A Guide to Submitting Comments on the Proposed Minimum Staffing Rule

October 19, 2023
About the Consumer Voice

*The leading national voice representing consumers in issues related to long-term care*

- **Advocate for public policies** that support quality of care and quality of life responsive to consumers’ needs in all long-term care settings.
- **Empower and educate** consumers and families with the knowledge and tools they need to advocate for themselves.
- **Train and support** individuals and groups that empower and advocate for consumers of long-term care.
- **Promote the critical role** of direct-care workers and best practices in quality care delivery.
Welcome

- The program is being **recorded**
- Use the **Q&A feature** for questions for the speakers
- Use the **chat feature** to submit comments or respond to questions from speakers or other attendees
- Please complete the **evaluation** questionnaire when the webinar is over.
- Links to **resources** will be posted in the chat box and will be posted to the Consumer Voice website – [theconsumervoice.org](http://theconsumervoice.org)
Speakers

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National Consumer Voice for Quality Long-Term Care

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Center for Medicare Advocacy

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Agenda

1) Overview and background
2) The staffing standard
3) Timeframes and Exemptions
4) Enforcement
5) Facility Assessments
6) Medicaid Transparency
7) How to comment
Lots to Cover!

- Comments are due November 6, 2023
- Critically important that CMS hears from residents, families, advocates, and others about the importance of a strong staffing standard.
- Today’s webinar designed to provide insight on specific and important issues in the proposed rule.
- CMS needs to hear your unique voice and experience. Just as important as detailed recommendations.
New 2023 CMS proposed minimum staffing levels are shockingly low

- Proposal set at 3.0 total nursing hours per resident day (HPRD) instead of 4.1 nursing HPRD
  - with .55 RN hours instead of .75 RN HPRD
- Proposal below the level
  - recommended by experts and research
  - the current national average
- We recommend 4.2 total nursing HPRD, .75 RN HPRD, 1.4 licensed nursing HPRD (total can be made up of RNs and LPNs) and 2.8 CNA HPRD minimum.
Minimum staffing hours per resident day (HPRD) for long stay residents to improve outcomes and avoid selected care problems

<table>
<thead>
<tr>
<th>Role</th>
<th>HPRD</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN</td>
<td>0.75</td>
</tr>
<tr>
<td>Licensed practical nurses</td>
<td>0.55</td>
</tr>
<tr>
<td>Nursing Assistants</td>
<td>2.80</td>
</tr>
<tr>
<td>Total nurse staffing</td>
<td>4.10</td>
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</table>

2004 Observation Study of Nursing Staffing and Quality of Care

- Observed 2 groups of NHs with higher and lower CNAs

- Higher staffed NHs had significantly lower resident care workloads (7.6 residents per 1 CNA) compared with low staffed NHs (9-10 residents per CNA)

- Higher staffed homes performed significantly better on 13 out 16 process measures compared to lower staffed homes

NHs with .55 RN HPRD did not meet minimal Quality Standards. Abt Study supports .75 RN hrpd or higher

Exhibit 4.7: Predicted Probability of Exceeding Minimum Acceptable Quality Standards for Total QM Score Across Case-Mix-Adjusted Nurse Staffing Deciles, by Staff Type

Research Shows Higher RN Staffing Protected Residents from Infections & Deaths

- CA LTCFs with less than .75 RN staffing HPRD were twice as likely to have COVID infections (Harrington et al 2020)

- CT LTCFs – every 20 minute increase in RN staffing reduced infections by 22% and deaths by 26% (Li et al., 2020)

- US LTCFs with 5 star ratings overall, for RN, and total staffing had lower cumulative Covid infections and deaths (Williams et al 2021)
NHs with .55 RN HPRD did not meet minimal Safety Standards. Abt Study supports .75 RN hrpd or higher
2023 Abt Staffing Study Simulation Model for Licensed Nurses

- Abt simulation model statistically estimated the time to complete 5 tasks and the number of times the tasks must be completed for a set of residents by the combination of RNs and LPNs

- Despite the simulation model being very limited, Abt found
  - 1.4 to 1.7 licensed (4 licensed nurses for 70 residents) nurse HPRD were needed to ensure delayed and omitted clinical care below 10 percent.
  - 1.0 licensed HPRD (3 licensed nurses for 70 residents) resulted in delayed or omitted care of 19 percent, which is unacceptable.
  - Total licensed nurses should be at least a minimum of 1.4 RN and LPN HPRD.

- CMS should have used these findings to set a minimum requirement of 1.4 licensed nurse HPRD

Based on five ADLs and seven workload categories, NA staffing needed to reduce omissions in basic care to below 10%:
- 2.8 HPRD for low resident acuity
- 3.6 HPRD for high resident acuity
- Average NHs have only 2.2 NA HPRD

Confirmed the 2001 CMS study recommending 2.8 NA hrpd minimum

NHs with higher than 2.45 CNA HPRD were more likely to have higher quality and safety scores

- CMS proposed only 2.45 HPRD of CNA care per day. This is the 1\textsuperscript{st} level that they saw improvement but they failed to look at higher levels and the 2.8.

- CNA staffing at 2.8 HPRD and higher substantially improved both safety and quality.

- Schnelle 2016 simulation study showed that CNA staffing of 2.45 HPRD had 15% omitted care

Total Minimum Staffing Standards

- CMS proposed only 3.0 total HPRD of CNA and RN care.
  - Or alternatively 3.48 total nursing HPRD
- CMS’s prosed 3.48 total nursing HPRD is completely inadequate
  - Would result in unacceptable levels of delayed and omitted care and harm to residents.
- CMS should establish a total minimum staffing of 4.2 HPRD. This standard should be composed of 1.4 licensed nurse HPRD (.75 of which must be RN care), and 2.8 CNA HPRD based on the:
  - 2001 Abt staffing study shows the need for .75 RN HPRD and the 2023 Abt staffing statistical analysis
  - 2023 Abt simulation study shows the need for 1.4 licensed nurses
  - Schnelle 2016 simulation study shows the need for 2.8 CNA HPRD
CMS Proposed Regulations Require 24-Hour Per Day RN Staffing

We strongly support and recommend:

24-Hour RN for Direct Care in addition to DON and administrative nurses

1 24-Hour RN for Direct Care for every 100 beds

- Coalition of Geriatric Nursing Organizations (CGNO). Nursing staffing requirements to meet the demands of today's long-term care consumer recommendations, 2013.
Timeframes

- 24/7 RN
  - Urban: 2 years from date of final publication of rule
  - Rural: 3 years from final publication of rule

- Minimum Staffing Standard
  - Urban: 3 years from final publication of rule
  - Rural: 5 years from final publication of rule
Implementation Times Too Long

- CMS has little evidence to support allowing facilities in rural areas to take five years to comply with overall standard
  - 2023 Study showed staffing in both areas almost identical
- Urban and rural timeframes must be identical
  - 2 years for the 24/7 RN and 3 years for total standard
- Must be phased in
  - CMS should establish reasonable timeframes with benchmark increases in staffing
    - Residents should not have to wait years to be safe
    - Prevents facilities from waiting to last minute
Waivers

- CMS will allow some facilities not to comply with minimum staffing standard. Four criteria for waivers and all must be met:
  - Location
  - Good faith efforts to hire
  - Demonstrated financial commitment
  - Certain exclusions from eligibility for waiver

- WE OPPOSE ALL WAIVERS
  - Staffing below the proposed levels in our comments would cause harm to residents
  - CMS cannot create a two-tier system where some residents are allowed to suffer and be harmed
Location

- Supply of health staff not sufficient
  - Must show that provider-population ratio is 20% or 40% below national average.
  - Multi-step calculation using data from Bureaus of Labor and Statistics
- OR, the next closest long-term care facility is 20 or more miles away.

<table>
<thead>
<tr>
<th></th>
<th># of Facilities</th>
<th>RN</th>
<th>LPN</th>
<th>CNA</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>10,973</td>
<td>.67</td>
<td>.91</td>
<td>2.21</td>
<td>3.80</td>
</tr>
<tr>
<td>Rural</td>
<td>4,174</td>
<td>.64</td>
<td>.80</td>
<td>2.23</td>
<td>3.66</td>
</tr>
</tbody>
</table>
Location (Suggested Comments)

- CMS should use the 20% provider to population ratio
- Eliminate the 20 miles or further away provision
  - Not based on anything scientific. (Rural and Urban staffing are almost identical)
  - Rural folks live far away from things!!!
- Should be based on actual availability of workers, not distance or location.
Good faith effort to hire

- Must have recruitment and retention plan in accordance with 42 C.F.R. § 483.71(b)(5)
- Diligent efforts to hire
  - Offering jobs at PREVAILING wages
  - Job listings in common recruitment forums, etc.
Suggested Comments on Good Faith Provision

- The wages should not be “prevailing.” Averages wages for CNAs are abysmal. $25,748 is median wage for CNA.
  

- CMS should require higher wages
  
  - MIT Living Wage calculator
  
  - Prevailing wage + 25%
Demonstrated Financial Commitment

- Vague requirement that a facility must document the financial resources it expends annually on nurse staffing relative to revenue
Demonstrated Financial Commitment Comments

- Must have explicit and detailed criteria
- Increased scrutiny on Medicare and Medicaid cost reports
  - Accountability for related party transactions and other costs not related to direct care
  - Home office costs, executive salaries, profits
- 80% of all Medicare and Medicaid dollars go towards direct care
  - Similar requirements in NY, NJ, and MA
  - Medicaid Access Rule: Required 80% of payments for Home and Community Based Services to go towards direct care
- Turnover measure? Reasonable reduction in staff turnover
Exclusions from Waivers

- Cannot be Special Focus Facility
  - Only 88 SFF in the country out of roughly 15,000 nursing homes
    - This should be expanded to the SFF list
- Cannot have been cited in previous 12 months for:
  - Widespread insufficient staffing with actual resident harm; or
  - Pattern of insufficient staffing with actual harm; or
  - Immediate jeopardy related to staffing
- Failed to submit staffing data (Payroll Based Journal)
Waivers Cont’d

► Consumer Voice opposes all waivers. All residents, regardless of geographical location, are entitled to safe and high-quality care

► Facilities still allowed to accept new residents, despite failure to be able to safely care for current residents

► No requirement that facility create better jobs or invest in staff

► Turnover not a factor
CONSUMER VOICE
Oct. 19, 2023

Toby Edelman
ENFORCEMENT

- CMS proposes to enforce staffing standards through the standard survey and enforcement system, 88 Fed. Reg., 61365.
- Advocates’ concern: survey and enforcement is necessary, but not sufficient, response
CONCERNS ABOUT USING SURVEY AND ENFORCEMENT SYSTEM

- Survey and enforcement system fails both (a) to cite deficiencies at all and (2) to properly identify scope and severity (how significant and widespread deficiencies are)
  - Most deficiencies (90+%) cited as no-harm, so no enforcement results
GAO REPORTS

- GAO has reported timidity and weaknesses of survey and enforcement for decades (e.g., Federal and State Oversight Inadequate to Protect Residents in Homes with Serious Care Violations, T-HEHS-98-219 (Jul. 28, 1998), Prevalence of Serious Quality Problems Remains Unacceptably High, Despite Some Decline, GAO-03-1016T (Jul. 17, 2003); Some Improvement Seem in Understatement of Serious Deficiencies, but Implications for the Longer-Term Trend Are Unclear, GAO-10-434R (Apr. 28, 2010); Nursing Homes: Improved Oversight Needed to Better Protect Residents from Abuse, GAO-19-433 (Jun. 2019))
ADVOCACY PROPOSAL

- CMS propose two requirements for staffing
  - Staffing ratios for RNs and aides (and we hope specific staffing ratios for licensed practical nurses and total nurse staffing in final rule)
  - “sufficient” staff requirement (which has been the standard since 1992 regulations)
ADVOCATES SUGGEST TWO TYPES OF ENFORCEMENT FOR FAILING TO MEET SPECIFIC RATIOS

▪ When facilities quarterly report to CMS through payroll-based journal (PBJ) staffing information indicating they have not met specific staffing ratios (proposed rule: 0.55 HPRD RN, 2.45 HPRD aides), then, automatically,
  • Civil money penalties (CMPs)
  • Denial of payment for new admissions (DPNAs)
    • Rationale: use existing staff to provide care to residents; do not subject additional residents to inadequate staffing levels
FAILURE TO MEET “SUFFICIENT” STAFFING REQUIREMENT

- As determined by standard (annual) or complaint survey
- Cite, as appropriate
- Cite range of remedies, as appropriate, including
  - CMPs, DPNAs, monitor, directed plan of correction, temporary management
The Center for Medicare Advocacy is a national, non-profit law organization that works to advance access to comprehensive Medicare coverage, health equity, and quality health care for older people and people with disabilities. Founded in 1986. Based in Washington, DC and CT, with additional attorneys in CA, MA, NJ.

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- Provides education, legal analysis, writing, assistance, and advocacy
- Systemic change – Policy and Litigation
  - Based on our experience with the problems of real people
- Medicare coverage and appeals expertise
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Facility Assessment

- Adds requirements to existing facility assessment regulations at 42 C.F.R. § 483.71
- Annual assessments that require facilities to assess resident needs
  - Staffing plans
  - Resource allocations
  - Emergency planning
- Would go into effect 1 year after publication of final rule
Facility Assessment

- No guidance on acuity. Essentially, this amounts to continuing the status quo of “sufficient” staff.

- Facilities must be told how to staff to acuity or they will not do it.

- CMS pays nursing homes based on resident acuity.
  - Patient Driven Payment Model
    - Facilities access acuity of residents and CMS pays based on care needs of residents
Facility Assessment, Continued

- Acuity staffing should be modeled on the PDPM model
- 2020 article laid out specific staffing levels based on the acuity levels present in the PDPM model
- Extremely concerned that acuity will be left to subjective assessments made by state survey agencies
- CMS must take a central role in prescribing and enforcing acuity
Medicaid Payment Transparency

- CMS proposed regulations require Medicaid programs to identify, at the facility level, the percent of Medicaid payments spent on compensation to: (i) Direct care workers; (ii) Support staff.

- While wage and benefit data are useful, comprehensive data on revenues and expenses are also needed.

- Unless Medicaid programs provide more comprehensive data on rates and payments as well as expenses, including wages and benefits, CMS will not be able to draw very useful conclusions.
CMS Should Implement MACPAC Recommendations for Medicaid Transparency

- State Medicaid programs should make NH revenue and cost data for each NH publicly available in a standard format

- Each NH should report payments and expenses for:
  - Base payments, Supplemental payments, Managed care directed payments, and Beneficiary contributions to share of costs & other revenue
  - Provider contributions (tax) to state Medicaid programs
  - Expenses for wages and benefits for nursing, ancillary, and support services and all other direct care expenses
  - Expenses for depreciation, administration, property, and profits
  - Expenses for related-party transactions, real estate, and disallowed costs

CMS Should Establish Medicaid Direct Care Spending Requirements to Increase Financial Accountability

Direct care spending legislation was enacted in NJ, MA, NY, and PA in 2020-23

- NY requires 70% of reimbursement be spent on resident care with 40% on direct care staff and a 5% limit on profits
- NJ set direct care ratio of 90% of a facility’s aggregate revenue on direct care of residents in 2021
- MA set direct care cost at least 75% and with downward rate adjustments for failure in 2021
CMS Should Establish Medicaid Direct Care Spending Requirements For NHs To Ensure Financial Accountability

CMS issued a HCBS proposed rule §441.302(k)(3)(i).

- At least 80 percent of all payments for services must be spent on compensation for direct care workers
- Each State must report to CMS annually on the percent of payments for certain services spent on compensation for direct care workers
- CMS must report the information on its website including worker payments

We recommend that CMS issue similar requirement for NHs so that 80% of NH Medicaid revenues would be spent on direct care services. CMS should limit administration, property, other non-direct care expenses, and profits to 20% of Medicaid revenues.
How to Comment
Visit the Consumer Voice Comment Page

Comment on the Proposed Minimum Staffing Standard in Nursing Homes

Use our step-by-step instructions to submit simple comments on CMS's proposed minimum staffing rule in nursing homes.

Submit Comments

The proposed rule does not go far enough to protect nursing home residents from harm.
Visit our comment page

Watch our video with step-by-step instructions

Scroll down for instructions on how to comment
To comment:

1.) Open the commenting webpage in a new tab: https://www.regulations.gov/commenton/CMS-2023-0144-0001

2.) In the comment box, state that:

The proposed rule does not go far enough to protect nursing home residents from harm.

Share your personal story or experience about the impact of inadequate staffing on you or someone you love.

3.) Use these suggested talking points (feel free to copy/paste):

In order to protect nursing home residents from harm and to ensure a high quality of life:

- Require nursing homes to meet a total staffing standard of 4.2 hours per resident day (HRPD) within the next two years. This total should be made up of at least:
  - 1.4 HRPD of total licensed nurse care, composed of at least .75 HRPD of registered nurse (RN) care and
  - 2.80 HRPD of certified nurse aide care (CNA).

  RNs, LPNs/LVN, and CNAs each have important roles in the provision of quality care to residents. A staffing standard should address total direct care for residents. These staffing levels are supported by decades of research and by the 2023 Staffing Study commissioned by CMS last year.

  These additional requirements are financially feasible because the costs would be less than five percent of the over $100 billion that nursing homes receive from Medicare and Medicaid annually.

- No waivers to facilities that cannot provide a level of care that ensures resident safety.

- Restrict admissions when minimum staffing standards are not met.

- Reduce the timeframes for implementation, particularly in rural areas, and require phased-in compliance. The 2023 Staffing Study found that staffing in rural homes is almost identical to staffing in homes located in urban areas. Residents in rural homes should not suffer for years before the staffing standard is implemented.

4.) In the drop-down question, “What is Your Comment About?” identify yourself from the choices.

5.) Complete the remaining questions on the form

6.) Click, “Submit Comment.”

All comments are due by November 6, 2023.
You are commenting on a Proposed Rule by the Centers for Medicare & Medicaid Services:
Medicare and Medicaid Programs: Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting

Write a Comment

Comment*
Start typing comment here...

What is your comment about?
Select a Comment Category

Attach Files
You can attach up to 20 files, but each file cannot exceed 10MB. Valid file types include: bmp, docx, gif, jpg, jpeg, pdf, png, pptx, rtf, sgml, tif, tiff, txt, wdp, xlsx, xml
What to Write

- A personal story or experience
- Reasons why the current standard does not go far enough to protect residents
  - Consumer Voice’s talking points
  - Information from this webinar
Important Points

- Go to https://www.regulations.gov/commenton/CMS-2023-0144-0001
- Personalize your story
- Use the Consumer Voice talking points
- Include information you’ve learned in this webinar
- Comment by November 6th
- Make your voice heard!!!!
Questions
Connect with us!

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The National Consumer Voice for Quality Long-Term Care
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