

June 10, 2022

Centers for Medicare & Medicaid Services
Submitted electronically, <https://www.regulations.gov>

Re: CMS-1765-P, Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2023; Request for Information on Revising the Requirements for Long-Term Care Facilities to Establish Mandatory Minimum Staffing Levels, 87 Fed. Reg. 22720 (Apr. 15, 2022), <https://www.govinfo.gov/content/pkg/FR-2022-04-15/pdf/2022-07906.pdf>

Dear CMS Administrator and Brooks-LaSure and CMS Colleagues:

National Consumer Voice for Quality Long-Term Care (Consumer Voice) strongly supports the Center for Medicare & Medicaid Services' (CMS) proposal to implement a minimum staffing standard. For decades, advocates for nursing home residents have been calling for a minimum staffing standard, and we applaud the Biden Administration's historic proposal to create this important requirement. We urge CMS to implement a standard that focuses on resident acuity and assures that each resident receives the care they need.

It is critical to note that the 1987 Nursing Home Reform Act provides the Secretary full authority to create and enforce minimum staffing standards. The law requires that the Secretary ensure that all nursing homes are providing each resident with high quality care (42 U.S.C. §1395i(b)(2)) and that Medicare and Medicaid payments are spent on resident care and not diverted to profits, management fees, and inflated payments to self-related parties. (42 U.S.C. §1395i-3(f)(1)). These broad and important powers provide the Secretary with clear authority to set minimum staffing standards.

While the creation of a minimum standard will be the most significant increase in protections for nursing home residents in decades, it will not solve all the problems that plague the nursing home industry. Additional steps, including addressing transparency in nursing home ownership and finances, increased enforcement and oversight, increasing job quality for direct care staff, and addressing issues of social and racial inequities in nursing home care, will be needed to ensure nursing home residents receive the high-quality care they need and deserve.

Below you will find our answers to the Request for Information regarding the minimum staffing standard along with select responses to other sections of the Notice of Proposed Rulemaking.

The National Consumer Voice for Quality Long-Term Care (formerly NCCNHR) is a 501(c)(3) nonprofit membership organization founded in 1975 by Elma L. Holder that advocates for quality care and quality of life for consumers in all long-term-care settings.

General Statement on the PPS System

One of the cornerstones of the Biden Administration nursing home reforms announced in February was transparency in nursing home finances. Currently, there is little scrutiny by CMS on how nursing homes spend Medicare and Medicaid dollars. Billions of dollars are paid to nursing homes each year for expected costs, but there is currently no system to audit whether these funds are being used for resident care or used to increase the profits of nursing home owners and operators.

For years, advocates for nursing home residents have called for increased scrutiny of Medicare cost reports. A GAO report from 2016 recommended that CMS increase scrutiny on Medicare cost reports and also make this data public.¹ In recent years, several states, including California², New York³, and New Jersey,⁴ have taken steps to increase scrutiny on how nursing homes spend Medicare and Medicaid dollars. California, in particular, passed legislation that requires nursing homes to submit consolidated cost reports, which requires increased disclosure of finances from all related-party companies.

In 2010, as part of the Affordable Care Act, Congress gave CMS the authority to require increased transparency in nursing home ownership and finances. Sections 6101 and 6104 mandated that CMS take additional steps to require facilities to disclose the ownership and financial information of nursing homes and related parties. Despite this requirement, CMS has still not taken regulatory action to implement these sections. We strongly urge CMS to fulfill its obligation under the ACA and implement these important sections.

SNF QRP Quality Measures Under Consideration for Future Years: Request for Information (RFI) (p. 22754)

We strongly support the inclusion of the newly proposed quality reporting measures. Particularly, we support increased scrutiny on inequities in healthcare related to race. However, we are concerned that the self-reporting of data or outcomes by nursing homes will be insufficient to address the long-standing racial disparities in care in nursing homes. To ensure progress is being made by nursing homes to address inequities in care, it will be important that CMS adopt measures that rely on data that can be verified and audited. For instance, CMS could use Medicare claims data to measure outcomes based on race. Additionally, complaint and survey information could be used to examine and address disparities in nursing homes. It is important CMS continue to explore measures that include data that is not solely self-reported by nursing homes.

Equally important is the need for CMS to partner with researchers and government agencies to explore disparities in care. Currently, CMS does not make data regarding race of nursing home residents public. As a result, there is inadequate data for researchers to study inequities in care and how they may be addressed. CMS should make this data public to ensure all necessary steps are being taken to address inequities.

Inclusion of the CoreQ: Short Stay Discharge Measure in a Future SNF QRP Program Year – Request for Information (RFI), (p. 22761)

Consumer Voice strongly opposes the use of the CoreQ measure in a future SNF QRP. The CoreQ measure, which was created by the American Health Care Association, relies only on four vague questions that assume nursing home residents have knowledge that, in many cases, they will not. For instance, asking a former resident about their discharge experience assumes that the resident is aware

of his or her discharge rights, when in most instances they will have been provided little to no knowledge regarding these important protections.

Additionally, the rating system is biased towards positive reviews. While the measure is based on a five-point scale, there is only one negative option (poor), with three positive responses (good, very good, and excellent). Equally troubling is using the rating “average”. How will a former resident know if their discharge experience was “average”? What is the definition of an “average” discharge? Further, most residents will not have experiences with nursing home discharges to formulate a reliable opinion on whether their discharge experience was average. The wording of the questions is problematic, as well. For instance, the first question is leading by stating “In recommending this facility...”, which implies a resident would recommend a facility. This language is biased towards a favorable review, which draws into question the legitimacy of the rating system itself.

The CoreQ measure excludes too many potential respondents, including residents who leave a facility against medical advice, who are discharged to another facility, and residents with guardians. We believe it would be particularly valuable to hear from residents who leave a nursing home against medical advice. Why did they leave? Were there issues with care? Why would we not want to hear from people discharged to another facility? Residents with guardians are able to express satisfaction about their care. Whether one has a guardian or not is a question of local law, but it does not exclude the possibility of expressing one’s opinion about care. To be accurate and helpful to CMS and consumers, a measure must include as many residents as possible.

Recently, the National Academy of Science, Engineering, and Medicine (NASEM) issued a report, “The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Families, and Staff,” in which it discussed the CoreQ measure.⁵ The report noted that industry-created measures like CoreQ have faced criticism for using formats that “may increase the tendency of respondents to provide socially appropriate response choices and thus provide only minimal variation in the scale.”⁶

The NASEM report did not endorse the use of the CoreQ measure, instead recommending that CMS add the Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures to Care Compare.⁷ The CAHPS measure gauges satisfaction of residents and families through the use of tested and verified measures. Like NASEM, Consumer Voice recommends that CMS use this measure. Additionally, CMS should contract with a third party to administer this survey. For the public to trust that surveys are reliable and accurate, CMS should not allow nursing homes to administer its own satisfaction surveys.

Proposal to Adopt the Total Nursing Hours per Resident Day Staffing Measure Beginning with the FY 2026 SNF VBP Program Year (pages 22771-22774)

Consumer Voice supports the inclusion of the Total Nursing Hours per Resident Day Staffing Measure in the SNF VBP. As noted in our responses to the minimum staffing standard RFI below¹, there is a documented strong relationship between increased staffing and better health outcomes for nursing home residents.

¹ See our responses to Question 1 of the minimum staffing request for information below.

However, we strongly urge CMS to exclude temporary nursing assistants (TNAs) from the measure of hours worked. In March of 2020, CMS waived the training requirements² for certified nursing assistants, allowing TNAs to work in nursing homes with little to no training.³ As a result, during the height of the pandemic, nursing home residents were being treated by TNAs with little to no training in infection control and other necessary skills to ensure residents were safe. This waiver has only just expired in June 2022. Consumer Voice has heard from residents and their families, as well as other direct care staff, that many of the TNAs provided substandard care. Despite the disparity in training and experience between CNAs and TNAs, CMS has included TNAs in staffing totals since the waiver began and has classified them as CNAs. TNA hours should be excluded from the total nursing measure and reported separately on Care Compare. Consumers should know whether a nursing home is employing trained CNAs or untrained TNAs.

The exclusion of TNA hours will continue to be important, despite the expiration of the waiver in June. In April 2021, CMS issued guidance to state survey agencies that included language suggesting states should consider allowing some of the hours worked by TNAs during the pandemic to count towards the 75-hour training requirement. This recommendation was made without any supporting evidence that TNAs have been receiving training equivalent to the requirements in the regulations. This policy from CMS will result in TNAs that have not met the training requirements in the regulations to continue to work in facilities. It is imperative that the public know that these workers are present in the facility, so that they may make informed decisions about their healthcare.

We also urge CMS to use the measure in the VBP in a way that only rewards facilities with the highest levels of staffing. Increases in staffing will benefit residents, but facilities should not be rewarded for increasing staffing that still does not meet the needs of residents. Facilities that do not meet the acuity needs of all residents in the facility should not be eligible for financial benefits under the VBP program.

Lastly, Consumer Voice opposes the baseline period of 2022 proposed on page 27779 of 2022. Currently, nursing homes are experiencing a staffing crisis, with over 1 out of 5 nursing homes reporting staff shortages in aides and RNs, according to data from CMS. The crisis is attributable in part to the COVID-19 pandemic, but it is also due to years of inadequate investment by nursing homes in direct care staff.⁴ Nursing homes should not be unjustly rewarded two years from now by comparing performance in 2024 to 2022, a year in which nursing homes are experiencing an unprecedented staffing crisis brought on, in part, by their own poor business practices. Rather, Consumer Voice recommends CMS use 2019 as the baseline period for this measure. Any baseline used by CMS should be pre-pandemic to account for the extraordinary circumstances brought about by the COVID-19 pandemic.

Proposal to Adopt the DTC-PAC Measure for SNFs (NQF #3481) Beginning With the FY 2027 SNF VBP Program Year (p. 22774)

While Consumer Voice supports the addition of a measure regarding the successful rate of return to the community, we are concerned that this measure excludes other equally important outcomes for residents. Not all residents will be able to return home. Nevertheless, Medicare Part A requires

² Federal regulations require that CNAs have 75 hours of training within four months of beginning work at a facility. This requirement includes specialized training in areas such as resident rights, infection control, transferring and feeding residents, and training in mental health and social services needs. CNAs must also pass a competency exam, as well.

³ In response to the waiver, the American Health Care Association created an online eight-hour training program that many nursing homes have used as a substitute for the normal training requirements.

⁴ See below Consumer Voice's response to Question 5 of the minimum staffing standard RFI below.

facilities to continue to provide care to these residents in order to maintain functioning or prevent their decline. This coverage for maintenance care was confirmed in *Jimmo v. Sebelius*, Civil Action No. 5:11-CV-17-CR (D. Vt. Jan. 24 2013). A VBP measure that rewards nursing homes solely based on improvement excludes Medicare beneficiaries who require maintenance and could result in disparities in care and coverage for this group of residents. Consumer Voice recommends that, until CMS creates and implements a SNF VBP measure regarding resident maintenance, it postpones adoption of the discharge measure.

Additionally, this measure excludes nursing home residents enrolled in Medicare Advantage (MA) plans. Almost half of Medicare beneficiaries are now enrolled in MA plans. Excluding them from the discharge measure gives an unequal and distorted picture of how all Medicare beneficiaries are treated. We recommend that CMS forgo implementation of this measure, until MA beneficiaries are included as well.

Request for Comment on Including Staffing Turnover Measures in a Future SNF VBP Program Year (22786-22787)

It is essential that CMS incentivize the reduction of staff turnover in nursing homes. Consumer Voice strongly supports the inclusion of a staffing turnover measure in the SNF VBP Program. Currently, CMS estimates the national annual average of direct care staff turnover to be 52.6%. A recent study estimated the national average of staff turnover to be 128%.⁵ High staff turnover has been consistently associated with poor quality care.⁸ Additionally, high staff turnover is often the result of poor job quality, which includes poor wages and benefits, high workloads, inadequate training, and lack of career advancement opportunities.⁹ Importantly, reduction in turnover will be essential to a successful implementation of a minimum staffing standard.

Request for Comment on the Validation of SNF Measures and Assessment Data (p. 22788)

Consumer Voice strongly supports increased validation of SNF measures and assessment data. The data submitted by facilities for resident assessments, Minimum Data Set 3.0 (MDS), must undergo further auditing. For years, advocates have stated that MDS data is inflated by facilities to falsely increase their scores on CMS' Five Star Quality-Measure Rating. A recent report by Consumer Voice showed that nursing homes with 5-Star Quality Measure ratings often have 1 to 2 star ratings in staffing or health inspections, measures composed of more reliable and verifiable data.¹⁰ Notably, the average staff and health ratings for nursing homes with five-star Quality Measure ratings were 3.05 and 3.06, respectively.¹¹ CMS must increase scrutiny of MDS data make sure that not only are VBP payments accurate, but also to ensure consumers are receiving accurate and reliable data.

It is important to note that increased scrutiny of assessment data was part of the Biden Administration's nursing home reforms announced in February of this year. The Administration promised to incorporate and rely more on data that is verifiable and not self-reported.¹² Accordingly increased scrutiny and use of validation of SNF measures is an important step in furthering this important reform.

⁵ The study authors looked at turnover of staffing hours annually, as compared with actual staff. Gandhi A, Yu H, Grabowski DC. High Nursing Staff Turnover In Nursing Homes Offers Important Quality Information. *Health Aff (Millwood)*. 2021 Mar;40(3):384-391. doi: 10.1377/hlthaff.2020.00957. PMID: 33646872; PMCID: PMC7992115.

Below are Consumer Voice's responses to the Request for Information regarding the implementation of a minimum staffing standard.

- 1. Is there evidence (other than the evidence reviewed in this RFI) that establishes appropriate minimum threshold staffing requirements for both nurses and other direct care workers? To what extent do older studies remain relevant? What are the benefits of adequate staffing in LTC facilities to residents and quality of care?**

In 2001, a study prepared for Centers for Medicare & Medicaid Services recommended a clear minimum staffing standard.¹³ The study found that each nursing home resident required at least .75 hours of Registered Nurse (RN) care per day (hprd), .55 hprd of Licensed Practical Nurse (LPN)/Licensed Vocational Nurse care, and 2.8 hprd of Certified Nursing Assistance (CNA) care.¹⁴ Although the CMS study was mentioned in the RFI, its importance must be reiterated here, as it has for the past twenty years been repeatedly verified through additional studies^{15 16} and considered the foundational measure of minimum staffing by experts and advocates.^{17 18 19 20}

The benefits to nursing home residents of adequate staffing are indisputable. Many studies have found a strong relationship between nursing staffing levels and improved quality of care in terms of both process and outcome measures.^{21 22 23 24 25} Recently, Consumer Voice conducted its own review of staffing data from CMS. The data showed that as staffing levels in nursing homes decrease, so do the overall, health inspection, and staffing five-star ratings²⁶. Most troubling, the data showed that as staffing levels decreased, the likelihood of a home being cited for abuse increased.²⁷ The report found that the vast majority of homes most highly rated in all five-star categories provided at least 4.1 hprd.

Extremely important to a resident's well-being is the presence of RN staff. Many studies have demonstrated that higher RN staffing levels result in better outcomes, including:

- Increased functional improvement;^{28 29 30}
- Reduced incontinence;³¹
- Reduced urinary tract infections and catheterizations;^{32 33 34 35}
- Reductions in pain,³⁶ pressure ulcers,^{37 38 39 40 41 42} weight loss and dehydration,^{43 44 45} use of antipsychotics,⁴⁶ restraint use,^{47 48} infections,^{49 50 51} falls,^{52 53} rehospitization and emergency department use,^{54 55} missed care,^{56 57 58 59} adverse outcomes,^{60 61} and mortality rates.^{62 63 64}
- Higher staffing levels are strongly associated with fewer deficiencies.^{65 66 67}

Studies conducted during the COVID-19 pandemic found that increased staffing levels led to fewer deaths from COVID-19.^{68 69 70} Although infection control violations plagued the nursing home industry prior to the pandemic, with 82% of nursing homes cited for an infection control deficiency, and with roughly half of those homes having persistent problems,⁷¹ CMS data shows that homes with higher staffing levels have lower rates of infection control violations.⁷² It is likely that the presence of a mandatory staffing minimum during the COVID-19 pandemic would have saved lives and decreased instances of infection control violations.

The landmark CMS study from 2001 recommended the establishment of appropriate minimum staffing standards. This standard has been confirmed by numerous subsequent studies and remains the most often cited minimum standard amongst experts. Studies and CMS data demonstrate the direct relationship between higher staffing levels and better health outcomes for residents.

2. What resident and facility factors should be considered in establishing a minimum staffing requirement for LTC facilities? How should the facility assessment of resident needs and acuity impact the minimum staffing requirement?

All nursing homes are required to have sufficient staff to meet the needs of its residents.⁷³ Accordingly, the establishment of a minimum standard is just that, a minimum or baseline. Many residents, because of increased care needs, will require more care each day than required by the minimum standard. That is why it is essential that CMS incorporate resident acuity into the establishment of minimum staffing standards. The amount of care nursing home residents require varies greatly. CMS, itself, acknowledges this variation in its Medicare Prospective Payment System, the Patient Driven Payment Model (PDPM), which assigns different levels of payment to providers based upon the care needs of residents.⁶ Although CMS pays nursing homes based on resident acuity, it does not use the PDPM framework to enforce staffing requirements or to ensure that facilities actually use the money to provide that level of care.

In a landmark 2020 paper, researchers assigned staffing level needs to the PDPM system acuity levels by using the 2001 staffing standard, along with an updated study on CNA⁷ staffing levels.⁷⁴ The study proposed six separate minimum staffing levels, each of which corresponded to an acuity level in the PDPM. There are two foundational principals that support an approach that centers minimum staffing levels on resident acuity. First, by law, all residents are entitled to person-centered care that meets their particular care needs. 42 U.S.C. §1395i(b)(2). Accordingly, nursing homes must meet the acuity needs of all residents. Second, CMS pays nursing homes tens of billions of taxpayer dollars each year based on resident acuity yet does little to ensure this money is actually spent on care. Using resident acuity as the primary factor in creating minimum staffing standards ensures all residents have their care needs met and that taxpayer dollars are spent on care.

Importantly, nursing homes are currently assessing resident acuity as required by federal regulations. First, they use the Minimum Data Set 3.0 assessment forms to determine the level of care for each resident. Second, a 2016 regulation requires that each facility must conduct a facility-wide self-assessment that determines “[t]he care required by the resident population considering the types of diseases, 4, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population.” 42 C.F.R. § 483.7(e)(ii).

Resident acuity level should be a primary determinant in establishing minimum staffing standards. Because CMS pays nursing homes based on resident acuity level, it makes sense to base minimum staffing levels on resident care needs.

3. Is there evidence of the actual cost of implementing recommended thresholds, that accounts for current levels as well as projected savings from reduced hospitalizations and other adverse events?

A 2022 study found that 95% of nursing homes did not meet all of the CMS recommended staffing levels from 2001, and 75% of nursing homes did not meet the 4.1 hprd.⁷⁵ In other words, residents

⁶ On pages 22727-8, CMS announces the rates of payment for fiscal year 2023. The rates are determined by resident acuity and decrease as the resident’s nursing needs diminish.

⁷ In 2016, research documented the need to adjust CNA staffing for resident acuity. The study found that residents needed between 2.8 to 3.6 hprd of CNA care, with 3.6 hprd representing the needs of residents with the highest acuity.⁷ Schnelle, J.F., Schroyer, L.D., Saraf, A.A., and Simmons, S.F. (2016). Determining nurse aide staffing requirements to provide care based on resident workload: A discrete event simulation model. *J. American Medical Directors Association*. 17:970-977.ee

in those nursing homes were receiving care at a level that put them at risk of harm. The same study estimated that it would cost the nursing home industry \$7.25 billion dollars to meet the standard, which only represented 4.2% of national nursing home expenditures in 2019.⁷⁶

An Office of Inspector General Report from 2011 found that 25% of nursing home residents were hospitalized, costing the Medicare program \$14.3 billion in 2011 alone.⁷⁷ Notably, nursing homes with a one-, two-, or three-star rating in staffing had hospitalization rates 5% higher than homes with four- or five-star ratings. Additional studies show that low staffing is related to rehospitalization and emergency room visits.^{78 79 80 81 82} By addressing inadequate staffing through a minimum staffing standard and reducing preventable hospitalizations, CMS will be saving Medicare money, while preventing harm to nursing home residents.

In 2011, Consumer Voice issued a report titled “The High Cost of Poor Care: The Financial Case for Prevention in American Nursing Homes.”⁸³ The report examined common conditions that result from poor care, including preventable falls, urinary incontinence, pressure ulcers, dehydration, and malnutrition, and how the treatment of these conditions cost tens of billions of dollars each year in the United States.⁸⁴ Although the costs in the report were not exclusive to nursing homes, these conditions are commonly found in nursing homes that have inadequate staff.⁸⁵ Another study, particular to nursing homes, demonstrated a net positive benefit to facilities that provide 30-40 minutes of RN care per day, when compared with those that provide less than ten minutes per day.⁸⁶

Lastly, we find it important to ask, what the costs are of not implementing a minimum staffing standard? Unfortunately, the COVID-19 pandemic provides the answer. While over 153,000⁸⁷ residents died of COVID-19, countless others suffered alone from isolation and neglect. Consumer Voice conducted two surveys of family members that were reunited with their loved ones after months of being apart. Roughly 9 out of 10 family members reported significant decline in their loved ones’ mental status and/or physical condition. Weight loss, poor hygiene, and filthy rooms were commonly reported by family members. A vast majority of families reported that the facility did not have sufficient staff.^{88 89}

The costs of increased staffing levels would largely be offset by lower costs that result from benefits of higher staffing, such as the better health outcomes, reductions in hospitalizations, and reduction in conditions commonly associated with neglect. The cost to residents for failing to implement staffing standards is evident in the countless studies that document the association between poor health outcomes and inadequate staffing.

4. Is there evidence that resources that could be spent on staffing are instead being used on expenses that are not necessary to quality patient care?

While the Biden Administration has made a minimum staffing standard the cornerstone of the reforms it announced on February 28, 2022⁹⁰, another priority for the administration is transparency in nursing home finances. Increased transparency is needed because the nursing home industry has adopted strategies, such as related-party transactions, to hide profit taking and making financial accountability more difficult. These practices have allowed nursing homes to disguise profits, while at the same time claiming they need more money from the Medicare & Medicaid programs.

Roughly 75% of all nursing homes purchase goods and services, such as management services, rent, therapy services, etc. from companies in which they have an ownership interest (related-parties), according to *The New York Times*.⁹¹ These rates are often inflated, and result in huge profits to

owners.⁹² Unsurprisingly, the *Times* article found that homes that use related party transactions have less direct care staff, higher amounts of violations and patient injuries, and two times the complaints of other facilities.⁹³

Research has documented that for-profit nursing homes generally perform poorly in quality metrics, have more violations, and have less staffing than their non-profit counterparts.^{94 95 96 97 98} Research also shows that nursing homes with the highest profit margins also have the poorest quality in the country.⁹⁹ Because the defining difference between the two types of homes is profit status, it is reasonable to presume that money that could be going towards care in for-profit homes is instead being directed to the profit of owners.

A recent study in California found that nursing homes are quite profitable and that only roughly sixty-four cents out of every dollar went to direct care.¹⁰⁰ The study found that roughly 30 cents of every dollar went towards administrative costs, property, and other expenses. The rest went to profit. The diversion of Medicare and Medicaid dollars to costs other than direct care has a direct impact on staffing. For instance, if nursing homes in California had spent seventy cents of every dollar on direct care, there would have been an additional \$765.6 million dollars going towards staffing.¹⁰¹

A recent lawsuit reveals how nursing homes in New York divert dollars away from direct care towards profit. In the lawsuit, filed by 238 of the 615 nursing homes in New York, the facilities reported they would have had to return \$824 million dollars in profit in 2019, had they had to spend 70% of every dollar on care, with 40% on direct care staff, and capped their profits at 5%.¹⁰²

Through the use of related parties and other accounting tactics, nursing homes have intentionally made it hard to discern just how much of Medicare and Medicaid dollars are spent on direct care. However, the information that is available reveals a profitable industry that diverts dollars away from direct care to profits and other expenses. With the implementation of a minimum staffing standard, it will also be essential that CMS implement the Biden Administration transparency reforms. CMS can start by implementing sections 6101 and 6104 of the Affordable Care Act, which require transparency in nursing home ownership and finances. Despite their passage over ten years ago, CMS has still failed to implement regulations enforcing these sections. In addition, CMS should require nursing homes to provide consolidated cost reports, which would lift the veil of opacity that hovers over nursing home finances.

U.S. taxpayers spend tens of billions of dollars on nursing home care each year, but little to no scrutiny is placed on how those dollars are spent. Essential to a minimum staffing standard is ensuring that dollars intended to go towards resident care are not diverted away to the profits of owners.

5. What factors impact a facility's capability to successfully recruit and retain nursing staff? What strategies could facilities employ to increase nurse staffing levels, including successful strategies for recruiting and retaining staff? What risks are associated with these strategies, and how could nursing homes mitigate these risks?

One of the most significant barriers to successful recruitment and retention of staff is job quality, which can be measured, in part, by facility staff turnover. CMS estimates that the average staff turnover for a nursing home is 52.6% annually.¹⁰³ Another recent study estimated the national

average of staff turnover to be 128%.⁸ A recent study showed that high turnover in nursing homes leads to poorer outcomes for nursing home residents.¹⁰⁴ In order to retain and attract new workers, facilities must address the issues that lead to turnover. Most commonly, high turnover is the result of poor wages and benefits, lack of training, poor management, lack of career advancement, and impossible workloads.¹⁰⁵ By directly addressing these issues, nursing homes will reduce turnover, attract new workers, and, importantly, provide better quality care to residents.

Important to the discussion of job quality is the issue of racial and social inequities in how nursing home staff are treated. Nine out of ten nursing home direct care staff are women.¹⁰⁶ 59% of CNAs are people of color.¹⁰⁷ As documented below, the wages, benefits, and job advancement opportunities offered to direct care staff, particularly CNAs, are paltry, and this most often falls on the back of workers of color. By addressing poor job quality, we will also be addressing the entrenched social and racial inequities that plague the nursing home direct care staff workforce.

Wages and Benefits

CNAs working in nursing homes are grossly underpaid for their work. The median annual income for a CNA in a nursing home is \$24,200, with 34% of CNAs relying on some kind of public assistance.¹⁰⁸ Only 62% of CNAs have health insurance through their employer. An additional 25% have Medicaid, and 13% have no coverage at all.¹⁰⁹ Throughout the COVID-19 pandemic, direct care staff were rightfully referred to as heroes, yet they were paid wages that kept them in poverty. RNs working in nursing homes are also underpaid. On average they make 7% less than RNs working in hospitals.¹¹⁰ This wage disparity can result in RNs being drawn away from working in nursing homes. Throughout the COVID-19 pandemic, direct care staff were rightfully referred to as heroes, yet they were paid wages that kept many of them in poverty.

Most nursing home direct care staff are not provided paid leave. One study showed 64% of nursing home staff stated they did not have paid leave.¹¹¹ Sick staff cannot afford to not work and fear losing their jobs, and resultingly end up going to work sick. This phenomenon was particularly damaging during the COVID-19 pandemic, where infected staff were the primary driver of COVID-19 infection in nursing homes.¹¹²

The nursing home industry has recognized the problem posed to nursing home care by low staff wages. A Leading Age study estimated raising wages of CNAs would reduce turnover and stabilize the workforce.¹¹³ The Leading Age report estimated that costs associated with increased wages would be offset by gains in productivity. Most importantly, the report stated that by increasing wages, care quality would increase, therefore resulting in better health outcomes for nursing home residents.

In order to reduce turnover and attract new direct care staff to nursing homes, all direct care staff must be paid a living and competitive wage. Nursing homes must be required to provide health insurance and paid leave benefits to direct care staff, as well. Until nursing home staff are paid wages commensurate with the services they provide, nursing homes will continue to lose staff and be unable to attract experienced and qualified workers.

Workloads

⁸ The study authors looked at turnover of staffing hours annually, as compared with actual staff. Gandhi A, Yu H, Grabowski DC. High Nursing Staff Turnover In Nursing Homes Offers Important Quality Information. *Health Aff (Millwood)*. 2021 Mar;40(3):384-391. doi: 10.1377/hlthaff.2020.00957. PMID: 33646872; PMCID: PMC7992115.

Inadequate staffing burdens existing staff. Research makes clear that high workloads for direct care staff contributes significantly to staff turnover.¹¹⁴ The 2001 CMS staffing study established the importance of having a minimum of 2.8 CNA hprd for each resident, which equates to CNAs not having more than 6 residents on the day and evening shifts to care for and no more than 13 residents at night.¹¹⁵ However, on average, CNAs in nursing homes provide care to 13 residents per shift.¹¹⁶ 1 in 10 CNAs in the U.S. are responsible for 17 or more residents.¹¹⁷ These impossible workloads make providing high-quality care impossible, resulting in residents waiting inordinate periods of time for necessary care, and often going without.

By addressing the issues that result in high staff turnover and inadequate recruitment, burdensome workloads will decrease, which will in turn increase staff retention.

Training

In addition to leading to high turnover, inadequate training results in poor health outcomes for residents. Research has demonstrated that direct care staff who receive tailored and ongoing training report higher job satisfaction which results in reduced turnover.¹¹⁸

CNAs reporting high-quality training are more likely to work in states requiring additional initial training hours and were more satisfied with their jobs than those with low-quality training.¹¹⁹ A 2008 study¹²⁰ by the Institute on Medicine (IOM) found the current minimum federal training requirements (75 hours) for CNAs to be inadequate, leading not only to poor health outcomes for residents, but also increased turnover in staff. The study recommended significant increases in the training requirement to at least 120 hours.¹²¹ The NASEM report made the same recommendation.¹²² The report also recommended that state and federal governments should provide free access to entry-level and continuing education training programs, and that nursing homes should pay workers for attending these training.

The current required training hours for CNAs is inadequate. CMS should heed the recommendations of the 2008 IOM report and the 2022 NASEM report and raise the required minimum training hours from 75 to 120 hours. Further, direct care staff should have access to free entry level training and continuing education classes. The time spent by direct care staff attending trainings should be paid for by nursing homes.

Career Advancement and CNA Empowerment

There is little opportunity for career advancement in nursing homes, particularly for people of color. 59% of CNAs are people of color.¹²³ However, the number of people of color in higher-level positions, such as LPNs or RNs, decreases as the educational requirements increase.¹²⁴ Research has shown that empowerment of CNAs and career opportunities can reduce staff turnover and increase care quality.¹²⁵

CNA empowerment was a main focus of the recent NASEM report, which found that increasing opportunities for CNAs could lead to a reduction in staff turnover.¹²⁶ The report noted that CMS's 2016 revised regulations for nursing homes required that CNAs be part of the interdisciplinary team and involved in care planning and suggested that further incorporation of CNAs into interdisciplinary care teams would result in reduced turnover.¹²⁷

To increase retention and create high quality jobs, nursing homes must provide more career advancement opportunities for direct care staff through sponsoring training and education.

Additionally, CNAs must be incorporated into care planning and given a more prominent role in care teams assigned to provide care to residents.

Administrators/Leadership

On average, nursing home administrators last little more than a year before leaving their positions.¹²⁸ A variety of factors contribute to administrator turnover, including burnout, lack of resources, and difficulty with corporate management.¹²⁹ Regardless of the causes, high turnover in administrative staff has been shown to be associated with high turnover in direct care staff.¹³⁰

To incentivize stability in management, CMS should incorporate administrator turnover into its value-based purchasing program. In addition, CMS should require all nursing home administrators to have, at a minimum, a bachelor's degree and training in topics relevant to their role.¹³¹ For instance, the National Association of Long Term Care Administrator Boards offers both accreditation and continuing education programs designed specifically for nursing home administrators.

In summary, the greatest barrier in attracting and retaining high quality staff is job quality. Nursing home direct care staff are underpaid and provided inadequate benefits. Inadequate training and impossible workloads result in burnout and increased staff turnover. Nursing homes must invest in the direct care staff by paying a living and competitive wage and by providing health insurance and paid leave. CMS should increase the minimum training requirement hours from 75 to 120 hours and provide avenues to staff for free and continuing training. CNAs must be empowered and given opportunities for career advancement.

6. What should CMS do if there are facilities that are unable to obtain adequate staffing despite good faith efforts to recruit workers? How would CMS define and assess what constitutes a good faith effort to recruit workers? How would CMS account for job quality, pay and benefits, and labor protections in assessing whether recruitment efforts were adequate and in good faith?

Facilities must ensure, at all times, that residents' needs are addressed. When facilities are unable to obtain adequate staff, CMS must require the facility to cease new admissions until the facility is able to meet the staffing requirement. Inadequate staffing is a threat to the health and well-being of residents. Additional steps must be taken by the facility to obtain additional staff, including temporary use of agency staff.

This question does not make clear why CMS would be developing and employing a "good faith effort assessment". If CMS is suggesting that it may apply a good faith determination as to whether a minimum staffing standard should be waived, we strongly oppose any such waiver. Minimum staffing standards should never be waived. A staffing standard establishes a baseline point, under which the risk of harm to residents is significantly increased. Instead, CMS should work with facilities to implement measures to increase staffing to meet the minimum requirement, as well as ensure that residents' needs are met.

Alternatively, if CMS is considering applying a good faith measure to an assessed penalty, we suggest that any such measure be used infrequently, and only in instances of emergencies. Any good faith

metric must be based on empirical data and should include a facility documenting its efforts to hire new staff and to retain staff through the investment in high quality jobs.

7. How should nursing staff turnover be considered in establishing a staffing standard? How should CMS consider the use of short-term (that is, travelling or agency) nurses?

Turnover is the primary barometer of how nursing homes are treating staff. Currently, CMS estimates that the average annual turnover rate is 52.6%. CMS recently began posting turnover rates on Care Compare, which is an important step in furthering transparency for consumers. CMS should continue to explore ways to incentivize the reduction of turnover rates, including using facility turnover rate as a measure in the SNF Value Based Purchasing Program.

In addition to financial incentives to reduce turnover, CMS should explore other strategies, including requiring nursing homes with high turnover rates to submit a plan to CMS that includes a pathway to reducing turnover. CMS may also consider a bright-line turnover average, beyond which a facility may face enforcement action.

The use of agency staff has been associated with poorer health outcomes for nursing home residents.¹³² Additionally, long-term use of agency staff may be indicative of a facility's failure to address underlying job quality issues in a facility. However, there may be instances where agency staff is needed, such as emergencies or pandemics. CMS should continue to monitor the use of agency staff and investigate its impact on resident care.

As discussed in Consumer Voice's response to Question 5, in order for a minimum staffing standard to be successful, we must address turnover in nursing homes. CMS must consider ways it can incentivize reduction in turnover, while also exploring regulatory and enforcement methods that address this important issue.

8. What fields and professions should be considered to count towards a minimum staffing requirement? Should RNs, LPNs/LVAs, and CNAs be grouped together under a single nursing care expectation? How or when should they be separated out? Should mental health workers be counted as direct care staff?

Only direct care nursing staff should be included in the minimum staffing standard. The landmark 2001 CMS study looked at only RNs, LPNs, and CNAs to determine what staffing levels were necessary to ensure care quality was not compromised. There is no evidence that any other nursing home staff, including physical therapists, occupational therapists, speech language pathologists, feeding assistants, social workers, and other mental health workers, are able to replace the care provided by RNs, LPNs, and CNAs. While we support the creation of standards for social workers and other mental health staff, those standards should be separate from a minimum staffing standard.

CMS must not group together RNs, LPNs, and CNAs into a single care expectation. CMS, itself, has acknowledged the important role that each nursing group provides. That is why in 2001, and in most studies since then, minimum recommendations have been made based on each nursing category. Any minimum standard must mandate hours for each nursing category and also provide staff to resident ratios. Failure to do so will result in facilities using the least costly nursing options,

CNAs, to fulfill the minimum obligation. This was proven true in states that failed to designate hours per nursing category.¹³³

We do urge CMS to adopt additional standards for other nursing home staff, particularly social workers and infection control preventionists. In its report, NASEM recommended that each nursing home employ at least one full-time social worker with at least a minimum of a bachelor's degree in social work from an accredited agency and one year of supervised experience in a health care setting.¹³⁴ NASEM emphasized the importance of social workers to the person-centered care model, while citing to studies that showed that social services staff with higher qualifications improve behavioral symptoms, reduce the use of antipsychotic medications, and play an important role in facilitating resident interactions.¹³⁵ Consumer Voice strongly supports these recommendations.

NASEM also noted the importance of having a qualified infection control preventionist. In its report, NASEM notes that the 2020 CMS Coronavirus Commission made several recommendations regarding infection control preventionists, and noted the current regulations are insufficient.¹³⁶ These recommendations included increased training for infection control preventionists and staff, and that CMS establish a full-time ratio of residents to infection control preventionists. We urge CMS to implement the recommendations of the CMS Coronavirus Commission. Additionally, NASEM recommended that infection control preventionist be an RN, advanced practice RN, or a physician. Consumer Voice supports this recommendation, as well.

9. How should administrative nursing time be considered in establishing a staffing standard? Should a standard account for a minimum time for administrative nursing, in addition to direct care? If so, should it be separated out?

Administrative time should not be counted towards a minimum staffing standard. The CMS staffing study from 2001 did not consider administrative time when establishing the 4.1 hprd standard. The purpose of hprd standards is to ensure residents receive CNA and nursing care to prevent illness or death related to lack of direct care.¹³⁷ There is no research demonstrating any kind of administrative standard that contributes to the prevention of resident illness or death. While CMS should continue to explore the role administrative time plays in nursing home care, it must not be included in a minimum staffing standard.

10. What should a minimum staffing requirement look like, that is, how should it be measured? Should there be some combination of options? For example, options could include establishing minimum 1 nurse HPRD, establishing minimum nurse to resident ratios, requiring that an RN be present in every facility either 24 hours a day or 16 hours a day, and requiring that an RN be on-call whenever an RN was not present in the facility. Should it include any non-nursing requirements? Is there data that supports a specific option?

It is essential that a minimum staffing standard incorporate both minimum nursing hprd and direct care staff to resident ratios. While an overall hprd minimum standard establishes the number of staffing hours each day needed to prevent resident harm, it can be confusing for staff, residents, and families in determining whether a facility has adequate staffing. Staff to resident ratios is a more practical and clear way to identify staffing capacity.

In its recent report, NASEM recommended the on-site presence of at least one RN 24-hours per day, 7 days per week.¹³⁸ Additionally, NASEM recommended that the number of RNs present be

adjusted for acuity and case-mix. This need for a 24 hour RN presence has also been endorsed by the nursing home industry.¹³⁹ Nursing facilities house populations with highest needs and complex medical issues which require RN experience.¹⁴⁰ Further, increased levels of RN care are associated with better health outcomes for residents.¹⁴¹ As noted several times throughout our responses, we recommend that CMS establish a minimum standard for all direct care staff, including RNs, which would result in a minimum hprd for RNs along with a RN to resident ratio.

As previously noted, a minimum staffing standard should not include time staff spend on administrative duties, including non-nursing requirements. It is unclear what non-nursing requirements CMS is referring to in this question, but we recognize that direct care staff must be trained and perform other non-direct care duties, but these tasks should not be incorporated into a minimum standard.

- 11. How should any new quantitative direct care staffing requirement interact with existing qualitative staffing requirements? We currently require that facilities have “sufficient nursing staff” based on a facility assessment and patient needs, including but not limited to the number of residents, resident acuity, range of diagnoses, and the content of care plans. We welcome comments on how facilities have implemented this qualitative requirement, including both successes and challenges and if or how this standard should work concurrently with a minimum staffing requirement. We would also welcome comments on how State laws limiting or otherwise restricting overtime for health care workers would interact with minimum staffing requirements.**

In our response to Question 2, we recommended that CMS adopt minimum staffing standards based on resident acuity, noting that CMS’s PDPM pays nursing homes based on resident acuity. In order for a facility to have “sufficient staff,” it must determine resident acuity (including residents’ mental and psychosocial needs) and provide the necessary number of staff to meet those needs. A minimum standard is just that, a minimum. Requiring facilities to have “sufficient nursing staff” on top of the minimum hprd clarifies that many residents will need beyond 4.1 hprd in order to be sufficient.¹⁴²

Overtime restrictions should not be considered for purposes of establishing minimum staffing standards. Facilities should recruit and train a high number of direct care workers without relying on a small number of workers with significant overtime. Overworked nursing home staff results in high rates of burnout and turnover, in addition to physical injury.¹⁴³

- 12. Have minimum staffing requirements been effective at the State level? What were facilities’ experiences transitioning to these requirements? We note that States have implemented a variety of these options, discussed in section VIII.A. of this proposed rule, and would welcome comment on experiences with State minimum staffing requirements.**

Several studies have shown that a state’s implementation of minimum staffing standards led to increased nursing hours, better health outcomes, and a reduction of deficiencies.¹⁴⁴ Quality of care improves with minimum staffing requirements primarily because residents experience fewer adverse outcomes (fewer pressure sores, restraints, and deficiencies, less extensive COVID outbreaks, and less mortality overall) and experience more positive outcomes (restoration of functioning, increased nutritional intake, and increased vaccination rates).¹⁴⁵

- 13. Are any of the existing State approaches particularly successful? Should CMS consider adopting one of the existing successful State approaches or specific parts of successful State approaches? Are there other approaches to consider in determining adequate direct care staffing? We invite information regarding research on these approaches which indicate an association of a particular approach or approaches and the quality of care and/or quality of life outcomes experienced by residents, as well as any efficiencies that might be realized through such approaches.**

Only the District of Columbia has set a minimum staffing standard that meets the recommended standard of 4.1 hprd.¹⁴⁶ The majority of states - 29 - require less than 3.5 hprd, with 15 of those states falling below 2.5 hprd.¹⁴⁷ Accordingly, CMS should not rely on state models to implement staffing standards.

Although CMS should not rely on state approaches, it should learn from mistakes made by states when implementing staffing standards. California, Ohio, and Florida, when implementing minimum standards, failed to specify minimums for each category of direct care staff (RN/LPN/CNA). As result, all three states experienced a decline in RN hours after the minimum was implemented.¹⁴⁸ By mandating minimum hprd and staff ratios for each direct care staff category, CMS will avoid this mistake.

- 14. The IOM has recommended in several reports that we require the presence of at least one RN within every facility at all times. Should CMS concurrently require the presence of an RN 24 hours a day 7 days a week? We also invite comment on the costs and benefits of a mandatory 24-hour RN presence, including savings from improved resident outcomes, as well as any unintended consequences of implementing this requirement.**

As previously noted in our response to Question 10, we support the requirement that all nursing homes have at least one RN present on-site at a minimum of 24 hours per day, 7 days per week. There is almost universal agreement in support of this requirement.^{149 150} However, this is a minimum standard. Because facilities must have “sufficient” staff, a minimum standard must establish a specific RN to resident ratio for each nursing shift, which may require the presence of more than one RN per shift, when accounting for facility size and resident acuity.

As noted in our response to Question 1, the strongest positive relationships between staffing and positive resident outcomes are in RN staffing.¹⁵¹ The care improvements for residents related to increased RN staffing saves Medicare and Medicaid money by reducing hospitalizations and the need for other expensive medical interventions.¹⁵²

- 15. Are there unintended consequences we should consider in implementing a minimum staffing ratio? How could these be mitigated? For example, how would a minimum staffing ratio impact and/or account for the development of innovative care options, particularly in smaller, more home-like settings, for a subset of residents who might benefit from and be appropriate for such a setting? Are there concerns about shifting non-nursing tasks to nursing staff in order to offset additions to nursing staff by reducing other categories of staff?**

As noted above, in Ohio and California, ratios for RNs, LPNS, and RNs were not separately mandated. As a result, RN hours decreased, while less skilled nursing staff hours increased.¹⁵³ To prevent these unintended consequences, nurse staffing ratios must identify the different categories of nursing staff. In addition, facilities must not be allowed to shift non-nursing tasks to nurses or to reduce the work hours of non-nursing staff, such as housekeeping, food services workers, and activities.

There is also evidence that alternative care settings are able to meet minimum staffing standards. For instance, researchers of the Green House Model¹⁵⁴ found that even though Shahbazim performed non-nursing tasks, “residents in GH [Green House] homes received approximately 0.4 more hprds (24 minutes) of direct care time from a Shahbazim than residents in traditional SNF settings.” Their conclusion that “The GH model allows for expanded responsibilities of CNAs in indirect care activities and more time in direct care activities and engaging directly with residents” suggests that alternative care settings, like Green Houses, can meet any minimum staffing standards that CMS might enact, without any need for accommodation.¹⁵⁵

16. Does geographic disparity in workforce numbers make a minimum staffing requirement challenging in rural and underserved areas? If yes, how can that be mitigated?

A minimum nurse staffing standard must be met by all facilities, regardless of their geographic location. Nursing home residents in rural or underserved areas have the same nursing needs as residents in urban areas. The challenges of recruiting staff in rural areas is nothing new. 40 years ago, the Institute of Medicine recognized this problem and recommended including educational outreach (including educational loan repayment programs, strengthening local educational opportunities for people from underserved communities who are more likely to continue living in those communities), upgrading existing staff in nursing homes, and ensuring appropriate payments.¹⁵⁶

There may be unique problems particular to direct staff recruitment in rural and underserved areas, but the issue of job quality is similar, if not identical, to urban areas. These facilities must take the steps outlined in our response to Question 5 to increase job quality to attract and retain staff. Job quality should be the number one priority for nursing homes in rural areas. Regardless of geographic location, nursing home staff want jobs where they are paid a competitive living wage, receive healthcare benefits and paid leave, and offer training and opportunities for career advancement.

It is important to note that one factor that may contribute to rural facilities having difficulties attracting RN staff is how CMS pays rural facilities less for RN care when compared to urban facilities. This NPRM itself documents this disparity on page 22728. It is unclear how much this disparity contributes to the problem of rural facilities attracting and retaining RN staff, but CMS should consider addressing this disparity to make RN wages the same regardless of geographic location.

17. What constitutes “an unacceptable level of risk of harm?” What outcomes and care processes should be considered in determining the level of staffing needed?

As advocates for nursing home residents, we believe there is no acceptable risk of harm to nursing home residents due to a facility's failure to have sufficient staffing to meet the needs of residents. The 1987 Nursing Home Reform Law and its implementing regulation place specific responsibilities on the Secretary and facilities to define and meet outcomes and care processes. Nowhere in the Reform Law is an acceptable or unacceptable risk of harm mentioned as a metric for care quality or a measure of what level of care facilities must provide to residents.

Rather, federal law requires that facilities, through comprehensive assessment and care planning, "provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." 42 U.S.C. §1395i(b)(2). This means that facilities are required not only to meet the standards that the Secretary establishes, including minimum staffing levels, but also any requirements to increase those staffing levels, as needed, to meet their own residents' specific and actual needs.

It is worth quoting here, in its entirety, 42 C.F.R. § 483.35, which states:

The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).")

Federal law and regulations make clear that any risk of harm due to a facility's failure to have sufficient staffing to meet the needs of its residents is unacceptable.

Thank you again for the opportunity to provide input on this critical issue. Consumer Voice staff are available to answer questions or provide additional information as needed.

Sincerely,

A handwritten signature in cursive script that reads "Lori Smetanka". The signature is written in black ink and is positioned below the word "Sincerely,".

Lori Smetanka
Executive Director

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