staff to provide patient care in the past 12 months	
Average statewide	11.7% (n=30)
Area 1: Northwest	0.0% (n=0)
Area 5: Southeast	16.8% (n=20)
Area 6: South Central	8.0% (n=4)

Benefits offered to direct care staff

	Statewide (n=253)	Area 1: Northwest (n=37)	Area 5: Southeast (n=118)	Area 6: South Central (n=48)
We do not/cannot offer benefits	45.9%	32.4%	53.4%	41.7%
Training	57.7%	73.0%	55.9%	47.9%
Flexible schedule	47.4%	59.5%	44.9%	39.6%
Bonus/reward system (incremental)	44.3%	46.0%	41.5%	50.0%
Retention bonus	36.0%	37.8%	39.0%	27.1%
Paid time off	35.6%	46.0%	28.8%	33.3%
Opportunities for paid continued education	24.9%	13.5%	28.8%	22.9%
Sign on bonus	19.4%	18.9%	21.2%	18.8%
Retirement plan	14.2%	21.6%	11.0%	12.5%
Health insurance	12.7%	8.1%	13.6%	14.6%
Other	11.1%	2.7%	5.1%	25.0%
Travel assistance (e.g., reduced bus pass)	7.1%	5.4%	11.9%	6.3%
Childcare assistance	6.3%	2.7%	4.2%	14.6%
Workforce housing	4.7%	10.8%	5.1%	4.2%

What was your percentage turnover in the past 12 months for the following positions?
Statewide Results

	Less than 10%	10-29%	30-49%	50-69%	70% or more
Registered Nurses	92.6%	4.2%	0.0%	2.1%	1.1%
Licensed Practical Nurses	92.2%	2.6%	0.0%	2.6%	2.6%
Certified Nursing Assistants	63.5%	11.5%	8.3%	10.4%	6.3%
Caregivers	19.4%	11.5%	21.7%	26.7%	20.7%
Administrators	71.0%	12.2%	8.4%	2.8%	5.6%

Percentage of respondents with turnover of 30% or more in the past 12 months for the following positions

	Area 1: Northwest	Area 5: Southeast	Area 6: South Central
Registered Nurses	6.7% (n=1)	4.4% (n=2)	0.0% (n=0)
Licensed Practical Nurses	0.0% (n=0)	5.1% (n=2)	0.0% (n=0)
Certified Nursing Assistants	10.0% (n=1)	26.4% (n=14)	31.3% (n=5)
Caregivers	71.9% (n=23)	77.2% (n=81)	51.3% (n=20)
Administrators	7.7% (n=1)	20.4% (n=10)	16.7% (n=4)

Percentage of respondents who had open beds for admission from referral sources but had to limit admissions due to staffing limitations in the past year	
Average statewide	34.4% (n=86)
Area 1: Northwest	37.8% (n=14)
Area 5: Southeast	41.9% (n=49)
Area 6: South Central	22.9% (n=11)

How many beds are typically occupied daily by persons on Medicaid-waiver sources?				
	0%	1-49%	50-99%	100%
Average statewide (n= 247)	6.9%	10.5%	25.1%	57.5%
Area 1: Northwest (n=36)	8.3%	13.9%	22.2%	55.6%
Area 5: Southeast (n=115)	7.0%	14.8%	26.1%	52.2%
Area 6: South Central (n=47)	4.3%	4.3%	34.0%	57.5%

Bed Capacity Needs/Future/Prospective

Percentage of respondents who anticipate participating in the Medicaid-waiver program for the next 12 months	
Average statewide	75.0% (n=189)
Area 1: Northwest	69.4% (n=25)
Area 5: Southeast	71.4% (n=85)
Area 6: South Central	79.6% (n=39)

Percentage of respondents who anticipate increasing Medicaid-waiver capacity in the next 12 months	
Average statewide	26.3% (n=66)
Area 1: Northwest	10.8% (n=4)
Area 5: Southeast	39.8% (n=47)
Area 6: South Central	25.0% (n=12)

Percentage of respondents who are limiting Medicaid-waiver admissions due to financial constraints	
Average statewide	20.3% (n=50)
Area 1: Northwest	13.5% (n=5)
Area 5: Southeast	19.8% (n=23)
Area 6: South Central	23.4% (n=11)

Do you anticipate accepting high acuity resident referrals on Medicaid-waiver in the next 12 months? ***Statewide Results***	
Yes, we provide high acuity services for Medicaid-waiver residents and will continue to do so for the next 12 months or longer.	38.6% (n=93)
No, we provide high acuity services for only private pay.	2.9% (n=7)
No, we do not provide high acuity services.	16.2% (n=39)
We are unsure whether we will provide high acuity services for persons on Medicaid-waiver in the next 12 months.	42.3% (n=102)

Do you anticipate accepting referrals for residents with complex behaviors and are on Medicaid-waiver in the next 12 months? ***Statewide Results***	
Yes, we provide these services for Medicaid-waiver residents and will continue to do so for the next 12 months or longer.	43.2% (n=104)
No, we serve residents with complex behaviors that pay privately only.	2.1% (n=5)
No, we do not serve residents with complex behaviors.	24.1% (n=58)
We are unsure whether we will provide these services for persons on Medicaid-waiver in the next 12 months.	30.7% (n=74)

Percentage of respondents who anticipate accepting high acuity resident referrals and/or referrals for residents with complex behaviors and on Medicaid-waiver in the next 12 months

	Area 1: Northwest	Area 5: Southeast	Area 6: South Central
High acuity referrals	27.0% (n=10)	41.6% (n=47)	36.2% (n=17)
Complex behaviors referrals	21.6% (n=8)	51.4% (n=57)	38.3% (n=18)

What changes other than reimbursement is needed for you to accept Medicaid-waiver admissions (direct, not through attrition)?	Statewide (n=226)	Area 1: Northwest (n=35)	Area 5: Southeast (n=110)	Area 6: South Central (n=41)
Managed Care Organization/provider relationship initiatives	55.8%	42.9%	56.1%	56.1%
Workforce initiatives to attract workers to the industry	54.4%	51.4%	61.0%	61.0%
Process improvement (resident assessments, communication, referrals, case management, etc.)	46.5%	34.3%	48.8%	48.8%
Increase in workforce to staff available beds	44.7%	54.3%	43.9%	43.9%
Managed Care Organization/provider relationship initiatives	43.8%	31.4%	46.3%	46.3%
Training programs for staff (for increasing acuity, etc.)	40.7%	25.7%	31.7%	31.7%
Image/branding improvement initiatives for the industry	16.8%	5.7%	22.0%	22.0%
Other	8.4%	11.4%	7.3%	7.3%
Presumptive eligibility	4.9%	2.9%	4.9%	4.9%

If the Department of Health Services increases Medicaid/Medicaid-waiver rates, what would you do with the money specifically?	Statewide (n=241)	Area 1: Northwest (n=37)	Area 5: Southeast (n=113)	Area 6: South Central (n=46)
Increase wages for current staff	93.8%	91.9%	97.4%	87.0%
Increase staff to resident ratio	45.2%	35.1%	49.6%	56.5%
Expand services (evaluate new services, add capacity, etc.)	42.3%	27.0%	51.3%	41.3%
Accept more Medicaid-waiver referrals	39.4%	40.5%	42.5%	37.0%
Invest in physical plant/infrastructure	38.2%	35.1%	35.4%	54.4%
Accept higher acuity referrals from sources	32.4%	27.0%	36.3%	30.4%
Save any excess funds	14.1%	13.5%	12.4%	15.2%
Other	10.0%	13.5%	10.6%	4.4%

CBRF Provider Survey Results

Demographics

Which Health Services Area(s) are you located in?		
Health Service Areas	**Percentage of Respondents**	**Respondents**
Area 1: Northwest (Douglas, Bayfield, Ashland, Burnett, Washburn, Sawyer, Polk, Barron, Rusk, Saint Croix, Dunn, Chippewa, Pierce, Pepin, Eau Claire Counties)	12.4%	23
Area 2: North Central (Iron, Vilas, Price, Oneida, Forest, Taylor, Lincoln, Langlade, Clark, Marathon, Wood, Portage Counties)	10.3%	19
Area 3: Northeast (Florence, Marinette, Oconto, Door, Kewaunee, Brown, Manitowoc Counties)	11.4%	21
Area 4: Fox Valley Area (Menominee, Shawano, Waupaca, Outagamie, Waushara, Winnebago, Calumet, Green Lake Counties)	13.5%	25
Area 5: Southeast (Fond du Lac, Sheboygan, Ozaukee, Washington, Milwaukee, Waukesha, Racine, Walworth, Kenosha Counties)	32.4%	60
Area 6: South Central (Juneau, Adams, Marquette, Richland, Sauk, Columbia, Dodge, Grant, Iowa, Dane, Jefferson, Lafayette, Green, Rock Counties)	21.1%	39
Area 7: Western (Buffalo, Trempealeau, Jackson, La Crosse, Monroe, Vernon, Crawford Counties)	7.6%	14
Total Respondents*		**189**

*Respondents may serve more than one Health Service Area. Percentages do not equal 100%.

Current Occupancy, 2022 Year to Date	
Average statewide	88.6% (n=154)
Area 5: Southeast	90.3% (n=50)

Ownership Type		
	Free Standing or Private Ownership	Part of a Corporate Chain
Average statewide	86.7%	13.3%
Area 5: Southeast	89.7%	10.3%

Characteristics of campus		
	Statewide	Area 5: Southeast
Community Based Residential Facility only	83.1%	81.0%
Memory care Community Based Residential Facility	29.0%	29.3%
Residential Care Apartment Complex	14.8%	20.7%
Senior housing/homes (market rate)	4.4%	5.2%
Affordable housing	0.6%	0.0%
Home health agency	1.1%	0.0%
Personal care agency/non-certified home care program	4.4%	3.5%
Nursing home	9.8%	3.5%
Adult day center	3.3%	3.5%
Other	8.7%	6.9%

Which groups do you routinely serve?		
	Statewide	Area 5: Southeast
Advanced aged/frail elderly	75.3%	81.0%
Dementia/Alzheimer’s	68.1%	69.0%
Alcohol and drug dependence/abuse	14.8%	13.8%
Physically disabled	45.1%	46.6%
Mental health conditions	38.5%	39.7%
Terminally ill	30.2%	32.8%
Traumatic brain injury	22.5%	20.7%
Complex behavioral conditions	16.5%	17.2%
Other	11.5%	12.1%

Initiatives

Which initiatives would be the most impactful on your organization if implemented? Rank order from most important (1) to least important (5)
Statewide Results

	1	2	3	4	5
Workforce initiatives to attract workers to the industry	80.7%	7.1%	3.6%	3.6%	5.0%
Initiatives to improve the living environment such as physical plant renovations, creating homelike environments, and other physical plant improvements for life enrichment of the residents and staff	7.4%	26.7%	27.4%	18.5%	20.0%
Initiatives to establish strategic options (e.g., affiliations, partnerships, and bed use agreements) with healthcare providers	5.6%	12.0%	19.0%	26.8%	36.6%
Initiatives to help improve the image and reputation of the long-term care industry	5.0%	30.9%	13.0%	21.6%	29.5%
Initiatives to improve relationships between long-term care and referral sources, such as hospitals, Managed Care Organizations, and others	4.3%	24.5%	35.3%	27.3%	8.6%

Which initiatives would be the most impactful on your organization if implemented? Rank order from most important (1) to least important (5)
Area 5: Southeast

	1	2	3	4	5
Workforce initiatives to attract workers to the industry	84.8%	6.5%	4.4%	2.2%	2.2%
Initiatives to improve the living environment such as physical plant renovations, creating homelike environments, and other physical plant improvements for life enrichment of the residents and staff	6.5%	21.7%	37.0%	10.9%	23.9%
Initiatives to improve relationships between long-term care and referral sources, such as hospitals, Managed Care Organizations, and others	4.4%	28.3%	32.6%	23.9%	10.9%
Initiatives to help improve the image and reputation of the long-term care industry	4.3%	29.8%	12.8%	21.3%	31.9%
Initiatives to establish strategic options (e.g., affiliations, partnerships, and bed use agreements) with healthcare providers	4.3%	14.9%	12.8%	36.2%	31.9%

Referral Patterns

From where do your referrals originate, regardless of payor source?		
	Statewide	Area 5: Southeast
Managed care organization	73.1%	71.7% (n=33)
Family of resident	64.5%	65.2% (n=30)
Local hospital	61.0%	54.4% (n=25)
Existing residents	51.8%	54.4% (n=25)
Nursing homes	48.9%	39.1% (n=18)
Aging and disability resource center	42.6%	28.3% (n=13)
County agency	41.1%	28.3% (n=13)
Assisted living facility in the area	30.5%	21.7% (n=10)
Home health agency serving the area	25.5%	28.3% (n=13)
Doctor of resident	24.8%	19.6% (n=9)
Other	22.0%	23.9% (n=11)

What percentage of your occupied beds are private pay, Medicaid-waiver, or other residents?			
	Less than 20%	20-79%	80% or more
Statewide			
Private Pay	42.1%	41.3%	16.5%
Medicaid-waiver	24.1%	42.9%	33.1%
Other	76.3%	6.8%	17.0%
Area 5: Southeast			
Private Pay	47.7% (n=21)	31.8% (n=14)	20.5% (n=9)
Medicaid-waiver	25.0% (n=11)	36.4% (n=16)	38.6% (n=17)
Other	86.7% (n=13)	0.0% (n=0)	13.3% (n=2)

Percentage of respondents who are limiting Medicaid-waiver admissions due to financial constraints	
Average statewide	43.3%
Area 5: Southeast	34.8% (n=16)

Percentage of respondents who accept Medicaid-waiver referrals as direct admissions	
Average statewide	64.3%
Area 5: Southeast	58.7% (n=27)

Reasons for not accepting Medicaid-waiver referrals directly		
	Statewide	Area 5: Southeast
Medicaid-waiver rates are below cost to provide care	53.1% (n=26)	70.0% (n=14)
We allow current residents to transition to Medicaid-waiver only	42.9% (n=21)	50.0% (n=10)
Other	22.5% (n=11)	20.0% (n=4)
We are not contracted with a Medicaid Managed Care Organization/Medicaid-waiver program	20.4% (n=10)	10.0% (n=2)
Other financial considerations	6.1% (n=3)	5.0% (n=1)

From where do you receive Medicaid-waiver resident referrals?		
	Statewide	Area 5: Southeast
Managed care organization	85.7%	83.3% (n=35)
Aging and disability resource center	41.3%	38.1% (n=16)
Local hospital	38.9%	45.2% (n=19)
Family of resident	36.5%	33.3% (n=14)
Nursing homes	33.3%	31.0% (n=13)
County agency	29.4%	16.7% (n=7)
Existing residents	28.6%	33.3% (n=14)
Another assisted living facility in the area	23.8%	28.6% (n=12)
Home health agency serving the area	17.5%	11.9% (n=5)
Doctor of resident	15.1%	11.9% (n=5)
Other	5.6%	4.8% (n=2)

Why do you turn down nursing home referrals?		
	Statewide	Area 5: Southeast
Acuity/resident condition	61.1%	53.7% (n=22)
Behaviors	52.4%	48.8% (n=20)
Payor source	31.8%	26.8% (n=11)
Worker shortage	27.0%	24.4% (n=10)
Other	23.8%	29.3% (n=12)
Not eligible for any of the public payor sources (e.g., Medicaid-waiver)	15.1%	14.6% (n=6)

Which areas are challenges to accepting Medicaid referrals?		
	Statewide	Area 5: Southeast
Referral is not appropriate for our setting	66.4%	67.5% (n=27)
Behavioral health needs	57.6%	62.5% (n=25)
Complexity of acuity	48.0%	55.0% (n=22)
Lack of open beds	40.8%	35.0% (n=14)
Resident condition at time of referral	40.0%	42.5% (n=17)
Staffing shortages	32.0%	32.5% (n=13)
Payor authorization	30.4%	22.5% (n=9)
Other	21.6%	25.0% (n=10)
Urgency/timing of the referral	16.8%	12.5% (n=5)
Distance of the referral from the facility/family	10.4%	15.0% (n=6)
Cost of treatment/medications	9.6%	5.0% (n=2)
Covid outbreaks	8.8%	10.0% (n=4)
Pharmacy coverage	0.8%	0.0% (n=0)

How long, on average, are your private pay residents paying privately before they transition to Medicaid-waiver?		
	Statewide	Area 5: Southeast
Not relevant, do not contract with Medicaid-waiver/Medicaid-Managed Care Organization	4.7%	4.9% (n=2)
Less than 1 year	14.7%	22.0% (n=9)
1-2 years	20.9%	14.6% (n=6)
3-4 years	20.9%	22.0% (n=9)
5-6 years	5.4%	2.4% (n=1)
7-9 years	0.8%	2.4% (n=1)
10 years or more	0.8%	0.0% (n=0)
Do not know/do not track	31.8%	31.7% (n=13)

How long, on average, are residents on Medicaid-waiver?		
	Statewide	Area 5: Southeast
Not relevant, do not contract with Medicaid-waiver/Medicaid-Managed Care Organization	5.4%	4.8% (n=2)
Less than 1 year	3.9%	7.1% (n=3)
1-2 years	10.1%	0.0% (n=0)
3-4 years	17.1%	23.8% (n=10)
5-6 years	14.0%	14.3% (n=6)
7-9 years	2.3%	0.0% (n=0)
10 years or more	10.1%	11.9% (n=5)
Do not know/do not track	37.2%	38.1% (n=16)

What barriers exist to contracting with Medicaid-waiver, other than financial/rates?		
	Statewide	Area 5: Southeast
Not relevant, do not contract with Medicaid-waiver/Medicaid-Managed Care Organization	6.8%	7.7% (n=3)
Managed Care Organization issues	47.0%	48.7% (n=19)
Resident assessment/functional screen process	42.7%	30.8% (n=12)
Communication	32.5%	28.2% (n=11)
Contract issues	31.6%	30.8% (n=12)
Other	19.7%	23.1% (n=9)
Referral and admission process	18.8%	18.0% (n=7)
Clinical team (external)	11.1%	5.1% (n=2)
Aging and disability resource center	9.4%	2.6% (n=1)

Percentage of respondents who get direct referrals from hospitals	
Average statewide	69.9%
Area 5: Southeast	63.6% (n=28)

What barriers, if any, are you experiencing with receiving referrals from hospitals directly?		
	Statewide	Area 5: Southeast
Referral is not appropriate for our setting	48.9%	50.0% (n=21)
Resident condition at time of referral	44.3%	45.2% (n=19)
Urgency/timing of the referral	40.5%	45.2% (n=19)
Lack of open beds	37.4%	31.0% (n=13)
Payment source of resident	30.5%	23.8% (n=10)
Staffing shortages	22.9%	16.7% (n=7)
Not applicable	21.4%	19.1% (n=8)
Covid outbreaks	3.8%	4.8% (n=2)
Other	3.8%	7.1% (n=3)

Labor Pool

Percentage of respondents who are experiencing challenges in their labor pool that impact their ability to take referrals	
Average statewide	57.0%
Area 5: Southeast	60.5% (n=26)

Regarding challenges in your labor pool that impact your ability to take referrals, please choose the affected disciplines		
	Statewide	Area 5: Southeast
Lack of caregivers	93.5%	84.6% (n=22)
Lack of available Certified Nursing Assistants	52.0%	46.2% (n=12)
Lack of available other direct care/support staff	48.1%	42.3% (n=11)
Lack of available housekeeping, other non-direct care support staff	31.2%	30.8% (n=8)
Lack of available dietary staff	24.7%	26.9% (n=7)
Lack of available Registered Nurses	20.8%	19.2% (n=5)
Lack of available intake staff	15.6%	19.2% (n=5)
Lack of available Licensed Practical Nurses	14.3%	11.5% (n=3)
Other	6.5%	11.5% (n=3)

Please identify other challenges in workforce		
	Statewide	Area 5: Southeast
Competitive rates/wages	89.0%	88.4% (n=38)
Recruitment	61.0%	62.8% (n=27)
Retention	58.8%	62.8% (n=27)
Labor pool experience level	48.5%	60.5% (n=26)
Staff attrition	40.4%	48.8% (n=21)
Non-Compensated benefits	36.8%	39.5% (n=17)
Initial and ongoing training requirements	36.0%	30.2% (n=13)
Geography/travel distance	18.4%	23.3% (n=10)
Other	8.1%	9.3% (n=4)

Please identify the challenges with attracting and retaining staff		
	Statewide	Area 5: Southeast
Competitive rates/wages	83.0%	81.4% (n=35)
Staff availability	61.5%	60.5% (n=26)
Complex needs of the resident population (e.g., behavioral health, dementia, very high acuity)	43.7%	39.5% (n=17)
Non-Compensated benefits	34.8%	30.2% (n=13)
Staff attrition	29.6%	34.9% (n=15)
Other	11.9%	11.6% (n=5)
Corporate culture	3.0%	0.0% (n=0)
Physical plant/environment	2.2%	0.0% (n=0)

Percentage of respondents who are involved in any collaborative initiatives to solve labor challenges	
Average statewide	50.4% (n=68)
Area 5: Southeast	46.5% (n=20)

Percentage of respondents who are part of Wisconsin Center for Collaborative Excellence in Assisted Living (WCCEAL)	
Average statewide	38.2% (n=26)
Area 5: Southeast	47.4% (n=9)

Percentage of respondents who needed to use agency/contracted staff to provide patient care in the past 18 months	
Average statewide	38.5% (n=52)
Area 5: Southeast	46.5% (n=20)

What percentage of your direct care time was performed by agency staff over the last 18 months? *Statewide Results*	
5% or less	26.7% (n=12)
6-10%	26.7% (n=12)
11-25%	26.7% (n=12)
26-40%	8.9% (n=4)
More than 40%	11.1% (n=5)

Benefits offered to direct care staff		
	Statewide	Area 5: Southeast
Paid time off	90.8%	82.9% (n=34)
Training	88.6%	87.8% (n=36)
Flexible schedule	79.4%	75.6% (n=31)
Bonus/reward system (incremental)	70.2%	73.2% (n=30)
Health insurance	59.5%	51.2% (n=21)
Retirement plan	58.0%	48.8% (n=20)
Opportunities for paid continued education	50.4%	46.3% (n=19)
Sign on bonus	42.0%	56.1% (n=23)
Retention bonus	38.9%	39.0% (n=16)
Other	13.7%	12.2% (n=5)
Travel assistance (e.g., reduced bus pass)	9.2%	14.6% (n=6)
Workforce housing	2.3%	2.4% (n=1)
Childcare assistance	1.5%	2.4% (n=1)

What was your percentage turnover in the past 12 months for the following positions? *Statewide Results (n=126)*	Less than 10%	10-29%	30-49%	50-69%	70% or more
Registered Nurse	71.4%	3.6%	6.0%	7.1%	11.9%
Certified Nursing Assistant	30.3%	21.1%	19.7%	14.5%	14.5%
Licensed Practical Nurse	83.3%	5.6%	3.7%	5.6%	1.9%
Caregiver	11.4%	17.9%	37.4%	20.3%	13.0%
Administrator	81.2%	7.3%	0.0%	4.4%	7.3%
Finance	93.2%	1.7%	3.4%	1.7%	0.0%
Office/administrative	76.9%	13.9%	6.2%	1.5%	1.5%
Other	54.6%	9.1%	27.3%	4.6%	4.6%

What was your percentage turnover in the past 12 months for the following positions? *Area 5: Southeast Results (n=40)*	Less than 10%	10-29%	30-49%	50-69%	70% or more
Registered Nurse	75.9%	3.5%	3.5%	6.9%	10.3%
Certified Nursing Assistant	29.2%	20.8%	25.0%	16.7%	8.3%
Licensed Practical Nurse	87.5%	6.3%	0.0%	6.3%	0.0%
Caregiver	15.0%	12.5%	42.5%	17.5%	12.5%
Administrator	81.8%	9.1%	0.0%	4.6%	4.6%
Finance	100.0%	0.0%	0.0%	0.0%	0.0%
Office/administrative	84.2%	15.8%	0.0%	0.0%	0.0%
Other	83.3%	0.0%	16.7%	0.0%	0.0%

Percentage of respondents who had open beds for admission from referral sources but had to limit admissions due to staffing limitations in the past year	
Average statewide	38.9% (n=51)
Area 5: Southeast	37.5% (n=15)

Percentage of respondents who had open beds for Medicaid-waiver admission from referral sources but had to limit admissions due to staffing limitations in the past year	
Average statewide	37.1% (n=49)
Area 5: Southeast	34.2% (n=14)

Bed Capacity Needs/Future/Prospective

Percentage of respondents who anticipate participating in the Medicaid-waiver program for the next 12 months	
Average statewide	75.6% (n=99)
Area 5: Southeast	82.9% (n=34)

Percentage of respondents who anticipate participating in the Medicaid-waiver program and accepting/keeping residents on Medicaid-waiver in their facility for the next 5 years	
Average statewide	67.2% (n=88)
Area 5: Southeast	73.2% (n=30)

Percentage of respondents who anticipate increasing Medicaid-waiver capacity (percent of admissions; percent of total beds) at their facility in the next 12 months	
Average statewide	22.1% (n=29)
Area 5: Southeast	31.7% (n=13)

Percentage of respondents who anticipate accepting Medicaid-waiver admissions directly at their facility in the next 12 months	
Average statewide	50.0% (n=64)
Area 5: Southeast	46.2% (n=18)

Percentage of respondents who anticipate providing memory care services/beds for persons on Medicaid-waiver in the next 12 months	
Average statewide	39.2% (n=49)
Area 5: Southeast	50.0% (n=19)

Percentage of respondents who anticipate accepting high acuity resident referrals on Medicaid-waiver in the next 12 months	
Average statewide	28.8% (n=36)
Area 5: Southeast	26.3% (n=10)

Percentage of respondents who anticipate accepting referrals for residents with complex behaviors and are on Medicaid-waiver in the next 12 months	
Average statewide	27.0% (n=34)
Area 5: Southeast	29.0% (n=11)

Resident units/room and amenity types

	Statewide	Area 5: Southeast
Average units/rooms with private bathroom	64.1% (n=118)	61.3% (n=34)
Average units/rooms with shared bathroom	33.8% (n=116)	36.8% (n=34)
Average units/rooms with private shower	45.1% (n=109)	48.3% (n=32)
Average units/rooms with shared shower	45.5% (n=108)	41.1% (n=32)

Resident rooms that are accessible	
Average statewide	91.5% (n=118)
Area 5: Southeast	89.7% (n=35)

What changes, other than reimbursement, are needed for you to accept Medicaid-waiver admissions (direct, not through attrition)?

	Statewide	Area 5: Southeast
Workforce initiatives to attract workers to the industry	61.9%	67.6% (n=25)
Managed Care Organization/provider relationship initiatives	54.2%	51.4% (n=19)
Increase in workforce to staff available beds	47.5%	43.2% (n=16)
Process improvement (resident assessments, communication, referrals, case management, etc.)	46.6%	51.4% (n=19)
Training programs for staff (for increasing acuity, etc.)	32.2%	32.4% (n=12)
Image/branding improvement initiatives for the industry	23.7%	16.2% (n=6)
Other	14.4%	13.5% (n=5)
Presumptive eligibility	8.5%	8.1% (n=3)

If the Department of Health Services increases Medicaid rates, what would you do with the money specifically?

	Statewide	Area 5: Southeast
Increase wages for current staff	88.5%	86.5% (n=32)
Accept more Medicaid-waiver referrals	50.0%	37.8% (n=14)
Increase staff to resident ratio	47.5%	37.8% (n=14)
Invest in physical plant/infrastructure	41.8%	32.4% (n=12)
Expand services (evaluate new services, add capacity, etc.)	31.2%	27.0% (n=10)
Accept higher acuity referrals	26.2%	18.9% (n=7)
Save any excess funds	13.1%	18.9% (n=7)
Reopen closed wings	9.8%	5.4% (n=2)
Other	8.2%	13.5% (n=5)

RCAC Provider Survey Results

Demographics

Which Health Services Area(s) are you located in?		
Health Service Areas	**Percentage of Respondents**	**Respondents**
Area 1: Northwest (Douglas, Bayfield, Ashland, Burnett, Washburn, Sawyer, Polk, Barron, Rusk, Saint Croix, Dunn, Chippewa, Pierce, Pepin, Eau Claire Counties)	12.5%	5
Area 2: North Central (Iron, Vilas, Price, Oneida, Forest, Taylor, Lincoln, Langlade, Clark, Marathon, Wood, Portage Counties)	10.0%	4
Area 3: Northeast (Florence, Marinette, Oconto, Door, Kewaunee, Brown, Manitowoc Counties)	7.5%	3
Area 4: Fox Valley Area (Menominee, Shawano, Waupaca, Outagamie, Waushara, Winnebago, Calumet, Green Lake Counties)	10.0%	4
Area 5: Southeast (Fond du Lac, Sheboygan, Ozaukee, Washington, Milwaukee, Waukesha, Racine, Walworth, Kenosha Counties)	27.5%	11
Area 6: South Central (Juneau, Adams, Marquette, Richland, Sauk, Columbia, Dodge, Grant, Iowa, Dane, Jefferson, Lafayette, Green, Rock Counties)	17.5%	7
Area 7: Western (Buffalo, Trempealeau, Jackson, La Crosse, Monroe, Vernon, Crawford Counties)	20.0%	8
Total Respondents*	**42**	

*Respondents may serve more than one Health Service Area. Percentages do not equal 100%.

Current Occupancy, 2022 Year to Date	
Average statewide	78.8% (n=36)

Ownership Type		
	Free Standing or Private Ownership	Part of a Corporate Chain
Average statewide	77.5%	22.5%

Characteristics of campus	
Residential Care Apartment Complex only	85.0%
Memory care Community Based Residential Facility	35.0%
Community Based Residential Facility	32.5%
Nursing home	32.5%
Senior housing/homes (market rate)	20.0%
Other	15.0%
Personal care agency/non-certified home care program	12.5%
Affordable housing	7.5%
Home health agency	7.5%
Adult day center	5.0%

Initiatives

Which initiatives would be the most impactful on your organization if implemented? Rank order from most important (1) to least important (5) *(n=35)*	1	2	3	4	5
Workforce initiatives to attract workers to the industry	68.6%	14.3%	5.7%	5.7%	5.7%
Initiatives to help improve the image and reputation of the long-term care industry	14.3%	20.0%	28.6%	20.0%	17.1%
Initiatives to improve the living environment such as physical plant renovations, creating homelike environments, and other physical plant improvements for life enrichment of the residents and staff	11.8%	32.4%	23.5%	20.6%	11.8%
Initiatives to improve relationships between long-term care and referral sources, such as hospitals, Managed Care Organizations, and others	5.7%	17.1%	31.4%	37.1%	8.6%
Initiatives to establish strategic options (e.g., affiliations, partnerships, and bed use agreements) with healthcare providers	0.0%	14.3%	11.4%	17.1%	57.1%

Referral Patterns

Medicaid-waiver referrals as direct admissions	
Accept	50.0% (n=18)
Do not accept (reasons below)	50.0% (n=18)
Medicaid-waiver rates are below cost to provide care	50.0% (n=9)
We allow current residents to transition to Medicaid-waiver only	33.3% (n=6)
We are not contracted with a Medicaid Managed Care Organization/Medicaid-waiver program	27.8% (n=5)
Other	16.7% (n=3)
Other financial considerations	11.1% (n=2)

What percentage of your occupied beds are private pay, Medicaid-waiver, or other residents? *(n=34)*

	Less than 20%	20-79%	80% or more
Private Pay	8.8%	44.1%	47.1%
Medicaid-waiver	29.6%	63.0%	7.4%
Other	100.0%	0.0%	0.0%

Percentage of respondents who are limiting Medicaid-waiver admissions due to financial constraints	
Average statewide	60.0% (n=21)

From where do your referrals originate, regardless of payor source? *(n=35)*	
Family of resident	94.3%
Existing residents	85.7%
Managed care organization	74.3%
Nursing homes	71.4%
Aging and disability resource center	62.9%
Doctor of resident	60.0%
Local hospital	54.3%
Home health agency serving the area	45.7%
Another assisted living facility in the area	40.0%
County agency	17.1%
Other	14.3%

What are significant barriers to taking referrals in general? *(n=36)*	
Payment source of resident	75.0%
Referral is not appropriate for our setting	69.4%
Resident condition at time of referral	63.9%
Behavioral health needs	55.6%
Complexity of acuity	44.4%
Staffing shortages	38.9%
Urgency/timing of the referral	38.9%
Lack of open beds	25.0%
Distance of the referral from the facility/family	19.4%
Covid outbreaks	8.3%
Other	0.0%

Which areas are challenges to accepting Medicaid referrals? *(n=31)*	
Referral is not appropriate for our setting	64.5%
Behavioral health needs	48.4%
Other	45.2%
Resident condition at time of referral	41.9%
Complexity of acuity	41.9%
Payor authorization	38.7%
Staffing shortages	29.0%
Lack of open beds	25.8%
Urgency/timing of the referral	22.6%
Cost of treatment/medications	22.6%
Covid outbreaks	9.7%
Distance of the referral from the facility/family	6.5%
Pharmacy coverage	3.2%

What barriers are you experiencing with receiving referrals from hospitals directly? *(n=33)*	
Referral is not appropriate for our setting	42.4%
Resident condition at time of referral	39.4%
Urgency/timing of the referral	39.4%
Not relevant, we do not receive referrals from hospitals	27.3%
Payment source of resident	27.3%
Lack of open beds	21.2%
Staffing shortages	12.1%
Other	12.1%
Covid outbreaks	9.1%

What barriers exist to contracting with Medicaid-waiver, other than financial/rates? *(n=30)*	
Not relevant, do not contract with Medicaid-waiver/Medicaid-Managed Care Organization	20.0%
Managed Care Organization issues	56.7%
Communication	46.7%
Resident assessment/functional screen process	46.7%
Referral and admission process	23.3%
Contract issues	23.3%
Other	20.0%
Aging and disability resource center	13.3%
Clinical team (external)	13.3%

How long, on average, are your private pay residents paying privately before they transition to Medicaid-waiver? *(n=36)*	
Not relevant, do not contract with Medicaid-waiver/Medicaid-Managed Care Organization	13.9%
Less than 1 year	2.8%
1-2 years	22.2%
3-4 years	30.6%
5-6 years	8.3%
7-9 years	8.3%
10 years or more	2.8%
Do not know/do not track	11.1%

How long, on average, are residents to Medicaid-waiver? *(n=36)*	
Not relevant, do not contract with Medicaid-waiver/Medicaid-Managed Care Organization	16.7%
Less than 1 year	0.0%
1-2 years	13.9%
3-4 years	27.8%
5-6 years	8.3%
7-9 years	5.6%
10 years or more	0.0%
Do not know/do not track	27.8%

Labor Pool

Percentage of respondents who are experiencing challenges in their labor pool that impact their ability to take referrals	
Average statewide	52.8% (n=19)
Affected disciplines:	
Lack of caregivers	94.7% (n=18)
Lack of available Certified Nursing Assistants	57.9% (n=11)
Lack of available other direct care/support staff	42.1% (n=8)
Lack of available housekeeping, other non-direct care support staff	26.3% (n=5)
Lack of available dietary staff	21.1% (n=4)
Lack of available Registered Nurses	15.8% (n=3)
Lack of available Licensed Practical Nurses	10.5% (n=2)

Please identify other challenges in workforce ***(n=35)***	
Competitive rates/wages	88.6%
Retention	60.0%
Recruitment	57.1%
Labor pool experience level	45.7%
Non-compensated benefits	40.0%
Staff attrition	20.0%
Geography/travel distance	20.0%
Initial and ongoing training requirements	20.0%
Other	8.6%

Please identify the challenges with attracting and retaining staff ***(n=35)***	
Competitive rates/wages	88.6%
Staff availability	68.6%
Non-compensated benefits	37.1%
Staff attrition	22.9%
Other	8.6%
Physical plant/environment	2.9%
Corporate culture	2.9%

Percentage of respondents who participate in any collaborative initiatives to solve labor challenges	
Average statewide	52.8% (n=19)

Percentage of respondents who are part of Wisconsin Center for Collaborative Excellence in Assisted Living (WCCEAL)	
Average statewide	68.4% (n=13)

Percentage of respondents who needed to use agency/contracted staff to provide patient care in the past 18 months	
Average statewide	33.3% (n=12)
Percent of direct care time was performed by agency staff:	
5% or less	54.5% (n=6)
6-10%	36.4% (n=4)
11-25%	9.1% (n=1)
26-40%	0.0% (n=0)
More than 40%	0.0% (n=0)

Benefits offered to direct care staff *(n=35)*	
Paid time off	88.6%
Flexible schedule	88.6%
Training	88.6%
Health insurance	77.1%
Retirement plan	71.4%
Bonus/reward system (incremental)	68.6%
Sign on bonus	62.9%
Opportunities for paid continued education	45.7%
Retention bonus	37.1%
Other	14.3%
Workforce housing	2.9%
Travel assistance (e.g., reduced bus pass)	2.9%
Childcare assistance	2.9%

What was your percentage turnover in the past 12 months for the following positions? *(n=31)*					
	Less than 10%	10-29%	30-49%	50-69%	70% or more
Registered Nurse	76.0%	4.0%	4.0%	4.0%	12.0%
Certified Nursing Assistant	28.0%	36.0%	16.0%	8.0%	12.0%
Caregiver	24.1%	24.1%	27.6%	10.3%	13.8%
Administrator	77.3%	9.1%	0.0%	4.6%	9.1%
Finance	94.7%	0.0%	0.0%	5.3%	0.0%
Office/administrative	85.0%	10.0%	5.0%	0.0%	0.0%
Other	63.6%	18.2%	9.1%	0.0%	9.1%

Percentage of respondents who had open beds for admission from referral sources but had to limit admissions due to staffing limitations in the past year	
Average statewide	28.6% (n=10)

Percentage of respondents who had open beds for Medicaid-waiver admission from referral sources but had to limit admissions due to staffing limitations in the past year	
Average statewide	22.9% (n=8)

Bed Capacity Needs/Future/Prospective

Anticipated Medicaid-waiver program participation in the next 12 months	
Anticipate participating in the Medicaid-waiver program	60.0% (n=21)
Anticipate participating in the program and accepting/keeping residents on Medicaid-waiver in the facility for the next 5 years	42.9% (n=15)
Anticipate increasing Medicaid-waiver capacity (percent of admissions; percent of total beds)	8.9% (n=3)
Anticipate accepting Medicaid-waiver admissions directly at the facility	34.3% (n=12)

What changes, other than reimbursement, are needed for you to accept Medicaid-waiver admissions (direct, not through attrition)? ***(n=29)***	
Managed Care Organization/provider relationship initiatives	69.0%
Process improvement (resident assessments, communication, referrals, case management, etc.)	65.5%
Workforce initiatives to attract workers to the industry	62.1%
Increase in workforce to staff available beds	48.3%
Training programs for staff (for increasing acuity, etc.)	24.1%
Other	24.1%
Image/branding improvement initiatives for the industry	20.7%
Presumptive eligibility	13.8%

If the Department of Health Services increases Medicaid rates, what would you do with the money specifically? ***(n=29)***	
Increase wages for current staff	89.7%
Accept more Medicaid-waiver referrals	65.5%
Invest in physical plant/infrastructure	58.6%
Increase staff to resident ratio	55.2%
Expand services (evaluate new services, add capacity, etc.)	34.5%
Accept higher acuity referrals	34.5%
Save any excess funds	6.9%
Reopen closed wings	6.9%
Other	6.9%

Nursing Home Provider Survey Results

Demographics

Which Health Services Area(s) are you located in?

Health Service Areas	Percentage of Respondents	Respondents
Area 1: Northwest (Douglas, Bayfield, Ashland, Burnett, Washburn, Sawyer, Polk, Barron, Rusk, Saint Croix, Dunn, Chippewa, Pierce, Pepin, Eau Claire Counties)	19.0%	27
Area 2: North Central (Iron, Vilas, Price, Oneida, Forest, Taylor, Lincoln, Langlade, Clark, Marathon, Wood, Portage Counties)	5.6%	8
Area 3: Northeast (Florence, Marinette, Oconto, Door, Kewaunee, Brown, Manitowoc Counties)	7.8%	11
Area 4: Fox Valley Area (Menominee, Shawano, Waupaca, Outagamie, Waushara, Winnebago, Calumet, Green Lake Counties)	11.3%	16
Area 5: Southeast (Fond du Lac, Sheboygan, Ozaukee, Washington, Milwaukee, Waukesha, Racine, Walworth, Kenosha Counties)	31.7%	45
Area 6: South Central (Juneau, Adams, Marquette, Richland, Sauk, Columbia, Dodge, Grant, Iowa, Dane, Jefferson, Lafayette, Green, Rock Counties)	23.9%	34
Area 7: Western (Buffalo, Trempealeau, Jackson, La Crosse, Monroe, Vernon, Crawford Counties)	9.2%	13
Total Respondents*		**142**

*Respondents may serve more than one Health Service Area. Percentages do not equal 100%.

Total number of "set up and staffed" beds by year

	2018	2019	2020	2021	2022 YTD
Statewide (n=134)	12,873	12,603	12,157	11,772	11,641
Area 5: Southeast (n=42)	6,030	5,978	5,683	5,538	5,417

On average in 2022, what percent of beds are occupied by long-term care residents (regardless of payor source)?

	Statewide	Area 5: Southeast
Less than 20%	1.5%	4.9%
20-29%	1.5%	0.0%
30-39%	2.2%	2.4%
40-49%	8.2%	17.1%
50-59%	12.7%	14.6%
60-69%	20.9%	22.0%
70-79%	24.6%	19.5%
80% or more	27.6%	17.1%
Not applicable, do not serve this population	0.8%	2.4%

On average in 2022, what percent of the total bed capacity is designated for persons with dementia/significant cognitive decline?		
	Statewide	Area 5: Southeast
Less than 20%	28.7%	38.1%
20-29%	16.9%	9.5%
30-39%	11.0%	11.9%
40-49%	7.4%	2.4%
50-59%	8.1%	7.1%
60-69%	3.7%	2.4%
70-79%	2.9%	2.4%
80% or more	7.4%	7.1%
Not applicable, do not serve this population	14.0%	19.1%

On average in 2022, what percent of the total bed capacity is designated for clinically complex and very high acuity residents?		
	Statewide	Area 5: Southeast
Less than 20%	33.3%	29.3%
20-29%	23.7%	14.6%
30-39%	13.3%	19.5%
40-49%	7.4%	7.3%
50-59%	4.4%	2.4%
60-69%	3.0%	4.9%
70-79%	2.2%	0.0%
80% or more	8.9%	17.1%
Not applicable, do not serve this population	3.7%	4.9%

On average in 2022, what percent of the total bed capacity is designated for complex behavior residents?		
	Statewide	Area 5: Southeast
Less than 20%	51.5%	48.8%
20-29%	6.6%	0.0%
30-39%	2.9%	4.7%
40-49%	0.7%	2.3%
50-59%	0.7%	2.3%
60-69%	1.5%	2.3%
70-79%	0.7%	0.0%
80% or more	3.7%	4.7%
Not applicable, do not serve this population	31.6%	34.9%

Ownership Type		
	Free Standing or Private Ownership	Part of a Corporate Chain
Average statewide	57.5%	42.5%
Area 5: Southeast	38.1%	61.9%

Characteristics of campus		
	Statewide	Area 5: Southeast
Nursing home only	83.9%	83.7%
Community Based Residential Facility	32.9%	30.2%
Memory care Community Based Residential Facility	18.3%	25.6%
Residential Care Apartment Complex	28.5%	25.6%
Senior housing/homes (market rate)	13.9%	11.6%
Affordable housing	2.2%	0.0%
Home health agency	6.6%	9.3%
Personal care agency/non-certified home care program	5.1%	4.7%
Adult day center	5.1%	2.3%
Other	8.8%	9.3%

Initiatives

Which initiatives would be the most impactful on your organization if implemented? Rank order from most important (1) to least important (5) *Statewide Results*					
	1	2	3	4	5
Workforce initiatives to attract workers to the industry	87.4%	6.3%	2.7%	1.8%	1.8%
Initiatives to help improve the image and reputation of the long-term care industry	5.4%	32.1%	26.8%	16.1%	19.6%
Initiatives to improve the living environment such as physical plant renovations, creating homelike environments, and other physical plant improvements for life enrichment of the residents and staff	4.5%	30.6%	24.3%	19.8%	20.7%
Initiatives to improve relationships between long-term care and referral sources, such as hospitals, Managed Care Organizations, and others	1.8%	22.1%	26.6%	32.7%	16.8%
Initiatives to establish strategic options (e.g., affiliations, partnerships, and bed use agreements) with healthcare providers	1.8%	9.7%	20.4%	28.3%	39.8%

Which initiatives would be the most impactful on your organization if implemented? Rank order from most important (1) to least important (5)
Area 5: Southeast

	1	2	3	4	5
Workforce initiatives to attract workers to the industry	83.3%	11.1%	0.0%	2.8%	2.8%
Initiatives to improve the living environment such as physical plant renovations, creating homelike environments, and other physical plant improvements for life enrichment of the residents and staff	8.3%	33.3%	22.2%	22.2%	13.9%
Initiatives to establish strategic options (e.g., affiliations, partnerships, and bed use agreements) with healthcare providers	5.6%	2.8%	11.1%	41.7%	38.9%
Initiatives to help improve the image and reputation of the long-term care industry	2.8%	33.3%	38.9%	5.6%	19.4%
Initiatives to improve relationships between long-term care and referral sources, such as hospitals, Managed Care Organizations, and others	0.0%	19.4%	27.8%	27.8%	25.0%

Referral Patterns

From where do your referrals originate, regardless of payor source?

	Statewide	Area 5: Southeast
Local hospital	100.0%	100.0% (n=36)
Family of resident	69.0%	61.1% (n=22)
Assisted living facility in the area	62.0%	55.6% (n=20)
Other nursing homes	57.5%	66.7% (n=24)
Managed care organization	56.6%	36.1% (n=13)
Doctor of resident	44.3%	33.3% (n=12)
Home health agency serving the area	37.2%	38.9% (n=14)
Existing residents	37.2%	44.4% (n=16)
Aging and disability resource center	25.7%	22.2% (n=8)
County agency	17.7%	13.9% (n=5)
Other	8.9%	11.1% (n=4)

For the past 12 months, what were reasons you declined referrals (from any source)?

	Statewide	Area 5: Southeast
Behavioral health needs	85.7%	83.3% (n=30)
Provider staffing issues	75.9%	58.3% (n=21)
Payor/insurance coverage	68.8%	66.7% (n=24)
Cost of treatment/medications	67.9%	69.4% (n=25)
Complexity of clinical acuity	65.2%	63.9% (n=23)
Covid outbreaks	58.0%	55.6% (n=20)
Payor/insurance authorization	55.4%	58.3% (n=21)
Payor/insurance acceptance	52.7%	63.9% (n=23)
Lack of safe/available housing for discharge	33.0%	38.9% (n=14)
Lack of available beds	29.5%	25.0% (n=9)
Other	6.3%	2.8% (n=1)
Pharmacy coverage	4.5%	2.8% (n=1)
Lack of primary care physician	1.8%	2.8% (n=1)
Physician orders	0.9%	0.0% (n=0)
Not applicable, did not decline any referrals	0.0%	0.0% (n=0)

Percentage of respondents who had open beds for admissions from hospital referrals but had to limit admissions due to staffing limitations in the past year

Average statewide	86.5%
Area 5: Southeast	77.1% (n=27)

For the past 12 months, how many patient referrals from hospitals did you decline?

	Statewide	Area 5: Southeast
We did not decline any referrals	0.9%	2.8% (n=1)
1-50	32.1%	30.6% (n=11)
51-100	19.6%	5.6% (n=2)
101 or more	39.3%	50.0% (n=18)
Do not know	8.0%	11.1% (n=4)

Of the total for the past 12 months, how many declined referrals from any source were Medicaid referrals?

	Statewide	Area 5: Southeast
We did not decline any referrals	6.4%	5.7% (n=2)
1-50	36.4%	31.4% (n=11)
51-100	8.2%	5.7% (n=2)
101 or more	10.0%	17.1% (n=6)
Do not know	39.1%	40.0% (n=14)

Percentage of respondents who belong to a preferred provider network	
Average statewide	50.0%
Area 5: Southeast	48.6% (n=17)

What ways could your referral sources support you as a provider of long-term care services?	Statewide	Area 5: Southeast
Shared electronic medical records system	67.3%	65.7% (n=23)
Better/more regular communication	53.3%	51.4% (n=18)
Regular update on discharge needs	46.7%	40.0% (n=14)
Staff training	42.1%	42.9% (n=15)
Affiliation	20.6%	28.6% (n=10)
Other	15.9%	17.1% (n=6)
Programming	10.3%	8.6% (n=3)
None of the above	7.5%	2.9% (n=1)

What are significant barriers to accepting referrals in general?	Statewide	Area 5: Southeast
Staffing shortages	79.1%	62.9% (n=22)
Behavioral health needs	77.3%	85.7% (n=30)
Referral is not appropriate for our setting	64.6%	54.3% (n=19)
Complexity of acuity	55.5%	60.0% (n=21)
Resident condition at time of referral	50.9%	51.4% (n=18)
Payment source of resident	47.3%	42.9% (n=15)
Covid outbreaks	30.0%	34.3% (n=12)
Lack of open beds	27.3%	17.1% (n=6)
Distance of the referral from the facility/family	17.3%	14.3% (n=5)
Lack of private rooms at the facility	16.4%	22.9% (n=8)
Urgency/timing of the referral	15.5%	5.7% (n=2)
Other	3.6%	8.6% (n=3)

Which areas are challenges to accepting Medicaid referrals?		
	Statewide	Area 5: Southeast
Staffing shortages	68.3%	44.8% (n=13)
Behavioral health needs	67.3%	65.5% (n=19)
Referral is not appropriate for our setting	64.4%	65.5% (n=19)
Complexity of acuity	51.9%	55.2% (n=16)
Cost of treatment/medications	37.5%	31.0% (n=9)
Resident condition at time of referral	35.6%	24.1% (n=7)
Lack of open beds	26.0%	17.2% (n=5)
Covid outbreaks	20.2%	20.7% (n=6)
Payor authorization	17.3%	24.1% (n=7)
Distance of the referral from the facility/family	15.4%	10.3% (n=3)
Other	14.4%	24.1% (n=7)
Urgency/timing of the referral	12.5%	10.3% (n=3)
Pharmacy coverage	3.9%	10.3% (n=3)

Labor Pool

Percentage of respondents who are experiencing challenges in their labor pool that impact their ability to take referrals	
Average statewide	86.4%
Area 5: Southeast	80.0% (n=28)

Regarding challenges in your labor pool that impact your ability to take referrals, please choose the affected disciplines		
	Statewide	Area 5: Southeast
Lack of available Certified Nursing Assistants	99.0%	96.4% (n=27)
Lack of available Registered Nurses	89.5%	92.9% (n=26)
Lack of Licensed Practical Nurses	80.0%	75.0% (n=21)
Lack of available dietary staff	60.0%	53.6% (n=15)
Agencies are unable to supply nurses, other direct care staff timely	52.6%	53.6% (n=15)
Lack of available housekeeping, other non-direct care support staff	47.4%	46.4% (n=13)
Lack of available other direct care/support staff	24.2%	25.0% (n=7)
Director of Nursing	20.0%	28.6% (n=8)
Lack of physical therapists	19.0%	17.9% (n=5)
Lack of speech therapists	15.8%	21.4% (n=6)
Lack of occupational therapists	14.7%	14.3% (n=4)
Open administrative positions (Nursing Home Administrator, other)	12.6%	17.9% (n=5)
Lack of available admissions staff	5.3%	7.1% (n=2)
Other	3.2%	3.6% (n=1)

Please identify other challenges in workforce		
	Statewide	Area 5: Southeast
Competitive rates/wages	91.6%	87.9% (n=29)
Recruitment	75.7%	72.7% (n=24)
Retention	66.4%	72.7% (n=24)
Staff attrition	47.7%	51.5% (n=17)
Labor pool experience level	43.9%	54.6% (n=18)
Non-Compensated benefits	30.8%	24.2% (n=8)
Initial and ongoing training requirements	27.1%	30.3% (n=10)
Geography/travel distance	23.4%	21.2% (n=7)
Other	13.1%	15.2% (n=5)

Please identify the challenges with attracting and retaining staff		
	Statewide	Area 5: Southeast
Competitive rates/wages	83.2%	76.5% (n=26)
Staff availability	76.6%	82.4% (n=28)
Complex needs of the resident population (e.g., behavioral health, dementia, very high acuity)	38.3%	41.2% (n=14)
Non-Compensated benefits	29.9%	23.5% (n=8)
Staff attrition	29.9%	29.4% (n=10)
Corporate culture	13.1%	26.5% (n=9)
Physical plant/environment	6.5%	5.9% (n=2)
Other	5.6%	5.9% (n=2)

Percentage of respondents who participate in any collaborative initiatives to solve labor challenges	
Average statewide	63.1% (n=67)
Area 5: Southeast	54.6% (n=18)

Percentage of respondents who needed to use agency/contracted staff to provide patient care in the past 18 months	
Average statewide	88.0% (n=95)
Area 5: Southeast	82.4% (n=28)

What percentage of your direct care time was performed by agency staff over the last 18 months? *Statewide Results*	
5% or less	23.0% (n=20)
6-10%	16.1% (n=14)
11-25%	25.3% (n=22)
26-40%	24.1% (n=21)
More than 40%	11.5% (n=10)

What percentage of your direct care time was performed by agency/contracted staff for the following years?
Statewide Results (n=100)

	None	1-9%	10-19%	20-29%	30-39%	40-49%	50%+
2019	58.1%	25.8%	10.8%	4.3%	0.0%	0.0%	1.1%
2020	52.1%	23.4%	10.6%	9.6%	2.1%	1.1%	1.1%
2021	26.0%	20.8%	25.0%	9.4%	9.4%	4.2%	5.2%
2022	12.0%	27.0%	18.0%	12.0%	8.0%	14.0%	9.0%

Benefits offered to direct care staff

	Statewide	Area 5: Southeast
Health insurance	99.1%	96.9% (n=31)
Paid time off	99.1%	100.0% (n=32)
Retirement plan	90.5%	84.4% (n=27)
Flexible schedule	83.8%	78.1% (n=25)
Training	82.9%	78.1% (n=25)
Bonus/reward system (incremental)	75.2%	75.0% (n=24)
Sign on bonus	75.2%	84.4% (n=27)
Opportunities for paid continued education	65.7%	71.9% (n=23)
Retention bonus	51.4%	59.4% (n=19)
Other	10.5%	9.4% (n=3)
Childcare assistance	5.7%	9.4% (n=3)
Travel assistance (e.g., reduced bus pass)	2.9%	6.3% (n=2)
Workforce housing	1.9%	6.3% (n=2)

What was your percentage turnover in the past 12 months for the following positions?
Statewide Results (n=94)

	Less than 10%	10-29%	30-49%	50-69%	70% or more
Registered Nurse	25.8%	46.2%	16.1%	7.5%	4.3%
Certified Nursing Assistant	2.2%	29.0%	39.8%	20.4%	8.6%
Licensed Practical Nurse	36.3%	31.9%	19.8%	8.8%	3.3%
Social Worker	63.2%	12.7%	4.6%	9.2%	10.3%
Administrator	77.4%	3.6%	4.8%	3.6%	10.7%
Finance	62.7%	15.7%	7.2%	4.8%	9.6%
Office/administrative	68.6%	17.4%	8.1%	4.7%	1.2%
Other	33.3%	31.4%	19.6%	7.8%	7.8%

Bed Capacity Needs/Future/Prospective

Percentage of respondents who are going to downsize bed capacity in the foreseeable future	
Average statewide	13.3% (n=14)
Area 5: Southeast	18.8% (n=6)

Reason for downsizing bed capacity ***Statewide Results (n=14)***	
Excess capacity	7.1% (n=1)
Medicaid reimbursement rate	21.4% (n=3)
Financial concerns	7.1% (n=1)
Workforce/labor shortage	50.0% (n=7)
Converting to an assisted living facility	0.0% (n=o)
Other	14.3% (n=2)

Period for downsizing bed capacity ***Statewide Results (n=12)***	
Within the next 12 months	76.9% (n=10)
12-24 months	23.1% (n=3)
Longer than 24 months	0.0% (n=0)

Percentage of respondents who are planning to decertify Medicaid and/or Medicare in their building(s) in the next 12-24 months				
	Plan to decertify	Medicare	Medicaid	Both
Average statewide	6.7% (n=7)	0.0% (n=0)	14.3% (n=1)	85.7% (n=6)
Area 5: Southeast	6.5% (n=2)	0.0% (n=0)	50.0% (n=1)	50.0% (n=1)

Percentage of respondents who are planning to delicense nursing home beds and transition space to an alternative use in the next 12-24 months	
Average statewide	8.7% (n=9)
Area 5: Southeast	12.9% (n=4)

Planned transition ***Statewide Results (n=8)***	
Other	50.0% (n=4)
Assisted living for private pay and Medicaid-waiver residents	37.5% (n=3)
Assisted living for private pay residents only	12.5% (n=1)

Percentage of respondents with plans to do one or more of the following		
	Statewide	Area 5: Southeast
Not applicable	89.7% (n=87)	90.0% (n=27)
Affiliate	5.2% (n=5)	10.0% (n=3)
Merge	5.2% (n=5)	3.3% (n=1)
Sell	4.1% (n=4)	3.3% (n=1)

Period to sell, merge, or affiliate ***Statewide Results***	
Within the next 12 months	70.0% (n=7)
12-24 months	30.0% (n=3)
Longer than 24 months	0.0% (n=0)

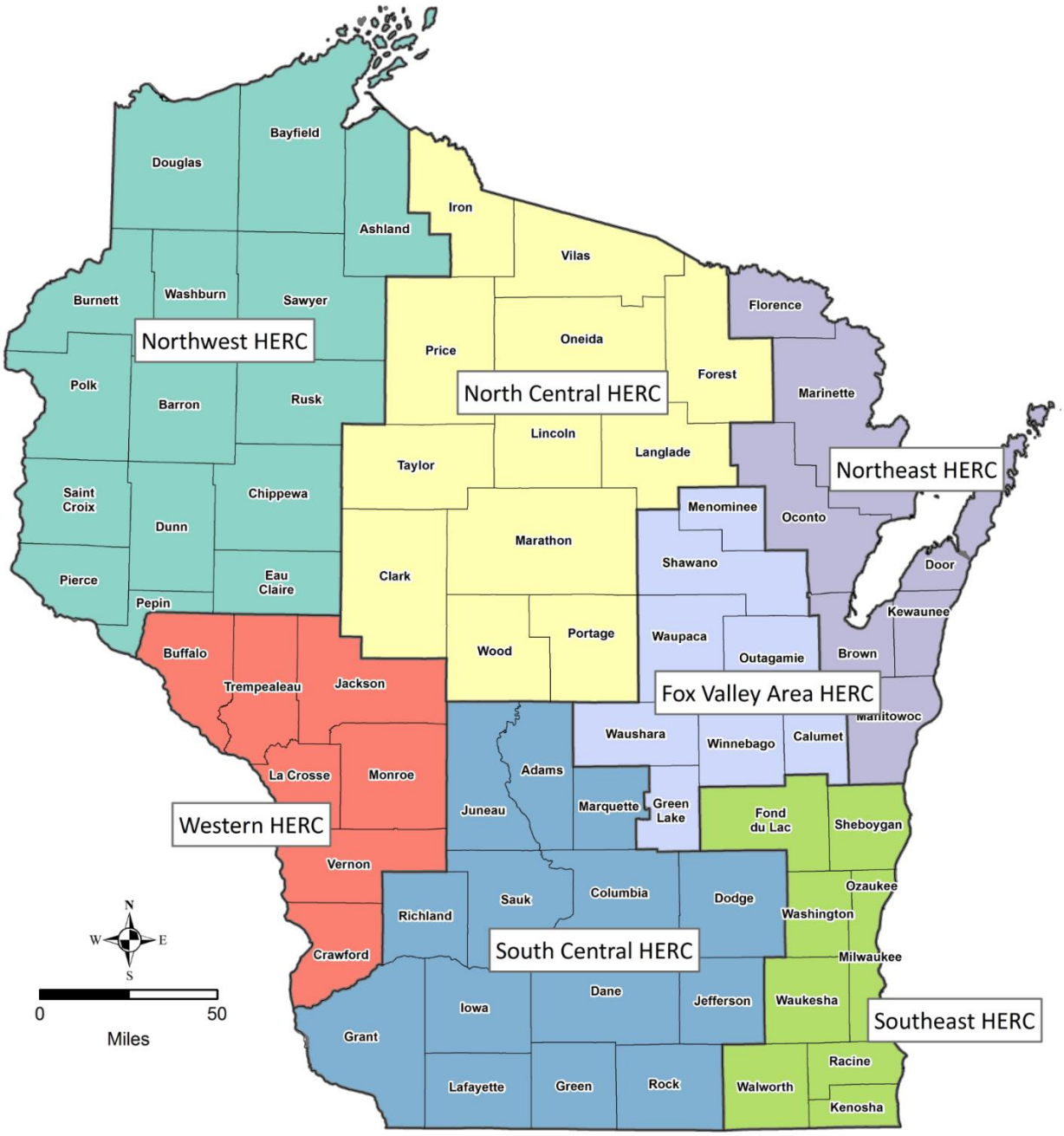
Condition of nursing home building		
	Statewide	Area 5: Southeast
Poor	5.0% (n=5)	6.7% (n=2)
Moderate	20.8% (n=21)	16.7% (n=5)
Good	44.6% (n=45)	56.7% (n=17)
Excellent	29.7% (n=30)	20.0% (n=6)

Room type and amenities		
	Statewide	Area 5: Southeast
Room Type		
Shared resident rooms	1,595 (n=86)	524 (n=20)
Private resident rooms	5,058 (n=90)	1,405 (n=22)
Private resident rooms with private restroom	4,017 (n=88)	837 (n=22)
Shower Type		
Within the resident unit	22.2% (n=22)	13.8% (n=4)
Common/shared shower room	40.4% (n=40)	44.8% (n=13)
Mix of both	37.4% (n=37)	41.4% (n=12)

If the Department of Health Services increases Medicaid rates, what would you do with the money specifically?		
	Statewide	Area 5: Southeast
Increase wages for current staff	91.3%	87.1% (n=27)
Invest in physical plant/infrastructure	52.4%	51.6% (n=16)
Increase staff to resident ratio	49.5%	45.2% (n=14)
Accept more Medicaid referrals	47.6%	45.2% (n=14)
Accept higher acuity referrals	33.0%	16.1% (n=5)
Reopen closed wings	27.2%	22.6% (n=7)
Expand services (evaluate new services, add capacity, etc.)	19.4%	22.6% (n=7)
Other	7.8%	12.9% (n=4)
Save any excess funds	6.8%	3.2% (n=1)

Appendix C: HERC Map

Wisconsin Healthcare Emergency Readiness Coalitions (HERC)



Appendix D: Long-range State Projections by age, by year, for 2020-2040

State Final Population Projections, by Broad Age Group, 2010-2040

	C2010	2015	2020	2025	2030	2035	2040	Num Change 2010-2040	Pct Change 2010-2040
0-4	358,443	348,765	367,375	374,170	378,340	377,720	373,940	15,497	4.3%
5-17	981,049	962,660	970,995	991,840	1,007,395	1,012,335	1,007,370	26,321	2.7%
18-24	549,256	538,960	543,630	555,295	564,005	566,770	563,995	14,739	2.7%
25-44	1,447,360	1,431,945	1,492,505	1,526,090	1,537,485	1,528,290	1,493,595	46,235	3.2%
45-64	1,573,564	1,605,765	1,566,645	1,498,940	1,464,365	1,482,520	1,517,370	- 56,194	- 3.6%
65-84	658,809	766,095	929,800	1,111,770	1,251,210	1,284,390	1,251,765	592,956	90.0%
85 & over	118,505	128,825	134,130	145,745	173,110	224,245	283,600	165,095	139.3%
TOTAL	5,686,986	5,783,015	6,005,080	6,203,850	6,375,910	6,476,270	6,491,635	804,649	14.1%
0-17	1,339,492	1,311,425	1,338,370	1,366,010	1,385,735	1,390,055	1,381,310	41,818	3.1%
18-64	3,570,180	3,576,670	3,602,780	3,580,325	3,565,855	3,577,580	3,574,960	4,780	0.1%
65 & over	777,314	894,920	1,063,930	1,257,515	1,424,320	1,508,635	1,535,365	758,051	97.5%

Source: WI Department of Administration

Appendix E: ESRI Demographics, 2022 to 2027, by HERC

Demographics of Working Aged Populations, by HERC

HERC Regions	Population by Working Age (18-64) Census 2010 Total 18-64	Census 2010 Percent of Total Population	Estimated 2022 Total 18-64	Estimated 2022 Percent of Total Population	Estimated 2022 Percent Increase/Decrease from 2010	Projected 2027 Total 18-64	Projected 2027 Percent of Total Population	Projected 2027 Percent Increase/Decrease from 2022
Fox Valley Area	334,017	62.5%	340,173	60.9%	1.8%	329,665	58.6%	-3.1%
Northeast	286,561	62.1%	295,184	60.2%	3.0%	286,179	57.8%	-3.1%
Northwest	356,170	62.9%	360,599	60.2%	1.2%	349,205	57.6%	-3.2%
Western	166,432	62.0%	167,315	59.6%	0.5%	160,774	57.0%	-3.9%
Southeast	1,402,156	62.7%	1,381,392	60.7%	-1.5%	1,333,435	58.7%	-3.5%
South Central	739,816	64.4%	781,050	62.4%	5.6%	768,708	60.5%	-1.6%
North Central	285,028	60.7%	278,121	58.5%	-2.4%	264,532	55.7%	-4.9%
Wisconsin	3,570,180	62.8%	3,603,834	60.8%	0.9%	3,492,498	58.6%	-3.1%
United States	194,296,087	62.9%	204,238,471	60.8%	5.1%	200,967,396	59.1%	-1.6%

Source: ESRI

Northwest HERC Region

Age and Income Eligible Households Northwest HERC
Ages 55+, 65+ and 75+ by Income

Age-and-Income Eligible Households	2022 (Estimated) 55-64	65-74	75+	Total 55+	Total 65+
Total Households:	49,750	42,635	31,301	123,686	73,936
Household Income - Under $0	0	0.00	0.00	0.00	0.00
Age-and-Income Eligible Households					
$0 - $14,999	3,690	3,125	3,709	10,524	6,834
$15,000 - $24,999	2,621	3,335	5,765	11,721	9,100
$25,000 - $34,999	2,924	3,805	5,533	12,262	9,338
$35,000 - $49,999	4,557	6,381	5,583	16,521	11,964
$50,000 - $74,999	10,053	9,493	4,218	23,764	13,711
$75,000 - $99,999	8,674	6,730	2,452	17,856	9,182
$100,000 plus	17,231	9,766	4,041	31,038	13,807
Total Age-and-Income Eligible Households	49,750	42,635	31,301	123,686	73,936
Percentage of Age-and-Income Eligible Households to Total Households	100.0%	100.0%	100.0%	100.0%	100.0%

Senior Population Change for Northwest HERC

	2022 (Estimated) Population	2027 (Projected) Population	Average Annual Compounded Percentage Change 2022 - 2027
Northwest HERC			
Total Population	599,285	606,273	0.2%
Age 55 to 64 Population	86,139	78,210	-1.9%
Age 65 to 74 Population	69,944	77,041	2.0%
Age 75 to 84 Population	33,473	42,702	5.0%
Age 85 plus Population	13,432	14,265	1.2%
Total 55 plus	202,988	212,218	0.9%
Total 65 plus	116,849	134,008	2.8%
Total 75 plus	46,905	56,967	4.0%

Adult Children Population Change for Northwest HERC

	2022 (Estimated) Population	2027 (Projected) Population	Average Annual Compounded Percentage Change 2022 - 2027
Age 45 to 54 Population	15,149	14,311	-1.1%
Age 55 to 64 Population	86,139	78,210	-1.9%
Total Age 45-64	101,288	92,521	-1.8%

Median Household Income			
	2022 (Estimated) Population	2027 (Projected) Population	Average Annual Compounded Percentage Change
Northwest HERC (All Age Groups)	$69,154	$80,178	3.0%
Householders Age 55 to 64	$77,178	$88,935	2.9%
Householders Age 65 to 74	$59,666	$71,948	3.8%
Householders Age 75 plus	$36,220	$45,163	4.5%

Estimated Net Worth						
	Householders Age 55-64		Householders Age 65-74		Householders Age 75+	
	Count	Percentage of Total	Count	Percentage of Total	Count	Percentage of Total
Total Households	9,977	100.0%	8,973	100.0%	7,549	100.0%
less than $15,000	1,656	16.6%	1,407	15.7%	652	8.6%
$15,000-$34,999	403	4.0%	501	5.6%	103	1.4%
$35,000-$49,999	237	2.4%	270	3.0%	137	1.8%
$50,000-$74,999	549	5.5%	318	3.5%	391	5.2%
$75,000-$99,999	515	5.2%	262	2.9%	342	4.5%
$100,000-$149,999	825	8.3%	487	5.4%	616	8.2%
$150,000-$249,999	1,170	11.7%	1,118	12.5%	1,768	23.4%
$250,000-$499,999	2,143	21.5%	1,873	20.9%	1,688	22.4%
$500,000-$999,999	1,448	14.5%	1,599	17.8%	901	11.9%
$1,000,000 or greater	1,031	10.3%	1,138	12.7%	951	12.6%
2022 Median Net Worth Northwest HERC		$210,338		$259,190		$230,575
2022 US Median		$251,504		$305,708		$285,062

North Central HERC Region

Age and Income Eligible Households North Central HERC
Ages 55+, 65+ and 75+ by Income

			2022 (Estimated)		
Age-and-Income Eligible Households	**55-64**	**65-74**	**75+**	**Total 55+**	**Total 65+**
Total Households:	41,606	36,007	28,895	106,508	64,902
Household Income - Under $0	0	0.00	0.00	0.00	0.00
Age-and-Income Eligible Households					
$0 - $14,999	3,206	2,662	3,428	9,296	6,090
$15,000 - $24,999	2,276	2,853	5,459	10,588	8,312
$25,000 - $34,999	2,720	3,932	5,759	12,411	9,691
$35,000 - $49,999	4,505	6,129	5,327	15,961	11,456
$50,000 - $74,999	8,929	7,957	3,456	20,342	11,413
$75,000 - $99,999	7,191	4,956	2,023	14,170	6,979
$100,000 plus	12,779	7,518	3,443	23,740	10,961
Total Age-and-Income Eligible Households	41,606	36,007	28,895	106,508	64,902
Percentage of Age-and-Income Eligible Households to Total Households	100.0%	100.0%	100.0%	100.0%	100.0%

			2027 (Projected)		
Age-and-Income Eligible Households	**55-64**	**65-74**	**75+**	**Total 55+**	**Total 65+**
Total Households:	37,717	39,635	33,256	110,608	72,891
Household Income - Under $0	0	0	0	0	0
Age-and-Income Eligible Households					
$0 - $14,999	2,128	2,185	3,423	7,736	5,608
$15,000 - $24,999	1,427	2,284	4,806	8,517	7,090
$25,000 - $34,999	1,891	3,378	5,467	10,736	8,845
$35,000 - $49,999	3,227	5,665	5,763	14,655	11,428
$50,000 - $74,999	7,585	8,994	4,698	21,277	13,692
$75,000 - $99,999	6,673	6,005	3,015	15,693	9,020
$100,000 plus	14,786	11,124	6,084	31,994	17,208
Total Age-and-Income Eligible Households	37,717	39,635	33,256	110,608	72,891
Percentage of Age-and-Income Eligible Households to Total Households	100.0%	100.0%	100.0%	100.0%	100.0%

Senior Population Change for North Central HERC

	2022 (Estimated) Population	2027 (Projected) Population	Average Annual Compounded Percentage Change 2022 - 2027
North Central HERC			
Total Population	475,275	474,911	0.0%
Age 55 to 64 Population	71,849	65,357	-1.9%
Age 65 to 74 Population	59,056	65,384	2.1%
Age 75 to 84 Population	30,760	36,968	3.7%
Age 85 plus Population	12,441	12,955	0.8%
Total 55 plus	174,106	180,664	0.7%
Total 65 plus	102,257	115,307	2.4%
Total 75 plus	43,201	49,923	2.9%

Adult Children Population Change fo North Central HERC

	2022 (Estimated) Population	2027 (Projected) Population	Average Annual Compounded Percentage Change 2022 - 2027
Age 45 to 54 Population	15,149	14,311	-1.1%
Age 55 to 64 Population	71,849	65,357	-1.9%
Total Age 45-64	86,998	79,668	-1.7%

Median Household Income	2022 (Estimated) Population	2027 (Projected) Population	Average Annual Compounded Percentage Change
North Central HERC (All Age Groups)	$63,203	$75,075	3.5%
Householders Age 55 to 64	$71,712	$82,869	2.9%
Householders Age 65 to 74	$55,477	$65,198	3.3%
Householders Age 75 plus	$34,523	$41,318	3.7%

Estimated Net Worth	Householders Age 55-64		Householders Age 65-74		Householders Age 75+	
	Count	Percentage of Total	Count	Percentage of Total	Count	Percentage of Total
Total Households	9,977	100.0%	8,973	100.0%	7,549	100.0%
less than $15,000	1,656	16.6%	1,407	15.7%	652	8.6%
$15,000-$34,999	403	4.0%	501	5.6%	103	1.4%
$35,000-$49,999	237	2.4%	270	3.0%	137	1.8%
$50,000-$74,999	549	5.5%	318	3.5%	391	5.2%
$75,000-$99,999	515	5.2%	262	2.9%	342	4.5%
$100,000-$149,999	825	8.3%	487	5.4%	616	8.2%
$150,000-$249,999	1,170	11.7%	1,118	12.5%	1,768	23.4%
$250,000-$499,999	2,143	21.5%	1,873	20.9%	1,688	22.4%
$500,000-$999,999	1,448	14.5%	1,599	17.8%	901	11.9%
$1,000,000 or greater	1,031	10.3%	1,138	12.7%	951	12.6%
2022 Median Net Worth North Central HERC		$210,338		$259,190		$230,575
2022 US Median		$251,504		$305,708		$285,062

Northeast HERC Region

Age and Income Eligible Households Northeast HERC
Ages 55+, 65+ and 75+ by Income

			2022 (Estimated)		
Age-and-Income Eligible Households	**55-64**	**65-74**	**75+**	**Total 55+**	**Total 65+**
Total Households:	41,620	33,871	25,867	101,358	59,738
Household Income - Under $0	0	0.00	0.00	0.00	0.00
Age-and-Income Eligible Households					
$0 - $14,999	3,094	2,487	2,830	8,411	5,317
$15,000 - $24,999	2,252	2,738	4,903	9,893	7,641
$25,000 - $34,999	2,255	2,944	4,244	9,443	7,188
$35,000 - $49,999	4,674	5,828	5,388	15,890	11,216
$50,000 - $74,999	8,172	7,330	3,519	19,021	10,849
$75,000 - $99,999	6,335	4,428	1,720	12,483	6,148
$100,000 plus	14,838	8,116	3,263	26,217	11,379
Total Age-and-Income Eligible Households	41,620	33,871	25,867	101,358	59,738
Percentage of Age-and-Income Eligible Households to Total Households	100.0%	100.0%	100.0%	100.0%	100.0%

			2027 (Projected)		
Age-and-Income Eligible Households	**55-64**	**65-74**	**75+**	**Total 55+**	**Total 65+**
Total Households:	37,836	37,600	30,232	105,668	67,832
Household Income - Under $0	0	0	0	0	0
Age-and-Income Eligible Households					
$0 - $14,999	1,937	1,990	2,729	6,656	4,719
$15,000 - $24,999	1,379	2,153	4,385	7,917	6,538
$25,000 - $34,999	1,540	2,582	3,940	8,062	6,522
$35,000 - $49,999	3,355	5,333	5,779	14,467	11,112
$50,000 - $74,999	6,825	7,967	4,792	19,584	12,759
$75,000 - $99,999	5,778	5,275	2,510	13,563	7,785
$100,000 plus	17,022	12,300	6,097	35,419	18,397
Total Age-and-Income Eligible Households	37,836	37,600	30,232	105,668	67,832
Percentage of Age-and-Income Eligible Households to Total Households	100.0%	100.0%	100.0%	100.0%	100.0%

Senior Population Change for Northeast HERC

	2022 (Estimated) Population	2027 (Projected) Population	Average Annual Compounded Percentage Change 2022 - 2027
Northeast HERC			
Total Population	490,457	495,246	0.2%
Age 55 to 64 Population	71,792	65,814	-1.7%
Age 65 to 74 Population	55,178	61,670	2.2%
Age 75 to 84 Population	27,269	33,488	4.2%
Age 85 plus Population	11,035	11,632	1.1%
Total 55 plus	165,274	172,604	0.9%
Total 65 plus	93,482	106,790	2.7%
Total 75 plus	38,304	45,120	3.3%

Adult Children Population Change for Northeast HERC

	2022 (Estimated) Population	2027 (Projected) Population	Average Annual Compounded Percentage Change 2022 - 2027
Age 45 to 54 Population	15,149	14,311	-1.1%
Age 55 to 64 Population	71,792	65,814	-1.7%
Total Age 45-64	86,941	80,125	-1.6%

Median Household Income	2022 (Estimated) Population	2027 (Projected) Population	Average Annual Compounded Percentage Change
Northeast HERC (All Age Groups)	$66,945	$79,989	3.6%
Householders Age 55 to 64	$76,057	$90,127	3.5%
Householders Age 65 to 74	$57,570	$69,715	3.9%
Householders Age 75 plus	$36,862	$44,349	3.8%

Estimated Net Worth	Householders Age 55-64		Householders Age 65-74		Householders Age 75+	
	Count	Percentage of Total	Count	Percentage of Total	Count	Percentage of Total
Total Households	9,977	100.0%	8,973	100.0%	7,549	100.0%
less than $15,000	1,656	16.6%	1,407	15.7%	652	8.6%
$15,000-$34,999	403	4.0%	501	5.6%	103	1.4%
$35,000-$49,999	237	2.4%	270	3.0%	137	1.8%
$50,000-$74,999	549	5.5%	318	3.5%	391	5.2%
$75,000-$99,999	515	5.2%	262	2.9%	342	4.5%
$100,000-$149,999	825	8.3%	487	5.4%	616	8.2%
$150,000-$249,999	1,170	11.7%	1,118	12.5%	1,768	23.4%
$250,000-$499,999	2,143	21.5%	1,873	20.9%	1,688	22.4%
$500,000-$999,999	1,448	14.5%	1,599	17.8%	901	11.9%
$1,000,000 or greater	1,031	10.3%	1,138	12.7%	951	12.6%
2022 Median Net Worth Northeast HERC		$210,338		$259,190		$230,575
2022 US Median		$251,504		$305,708		$285,062

Fox Valley Area HERC Region

Age and Income Eligible Households in Fox Valley Area
Ages 55+, 65+ and 75+ by Income

	2022 (Estimated)				
Age-and-Income Eligible Households	**55-64**	**65-74**	**75+**	**Total 55+**	**Total 65+**
Total Households:	45,414	36,062	28,326	109,802	64,388
Household Income - Under $0	0	0.00	0.00	0.00	0.00
Age-and-Income Eligible Households					
$0 - $14,999	2,627	2,291	2,870	7,788	5,161
$15,000 - $24,999	2,459	3,209	5,836	11,504	9,045
$25,000 - $34,999	2,502	3,568	5,320	11,390	8,888
$35,000 - $49,999	4,505	6,183	5,209	15,897	11,392
$50,000 - $74,999	9,939	8,180	3,497	21,616	11,677
$75,000 - $99,999	7,871	4,777	2,173	14,821	6,950
$100,000 plus	15,511	7,854	3,421	26,786	11,275
Total Age-and-Income Eligible Households	45,414	36,062	28,326	109,802	64,388
Percentage of Age-and-Income Eligible Households to Total Households	100.0%	100.0%	100.0%	100.0%	100.0%

	2027 (Projected)				
Age-and-Income Eligible Households	**55-64**	**65-74**	**75+**	**Total 55+**	**Total 65+**
Total Households:	42,067	40,088	32,864	115,019	72,952
Household Income - Under $0	0	0	0	0	0
Age-and-Income Eligible Households					
$0 - $14,999	1,626	1,821	2,817	6,264	4,638
$15,000 - $24,999	1,514	2,525	5,120	9,159	7,645
$25,000 - $34,999	1,691	2,990	4,843	9,524	7,833
$35,000 - $49,999	3,293	5,714	5,547	14,554	11,261
$50,000 - $74,999	8,295	9,196	4,902	22,393	14,098
$75,000 - $99,999	7,370	5,847	3,202	16,419	9,049
$100,000 plus	18,278	11,995	6,433	36,706	18,428
Total Age-and-Income Eligible Households	42,067	40,088	32,864	115,019	72,952
Percentage of Age-and-Income Eligible Households to Total Households	100.0%	100.0%	100.0%	100.0%	100.0%

Senior Population Change for Fox Valley Area HERC

	2022 (Estimated) Population	2027 (Projected) Population	Average Annual Compounded Percentage Change 2022 - 2027
Fox Valley Area HERC			
Total Population	558,895	562,455	0.1%
Age 55 to 64 Population	78,852	73,728	-1.3%
Age 65 to 74 Population	59,045	66,317	2.4%
Age 75 to 84 Population	30,039	36,648	4.1%
Age 85 plus Population	12,725	13,363	1.0%
Total 55 plus	180,661	190,056	1.0%
Total 65 plus	101,809	116,328	2.7%
Total 75 plus	42,764	50,011	3.2%

Adult Children Population Change for Fox Valley Area HERC

	2022 (Estimated) Population	2027 (Projected) Population	Average Annual Compounded Percentage Change 2022 - 2027
Age 45 to 54 Population	15,149	14,311	-1.1%
Age 55 to 64 Population	78,852	73,728	-1.3%
Total Age 45-64	94,001	88,039	-1.3%

Median Household Income	2022 (Estimated) Population	2027 (Projected) Population	Average Annual Compounded Percentage Change
Fox Valley Area HERC (All Age Groups)	$67,998	$79,594	3.2%
Householders Age 55 to 64	$76,556	$88,759	3.0%
Householders Age 65 to 74	$56,174	$66,952	3.6%
Householders Age 75 plus	$35,266	$43,676	4.4%

Estimated Net Worth	Householders Age 55-64		Householders Age 65-74		Householders Age 75+	
	Count	Percentage of Total	Count	Percentage of Total	Count	Percentage of Total
Total Households	9,977	100.0%	8,973	100.0%	7,549	100.0%
less than $15,000	1,656	16.6%	1,407	15.7%	652	8.6%
$15,000-$34,999	403	4.0%	501	5.6%	103	1.4%
$35,000-$49,999	237	2.4%	270	3.0%	137	1.8%
$50,000-$74,999	549	5.5%	318	3.5%	391	5.2%
$75,000-$99,999	515	5.2%	262	2.9%	342	4.5%
$100,000-$149,999	825	8.3%	487	5.4%	616	8.2%
$150,000-$249,999	1,170	11.7%	1,118	12.5%	1,768	23.4%
$250,000-$499,999	2,143	21.5%	1,873	20.9%	1,688	22.4%
$500,000-$999,999	1,448	14.5%	1,599	17.8%	901	11.9%
$1,000,000 or greater	1,031	10.3%	1,138	12.7%	951	12.6%
2022 Median Net Worth Fox Valley HERC		$210,338		$259,190		$230,575
2022 US Median		$251,504		$305,708		$285,062

Western HERC Region

Age and Income Eligible Households Western HERC
Ages 55+, 65+ and 75+ by Income

			2022 (Estimated)		
Age-and-Income Eligible Households	**55-64**	**65-74**	**75+**	**Total 55+**	**Total 65+**
Total Households:	22,249	19,440	15,388	57,077	34,828
Household Income - Under $0	0	0.00	0.00	0.00	0.00
Age-and-Income Eligible Households					
$0 - $14,999	1,669	1,562	1,714	4,945	3,276
$15,000 - $24,999	1,279	1,670	3,232	6,181	4,902
$25,000 - $34,999	1,235	1,950	2,658	5,843	4,608
$35,000 - $49,999	2,344	3,397	2,924	8,665	6,321
$50,000 - $74,999	5,155	4,710	2,032	11,897	6,742
$75,000 - $99,999	3,893	2,645	1,093	7,631	3,738
$100,000 plus	6,674	3,506	1,735	11,915	5,241
Total Age-and-Income Eligible Households	22,249	19,440	15,388	57,077	34,828
Percentage of Age-and-Income Eligible Households to Total Households	100.0%	100.0%	100.0%	100.0%	100.0%

			2027 (Projected)		
Age-and-Income Eligible Households	**55-64**	**65-74**	**75+**	**Total 55+**	**Total 65+**
Total Households:	20,129	20,929	18,170	59,228	39,099
Household Income - Under $0	0	0	0	0	0
Age-and-Income Eligible Households					
$0 - $14,999	1,085	1,275	1,778	4,138	3,053
$15,000 - $24,999	805	1,311	2,898	5,014	4,209
$25,000 - $34,999	820	1,581	2,595	4,996	4,176
$35,000 - $49,999	1,693	3,083	3,187	7,963	6,270
$50,000 - $74,999	4,331	5,224	2,783	12,338	8,007
$75,000 - $99,999	3,611	3,256	1,716	8,583	4,972
$100,000 plus	7,784	5,199	3,213	16,196	8,412
Total Age-and-Income Eligible Households	20,129	20,929	18,170	59,228	39,099
Percentage of Age-and-Income Eligible Households to Total Households	100.0%	100.0%	100.0%	100.0%	100.0%

Senior Population Change for Western HERC

	2022 (Estimated) Population	2027 (Projected) Population	Average Annual Compounded Percentage Change 2022 - 2027
Western HERC			
Total Population	280,825	281,913	0.1%
Age 55 to 64 Population	38,507	35,050	-1.9%
Age 65 to 74 Population	31,608	34,323	1.7%
Age 75 to 84 Population	16,048	19,894	4.4%
Age 85 plus Population	6,711	7,135	1.2%
Total 55 plus	92,874	96,402	0.7%
Total 65 plus	54,367	61,352	2.4%
Total 75 plus	22,759	27,029	3.5%

Adult Children Population Change Western HERC

	2022 (Estimated) Population	2027 (Projected) Population	Average Annual Compounded Percentage Change 2022 - 2027
Age 45 to 54 Population	15,149	14,311	-1.1%
Age 55 to 64 Population	38,507	35,050	-1.9%
Total Age 45-64	53,656	49,361	-1.7%

Median Household Income	2022 (Estimated) Population	2027 (Projected) Population	Average Annual Compounded Percentage Change
Western HERC (All Age Groups)	$62,509	$73,094	3.2%
Householders Age 55 to 64	$71,166	$82,369	3.0%
Householders Age 65 to 74	$54,119	$62,664	3.0%
Householders Age 75 plus	$35,310	$42,227	3.6%

Estimated Net Worth	Householders Age 55-64		Householders Age 65-74		Householders Age 75+	
	Count	Percentage of Total	Count	Percentage of Total	Count	Percentage of Total
Total Households	9,977	100.0%	8,973	100.0%	7,549	100.0%
less than $15,000	1,656	16.6%	1,407	15.7%	652	8.6%
$15,000-$34,999	403	4.0%	501	5.6%	103	1.4%
$35,000-$49,999	237	2.4%	270	3.0%	137	1.8%
$50,000-$74,999	549	5.5%	318	3.5%	391	5.2%
$75,000-$99,999	515	5.2%	262	2.9%	342	4.5%
$100,000-$149,999	825	8.3%	487	5.4%	616	8.2%
$150,000-$249,999	1,170	11.7%	1,118	12.5%	1,768	23.4%
$250,000-$499,999	2,143	21.5%	1,873	20.9%	1,688	22.4%
$500,000-$999,999	1,448	14.5%	1,599	17.8%	901	11.9%
$1,000,000 or greater	1,031	10.3%	1,138	12.7%	951	12.6%
2022 Median Net Worth Western HERC		$210,338		$259,190		$230,575
2022 US Median		$251,504		$305,708		$285,062

South Central HERC Region

Age and Income Eligible Households South Central HERC
Ages 55+, 65+ and 75+ by Income

	2022 (Estimated)				
Age-and-Income Eligible Households	**55-64**	**65-74**	**75+**	**Total 55+**	**Total 65+**
Total Households:	98,366	79,929	58,413	236,708	138,342
Household Income - Under $0	0	0.00	0.00	0.00	0.00
Age-and-Income Eligible Households					
$0 - $14,999	5,198	4,504	5,069	14,771	9,573
$15,000 - $24,999	4,323	5,289	9,030	18,642	14,319
$25,000 - $34,999	5,295	6,876	9,994	22,165	16,870
$35,000 - $49,999	8,519	11,296	10,840	30,655	22,136
$50,000 - $74,999	18,385	17,339	8,746	44,470	26,085
$75,000 - $99,999	16,051	11,934	5,116	33,101	17,050
$100,000 plus	40,595	22,691	9,618	72,904	32,309
Total Age-and-Income Eligible Households	98,366	79,929	58,413	236,708	138,342
Percentage of Age-and-Income Eligible Households to Total Households	100.0%	100.0%	100.0%	100.0%	100.0%

	2027 (Projected)				
Age-and-Income Eligible Households	**55-64**	**65-74**	**75+**	**Total 55+**	**Total 65+**
Total Households:	90,500	87,377	70,109	247,986	157,486
Household Income - Under $0	0	0	0	0	0
Age-and-Income Eligible Households					
$0 - $14,999	3,143	3,343	4,854	11,340	8,197
$15,000 - $24,999	2,584	3,983	7,945	14,512	11,928
$25,000 - $34,999	3,528	5,581	9,228	18,337	14,809
$35,000 - $49,999	5,945	9,873	11,136	26,954	21,009
$50,000 - $74,999	14,968	18,194	11,530	44,692	29,724
$75,000 - $99,999	14,445	13,722	7,517	35,684	21,239
$100,000 plus	45,887	32,681	17,899	96,467	50,580
Total Age-and-Income Eligible Households	90,500	87,377	70,109	247,986	157,486
Percentage of Age-and-Income Eligible Households to Total Households	100.0%	100.0%	100.0%	100.0%	100.0%

Senior Population Change South Central HERC

	2022 (Estimated) Population	2027 (Projected) Population	Average Annual Compounded Percentage Change 2022 - 2027
South Central HERC			
Total Population	1,251,066	1,270,797	0.3%
Age 55 to 64 Population	168,052	155,551	-1.5%
Age 65 to 74 Population	129,232	142,539	2.0%
Age 75 to 84 Population	62,172	78,736	4.8%
Age 85 plus Population	24,987	26,635	1.3%
Total 55 plus	384,443	403,461	1.0%
Total 65 plus	216,391	247,910	2.8%
Total 75 plus	87,159	105,371	3.9%

Adult Children Population Change South Central HERC

	2022 (Estimated) Population	2027 (Projected) Population	Average Annual Compounded Percentage Change 2022 - 2027
Age 45 to 54 Population	15,149	14,311	-1.1%
Age 55 to 64 Population	168,052	155,551	-1.5%
Total Age 45-64	183,201	169,862	-1.5%

Median Household Income	2022 (Estimated) Population	2027 (Projected) Population	Average Annual Compounded Percentage Change
South Central HERC (All Age Groups)	$76,346	$88,229	2.9%
Householders Age 55 to 64	$84,730	$100,734	3.5%
Householders Age 65 to 74	$64,991	$78,803	3.9%
Householders Age 75 plus	$40,729	$52,931	5.4%

Estimated Net Worth	Householders Age 55-64		Householders Age 65-74		Householders Age 75+	
	Count	Percentage of Total	Count	Percentage of Total	Count	Percentage of Total
Total Households	9,977	100.0%	8,973	100.0%	7,549	100.0%
less than $15,000	1,656	16.6%	1,407	15.7%	652	8.6%
$15,000-$34,999	403	4.0%	501	5.6%	103	1.4%
$35,000-$49,999	237	2.4%	270	3.0%	137	1.8%
$50,000-$74,999	549	5.5%	318	3.5%	391	5.2%
$75,000-$99,999	515	5.2%	262	2.9%	342	4.5%
$100,000-$149,999	825	8.3%	487	5.4%	616	8.2%
$150,000-$249,999	1,170	11.7%	1,118	12.5%	1,768	23.4%
$250,000-$499,999	2,143	21.5%	1,873	20.9%	1,688	22.4%
$500,000-$999,999	1,448	14.5%	1,599	17.8%	901	11.9%
$1,000,000 or greater	1,031	10.3%	1,138	12.7%	951	12.6%
2022 Median Net Worth South Central PMA		$210,338		$259,190		$230,575
2022 US Median		$251,504		$305,708		$285,062

Southeast HERC Region

Age and Income Eligible Households Southeast HERC
Ages 55+, 65+ and 75+ by Income

	2022 (Estimated)				
Age-and-Income Eligible Households	**55-64**	**65-74**	**75+**	**Total 55+**	**Total 65+**
Total Households:	183,817	145,929	112,810	442,556	258,739
Household Income - Under $0	0	0.00	0.00	0.00	0.00
Age-and-Income Eligible Households					
$0 - $14,999	12,572	10,679	11,832	35,083	22,511
$15,000 - $24,999	10,740	12,107	19,050	41,897	31,157
$25,000 - $34,999	10,114	11,463	15,827	37,404	27,290
$35,000 - $49,999	17,434	20,842	21,750	60,026	42,592
$50,000 - $74,999	31,176	29,527	17,130	77,833	46,657
$75,000 - $99,999	27,309	20,390	8,864	56,563	29,254
$100,000 plus	74,472	40,921	18,357	133,750	59,278
Total Age-and-Income Eligible Households	183,817	145,929	112,810	442,556	258,739
Percentage of Age-and-Income Eligible Households to Total Households	100.0%	100.0%	100.0%	100.0%	100.0%

	2027 (Projected)				
Age-and-Income Eligible Households	**55-64**	**65-74**	**75+**	**Total 55+**	**Total 65+**
Total Households:	165,582	158,933	132,235	456,750	291,168
Household Income - Under $0	0	0	0	0	0
Age-and-Income Eligible Households					
$0 - $14,999	7,845	8,062	10,813	26,720	18,875
$15,000 - $24,999	6,781	9,324	16,254	32,359	25,578
$25,000 - $34,999	6,711	9,509	14,396	30,616	23,905
$35,000 - $49,999	12,679	18,810	22,430	53,919	41,240
$50,000 - $74,999	24,982	30,503	21,714	77,199	52,217
$75,000 - $99,999	24,126	23,436	12,532	60,094	35,968
$100,000 plus	82,458	59,289	34,096	175,843	93,385
Total Age-and-Income Eligible Households	165,582	158,933	132,235	456,750	291,168
Percentage of Age-and-Income Eligible Households to Total Households	100.0%	100.0%	100.0%	100.0%	100.0%

Senior Population Change Southeast HERC

	2022 (Estimated) Population	2027 (Projected) Population	Average Annual Compounded Percentage Change 2022 - 2027
Southeast HERC			
Total Population	2,275,570	2,270,204	0.0%
Age 55 to 64 Population	308,626	281,086	-1.9%
Age 65 to 74 Population	230,995	254,933	2.0%
Age 75 to 84 Population	114,806	143,751	4.6%
Age 85 plus Population	51,916	54,033	0.8%
Total 55 plus	706,343	733,803	0.8%
Total 65 plus	397,717	452,717	2.6%
Total 75 plus	166,722	197,784	3.5%

Adult Children Population Change Southeast HERC

	2022 (Estimated) Population	2027 (Projected) Population	Average Annual Compounded Percentage Change 2022 - 2027
Age 45 to 54 Population	15,149	14,311	-1.1%
Age 55 to 64 Population	308,626	281,086	-1.9%
Total Age 45-64	323,775	295,397	-1.8%

Median Household Income	2022 (Estimated) Population	2027 (Projected) Population	Average Annual Compounded Percentage Change
Southeast HERC (All Age Groups)	$71,814	$84,938	3.4%
Householders Age 55 to 64	$82,388	$99,549	3.9%
Householders Age 65 to 74	$62,678	$77,649	4.4%
Householders Age 75 plus	$40,331	$51,786	5.1%

Estimated Net Worth	Householders Age 55-64		Householders Age 65-74		Householders Age 75+	
	Count	Percentage of Total	Count	Percentage of Total	Count	Percentage of Total
Total Households	9,977	100.0%	8,973	100.0%	7,549	100.0%
less than $15,000	1,656	16.6%	1,407	15.7%	652	8.6%
$15,000-$34,999	403	4.0%	501	5.6%	103	1.4%
$35,000-$49,999	237	2.4%	270	3.0%	137	1.8%
$50,000-$74,999	549	5.5%	318	3.5%	391	5.2%
$75,000-$99,999	515	5.2%	262	2.9%	342	4.5%
$100,000-$149,999	825	8.3%	487	5.4%	616	8.2%
$150,000-$249,999	1,170	11.7%	1,118	12.5%	1,768	23.4%
$250,000-$499,999	2,143	21.5%	1,873	20.9%	1,688	22.4%
$500,000-$999,999	1,448	14.5%	1,599	17.8%	901	11.9%
$1,000,000 or greater	1,031	10.3%	1,138	12.7%	951	12.6%
2022 Median Net Worth Southeast HERC		$210,338		$259,190		$230,575
2022 US Median		$251,504		$305,708		$285,062

Appendix F: LTC Provider Tables, by HERC, 2022

Assisted Living Supply, by Provider Type
For 2022

	Facilities	Beds/Units	Facilities	Beds/Units	Facilities	Beds/Units	Facilities	Beds/Units
	Fox Valley		North Central		Northeast		Northwest	
AL AFH	97	375	117	463	103	406	252	990
AL CBRF	183	4,050	138	2,480	139	2,989	159	3,078
AL RCAC	31	1,646	31	1,202	25	1,234	39	1,245
Nursing Homes	33	2,756	32	2,594	29	2,399	57	3,204
Total	311	6,071	286	4,145	267	4,629	450	5,313
	South Central		Southeast		Western		Wisconsin Totals	
AL AFH	286	1,106	1,082	4,132	105	418	2,042	7,890
AL CBRF	332	6,712	587	13,826	67	1,304	1,605	34,439
AL RCAC	71	3,621	125	6,839	33	1,123	355	16,910
Nursing Homes	78	5,472	99	9,094	25	1,626	353	27,145
Total	689	11,439	1,794	24,797	205	2,845	4,002	59,239

Source: Department of Health Services, Directories of Assisted Living Facilities

Total LTC Facility Supply

	Wisconsin	
	Facilities	Beds/Units
Adult Family Homes	2,042	7,890
Community Based Residential Facilities	1,605	34,439
Residential Care Apartment Complexes	355	16,910
Nursing Homes	353	27,145
Total	4,355	86,384

*AFH listed are for 3-4 bed only. 1-2 bed AFHs are regulated by each county's Human Services department

	Wisconsin		Fox Valley		North Central		Northeast	
	Facilities	Beds/Units	Facilities	Beds/Units	Facilities	Beds/Units	Facilities	Beds/Units
AL AFH	2042	7890	97	375	117	463	103	406
AL CBRF	1605	34439	183	4050	138	2480	139	2989
AL RCAC	355	16910	31	1646	31	1202	25	1234
Nursing Homes	353	27145	33	2756	32	2594	29	2399
Total	4355	86384	344	8827	318	6739	296	7028

Home Health Providers by HERC from Wisconsin Department of Health Services, Home Health Agency 1572A Records 2017- July 2021

SUMMARY		
COUNTY	HERC	Count of Provider
CALUMET	Fox Valley	17
GREEN LAKE	Fox Valley	14
MENOMINEE	Fox Valley	8
OUTAGAMIE	Fox Valley	17
SHAWANO	Fox Valley	17
WAUPACA	Fox Valley	12
WAUSHARA	Fox Valley	12
WINNEBAGO	Fox Valley	15

SUMMARY		
COUNTY	HERC	Count of Provider
CLARK	North Central	9
FOREST	North Central	3
IRON	North Central	5
LANGLADE	North Central	7
LINCOLN	North Central	6
MARATHON	North Central	8
ONEIDA	North Central	8
PORTAGE	North Central	11
PRICE	North Central	5
TAYLOR	North Central	7
VILAS	North Central	4
WOOD	North Central	9

SUMMARY		
COUNTY	HERC	Count of Provider
CLARK	North Central	9
FOREST	North Central	3
IRON	North Central	5
LANGLADE	North Central	7
LINCOLN	North Central	6
MARATHON	North Central	8
ONEIDA	North Central	8
PORTAGE	North Central	11
PRICE	North Central	5
TAYLOR	North Central	7
VILAS	North Central	4
WOOD	North Central	9

SUMMARY

COUNTY	HERC	Count of Provider
BROWN	Northeast	16
DOOR	Northeast	6
KEWAUNEE	Northeast	9
MANITOWOC	Northeast	13
MARINETTE	Northeast	8
OCONTO	Northeast	10

SUMMARY

COUNTY	HERC	Count of Provider
ASHLAND	Northwest	5
BARRON	Northwest	12
BAYFIELD	Northwest	4
BURNETT	Northwest	9
CHIPPEWA	Northwest	9
DOUGLAS	Northwest	3
DUNN	Northwest	9
EAU CLAIRE	Northwest	8
PEPIN	Northwest	4
PIERCE	Northwest	5
POLK	Northwest	7
RUSK	Northwest	7
SAINT CROIX	Northwest	6
SAWYER	Northwest	10
WASHBURN	Northwest	9

SUMMARY

COUNTY	HERC	Count of Provider
ADAMS	South Central	10
COLUMBIA	South Central	13
DANE	South Central	18
DODGE	South Central	26
GRANT	South Central	10
GREEN	South Central	11
IOWA	South Central	11
JEFFERSON	South Central	21
JUNEAU	South Central	9
LAFAYETTE	South Central	8
MARQUETTE	South Central	12
RICHLAND	South Central	10
ROCK	South Central	15
SAUK	South Central	9

SUMMARY		
COUNTY	HERC	Count of Provider
FOND DU LAC	Southeast	22
KENOSHA	Southeast	28
MILWAUKEE	Southeast	39
OZAUKEE	Southeast	32
RACINE	Southeast	32
SHEBOYGAN	Southeast	18
WALWORTH	Southeast	24
WASHINGTON	Southeast	35
WAUKESHA	Southeast	37

SUMMARY		
COUNTY	HERC	Count of Provider
BUFFALO	Western	4
CRAWFORD	Western	9
JACKSON	Western	8
LA CROSSE	Western	7
MONROE	Western	9
TREMPEALEAU	Western	8
VERNON	Western	10

Hospice Providers by HERC from Wisconsin Department of Health Services, Hospice Agency 643 Records 2017- September 2022

SUMMARY		
COUNTY	HERC	Count of Provider
CALUMET	Fox Valley	13
GREEN LAKE	Fox Valley	12
MENOMINEE	Fox Valley	4
OUTAGAMIE	Fox Valley	8
SHAWANO	Fox Valley	7
WAUPACA	Fox Valley	8
WAUSHARA	Fox Valley	11
WINNEBAGO	Fox Valley	10

SUMMARY		
COUNTY	HERC	Count of Provider
CLARK	North Central	7
FOREST	North Central	4
IRON	North Central	3
LANGLADE	North Central	5
LINCOLN	North Central	6
MARATHON	North Central	8
ONEIDA	North Central	5

PORTAGE	North Central	7
PRICE	North Central	5
TAYLOR	North Central	6
VILAS	North Central	4
WOOD	North Central	5

SUMMARY

COUNTY	HERC	Count of Provider
BROWN	Northeast	7
DOOR	Northeast	3
FLORENCE	Northeast	3
KEWAUNEE	Northeast	3
MANITOWOC	Northeast	14
MARINETTE	Northeast	3
OCONTO	Northeast	5

SUMMARY

COUNTY	HERC	Count of Provider
ASHLAND	Northwest	2
BARRON	Northwest	3
BAYFIELD	Northwest	1
BURNETT	Northwest	2
CHIPPEWA	Northwest	6
DOUGLAS	Northwest	1
DUNN	Northwest	4
EAU CLAIRE	Northwest	3
PEPIN	Northwest	3
PIERCE	Northwest	3
POLK	Northwest	4
RUSK	Northwest	6
SAINT CROIX	Northwest	3
SAWYER	Northwest	2
WASHBURN	Northwest	1

SUMMARY

COUNTY	HERC	Count of Provider
ADAMS	South Central	9
COLUMBIA	South Central	12
DANE	South Central	16
DODGE	South Central	24
GRANT	South Central	7
GREEN	South Central	8
IOWA	South Central	6
JEFFERSON	South Central	20
JUNEAU	South Central	8
LAFAYETTE	South Central	8

MARQUETTE	South Central	9
RICHLAND	South Central	8
ROCK	South Central	12
SAUK	South Central	7

SUMMARY

COUNTY	HERC	Count of Provider
FOND DU LAC	Southeast	16
KENOSHA	Southeast	16
MILWAUKEE	Southeast	22
OZAUKEE	Southeast	22
RACINE	Southeast	17
SHEBOYGAN	Southeast	14
WALWORTH	Southeast	19
WASHINGTON	Southeast	23
WAUKESHA	Southeast	22

SUMMARY

COUNTY	HERC	Count of Provider
BUFFALO	Western	3
CRAWFORD	Western	7
JACKSON	Western	2
LA CROSSE	Western	4
MONROE	Western	6
TREMPEALEAU	Western	4
VERNON	Western	6

Appendix G: Nursing Home Utilization Trends, by HERC, 2015-2021

Nursing Home Utilization Trends, 2015 to 2021 Wisconsin									
	Capacity/Utilization			Medicaid Payor Breakout			Total Payor Mix		
Year	Total Number of Providers	Total Licensed Beds	Total Occupancy	Family Care	Other Medicaid Managed Care	All Other Medicaid	Total Medicaid	Total Medicare	Total Private Pay / Insurance / Other
2015	373	33,798	78%	8%	1%	56%	65%	14%	21%
2016	365	32,414	78%	9%	<1%	55%	64%	14%	22%
2017	362	32,214	74%	10%	1%	54%	65%	14%	21%
2018	351	30,577	75%	10%	1%	53%	64%	15%	21%
2019	335	27,497	75%	11%	2%	50%	63%	16%	21%
2020	325	26,832	71%	11%	3%	50%	64%	15%	20%
2021	321	25,752	67%	NA	NA	NA	NA	NA	NA
Change by Year									
Change 2015-2016	-8	(1,384)	0%	1%	0%	-1%	-1%	0%	1%
Change 2016-2017	-3	(200)	-4%	1%	0%	-1%	1%	0%	-1%
Change 2017-2018	-11	(1,637)	1%	0%	0%	-1%	-1%	1%	0%
Change 2018-2019	-16	(3,080)	0%	1%	0%	-3%	-1%	1%	0%
Change 2019-2020	-10	(665)	-4%	0%	0%	0%	1%	-1%	-1%
Change 2020-2021	-4	(1,080)	-4%	NA	NA	NA	NA	NA	NA

Source: Wisconsin Medicaid Cost Reports, Wisconsin Department of Health Services

Nursing Home Utilization Trends, 2015 to 2021 Fox Valley Area HERC									
	Capacity/Utilization			**Medicaid Payor Breakout**			**Total Payor Mix**		
Year	Total Number of Providers	Total Licensed Beds	Total Occupancy	Family Care	Other Medicaid Managed Care	All Other Medicaid	Total Medicaid	Total Medicare	Total Private Pay / Insurance / Other
2015	38	3,814	79%	3%	<1%	62%	65%	10%	25%
2016	37	3,727	78%	3%	<1%	60%	63%	10%	27%
2017	37	3,727	73%	5%	<1%	58%	63%	11%	26%
2018	34	3,457	74%	6%	<1%	58%	64%	12%	24%
2019	31	2,429	75%	7%	2%	52%	61%	16%	22%
2020	31	2,330	75%	10%	3%	49%	62%	14%	24%
2021	30	2,343	65%	NA	NA	NA	NA	NA	NA
Change by Year									
Change 2015-2016	-1	-87	-1%	0%	0%	-2%	-2%	0%	2%
Change 2016-2017	0	0	-5%	2%	0%	-2%	0%	1%	-1%
Change 2017-2018	-3	-270	1%	1%	0%	0%	1%	1%	-2%
Change 2018-2019	-3	-1028	1%	1%	0%	-6%	-3%	4%	-2%
Change 2019-2020	0	-99	0%	3%	0%	-3%	1%	-2%	2%
Change 2020-2021	-1	13	-10%	NA	NA	NA	NA	NA	NA

Source: Wisconsin Medicaid Cost Reports, Wisconsin Department of Health Services

North Central HERC									
	Capacity/Utilization			***Medicaid Payor Breakout***			***Total Payor Mix***		
Year	Total Number of Providers	Total Licensed Beds	Total Occupancy	Family Care	Other Medicaid Managed Care	All Other Medicaid	Total Medicaid	Total Medicare	Total Private Pay / Insurance / Other
2015	36	3,416	72%	5%	<1%	63%	68%	15%	17%
2016	35	3,286	71%	6%	<1%	57%	63%	10%	27%
2017	35	3,278	67%	8%	1%	61%	70%	15%	15%
2018	34	3,085	71%	8%	<1%	61%	69%	15%	16%
2019	33	2,881	72%	8%	1%	60%	69%	16%	15%
2020	31	2,718	67%	9%	2%	59%	70%	16%	15%
2021	32	2,678	62%	NA	NA	NA	NA	NA	NA
Change by Year									
Change 2015-2016	-1	-130	-1%	1%	0%	-6%	-5%	-5%	10%
Change 2016-2017	0	-8	-4%	2%	0%	4%	7%	5%	-12%
Change 2017-2018	-1	-193	4%	0%	0%	0%	-1%	0%	1%
Change 2018-2019	-1	-204	1%	0%	0%	-1%	0%	1%	-1%
Change 2019-2020	-2	-163	-5%	1%	1%	-1%	1%	0%	0%
Change 2020-2021	1	-40	-5%	NA	NA	NA	NA	NA	NA

Source: Wisconsin Medicaid Cost Reports, Wisconsin Department of Health Services

Northeast HERC									
	Capacity/Utilization			*Medicaid Payor Breakout*			*Total Payor Mix*		
Year	Total Number of Providers	Total Licensed Beds	Total Occupancy	Family Care	Other Medicaid Managed Care	All Other Medicaid	Total Medicaid	Total Medicare	Total Private Pay / Insurance / Other
2015	33	2,973	78%	2%	1%	65%	68%	14%	18%
2016	34	2,958	75%	5%	<1%	62%	67%	14%	19%
2017	33	2,901	70%	7%	1%	59%	67%	16%	17%
2018	31	2,689	69%	8%	<1%	56%	64%	16%	20%
2019	30	2,669	67%	8%	1%	54%	63%	17%	20%
2020	28	2,538	66%	8%	1%	53%	62%	17%	21%
2021	28	2,355	67%	NA	NA	NA	NA	NA	NA
Change by Year									
Change 2015-2016	1	-15	-3%	3%	0%	-3%	-1%	0%	1%
Change 2016-2017	-1	-57	-5%	2%	0%	-3%	0%	2%	-2%
Change 2017-2018	-2	-212	-1%	1%	0%	-3%	-3%	0%	3%
Change 2018-2019	-1	-20	-2%	0%	0%	-2%	-1%	1%	0%
Change 2019-2020	-2	-131	-1%	0%	0%	-1%	-1%	0%	1%
Change 2020-2021	0	-183	1%	NA	NA	NA	NA	NA	NA

Source: Wisconsin Medicaid Cost Reports, Wisconsin Department of Health Services

Northwest HERC									
	Capacity/Utilization			*Medicaid Payor Breakout*			*Total Payor Mix*		
Year	Total Number of Providers	Total Licensed Beds	Total Occupancy	Family Care	Other Medicaid Managed Care	All Other Medicaid	Total Medicaid	Total Medicare	Total Private Pay / Insurance / Other
2015	64	4,134	77%	6%	<1%	57%	63%	14%	23%
2016	62	4,032	74%	7%	<1%	57%	64%	14%	22%
2017	60	3,767	71%	8%	<1%	57%	65%	13%	22%
2018	61	3,725	76%	7%	<1%	56%	63%	14%	23%
2019	59	3,449	75%	6%	2%	55%	63%	15%	22%
2020	59	3,414	71%	6%	2%	56%	64%	15%	21%
2021	54	3,095	64%	NA	NA	NA	NA	NA	NA
Change by Year									
Change 2015-2016	-2	-102	-3%	1%	0%	0%	1%	0%	-1%
Change 2016-2017	-2	-265	-3%	1%	0%	0%	1%	-1%	0%
Change 2017-2018	1	-42	5%	-1%	0%	-1%	-2%	1%	1%
Change 2018-2019	-2	-276	-1%	-1%	1%	-1%	0%	1%	-1%
Change 2019-2020	0	-35	-4%	0%	0%	1%	1%	0%	-1%
Change 2020-2021	-5	-319	-7%	NA	NA	NA	NA	NA	NA

Source: Wisconsin Medicaid Cost Reports, Wisconsin Department of Health Services

South Central HERC									
	Capacity/Utilization			***Medicaid Payor Breakout***			***Total Payor Mix***		
Year	Total Number of Providers	Total Licensed Beds	Total Occupancy	Family Care	Other Medicaid Managed Care	All Other Medicaid	Total Medicaid	Total Medicare	Total Private Pay / Insurance / Other
2015	76	6,299	80%	5%	<1%	60%	65%	15%	20%
2016	73	5,862	79%	6%	<1%	58%	64%	15%	21%
2017	74	6,081	79%	6%	1%	58%	65%	15%	20%
2018	72	5,963	76%	7%	1%	57%	65%	15%	20%
2019	70	5,438	77%	8%	2%	53%	63%	16%	22%
2020	65	5,273	74%	8%	2%	55%	65%	14%	21%
2021	68	5,293	68%	NA	NA	NA	NA	NA	NA
Change by Year									
Change 2015-2016	-3	-437	-1%	1%	0%	-2%	-1%	0%	1%
Change 2016-2017	1	219	0%	0%	0%	0%	1%	0%	-1%
Change 2017-2018	-2	-118	-3%	1%	0%	-1%	0%	0%	0%
Change 2018-2019	-2	-525	1%	1%	1%	-4%	-2%	1%	2%
Change 2019-2020	-5	-165	-3%	0%	0%	2%	2%	-2%	-1%
Change 2020-2021	3	20	-6%	NA	NA	NA	NA	NA	NA

Source: Wisconsin Medicaid Cost Reports, Wisconsin Department of Health Services

Southeast HERC									
	Capacity/Utilization			***Medicaid Payor Breakout***			***Total Payor Mix***		
Year	Total Number of Providers	Total Licensed Beds	Total Occupancy	Family Care	Other Medicaid Managed Care	All Other Medicaid	Total Medicaid	Total Medicare	Total Private Pay / Insurance / Other
2015	101	11,096	79%	12%	2%	49%	63%	16%	21%
2016	100	10,578	79%	14%	1%	49%	64%	16%	20%
2017	99	10,535	74%	15%	1%	48%	64%	16%	20%
2018	95	9,796	76%	14%	2%	47%	63%	17%	21%
2019	88	8,813	77%	15%	3%	46%	64%	16%	20%
2020	87	8,758	70%	16%	4%	45%	65%	17%	19%
2021	86	8,347	67%	NA	NA	NA	NA	NA	NA
Change by Year									
Change 2015-2016	-1	-518	0%	2%	-1%	0%	1%	0%	-1%
Change 2016-2017	-1	-43	-5%	1%	0%	-1%	0%	0%	0%
Change 2017-2018	-4	-739	2%	-1%	1%	-1%	-1%	1%	1%
Change 2018-2019	-7	-983	1%	1%	1%	-1%	1%	-1%	-1%
Change 2019-2020	-1	-55	-7%	1%	1%	-1%	1%	1%	-1%
Change 2020-2021	-1	-411	-3%	NA	NA	NA	NA	NA	NA

Source: Wisconsin Medicaid Cost Reports, Wisconsin Department of Health Services

Western HERC									
	Capacity/Utilization			***Medicaid Payor Breakout***			***Total Payor Mix***		
Year	Total Number of Providers	Total Licensed Beds	Total Occupancy	Family Care	Other Medicaid Managed Care	All Other Medicaid	Total Medicaid	Total Medicare	Total Private Pay / Insurance / Other
2015	25	2,066	87%	17%	<1%	47%	64%	8%	28%
2016	24	1,971	86%	18%	<1%	45%	63%	8%	29%
2017	24	1,925	79%	18%	<1%	43%	61%	9%	30%
2018	24	1,862	82%	17%	1%	43%	61%	10%	30%
2019	24	1,818	79%	19%	<1%	41%	60%	10%	30%
2020	24	1,801	78%	21%	1%	38%	60%	10%	30%
2021	23	1,641	76%	NA	NA	NA	NA	NA	NA
Change by Year									
Change 2015-2016	-1	-95	-1%	1%	0%	-2%	-1%	0%	1%
Change 2016-2017	0	-46	-7%	0%	0%	-2%	-2%	1%	1%
Change 2017-2018	0	-63	3%	-1%	0%	0%	0%	1%	0%
Change 2018-2019	0	-44	-3%	2%	0%	-2%	-1%	0%	0%
Change 2019-2020	0	-17	-1%	2%	0%	-3%	0%	0%	0%
Change 2020-2021	-1	-160	-2%	NA	NA	NA	NA	NA	NA

Source: Wisconsin Medicaid Cost Reports, Wisconsin Department of Health Services

Appendix H. Medicaid Application Process

Timeliness of Application.

MAGI Application Processing Time Report by State

State	Month	Percent of Determinations Processed < 24 Hours	Percent of Determinations Processed 1–7 Days	Percent of Determinations Processed 8–30 Days	Percent of Determinations Processed 31–45 Days	Percent of Determinations Processed > 45 Days
West Virginia	April*	26%	33%	32%	6%	3%
	May*	27%	35%	29%	5%	5%
	June*	26%	30%	34%	6%	3%
Wisconsin	April(III)*	41%	19%	31%	10%	1%
	May(III)*	41%	18%	30%	11%	1%
	June(III)*	39%	21%	32%	9%	0%
Wyoming	April*	22%	4%	4%	4%	66%
	May*	30%	5%	5%	3%	58%
	June*	8%	1%	2%	2%	87%
National Totals[i]	**April**	**52%**	**15%**	**18%**	**6%**	**9%**
	May	**54%**	**16%**	**18%**	**5%**	**6%**
	June	**51%**	**18%**	**19%**	**5%**	**7%**

CMS Timeliness Report, https://www.medicaid.gov/state-overviews/downloads/magi-app-process-time-snapshot-rpt-apr-jun-2022.pdf

Appendix I: Medicaid Expansion

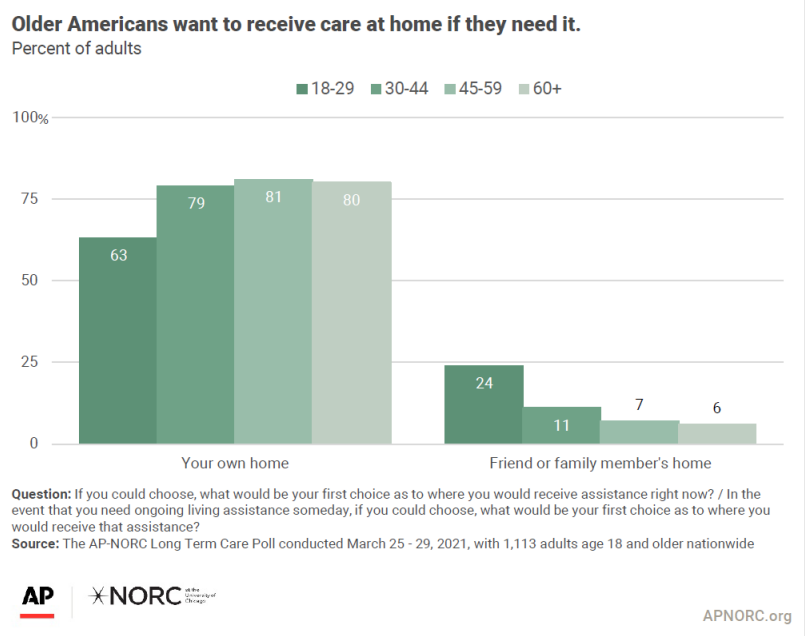
Studies used to support statements and conclusions include:

- *J Gen Intern Med 2018 Mar;33(3):376-383. doi: 10.1007/s11606-017-4217-5. Epub 2017 Nov 27/ Medicaid Expansion, Mental Health, and Access to Care among Childless Adults with and without Chronic Conditions/ https://pubmed.ncbi.nlm.nih.gov/29181792/*
- *Health Serv Res 2023 Feb 23. doi: 10.1111/1475-6773.14144. Impact of State Medicaid Expansion on Cross-Sector Health and Social Service Networks: Evidence from a Longitudinal Cohort Study/ https://pubmed.ncbi.nlm.nih.gov/36815298/*
- Ndumele CD, Schpero WL, Trivedi AN. Medicaid Expansion and Health Plan Quality in Medicaid Managed Care. Health Serv Res. 2018 Aug;53 Suppl 1(Suppl Suppl 1):2821-2838. doi: 10.1111/1475-6773.12814. Epub 2017 Dec 12. PMID: 29230801; PMCID: PMC6056574.
- Tilhou AS, Huguet N, DeVoe J, Angier H. The Affordable Care Act Medicaid Expansion Positively Impacted Community Health Centers and Their Patients. J Gen Intern Med. 2020 Apr;35(4):1292-1295. doi: 10.1007/s11606-019-05571-w. Epub 2020 Jan 2. PMID: 31898120; PMCID: PMC7174462.
- Breslau J, Han B, Lai J, Yu H. Impact of the Affordable Care Act Medicaid Expansion on Utilization of Mental Health Care. Med Care. 2020 Sep;58(9):757-762. doi: 10.1097/MLR.0000000000001373. PMID: 32732786; PMCID: PMC7483910.
- Kendrick KN, Marcondes FO, Stanford FC, Mukamal KJ. Medicaid expansion and health care access for individuals with obesity in the United States. Obesity (Silver Spring). 2022 Sep;30(9):1787-1795. doi: 10.1002/oby.23531. PMID: 36000245; PMCID: PMC9413362.
- Rosland AM, Kieffer EC, Tipirneni R, Kullgren JT, Kirch M, Arntson EK, Clark SJ, Lee S, Solway E, Beathard E, Ayanian JZ, Goold SD. Diagnosis and Care of Chronic Health Conditions Among Medicaid Expansion Enrollees: A Mixed-Methods Observational Study. J Gen Intern Med. 2019 Nov;34(11):2549-2558. doi: 10.1007/s11606-019-05323-w. Epub 2019 Sep 11. PMID: 31512184; PMCID: PMC6848397.
- Commonwealth Fund: The Economic and Employment Effects of Medicaid Expansion Under the American Rescue Plan/ https://www.commonwealthfund.org/publications/issue-briefs/2021/may/economic-employment-effects-medicaid-expansion-under-arp
- Buchmueller TC, Cliff BQ, Levy H. The Benefits of Medicaid Expansion. *JAMA Health Forum.* 2020;1(7):e200879. doi:10.1001/jamahealthforum.2020.0879
- Center on Budget & Policy Priorities/ ACA Medicaid Expansion/ https://www.cbpp.org/aca-medicaid-expansion-improving-access-to-care-health-and-financial-security-research-finds
- Tarazi WW. Associations between Medicaid expansion and nurse staffing ratios and hospital readmissions. Health Serv Res. 2020 Jun;55(3):375-382. doi: 10.1111/1475-6773.13273. Epub 2020 Feb 13. PMID: 32056212; PMCID: PMC7240770.

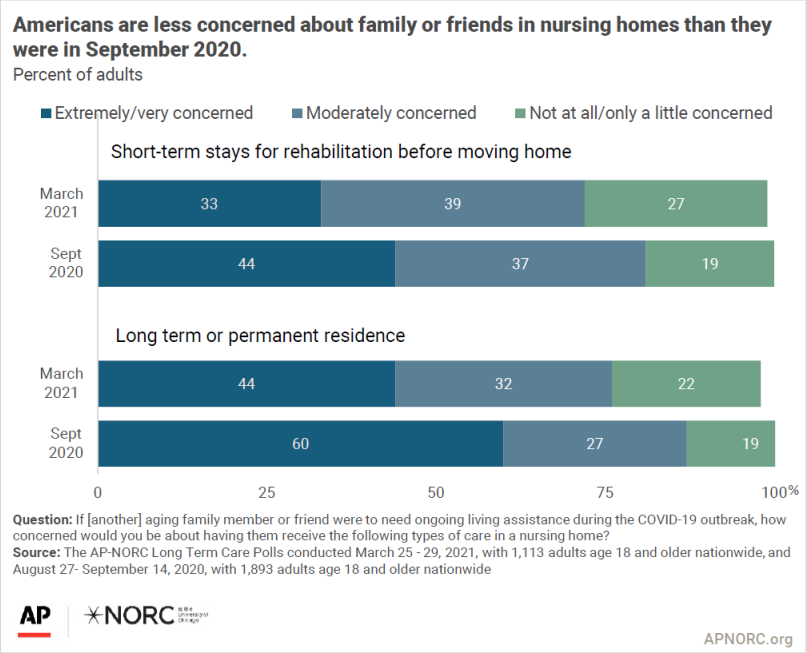
Appendix J: HCBS Reference Studies

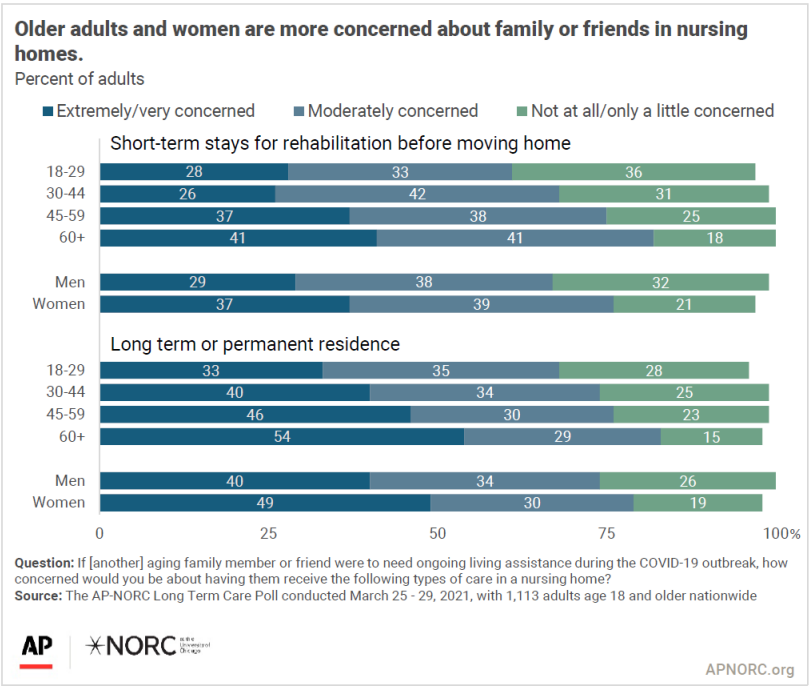
Relevant statistics and studies regarding future consumer/patient demand for long-term care services

1. Americans have strong preference to age at Home

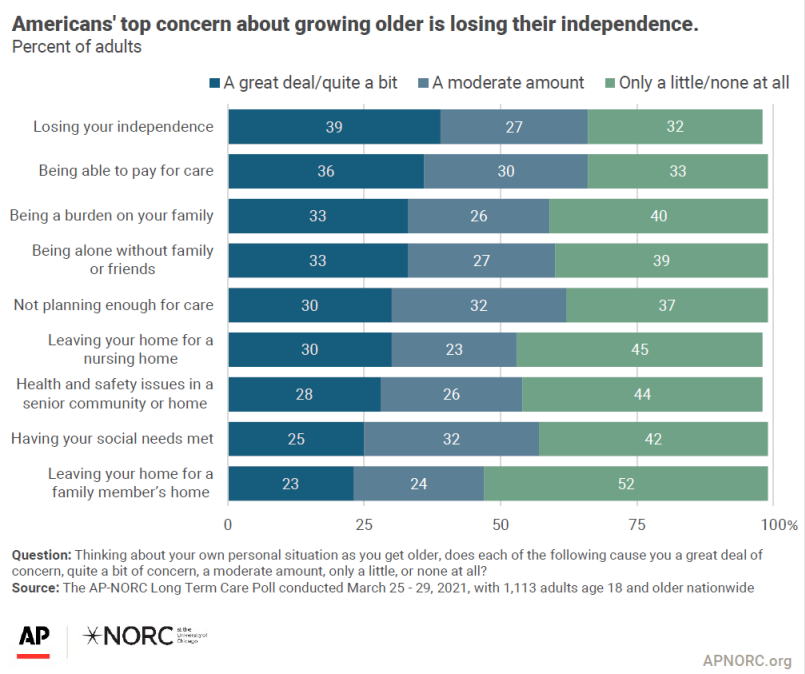


2. In addition to their own future needs, Americans remain skeptical about nursing home facilities for both long and short term stays for loved ones. A third would be very or extremely concerned about a loved one receiving care in a nursing home for a short-term stay for rehabilitation, and 44% say the same about a long-term stay or permanent residence. Although Americans still express reservations about nursing homes, these concerns have decreased since September 2020.





3. Reflecting their strong preference to age in a home setting, the top worry on Americans' minds when asked about potential concerns as they grow older is losing their independence. Many are also worried about being alone without family or friends around them, having to leave their home, and being a burden on family.

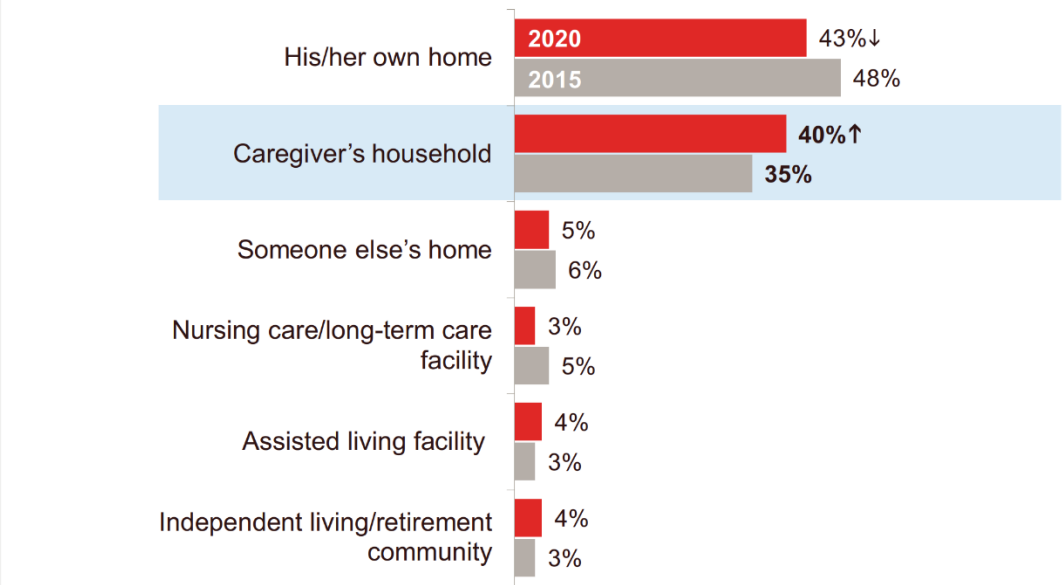


The full report including consumer opinions on funding and support can be found at:
https://apnorc.org/wp-content/uploads/2021/04/LTC_Report_AgingatHome_final.pdf

Personal Care Services

- National Alliance for Caregiving and AARP Public Policy Institute, Caregiving in the US 2020
- Genworth Cost of Care Survey 2004-2021, Conducted by CareScout®
- Ralph NL, Mielenz TJ, Parton H, Flatley A, Thorpe LE. Multiple Chronic Conditions and Limitations in Activities of Daily Living in a Community-Based Sample of Older Adults in New York City, 2009. Prev Chronic Dis 2013;10:130159. DOI: http://dx.doi.org/10.5888/pcd10.130159.

Figure 19. Where Care Recipient Lives

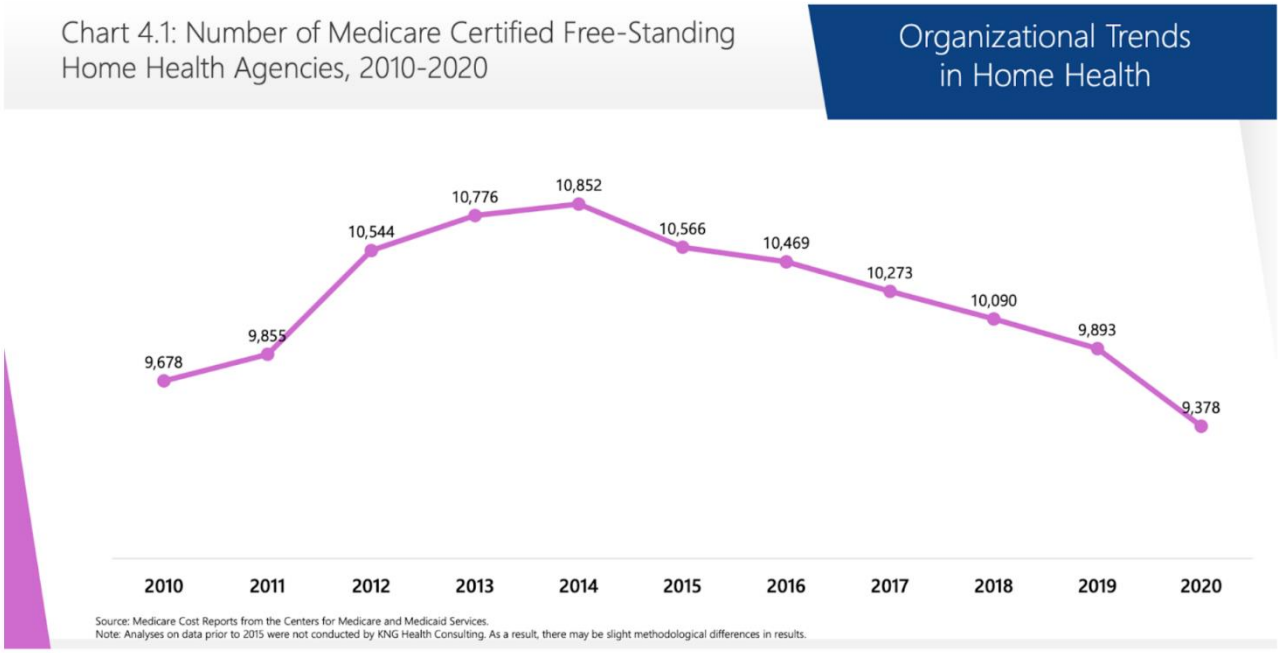


Q13. Which of the following best describes where your [relation] lives/lived at the time you provided care?

2020 Base: Caregivers of Recipient Age 18+ Who Reported Living Arrangement (n=1,389)
2015 Base: Caregivers of Recipient Age 18+ Who Reported Living Arrangement (n=1,236)

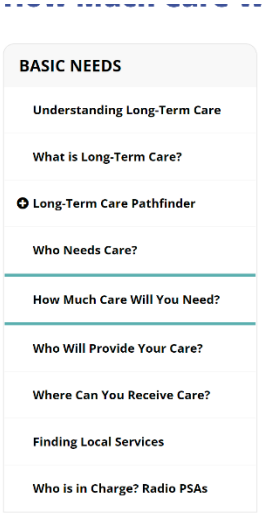
Note: Results are rounded and don't know/refused responses are not shown; results may not add to 100 percent.

National Decline in Medicare Certified Home Health Providers
https://homehealthcarenews.com/2023/01/top-home-health-trends-for-2023/



Medicare Mortality Rate: *https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05390*

Personal Care Agency Utilization from the LongTermCare.gov site:



The duration and level of long-term care will **vary from person to person** and often change over time. Here are some statistics (all are "on average") you should consider:

- Someone turning age 65 today has almost a 70% chance of needing some type of long-term care services and supports in their remaining years
- **Women need care longer** (3.7 years) than men (2.2 years)
- **One-third of today's 65 year-olds** may never need long-term care support, but 20 percent will need it for longer than 5 years

The table below shows that, overall, more people use long-term care services at home (and for longer) than in facilities.

Distribution and duration of long-term care services

Type of care	Average number of years people use this type of care	Percent of people who use this type of care (%)
Any Services	3 years	69
	At Home	
Unpaid care only	1 year	59
Paid care	Less than 1 year	42
Any care at home	2 years	65
	In Facilities	
Nursing facilities	1 year	35
Assisted living	Less than 1 year	13
Any care in facilities	1 year	37

https://acl.gov/ltc/basic-needs/how-much-care-will-you-need#:~:text=Someone%20turning%20age%2065%20today,)%20than%20men%20(2.2%20years)

Personal Care averages: *https://www.caregiver.org/resource/caregiver-statistics-demographics/*

- MedPac March 2022 Report to Congress https://www.medpac.gov/document/march-2022-report-to-the-congress-medicare-payment-policy
- Wisconsin Department of Health Services Life Expectancy Tables https://dhs.wisconsin.gov/stats/life-expectancy.htm
- "Long-Term Care in America: Americans Want to Age at Home" The Associated Press-NORC Center for Public Affairs Research https://apnorc.org/wpcontent/uploads/2021/04/LTC_Report_AgingatHome_final.pdf

Appendix K: Workforce

- Expanding Scope of Practice:
- *Yang B.K., Johantgen M.E., Trinkoff A.M., Idzik S.R., Wince J., Tomlinson C. State nurse practitioner practice regulations and US health care delivery outcomes: A systematic review. Medical Care Research and Review. 2020 doi: 10.1177/1077558719901216.*
- Interstate Medical Licensure Compact https://www.imlcc.org/
- Psychology Interjurisdictional Compact https://psypact.org/
- Nursing Licensure Compact https://nurse.org/articles/enhanced-compact-multi-state-license-eNLC/
- Counseling Compact https://counselingcompact.org/
- The Physical Therapy Compact https://ptcompact.org/
- Recognition of Emergency Medical Services Personnel Licensure Interstate Compact (REPLICA) https://www.emscompact.gov/
- California Health Workforce Pilot Program (HWPP)
- *https://hcai.ca.gov/workforce-capacity/health-workforce-pilot-projects/*WorkforceTechnology:

Studies/Presentations

Telehealth:

- *https://www.behavioralhealthworkforce.org/wp-content/uploads/2021/04/Telebehavioral-Health-Workforce-Opportunities_National-Council_FULL-REPORT_FINAL-1.pdf*
- *Lessons From Tele-Emergency: Improving Care Quality And Health Outcomes By Expanding Support For Rural Care Systems: https://www.healthaffairs.org/doi/10.1377/hlthaff.2013.1016*
- *USING TELEHEALTH TO ADDRESS CHALLENGES, BARRIERS, AND WORKFORCE SHORTAGES: https://cha.com/wp-content/uploads/2018/10/Dixon_Key-Considerations-Best-Practices1.pdf*

Other Technology Studies

- *MIT "The Impact of New Technology on the Healthcare Workforce" https://workofthefuture.mit.edu/wp-content/uploads/2020/10/2020-Research-Brief-Bronsoler-Doyle-VanReenen.pdf*
- *Empowering-Health-Workforce-Digital-Revolution: https://www.oecd.org/health/health-systems/Empowering-Health-Workforce-Digital-Revolution.pdf*

Appendix L: Complex Patients References Material

Dementia & Mental Health Patients (statistical data sources):

- *National Institute of Health Study: https://www.nimh.nih.gov/health/statistics/mental-illness*
- *Population Review Board Dementia Trends: https://www.prb.org/resources/fact-sheet-u-s-dementia-trends/*
- *National Institute for Health and Care Excellence. Multimorbidity and polypharmacy. Available at: https://www.nice.org.uk/advice/ktt18/chapter/evidence-context. Accessed January 2022.*
- *Divo MJ, Martinez CH, Mannino DM. Ageing, and the epidemiology of multimorbidity. Eur Respir J. 2014;44(4):1055-1068. doi:10.1183/09031936.00059814.*
- *de Lima JD, Teixeira IA, Silva FO, Deslandes AC. The comorbidity conditions and polypharmacy in elderly patients with mental illness in a middle-income country: a cross-sectional study⋆. IBRO Rep. 2020 Jul 16;9:96-101. doi: 10.1016/j.ibror.2020.07.008.*

Obesity/Bariatric Patients (statistical data sources):

- *NIH: Med Care2014 Jul;52(7):658-63. doi: 10.1097/MLR.0000000000000154 Aricle III The burden of overweight and obesity on long-term care and Medicaid financing*
- *Reference to study in the Online Journal of Nursing which provides an excellent explanation of the interrelationship of obesity and other medical conditions: https://ojin.nursingworld.org/table-of-contents/volume-14-2009/number-1-january-2009/obesity-an-emerging-concern/*
- *Risks to Healthcare Organizations and Staff Who Manage Obese (Bariatric) Patients and Use of Obesity Data to Mitigate Risks: A Literature Review https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7954428/I*

Patients with unmanaged Chronic Conditions (statistical data sources):

- *The Relation of the Chronic Disease Epidemic to the Health Care Crisis https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7077778/*

Table. Percentage and Number of US Adults Aged 18 Years or Older With Chronic Conditions,[a] by Select Characteristics, United States, 2018

Characteristic	0 Chronic Conditions		1 Chronic Condition		≥2 Chronic Conditions	
	% Population[b] (95% CI)	N	% Population[b] (95% CI)	N	% Population[b] (95% CI)	N
Total[c]	48.2 (47.3–49.1)	120,230	24.6 (23.9–25.3)	61,371	27.2 (26.5–27.9)	67,854
Sex[d]						
Male	49.8 (48.5–51.0)	59,921	24.4 (23.4–25.4)	29,346	25.9 (24.9–26.9)	31,175
Female	46.7 (45.6–47.9)	60,309	24.8 (23.9–25.7)	32,025	28.4 (27.5–29.4)	36,679
Race/ethnicity[e]						
Non-Hispanic White	43.8 (42.7–44.8)	68,839	25.6 (24.8–26.4)	40,248	30.6 (29.7–31.6)	48,202
Non-Hispanic Black	47.6 (45.0–50.2)	13,845	25.4 (23.3–27.6)	7,390	27.0 (25.0–29.1)	7,855
Non-Hispanic Asian	62.0 (58.6–65.2)	9,400	21.6 (19.0–24.4)	3,280	16.4 (14.0–19.0)	2,486
Hispanic	61.5 (59.3–63.5)	25,042	20.8 (19.1–22.5)	8,478	17.7 (16.2–19.3)	7,230
Age, y[d]						
18–44	72.6 (71.4–73.7)	83,444	20.7 (19.7–21.8)	23,841	6.7 (6.1–7.3)	7,723
45–64	36.6 (35.3–37.9)	30,404	30.4 (29.2–31.6)	25,250	33.0 (31.7–34.3)	27,383
≥65	12.4 (11.5–13.3)	6,382	23.9 (22.7–25.1)	12,280	63.7 (62.3–65.1)	32,748
Health insurance coverage[f]						
Age 18–64 y[d]						
Private	58.6 (57.5–59.8)	80,085	25.7 (24.7–26.7)	35,065	15.7 (14.9–16.5)	21,418
Public	48.9 (46.3–51.6)	12,192	23.4 (21.4–25.5)	5,830	27.6 (25.5–29.9)	6,886
Uninsured	66.8 (64.3–69.3)	17,059	21.6 (19.4–23.9)	5,511	11.6 (10.1–13.2)	2,995
Age ≥65 y[g]						
Private	12.4 (11.1–13.8)	2,633	24.4 (22.6–26.3)	5,190	63.2 (61.2–65.3)	13,451
Dual eligible	6.8 (4.6–9.6)	239	16.4 (13.0–20.1)	577	76.9 (72.5–80.8)	2,713
Medicare Advantage	11.9 (10.2–13.6)	1,556	25.2 (22.9–27.6)	3,300	63.0 (60.3–65.6)	8,257
Medicare only excluding Medicare Advantage	16.1 (13.6–18.8)	1,280	25.4 (22.2–28.9)	2,020	58.5 (54.8–62.1)	4,645
Location of residence[d]						
Urban	49.5 (48.5–50.5)	107,383	24.5 (23.7–25.2)	53,125	26.1 (25.3–26.9)	56,577
Rural	39.7 (37.3–42.1)	12,847	25.5 (23.8–27.2)	8,246	34.8 (32.8–37.0)	11,277

Table and full report found at: https://www.cdc.gov/pcd/issues/2020/20_0130.htm#T1_down

Study on the cost of chronic disease patients: https://www.ajmc.com/view/persistent-high-utilization-in-a-privately-insured-population

Appendix M: Data Request

Data Requested from Wisconsin Health Systems (Pending)

Data tracking for Long-Term Care.

The following items were developed in collaboration with our health system interview and work group participants to measure and identify costs, trends and obstacles impacting long-term care in Wisconsin.

1. Define the problem: How large is the LTC discharge dilemma and how can we refine the data.
    a. Excess day that can be attributed to the inability to place an LTC patient (both facility and non-facility patients)
        i. SNF & ALF discharge and barrier data
        ii. HCBS data, including 'unsafe' environment or "unavailable care.'
    b. Same as above with avoidable days
    c. Patients admitted under denial.
    d. Patients admitted for placement.
    e. Quantifiable metrics which can measure MCO placement delays.
        i. Secondary data from long-term care divisions/partners
2. The impact of these patients on access to services
    a. Impact of patients awaiting placement on hospital census
    b. Impact on ED wait times.
    c. Impact of ED boarding
    d. # Of deferred elective surgeries
    e. # or increase in patients who have left without service or left AMA
    f. For the systems who track it, # of patient transfers denied attributable to the LTC population
3. The trickle-down effect on delays and wait times:
    a. Boarders in other departments (ICU, etc.) that can be attributed to LTC placement
    b. If tracked in the EMR, how many patients are at the wrong level of care due to unavailable beds.
    c. Any readmission data on patients who have not been placed in the appropriate setting due to lack of beds
    d. Any measurable patient satisfaction or quality of life data
    e. Measurable impact on patients in observation
4. Community Impact Statement
    a. In development/dependent on data

Appendix N: List of Persons Interviewed

AA Healthcare
Attic Angel Community, Middleton WI
Avanti Health Systems, Hurly WI
Azura Assisted Living & Memory Care, Milwaukee WI
Bellin Health, Green Bay WI
Benedictine Living, La Crosse WI
Bethany Lutheran Home, LaCrosse WI
Bethany Lutheran Home/Eaglecrest North, Onalaska, WI
Bethany St. Joseph, LaCrosse WI
Birch Haven Senior Living
Brookside Care Center, Kenosha WI
Campion Care
Christian Community Home, Hudson WI
Cedar Communities, Cederberg WI
Door County Medical Center, Sturgeon Bay WI
Dove Healthcare, Eau Claire WI
Froedtert Hospital, Milwaukee WI
Gunderson Lutheran Hospital, LaCrosse, WI
Holly House AFH
Hillview Health Center/Lakeview Health Center, LaCrosse/West Salem, WI
Homme Inc. of Wisconsin, Wittenberg WI
Hope Health & Rehab
Inspiration Ministries, Lake Geneva WI
Luther Manor, Milwaukee WI
Maplewood of Sauk Prairie, Sauk City WI
North Shore Healthcare LLC, Milwaukee, WI
New Glarus Home, New Glarus, WI
Oakwood Village, Madison WI
Oak Park Place, Madison W
Oakridge Gardens, Menasha WI
Park View Home, Inc., Woodville WI
Park Manor, LTD, Park Falls WI
ProHealthcare Regency Senior Communities, Milwaukee WI
Rainbow House
REM Wisconsin, Janesville WI
Rocky Knoll, Plymouth WI

Sheboygan Senior Community, Sheboygan WI
St. Croix Health Center, Richmond WI
Skaalen Retirement Communities,
SSM Health, Madison WI
St Paul Home, Kaukauna, WI
The Neighbors of Dunn County, Menomonie WI
The Lutheran Home, Milwaukee WI
Twin Ports Health Services, Superior WI
Willowcrest Health Services, South Milwaukee WI

Trade Association/Advocacy Groups

LeadingAge WI
LeadingAge MN
Leading Age OH
Disability Service Provider Network
Wisconsin Health Care Association
Wisconsin Assisted Living Association
Wisconsin Personal Services Association
IRIS/TMG
AARP
Wisconsin Primary Health Care Association
SEIU
Rural Health Cooperative
Wisconsin Council on Medical Education and Workforce
LeadingAge Choice Program
Wisconsin Hospital Association
WI Council on Medical Education and Workforce
Rural Wisconsin Health Cooperative

Appendix O: Assisted Living Market Penetration Rate (Market Demand) Methodology Tables, by HERC

The following tables summarize the methodology for the elderly, 65+ assisted living and memory care assisted living demand (market penetration rate) analysis. The acronym “PMA” (Primary Market Area) noted in the exhibits below refers to the HERC regions.

Assisted Living Market Penetration Rate Tables (non-memory care)

Private Pay Demand/Capacity/Need Projections, 2022 to 2027, by HERC

The following tables summarize the market demand projections, by HERC, for 65+ households that earn more than $25,000 annually and would potentially need and demand a non-memory-care assisted living facility.

Southeast Region
Estimated Number of Age 75+ Assisted Living Eligible Individuals in the Region
Years 2022 and 2027

	2022	2027
Estimated Age-Eligible Households	112,810	132,235
Estimated Age-and-Income Eligible Households	81,928	105,168
Percentage of Individuals Requiring Assistance	27.6%	27.6%
Percentage of Individuals Living Alone	51.4%	51.4%
Estimated Age-Eligible Individuals	16,004	18,759
Estimated Age-and-Income Eligible Individuals	11,623	14,920

Southeast Region
Assisted Living Market Penetration Rates

	Age-Eligible Individuals	Age-and-Income Eligible Individuals	
	2022	2022	2027
Number of qualified individuals	16,004	11,623	14,920
Number of individuals at the Community	-	-	-
Number of individuals in existing comparable units	11,360	11,360	11,360
Total qualified Individuals **[a]**	**27,364**	**22,983**	**26,280**
Number of individuals at the Community	-	-	-
Number of individuals in existing and planned comparable units	11,360	11,360	11,360
Total beds in the AL PMA **[b]**	**11,360**	**11,360**	**11,360**
Market Penetration Rate [b/a]	**41.5%**	**49.4%**	**43.2%**
Beds needed in the PMA to meet Market Penetration Threshold (35% age-eligible; 50% age-and-income eligible)	9,577	11,492	13,140
Difference in needed vs. existing beds in the PMA to meet Market Penetration Threshold (surplus or deficit)	1,783	(132)	(1,780)

Fox Valley Region
Estimated Number of Age 75+ Assisted Living Eligible Individuals in the Region Years 2022 and 2027

	2022	2027
Estimated Age-Eligible Households	28,326	32,864
Estimated Age-and-Income Eligible Households	19,620	24,927
Percentage of Individuals Requiring Assistance	27.6%	27.6%
Percentage of Individuals Living Alone	51.7%	51.7%
Estimated Age-Eligible Individuals	4,042	4,689
Estimated Age-and-Income Eligible Individuals	2,800	3,557

Fox Valley Region
Assisted Living Market Penetration Rates

	Age-Eligible Individuals		Age-and-Income Eligible Individuals	
	2022	2027	2022	2027
Number of qualified individuals	4,042	4,689	2,800	3,557
Number of individuals at the Community	-	-	-	-
Number of individuals in existing comparable units	3,051	3,051	3,051	3,051
Total qualified Individuals **[a]**	**7,093**	**7,740**	**5,851**	**6,608**
Number of individuals at the Community	-	-	-	-
Number of individuals in existing and planned comparable units	3,051	3,051	3,051	3,051
Total beds in the AL PMA **[b]**	**3,051**	**3,051**	**3,051**	**3,051**
Market Penetration Rate [b/a]	**43.0%**	**39.4%**	**52.1%**	**46.2%**
Beds needed in the PMA to meet Market Penetration Threshold (35% age-eligible; 50% age-and-income eligible)	2,483	2,709	2,926	3,304
Difference in needed vs. existing beds in the PMA to meet Market Penetration Threshold (surplus or deficit)	568	342	126	(253)

Northwest Region

Estimated Number of Age 75+ Assisted Living Eligible Individuals in the Region Years 2022 and 2027

	2022	2027
Estimated Age-Eligible Households	31,301	37,727
Estimated Age-and-Income Eligible Households	21,827	28,652
Percentage of Individuals Requiring Assistance	27.6%	27.6%
Percentage of Individuals Living Alone	50.9%	50.9%
Estimated Age-Eligible Individuals	4,397	5,300
Estimated Age-and-Income Eligible Individuals	3,066	4,025

Northwest Region
Assisted Living Market Penetration Rates

	Age-Eligible Individuals		Age-and-Income Eligible Individuals	
	2022	**2027**	**2022**	**2027**
Number of qualified individuals	4,397	5,300	3,066	4,025
Number of individuals at the Community	-	-	-	-
Number of individuals in existing comparable units	2,526	2,526	2,526	2,526
Total qualified Individuals **[a]**	**6,923**	**7,826**	**5,592**	**6,551**
Number of individuals at the Community	-	-	-	-
Number of individuals in existing and planned comparable units	2,526	2,526	2,526	2,526
Total beds in the AL PMA **[b]**	**2,526**	**2,526**	**2,526**	**2,526**
Market Penetration Rate [b/a]	**36.5%**	**32.3%**	**45.2%**	**38.6%**
Beds needed in the PMA to meet Market Penetration Threshold (35% age-eligible; 50% age-and-income eligible)	2,423	2,739	2,796	3,276
Difference in needed vs. existing beds in the PMA to meet Market Penetration Threshold (surplus or deficit)	103	(213)	(270)	(750)

North Central Region
Estimated Number of Age 75+ Assisted Living Eligible Individuals in the Region Years 2024 and 2027

	2022	**2027**
Estimated Age-Eligible Households	28,895	33,256
Estimated Age-and-Income Eligible Households	20,008	25,027
Percentage of Individuals Requiring Assistance	27.6%	27.6%
Percentage of Individuals Living Alone	50.1%	50.1%
Estimated Age-Eligible Individuals	3,995	4,599
Estimated Age-and-Income Eligible Individuals	2,767	3,461

North Central Region
Assisted Living Market Penetration Rates

	Age-Eligible Individuals		Age-and-Income Eligible Individuals	
	2022	**2027**	**2022**	**2027**
Number of qualified individuals	3,995	4,599	2,767	3,461
Number of individuals at the Community	-	-	-	-
Number of individuals in existing comparable units	2,086	2,086	2,086	2,086
Total qualified Individuals **[a]**	**6,081**	**6,685**	**4,853**	**5,547**
Number of individuals at the Community	-	-	-	-
Number of individuals in existing and planned comparable units	2,086	2,086	2,086	2,086
Total beds in the AL PMA **[b]**	**2,086**	**2,086**	**2,086**	**2,086**
Market Penetration Rate [b/a]	**34.3%**	**31.2%**	**43.0%**	**37.6%**
Beds needed in the PMA to meet Market Penetration Threshold (35% age-eligible; 50% age-and-income eligible)	2,128	2,340	2,427	2,774
Difference in needed vs. existing beds in the PMA to meet Market Penetration Threshold (surplus or deficit)	(42)	(254)	(341)	(688)

Northeast Region

Estimated Number of Age 75+ Assisted Living Eligible Individuals in the Region Years 2022 and 2027

	2022	**2027**
Estimated Age-Eligible Households	25,867	30,232
Estimated Age-and-Income Eligible Households	18,134	23,118
Percentage of Individuals Requiring Assistance	27.6%	27.6%
Percentage of Individuals Living Alone	52.4%	52.4%
Estimated Age-Eligible Individuals	3,741	4,372
Estimated Age-and-Income Eligible Individuals	2,623	3,343

Northeast Region
Assisted Living Market Penetration Rates

	Age-Eligible Individuals		Age-and-Income Eligible Individuals	
	2022	**2027**	**2022**	**2027**
Number of qualified individuals	3,741	4,372	2,623	3,343
Number of individuals at the Community	-	-	-	-
Number of individuals in existing comparable units	2,270	2,270	2,270	2,270
Total qualified Individuals **[a]**	**6,011**	**6,642**	**4,893**	**5,613**
Number of individuals at the Community	-	-	-	-
Number of individuals in existing and planned comparable units	2,270	2,270	2,270	2,270
Total beds in the AL PMA **[b]**	**2,270**	**2,270**	**2,270**	**2,270**
Market Penetration Rate [b/a]	**37.8%**	**34.2%**	**46.4%**	**40.4%**
Beds needed in the PMA to meet Market Penetration Threshold (35% age-eligible; 50% age-and-income eligible)	2,104	2,325	2,447	2,807
Difference in needed vs. existing beds in the PMA to meet Market Penetration Threshold (surplus or deficit)	166	(55)	(177)	(537)

South Central Region
Estimated Number of Age 75+ Assisted Living Eligible Individuals in the Region Years 2022 and 2027

	2022	**2027**
Estimated Age-Eligible Households	58,413	70,109
Estimated Age-and-Income Eligible Households	44,314	57,310
Percentage of Individuals Requiring Assistance	27.6%	27.6%
Percentage of Individuals Living Alone	51.4%	51.4%
Estimated Age-Eligible Individuals	8,287	9,946
Estimated Age-and-Income Eligible Individuals	6,287	8,130

South Central Region
Assisted Living Market Penetration Rates

	Age-Eligible Individuals		Age-and-Income Eligible	
	2022	**2027**	**2022**	**2027**
Number of qualified individuals	8,287	9,946	6,287	8,130
Number of individuals at the Community	-	-	-	-
Number of individuals in existing comparable units	6,148	6,148	6,148	6,148
Total qualified Individuals **[a]**	**14,435**	**16,094**	**12,435**	**14,278**
Number of individuals at the Community	-	-	-	-
Number of individuals in existing and planned comparable units	6,148	6,148	6,148	6,148
Total beds in the AL PMA **[b]**	**6,148**	**6,148**	**6,148**	**6,148**
Market Penetration Rate [b/a]	**42.6%**	**38.2%**	**49.4%**	**43.1%**
Beds needed in the PMA to meet Market Penetration Threshold (35% age-eligible; 50% age-and-income eligible)	5,052	5,633	6,218	7,139
Difference in needed vs. existing beds in the PMA to meet Market Penetration Threshold (surplus or deficit)	1,096	515	(70)	(991)

Western Region
Estimated Number of Age 75+ Assisted Living Eligible Individuals in the Region Years 2022 and 2027

	2022	**2027**
Estimated Age-Eligible Households	15,388	18,170
Estimated Age-and-Income Eligible Households	10,442	13,494
Percentage of Individuals Requiring Assistance	27.6%	27.6%
Percentage of Individuals Living Alone	52.2%	52.2%
Estimated Age-Eligible Individuals	2,217	2,618
Estimated Age-and-Income Eligible Individuals	1,504	1,944

Western Region
Assisted Living Market Penetration Rates

	Age-Eligible Individuals		Age-and-Income	
	2022	**2027**	**2022**	**2027**
Number of qualified individuals	2,217	2,618	1,504	1,944
Number of individuals at the Community	-	-	-	-
Number of individuals in existing comparable units	1,404	1,404	1,404	1,404
Total qualified Individuals **[a]**	**3,621**	**4,022**	**2,908**	**3,348**
Number of individuals at the Community	-	-	-	-
Number of individuals in existing and planned comparable units	1,404	1,404	1,404	1,404
Total beds in the AL PMA **[b]**	**1,404**	**1,404**	**1,404**	**1,404**
Market Penetration Rate [b/a]	**38.8%**	**34.9%**	**48.3%**	**41.9%**
Beds needed in the PMA to meet Market Penetration Threshold (35% age-eligible; 50% age-and-income eligible)	1,267	1,408	1,454	1,674
Difference in needed vs. existing beds in the PMA to meet Market Penetration Threshold (surplus or deficit)	137	(4)	(50)	(270)

Lower-income/Medicaid Capacity Need/Demand Projections, by HERC

The following tables summarize the market demand projections, by HERC, for 65+ households earning less than $25,000 annually and would potentially need and demand a non-memory-care specific assisted living facility.

Southeast Region
Estimated Number of Age 75+ Assisted Living Eligible Individuals in the Region Years 2022 and 2027

	2022	2027
Estimated Age-Eligible Households	112,810	132,235
Estimated Age-and-Income Eligible Households	30,882	27,067
Percentage of Individuals Requiring Assistance	27.6%	27.6%
Percentage of Individuals Living Alone	51.4%	51.4%
Estimated Age-Eligible Individuals	16,004	18,759
Estimated Age-and-Income Eligible Individuals	4,381	3,840

Southeast Region
Assisted Living Market Penetration Rates

	Age-Eligible Individuals		Age-and-Income Eligible Individuals	
	2022	2027	2022	2027
Number of qualified individuals	16,004	18,759	4,381	3,840
Number of individuals at the Community	-	-	-	-
Number of individuals in existing comparable units	2,539	2,539	2,539	2,539
Total qualified Individuals **[a]**	**18,543**	**21,298**	**6,920**	**6,379**
Number of individuals at the Community	-	-	-	-
Number of individuals in existing and planned comparable units	2,539	2,539	2,539	2,539
Total beds in the AL PMA **[b]**	**2,539**	**2,539**	**2,539**	**2,539**
Market Penetration Rate [b/a]	**13.7%**	**11.9%**	**36.7%**	**39.8%**
Beds needed in the PMA to meet Market Penetration Threshold (35% age-eligible; 50% age-and-income eligible)	6,490	7,454	3,460	3,190
Difference in needed vs. existing beds in the PMA to meet Market Penetration Threshold (surplus or deficit)	(3,951)	(4,915)	(921)	(651)

Fox Valley Region
Estimated Number of Age 75+ Assisted Living Eligible Individuals in the Region Years 2022 and 2027

	2022	2027
Estimated Age-Eligible Households	28,326	32,864
Estimated Age-and-Income Eligible Households	8,706	7,937
Percentage of Individuals Requiring Assistance	27.6%	27.6%
Percentage of Individuals Living Alone	51.7%	51.7%
Estimated Age-Eligible Individuals	4,042	4,689
Estimated Age-and-Income Eligible Individuals	1,242	1,133

Fox Valley Region
Assisted Living Market Penetration Rates

	Age-Eligible Individuals		Age-and-Income Eligible Individuals	
	2022	2027	2022	2027
Number of qualified individuals	4,042	4,689	1,242	1,133
Number of individuals at the Community	-	-	-	-
Number of individuals in existing comparable units	686	686	686	686
Total qualified Individuals **[a]**	**4,728**	**5,375**	**1,928**	**1,819**
Number of individuals at the Community	-	-	-	-
Number of individuals in existing and planned comparable units	686	686	686	686
Total beds in the AL PMA **[b]**	**686**	**686**	**686**	**686**
Market Penetration Rate [b/a]	**14.5%**	**12.8%**	**35.6%**	**37.7%**
Beds needed in the PMA to meet Market Penetration Threshold (35% age-eligible; 50% age-and-income eligible)	1,655	1,881	964	910
Difference in needed vs. existing beds in the PMA to meet Market Penetration Threshold (surplus or deficit)	(969)	(1,195)	(278)	(224)

Northwest Region
Estimated Number of Age 75+ Assisted Living Eligible Individuals in the Region Years 2022 and 2027

.	2022	2027
Estimated Age-Eligible Households	31,301	37,727
Estimated Age-and-Income Eligible Households	9,474	9,075
Percentage of Individuals Requiring Assistance	27.6%	27.6%
Percentage of Individuals Living Alone	50.9%	50.9%
Estimated Age-Eligible Individuals	4,397	5,300
Estimated Age-and-Income Eligible Individuals	1,331	1,275

Northwest Region
Assisted Living Market Penetration Rates

	Age-Eligible Individuals		Age-and-Income Eligible Individuals	
	2022	**2027**	**2022**	**2027**
Number of qualified individuals	4,397	5,300	1,331	1,275
Number of individuals at the Community	-	-	-	-
Number of individuals in existing comparable units	575	575	575	575
Total qualified Individuals **[a]**	**4,972**	**5,875**	**1,906**	**1,850**
Number of individuals at the Community	-	-	-	-
Number of individuals in existing and planned comparable units	575	575	575	575
Total beds in the AL PMA **[b]**	**575**	**575**	**575**	**575**
Market Penetration Rate [b/a]	**11.6%**	**9.8%**	**30.2%**	**31.1%**
Beds needed in the PMA to meet Market Penetration Threshold (35% age-eligible; 50% age-and-income eligible)	1,740	2,056	953	925
Difference in needed vs. existing beds in the PMA to meet Market Penetration Threshold (surplus or deficit)	(1,165)	(1,481)	(378)	(350)

Northeast Region
Estimated Number of Age 75+ Assisted Living Eligible Individuals in the Region Years 2022 and 2027

	2022	**2027**
Estimated Age-Eligible Households	25,867	30,232
Estimated Age-and-Income Eligible Households	7,733	7,114
Percentage of Individuals Requiring Assistance	27.6%	27.6%
Percentage of Individuals Living Alone	52.4%	52.4%
Estimated Age-Eligible Individuals	3,741	4,372
Estimated Age-and-Income Eligible Individuals	1,118	1,029

Northeast Region
Assisted Living Market Penetration Rates

	Age-Eligible Individuals		Age-and-Income Eligible Individuals	
	2022	**2027**	**2022**	**2027**
Number of qualified individuals	3,741	4,372	1,118	1,029
Number of individuals at the Community	-	-	-	-
Number of individuals in existing comparable units	496	496	496	496
Total qualified Individuals **[a]**	**4,237**	**4,868**	**1,614**	**1,525**
Number of individuals at the Community	-	-	-	-
Number of individuals in existing and planned comparable units	496	496	496	496
Total beds in the AL PMA **[b]**	**496**	**496**	**496**	**496**
Market Penetration Rate [b/a]	**11.7%**	**10.2%**	**30.7%**	**32.5%**
Beds needed in the PMA to meet Market Penetration Threshold (35% age-eligible; 50% age-and-income eligible)	1,483	1,704	807	763
Difference in needed vs. existing beds in the PMA to meet Market Penetration Threshold (surplus or deficit)	(987)	(1,208)	(311)	(267)

North Central Region
Estimated Number of Age 75+ Assisted Living Eligible Individuals in the Region
Years 2022 and 2027

	2022	**2027**
Estimated Age-Eligible Households	28,895	33,256
Estimated Age-and-Income Eligible Households	8,887	8,229
Percentage of Individuals Requiring Assistance	27.6%	27.6%
Percentage of Individuals Living Alone	50.1%	50.1%
Estimated Age-Eligible Individuals	3,995	4,599
Estimated Age-and-Income Eligible Individuals	1,229	1,138

North Central Region
Assisted Living Market Penetration Rates

	Age-Eligible Individuals		Age-and-Income Eligible	
	2022	**2027**	**2022**	**2027**
Number of qualified individuals	3,995	4,599	1,229	1,138
Number of individuals at the Community	-	-	-	-
Number of individuals in existing comparable units	481	481	481	481
Total qualified Individuals **[a]**	**4,476**	**5,080**	**1,710**	**1,619**
Number of individuals at the Community	-	-	-	-
Number of individuals in existing and planned comparable units	481	481	481	481
Total beds in the AL PMA **[b]**	**481**	**481**	**481**	**481**
Market Penetration Rate [b/a]	**10.7%**	**9.5%**	**28.1%**	**29.7%**
Beds needed in the PMA to meet Market Penetration Threshold (35% age-eligible; 50% age-and-income eligible)	1,567	1,778	855	810
Difference in needed vs. existing beds in the PMA to meet Market Penetration Threshold (surplus or deficit)	(1,086)	(1,297)	(374)	(329)

South Central Region
Estimated Number of Age 75+ Assisted Living Eligible Individuals in the Region Years 2022 and 2027

	2022	**2027**
Estimated Age-Eligible Households	58,413	70,109
Estimated Age-and-Income Eligible Households	14,099	12,799
Percentage of Individuals Requiring Assistance	27.6%	27.6%
Percentage of Individuals Living Alone	51.4%	51.4%
Estimated Age-Eligible Individuals	8,287	9,946
Estimated Age-and-Income Eligible Individuals	2,000	1,816

South Central Region
Assisted Living Market Penetration Rates

	Age-Eligible Individuals		Age-and-Income Eligible Individuals	
	2022	**2027**	**2022**	**2027**
Number of qualified individuals	8,287	9,946	2,000	1,816
Number of individuals at the Community	-	-	-	-
Number of individuals in existing comparable units	1,282	1,282	1,282	1,282
Total qualified Individuals **[a]**	**9,569**	**11,228**	**3,282**	**3,098**
Number of individuals at the Community	-	-	-	-
Number of individuals in existing and planned comparable units	1,282	1,282	1,282	1,282
Total beds in the AL PMA **[b]**	**1,282**	**1,282**	**1,282**	**1,282**
Market Penetration Rate [b/a]	**13.4%**	**11.4%**	**39.1%**	**41.4%**
Beds needed in the PMA to meet Market Penetration Threshold (35% age-eligible; 50% age-and-income eligible)	3,349	3,930	1,641	1,549
Difference in needed vs. existing beds in the PMA to meet Market Penetration Threshold (surplus or deficit)	(2,067)	(2,648)	(359)	(267)

Western Region
Estimated Number of Age 75+ Assisted Living Eligible Individuals in the Region Years 2022 and 2027

	2022	**2027**
Estimated Age-Eligible Households	15,388	18,170
Estimated Age-and-Income Eligible Households	4,946	4,676
Percentage of Individuals Requiring Assistance	27.6%	27.6%
Percentage of Individuals Living Alone	52.2%	52.2%
Estimated Age-Eligible Individuals	2,217	2,618
Estimated Age-and-Income Eligible Individuals	713	674

Western Region
Assisted Living Market Penetration Rates

	Age-Eligible Individuals		Age-and-Income Eligible	
	2022	**2027**	**2022**	**2027**
Number of qualified individuals	2,217	2,618	713	674
Number of individuals at the Community	-	-	-	-
Number of individuals in existing comparable units	280	280	280	280
Total qualified Individuals **[a]**	**2,497**	**2,898**	**993**	**954**
Number of individuals at the Community	-	-	-	-
Number of individuals in existing and planned comparable units	280	280	280	280
Total beds in the AL PMA **[b]**	**280**	**280**	**280**	**280**
Market Penetration Rate [b/a]	**11.2%**	**9.7%**	**28.2%**	**29.4%**
Beds needed in the PMA to meet Market Penetration Threshold (35% age-eligible; 50% age-and-income eligible)	874	1,014	497	477
Difference in needed vs. existing beds in the PMA to meet Market Penetration Threshold (surplus or deficit)	(594)	(734)	(217)	(197)

Memory Care Market Penetration Rate Tables

Private Pay Demand/Capacity/Need Projections, 2022 to 2027, by HERC

The following tables summarize the market demand projections, by HERC, for 65+ households that earn more than $50,000 annually and would potentially need and demand a memory-care specific assisted living facility.

Southeast Region
Estimated Number of Age 75+ Assisted Living Memory Care Eligible Individuals in the Region for Years 2022 and 2027

	2022	2027
Estimated Age-Eligible Households	112,810	132,235
Estimated Age-and-Income Eligible Households	81,928	105,168
Percentage of Individuals Requiring Assistance	50.0%	50.0%
Percentage of Individuals Living Alone	51.4%	51.4%
Percentage of Individuals with Dementia	19.4%	18.6%
Estimated Age-Eligible Individuals	5,624	6,321
Estimated Age-and-Income Eligible Individuals	4,085	5,027

Southeast Region
Assisted Living Memory Care Market Penetration Rates

	Age-Eligible Individuals		Age-and-Income Eligible Individuals	
	2022	**2027**	**2022**	**2027**
Number of qualified individuals	5,624	6,321	4,085	5,027
Number of individuals at the Community	-	-	-	-
Number of individuals in existing comparable units	3,337	3,337	3,337	3,337
Total qualified Individuals **[a]**	**8,961**	**9,658**	**7,422**	**8,364**
Number of individuals at the Community	-	-	-	-
Number of individuals in existing and planned comparable units	3,337	3,337	3,337	3,337
Total beds in the AL PMA **[b]**	**3,337**	**3,337**	**3,337**	**3,337**
Market Penetration Rate [b/a]	**37.2%**	**34.6%**	**45.0%**	**39.9%**
Beds needed in the PMA to meet Market Penetration Threshold (35% age-eligible; 50% age-and-income eligible)	3,136	3,380	3,711	4,182
Difference in needed vs. existing beds in the PMA to meet Market Penetration Threshold (surplus or deficit)	201	(43)	(374)	(845)

Fox Valley Region
Estimated Number of Age 75+ Assisted Living Memory Care Eligible Individuals in the Region Years 2022 and 2027

	2022	2027
Estimated Age-Eligible Households	28,326	32,864
Estimated Age-and-Income Eligible Households	19,620	24,927
Percentage of Individuals Requiring Assistance	50.0%	50.0%
Percentage of Individuals Living Alone	51.7%	51.7%
Percentage of Individuals with Dementia	19.1%	18.5%
Estimated Age-Eligible Individuals	1,399	1,572
Estimated Age-and-Income Eligible Individuals	969	1,192

Fox Valley Region
Assisted Living Memory Care Market Penetration Rates

	Age-Eligible Individuals		Age-and-Income Eligible Individuals	
	2022	**2027**	**2022**	**2027**
Number of qualified individuals	1,399	1,572	969	1,192
Number of individuals at the Community	-	-	-	-
Number of individuals in existing comparable units	947	947	947	947
Total qualified Individuals **[a]**	**2,346**	**2,519**	**1,916**	**2,139**
Number of individuals at the Community	-	-	-	-
Number of individuals in existing and planned comparable units	947	947	947	947
Total beds in the AL PMA **[b]**	**947**	**947**	**947**	**947**
Market Penetration Rate [b/a]	**40.4%**	**37.6%**	**49.4%**	**44.3%**
Beds needed in the PMA to meet Market Penetration Threshold (35% age-eligible; 50% age-and-income eligible)	821	882	958	1,070
Difference in needed vs. existing beds in the PMA to meet Market Penetration Threshold (surplus or deficit)	126	65	(11)	(123)

Northwest Region
Estimated Number of Age 75+ Assisted Living Memory Care Eligible Individuals in the Region Years 2022 and 2027

	2022	2027
Estimated Age-Eligible Households	31,301	37,727
Estimated Age-and-Income Eligible Households	21,827	28,652
Percentage of Individuals Requiring Assistance	50.0%	50.0%
Percentage of Individuals Living Alone	50.9%	50.9%
Percentage of Individuals with Dementia	18.9%	18.1%
Estimated Age-Eligible Individuals	1,506	1,738
Estimated Age-and-Income Eligible Individuals	1,050	1,320

Northwest Region
Assisted Living Memory Care Market Penetration Rates

	Age-Eligible Individuals		Age-and-Income Eligible Individuals	
	2022	**2027**	**2022**	**2027**
Number of qualified individuals	1,506	1,738	1,050	1,320
Number of individuals at the Community	-	-	-	-
Number of individuals in existing comparable units	796	796	796	796
alified Individuals **[a]**	**2,302**	**2,534**	**1,846**	**2,116**
Number of individuals at the Community	-	-	-	-
Number of individuals in existing and planned comparable units	796	796	796	796
ds in the AL PMA **[b]**	**796**	**796**	**796**	**796**
Market Penetration Rate [b/a]	**34.6%**	**31.4%**	**43.1%**	**37.6%**
Beds needed in the PMA to meet Market Penetration Threshold (35% age-eligible; 50% age-and-income eligible)	806	887	923	1,058
Difference in needed vs. existing beds in the PMA to meet Market Penetration Threshold (surplus or deficit)	(10)	(91)	(127)	(262)

North Central Region
Estimated Number of Age 75+ Assisted Living Memory Care Eligible Individuals in the Region Years 2022 and 2027

	2022	**2027**
Estimated Age-Eligible Households	28,895	33,256
Estimated Age-and-Income Eligible Households	20,008	25,027
Percentage of Individuals Requiring Assistance	50.0%	50.0%
Percentage of Individuals Living Alone	50.1%	50.1%
Percentage of Individuals with Dementia	18.9%	18.3%
Estimated Age-Eligible Individuals	1,368	1,525
Estimated Age-and-Income Eligible Individuals	947	1,147

North Central
Assisted Living Memory Care Market Penetration Rates

	Age-Eligible Individuals		Age-and-Income Eligible Individuals	
	2022	**2027**	**2022**	**2027**
Number of qualified individuals	1,368	1,525	947	1,147
Number of individuals at the Community	-	-	-	-
Number of individuals in existing comparable units	619	619	619	619
Total qualified Individuals **[a]**	**1,987**	**2,144**	**1,566**	**1,766**
Number of individuals at the Community	-	-	-	-
Number of individuals in existing and planned comparable units	619	619	619	619
Total beds in the AL PMA **[b]**	**619**	**619**	**619**	**619**
Market Penetration Rate [b/a]	**31.2%**	**28.9%**	**39.5%**	**35.1%**
Beds needed in the PMA to meet Market Penetration Threshold (35% age-eligible; 50% age-and-income eligible)	695	750	783	883
Difference in needed vs. existing beds in the PMA to meet Market Penetration Threshold (surplus or deficit)	(76)	(131)	(164)	(264)

Northeast Region

Estimated Number of Age 75+ Assisted Living Memory Care Eligible Individuals in the Region Years 2022 and 2027

	2022	**2027**
Estimated Age-Eligible Households	25,867	30,232
Estimated Age-and-Income Eligible Households	18,134	23,118
Percentage of Individuals Requiring Assistance	50.0%	50.0%
Percentage of Individuals Living Alone	52.4%	52.4%
Percentage of Individuals with Dementia	18.9%	18.3%
Estimated Age-Eligible Individuals	1,281	1,450
Estimated Age-and-Income Eligible Individuals	898	1,108

Northeast Region
Assisted Living Memory Care Market Penetration Rates

	Age-Eligible Individuals		Age-and-Income Eligible Individuals	
	2022	**2027**	**2022**	**2027**
Number of qualified individuals	1,281	1,450	898	1,108
Number of individuals at the Community	-	-	-	-
Number of individuals in existing comparable units	627	627	627	627
Total qualified Individuals **[a]**	**1,908**	**2,077**	**1,525**	**1,735**
Number of individuals at the Community	-	-	-	-
Number of individuals in existing and planned comparable units	627	627	627	627
Total beds in the AL PMA **[b]**	**627**	**627**	**627**	**627**
Market Penetration Rate [b/a]	**32.9%**	**30.2%**	**41.1%**	**36.1%**
Beds needed in the PMA to meet Market Penetration Threshold (35% age-eligible; 50% age-and-income eligible)			763	868
Difference in needed vs. existing beds in the PMA to meet Market Penetration Threshold (surplus or deficit)			(136)	(241)

South Central Region
Estimated Number of Age 75+ Assisted Living Memory Care Eligible Individuals in the Region Years 2022 and 2027

	2022	**2027**
Estimated Age-Eligible Households	58,413	70,109
Estimated Age-and-Income Eligible Households	44,314	57,310
Percentage of Individuals Requiring Assistance	50.0%	50.0%
Percentage of Individuals Living Alone	51.4%	51.4%
Percentage of Individuals with Dementia	18.9%	18.2%
Estimated Age-Eligible Individuals	2,837	3,279
Estimated Age-and-Income Eligible Individuals	2,152	2,681

South Central Region
Assisted Living Memory Care Market Penetration Rates

	Age-Eligible Individuals		Age-and-Income	
	2022	**2027**	**2022**	**2027**
Number of qualified individuals	2,837	3,279	2,152	2,681
Number of individuals at the Community	-	-	-	-
Number of individuals in existing comparable units	1,802	1,802	1,802	1,802
Total qualified Individuals **[a]**	**4,639**	**5,081**	**3,954**	**4,483**
Number of individuals at the Community	-	-	-	-
Number of individuals in existing and planned comparable units	1,802	1,802	1,802	1,802
Total beds in the AL PMA **[b]**	**1,802**	**1,802**	**1,802**	**1,802**
Market Penetration Rate [b/a]	**38.8%**	**35.5%**	**45.6%**	**40.2%**
Beds needed in the PMA to meet Market Penetration Threshold (35% age-eligible; 50% age-and-income eligible)	1,624	1,778	1,977	2,242
Difference in needed vs. existing beds in the PMA to meet Market Penetration Threshold (surplus or deficit)	178	24	(175)	(440)

Western Region
Estimated Number of Age 75+ Assisted Living Memory Care Eligible Individuals in the Region Years 2022 and 2027

	2022	**2027**
Estimated Age-Eligible Households	15,388	18,170
Estimated Age-and-Income Eligible Households	10,442	13,494
Percentage of Individuals Requiring Assistance	50.0%	50.0%
Percentage of Individuals Living Alone	52.2%	52.2%
Percentage of Individuals with Dementia	19.0%	18.4%
Estimated Age-Eligible Individuals	763	873
Estimated Age-and-Income Eligible Individuals	518	648

Western Region
Assisted Living Memory Care Market Penetration Rates

	Age-Eligible Individuals		Age-and-Income Eligible	
	2022	**2027**	**2022**	**2027**
Number of qualified individuals	763	873	518	648
Number of individuals at the Community	-	-	-	-
Number of individuals in existing comparable units	335	335	335	335
Total qualified Individuals **[a]**	**1,098**	**1,208**	**853**	**983**
Number of individuals at the Community	-	-	-	-
Number of individuals in existing and planned comparable units	335	335	335	335
Total beds in the AL PMA **[b]**	**335**	**335**	**335**	**335**
Market Penetration Rate [b/a]	**30.5%**	**27.7%**	**39.3%**	**34.1%**
Beds needed in the PMA to meet Market Penetration Threshold (35% age-eligible; 50% age-and-income eligible)	384	423	427	492
Difference in needed vs. existing beds in the PMA to meet Market Penetration Threshold (surplus or deficit)	(49)	(88)	(92)	(157)

Lower-income/Medicaid Capacity Need/Demand Projections, by HERC

The following tables summarizes the market demand projections, by HERC, for 65+ households earning less than $25,000 annually and would potentially need and demand a memory-care specific assisted living facility.

Southeast Region

Estimated Number of Age 75+ Assisted Living Memory Care Eligible Individuals in the Region Years 2022 and 2027

	2022	2027
Estimated Age-Eligible Households	112,810	132,235
Estimated Age-and-Income Eligible Households	30,882	27,067
Percentage of Individuals Requiring Assistance	100.0%	100.0%
Percentage of Individuals Living Alone	51.4%	51.4%
Percentage of Individuals with Dementia	19.4%	18.6%
Estimated Age-Eligible Individuals	11,249	12,642
Estimated Age-and-Income Eligible Individuals	3,079	2,588

Southeast Region

Assisted Living Memory Care Market Penetration Rates

	Age-Eligible Individuals		Age-and-Income Eligible Individuals	
	2022	**2027**	**2022**	**2027**
ıer of qualified individuals	11,249	12,642	3,079	2,588
ıer of individuals at the Community	-	-	-	-
ıer of individuals in existing comparable units	843	843	843	843
ɔtal qualified Individuals **[a]**	**12,092**	**13,485**	**3,922**	**3,431**
ıer of individuals at the Community	-	-	-	-
Number of individuals in existing and planned comparable units	843	843	843	843
ɔtal beds in the AL PMA **[b]**	**843**	**843**	**843**	**843**
et Penetration Rate [b/a]	**7.0%**	**6.3%**	**21.5%**	**24.6%**
Beds needed in the PMA to meet Market Penetration Threshold (35% age-eligible; 50% age-and-income eligible)	4,232	4,720	1,961	1,716
Difference in needed vs. existing beds in the PMA to meet Market Penetration Threshold (surplus or deficit)	(3,389)	(3,877)	(1,118)	(873)

Fox Valley Region
Estimated Number of Age 75+ Assisted Living Memory Care Eligible Individuals in the Region Years 2022 and 2027

	2022	2027
Estimated Age-Eligible Households	28,326	32,864
Estimated Age-and-Income Eligible Households	8,706	7,937
Percentage of Individuals Requiring Assistance	100.0%	100.0%
Percentage of Individuals Living Alone	51.7%	51.7%
Percentage of Individuals with Dementia	19.1%	18.5%
Estimated Age-Eligible Individuals	2,797	3,143
Estimated Age-and-Income Eligible Individuals	860	759

Fox Valley Region
Assisted Living Memory Care Market Penetration Rates

	Age-Eligible Individuals		Age-and-Income Eligible Individuals	
	2022	**2027**	**2022**	**2027**
Number of qualified individuals	2,797	3,143	860	759
Number of individuals at the Community	-	-	-	-
Number of individuals in existing comparable units	238	238	238	238
Total qualified Individuals **[a]**	**3,035**	**3,381**	**1,098**	**997**
Number of individuals at the Community	-	-	-	-
Number of individuals in existing and planned comparable units	238	238	238	238
Total beds in the AL PMA **[b]**	**238**	**238**	**238**	**238**
Market Penetration Rate [b/a]	**7.8%**	**7.0%**	**21.7%**	**23.9%**
Beds needed in the PMA to meet Market Penetration Threshold (35% age-eligible; 50% age-and-income eligible)	1,062	1,183	549	499
Difference in needed vs. existing beds in the PMA to meet Market Penetration Threshold (surplus or deficit)	(824)	(945)	(311)	(261)

Northwest Region
Estimated Number of Age 75+ Assisted Living Memory Care Eligible Individuals in the Region Years 2022 and 2027

	2022	2027
Estimated Age-Eligible Households	31,301	37,727
Estimated Age-and-Income Eligible Households	9,474	9,075
Percentage of Individuals Requiring Assistance	100.0%	100.0%
Percentage of Individuals Living Alone	50.9%	50.9%
Percentage of Individuals with Dementia	18.9%	18.1%
Estimated Age-Eligible Individuals	3,011	3,476
Estimated Age-and-Income Eligible Individuals	911	836

Northwest Region
Assisted Living Memory Care Market Penetration Rates

	Age-Eligible Individuals		Age-and-Income Eligible Individuals	
	2022	**2027**	**2022**	**2027**
Number of qualified individuals	3,011	3,476	911	836
Number of individuals at the Community	-	-	-	-
Number of individuals in existing comparable units	200	200	200	200
Total qualified Individuals **[a]**	**3,211**	**3,676**	**1,111**	**1,036**
Number of individuals at the Community	-	-	-	-
Number of individuals in existing and planned comparable units	200	200	200	200
Total beds in the AL PMA **[b]**	**200**	**200**	**200**	**200**
Market Penetration Rate [b/a]	**6.2%**	**5.4%**	**18.0%**	**19.3%**
Beds needed in the PMA to meet Market Penetration Threshold (35% age-eligible; 50% age-and-income eligible)	1,124	1,287	556	518
Difference in needed vs. existing beds in the PMA to meet Market Penetration Threshold (surplus or deficit)	(924)	(1,087)	(356)	(318)

Northeast Region
Estimated Number of Age 75+ Assisted Living Memory Care Eligible Individuals in the Region Years 2022 and 2027

	2022	**2027**
Estimated Age-Eligible Households	25,867	30,232
Estimated Age-and-Income Eligible Households	7,733	7,114
Percentage of Individuals Requiring Assistance	100.0%	100.0%
Percentage of Individuals Living Alone	52.4%	52.4%
Percentage of Individuals with Dementia	18.9%	18.3%
Estimated Age-Eligible Individuals	2,562	2,899
Estimated Age-and-Income Eligible Individuals	766	682

Northeast Region
Assisted Living Memory Care Market Penetration Rates

	Age-Eligible Individuals		Age-and-Income Eligible Individuals	
	2022	**2027**	**2022**	**2027**
Number of qualified individuals	2,562	2,899	766	682
Number of individuals at the Community	-	-	-	-
Number of individuals in existing comparable units	157	157	157	157
otal qualified Individuals **[a]**	**2,719**	**3,056**	**923**	**839**
Number of individuals at the Community	-	-	-	-
Number of individuals in existing and planned comparable units	157	157	157	157
otal beds in the AL PMA **[b]**	**157**	**157**	**157**	**157**
Market Penetration Rate [b/a]	**5.8%**	**5.1%**	**17.0%**	**18.7%**
Beds needed in the PMA to meet Market Penetration Threshold (35% age-eligible; 50% age-and-income eligible)	952	1,070	462	420
Difference in needed vs. existing beds in the PMA to meet Market Penetration Threshold (surplus or deficit)	(795)	(913)	(305)	(263)

North Central Region
Estimated Number of Age 75+ Assisted Living Memory Care Eligible Individuals in the Region Years 2022 and 2027

	2022	**2027**
Estimated Age-Eligible Households	28,895	33,256
Estimated Age-and-Income Eligible Households	8,887	8,229
Percentage of Individuals Requiring Assistance	100.0%	100.0%
Percentage of Individuals Living Alone	50.1%	50.1%
Percentage of Individuals with Dementia	18.9%	18.3%
Estimated Age-Eligible Individuals	2,736	3,049
Estimated Age-and-Income Eligible Individuals	842	754

North Central Region
Assisted Living Memory Care Market Penetration Rates

	Age-Eligible Individuals		Age-and-Income Eligible	
	2022	**2027**	**2022**	**2027**
Number of qualified individuals	2,736	3,049	842	754
Number of individuals at the Community	-	-	-	-
Number of individuals in existing comparable units	156	156	156	156
Total qualified Individuals **[a]**	**2,892**	**3,205**	**998**	**910**
Number of individuals at the Community	-	-	-	-
Number of individuals in existing and planned comparable units	156	156	156	156
Total beds in the AL PMA **[b]**	**156**	**156**	**156**	**156**
Market Penetration Rate [b/a]	**5.4%**	**4.9%**	**15.6%**	**17.1%**
Beds needed in the PMA to meet Market Penetration Threshold (35% age-eligible; 50% age-and-income eligible)	1,012	1,122	499	455
Difference in needed vs. existing beds in the PMA to meet Market Penetration Threshold (surplus or deficit)	(856)	(966)	(343)	(299)

South Central Region
Estimated Number of Age 75+ Assisted Living Memory Care Eligible Individuals in the Region Years 2022 and 2027

	2022	**2027**
Estimated Age-Eligible Households	58,413	70,109
Estimated Age-and-Income Eligible Households	14,099	12,799
Percentage of Individuals Requiring Assistance	100.0%	100.0%
Percentage of Individuals Living Alone	51.4%	51.4%
Percentage of Individuals with Dementia	18.9%	18.2%
Estimated Age-Eligible Individuals	5,675	6,559
Estimated Age-and-Income Eligible Individuals	1,370	1,197

South Central Region
Assisted Living Memory Care Market Penetration Rates

	Age-Eligible Individuals		Age-and-Income Eligible Individuals	
	2022	**2027**	**2022**	**2027**
Number of qualified individuals	5,675	6,559	1,370	1,197
Number of individuals at the Community	-	-	-	-
Number of individuals in existing comparable units	454	454	454	454
Total qualified Individuals **[a]**	**6,129**	**7,013**	**1,824**	**1,651**
Number of individuals at the Community	-	-	-	-
Number of individuals in existing and planned comparable units	454	454	454	454
Total beds in the AL PMA **[b]**	**454**	**454**	**454**	**454**
Market Penetration Rate [b/a]	**7.4%**	**6.5%**	**24.9%**	**27.5%**
Beds needed in the PMA to meet Market Penetration Threshold (35% age-eligible; 50% age-and-income eligible)	2,145	2,455	912	826
Difference in needed vs. existing beds in the PMA to meet Market Penetration Threshold (surplus or deficit)	(1,691)	(2,001)	(458)	(372)

Western Region

Estimated Number of Age 75+ Assisted Living Memory Care Eligible Individuals in the Region Years 2022 and 2027

	2022	**2027**
Estimated Age-Eligible Households	15,388	18,170
Estimated Age-and-Income Eligible Households	4,946	4,676
Percentage of Individuals Requiring Assistance	100.0%	100.0%
Percentage of Individuals Living Alone	52.2%	52.2%
Percentage of Individuals with Dementia	19.0%	18.4%
Estimated Age-Eligible Individuals	1,526	1,745
Estimated Age-and-Income Eligible Individuals	491	449

Western Region
Assisted Living Memory Care Market Penetration Rates

	Age-Eligible Individuals		Age-and-Income Eligible Individuals	
	2022	**2027**	**2022**	**2027**
Number of qualified individuals	1,526	1,745	491	449
Number of individuals at the Community	-	-	-	-
Number of individuals in existing comparable units	84	84	84	84
Total qualified Individuals **[a]**	**1,610**	**1,829**	**575**	**533**
Number of individuals at the Community	-	-	-	-
Number of individuals in existing and planned comparable units	84	84	84	84
Total beds in the AL PMA **[b]**	**84**	**84**	**84**	**84**
Market Penetration Rate [b/a]	**5.2%**	**4.6%**	**14.6%**	**15.8%**
Beds needed in the PMA to meet Market Penetration Threshold (35% age-eligible; 50% age-and-income eligible)	564	640	288	267
Difference in needed vs. existing beds in the PMA to meet Market Penetration Threshold (surplus or deficit)	(480)	(556)	(204)	(183)