

November 6, 2023

Submitted electronically via regulations.gov

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201


Re: Medicare and Medicaid Programs: Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting [CMS-3442-P; RIN 0938-AV25], 88 Fed. Reg. 61352.

Dear Administrator Brooks-LaSure:

The undersigned organizations and individuals appreciate the opportunity to comment on the proposed rule to establish nurse staffing standards for nursing homes that participate in Medicare and Medicaid. We strongly support the Administration’s initiative to improve the quality of care in nursing homes. For decades, health researchers, geriatricians, nurses, and other clinical experts have recommended minimum nursing staffing requirements to improve the quality of care at nursing homes. A wide range of peer-reviewed literature demonstrates the causal connection between staffing and quality of care in nursing homes. As far back as 2001, the Centers for Medicare & Medicaid Services (CMS) noted the “strong and compelling” evidence for having minimum staffing levels, even in an economy with a chronic workforce shortage. Moreover, a blue-ribbon panel convened by the National Academy of Science, Engineering, and Medicine (NASEM) noted in its 2022 report that increasing overall nurse staffing has been a consistent and longstanding recommendation for improving the quality of care in nursing homes.

There is a pressing need for national nursing home staffing standards for certified nursing assistants—certified nurse aides (CNAs), licensed practical nurses (LPNs), and registered nurses (RNs) who provide direct care to residents. The continued pattern of poor staffing and the significant variability in the nurse-to-resident ratios across facilities and states increases the likelihood of residents receiving unsafe and low-quality care, particularly during a public health crisis. All residents, regardless of zip code, are entitled to appropriate professional nursing care.

This Notice of Proposed Rulemaking (NPRM) sets a minimum nursing staffing standard; it does not create a ceiling on staffing or impose a “one-size-fits-all” solution. Furthermore, the NPRM does nothing to change the moral and legal obligations to provide resident-centered care. The



1987 Nursing Home Reform Act (NHRA) required all nursing homes to provide “nursing services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.” Facilities with a higher acuity case mix would still be required to staff at a level appropriate to meet the needs of those residents. Thus, a minimum staffing standard sets a floor of minimum care, not a ceiling.

We understand that many facilities may find staffing a challenge. Nursing staffing has been a chronic problem that preceded the pandemic. With the average CNA earning just over \$17/hour, it remains difficult for facilities to find people willing to undertake such physically and emotionally draining work—work with a significant risk of injury. For many CNAs, other less strenuous and more economically rewarding opportunities are available.


The core of the problem is not hiring but lack of retention. On average, nursing homes lose more than half their direct care staff annually. This churn in staff shows that people are initially willing to do the work but end up leaving because of the poor compensation, lack of benefits, and difficult working conditions. Chronic churn leads to understaffing that creates an endless cycle of turnover due to the extra burden placed on existing staff from CNAs to RNs.

Moreover, inadequate staffing is primarily a problem in the for-profit sector. Governmental and nongovernmental nonprofits already meet or exceed the 4.1 hours per resident day standard identified in the 2001 study by Abt Associates. The Administration should not forego policies that would improve the quality of care simply because one segment of the industry — for-profit facilities — has created a workforce problem.

We commend the Administration for proposing minimum nursing staffing standards. The NPRM represents a paradigm shift in nursing home oversight to promote quality of care. At the same time, we strongly urge CMS to strengthen the proposed minimum nurse staffing standard, as detailed below. These proposed changes will increase the likelihood that the minimum staffing standard reaches the goal laid out in the original 2001 Abt study: to meet the requirements of the NHRA by identifying “staffing thresholds below which quality of care was compromised and above which there was no further benefit of additional staffing concerning quality.”

Recommended Changes

We strongly support a final rule that requires the presence of an RN in facilities 24 hours a day, seven days a week, as proposed in the NPRM. However, we believe only RNs providing direct care to residents should be counted towards this staffing requirement; RNs who perform solely administrative duties should not be included. In addition, the Director of Nursing in facilities with more than 30 residents should not count towards this requirement. Research shows that it is actual direct care provided by RNs that improves health outcomes for residents, not their mere presence in the building.



With respect to direct care, we strongly support a final rule that would strengthen the staffing requirements by requiring:

- The care provided by a licensed nurse should be set at 1.4 hours per resident day (HPRD), with at least 0.75 of that provided by an RN. CMS could choose to allow the facilities to meet the remainder of the licensed nurse requirement (.65 HPRD) with LPNs or RNs, or could mandate that time be met solely by LPNs; and
- The care provided by a CNA should be 2.8 HPRD.


These staffing levels are more protective of residents and direct care staff and, consequently, are more likely to meet both the statutory goals of the NHRA and the goals of the NPRM. Additionally, the aforementioned staffing levels are consistent with the goal of establishing a minimum nursing staffing standard that avoids unacceptable levels of omitted and delayed care and reduces the likelihood of compromised care—goals articulated in the 2001 Abt study and echoed by the 2023 Abt study.

It is worth noting that the suggested RN level is taken directly from the simulation study conducted by Abt as part of the 2023 study. The suggested CNA level is taken from the authoritative work of Professor John Schnelle and cited approvingly by the 2023 Abt study; the 2023 Abt study did not conduct a simulation study for CNAs. In both cases, these are the staffing levels needed to keep delayed or omitted care below 10 percent; they are also staffing levels supported by qualitative analysis in the 2023 study. These staffing standards are reasonable and achievable when nongovernmental nonprofit homes average 4.19 HPRD, according to the latest CMS data.

Waivers

Since a minimum nurse staffing requirement is necessary to keep residents and direct care staff safe, CMS should not allow for waivers or exemptions—particularly if enforcement is measured over a lengthy time period that allows for fluctuations in staffing, such as average daily staffing per quarter. Facilities that are unable to meet nurse staffing requirements should not receive payment for new admissions until they demonstrate the ability to provide safe and adequate nursing services. It is untenable to establish a nurse staffing standard based on resident safety, to acknowledge that a facility is falling short of that standard, and nevertheless continue to pay for new admissions. Such action will only exacerbate the problem of inadequate staffing for existing and new residents.

To the extent that waivers exist, they should be limited in number and frequency. A facility should only be granted a waiver if it has demonstrated clearly identifiable progress on nursing staffing, including documenting a reduction in turnover and an increase in wages.



Demonstrations of a good-faith effort to hire sufficient nursing staff should include evidence that the facility has offered what constitutes a living wage for that community.

Any facility granted a waiver should be under more intense scrutiny. For example, survey frequency should be increased, and CMS and state survey agencies could appoint an independent entity to monitor the facility's performance. Finally, any waiver that is granted should be prominently displayed on the Nursing Home Compare website, along with a warning about the possible consequence of nursing understaffing. A similar notice should be required to be posted in the nursing facility and provided to any individual seeking admission to the facility.

Other Issues

We appreciate the fact that the success of any nurse staffing standard relies on the enforcement regime backing it up. We urge CMS to consider policy opportunities to bolster the current state survey and certification process and hasten the implementation timeline. We applaud CMS for seeking to increase the transparency of Medicaid reimbursement; at the same time, we think facilities should be required to show how much of their total revenue goes to resident care. Specifically, reporting requirements should include both the percentage of revenue spent on direct care workers and support staff as well as median hourly wages for each category of employees. Further, the data should be disaggregated by job duty since wages for different types of direct care workers and support staff are incredibly wide-ranging. Just posting broad categorical percentages or median hourly wages for a range of job classifications does not provide transparency as to how each type of worker is actually compensated. We also believe that nursing homes should be required to detail other expenses, including any payments to related parties. A strong nurse staffing standard and greater financial transparency in the sector are necessary prerequisites for any discussion of the need for greater nursing home reimbursement.

Conclusion

We heartily applaud the Administration for taking up the critical issue of nurse staffing in nursing homes. This is a critical issue as nursing homes continue to care for an increasing number of residents with high acuity. It is also an important issue as nursing homes are also increasingly the site of post-acute care for individuals with an acute care episode that requires a brief stay in a nursing home for rehabilitative care before returning to their homes.

CMS's initial efforts to define an appropriate minimum nurse staffing standard culminated in the 2001 Abt study, which sought to answer the critical question of whether staffing ratios were necessary to achieve high quality of care for residents. The answer then and now is a resounding "yes." But staffing ratios can be meaningful and effective only if they are designed to ensure that residents actually receive the care they need. We urge CMS to accept our recommendations and publish a final rule that requires appropriate staffing ratios.



Sincerely,

Action NC

AFL-CIO

Americans for Financial Reform Education Fund

Asian & Pacific Islander American Health Forum

Battle Born Progress

California Advocates for Nursing Home Reform (CANHR)

California Alliance for Retired Americans

California Long Term Care Ombudsman Association

Catholic Charities-Diocese of Rockford Long Term Care Ombudsman Program

Center for Medicare Advocacy

Citizen Action of New York

Citizen Action of Wisconsin

Consumer Federation of California

Disability Policy Consortium

Diverse Elders Coalition

Engage NH

Equal Rights Advocates

Families USA

Florida Alliance for Retired Americans

Friends of Residents in Long Term Care

Geriatric Circle

Granite State Organizing Project

Granite State Progress

Health Care For America NOW - Iowa

Health Care for America Now (HCAN)

Health Care Justice NC

Illinois Association Long Term Care Ombudsmen (IALTCO)

Illinois Long-Term Care Ombudsman Program

Iowa Citizen Action Network

Jewish Women International

Justice in Aging


Law Foundation of Silicon Valley

Legal Assistance for Seniors

LifePath, Inc in Greenfield, MA

Long Term Care Community Coalition

Lower Drug Prices Now - Iowa



Maine Long Term Care Ombudsman Program
Maine People's Alliance
Maine Veterans Home - Scarborough
Massachusetts State Long Term Care Ombudsman Program
Medicare Rights Center
Metro New York Health Care for All
Michigan Elder Justice Initiative
Michigan Long Term Care Ombudsman Program
National Association of Local Long Term Care Ombudsman (NALLTCO)
National Association of Social Workers (NASW)
National Association of State Long Term Care Ombudsman Programs
National Committee to Preserve Social Security and Medicare
National Consumer Voice for Quality Long-Term Care
National Disability Rights Network (NDRN)
National Urban League
New Hampshire Office of the Long Term Care Ombudsman
New Jersey Citizen Action
North Carolina State AFL-CIO
Office of the Kansas State Long-Term Care Ombudsman
Oregon Office of the Long Term Care Ombudsman
Our Mother's Voice
Pennsylvania Health Access Network
Pennsylvania Policy Center
Rise Up WV
Senior Advocacy Network
Senior Advocacy Services
Senior Services Coalition of Alameda County
SF Gray Panthers
The Breckenridge Trust
The Elder Justice Coalition
The Leadership Conference on Civil and Human Rights
The National Association of Nutrition and Aging Services Programs
(NANASP)
The National Women's Law Center
Vermont Long Term Care Ombudsman Program
Virginia Office of the State Long-Term Care Ombudsman
Virginia Organizing
West Virginia State Long-term Care Ombudsman Program
WISE & Healthy Aging
WV Citizen Action