

November 6, 2023

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Comments submitted by email, <http://www.regulations.gov>

Re: Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting, CMS-3442-P

Dear CMS Colleagues:

The National Consumer Voice for Quality Long-Term Care (Consumer Voice) submits comments regarding the Notice of Proposed Rulemaking (NPRM) published on September 6, 2023, that would implement a minimum staffing standard in nursing homes. Consumer Voice is the leading national voice representing consumers in issues related to long-term care. We are a primary source of information and tools for consumers, families, caregivers, advocates, and ombudsmen to help ensure quality care for the individual. Consumer Voice has nearly 50 years' experience advocating for quality nursing home care.

Consumer Voice strongly supports the proposed requirement that a nursing home have at least one registered nurse (RN) on site 24 hours per day, seven days per week. The current requirement of eight hours per day is insufficient and places residents at risk of harm.

While Consumer Voice supports the implementation of a minimum staffing standard, the proposed standard is too low and must be increased. Additionally, we oppose the proposal that will permit waivers/exemptions from requiring nursing homes to comply with a minimum staffing standard if they meet certain criteria. We urge CMS to reduce the timeframes for implementation and use a phased-in approach; and to adopt a more stringent system for monitoring and enforcing compliance with staffing standards. Consumer Voice supports increased Medicaid transparency regarding direct care wages but believes more can be done. While we support the proposed additions to the facility assessment regulation, we note that these additions will only be effective with proper guidance and enforcement.

Background

In 1987, Congress passed the Nursing Home Reform Act (NHRA) that implemented significant protections for nursing home residents, including the requirement that every skilled nursing facility provide “nursing services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.” 42 U.S.C. § 1395i-3(b)(4)(A)(i). Instead of requiring minimum staffing levels, the law and subsequent regulation called only for a registered nurse (RN) for at least 8 consecutive hours per day, 7 days per week; a licensed nurse 24 hours per day; and “sufficient staff” to provide care to all residents in accordance plans of care.¹ Despite longstanding complaints, concerns, and reports related to insufficient staffing and quality care in nursing homes, it took nearly a decade before CMS undertook to study the need for staffing levels in this setting.

As noted in the NPRM, CMS commissioned a years-long staffing study to determine “what nurse staffing thresholds are minimally necessary to provide care consistent,” with the NHRA of 1987.² The study (“2001 Study”) found that each nursing home resident needed at least 4.1 hours of direct care per (HPRD)ⁱ to avoid compromised care and to meet the statutory requirements of the NHRA.³

Rather than implementing this recommended minimum standard, CMS maintained the language for “sufficient”⁴ staff in regulation. As a result, nursing home residents across the country have experienced disparate levels of staffing for decades.⁵ Because of CMS’ failure to adopt the 4.1 HPRD standard, nursing home residents, their families, workers, and advocates have fought for years to have the standard implemented.

It was not until after 200,000 nursing home residents and workers died during the COVID-19 pandemic,⁶ that many people began to pay attention to the deficient quality of nursing home care in the United States. Despite only being .004% of the population of the United States, nursing home residents made up 20% of all COVID-19 deaths. Numerous studies⁷⁸⁹ have shown that understaffing contributed to the catastrophic effects of COVID-19 on nursing home residents.

On February 28, 2023, President Biden announced a historic set of reforms to improve quality care and safety in nursing homes.¹⁰ These reforms would bring much-needed transparency and accountability to the nursing home industry. Central to President Biden’s announcement was the implementation of a minimum staffing standard in nursing homes.

Since President Biden’s announcement, Consumer Voice has expressed unflagging support for a strong minimum staffing standard. In response to a Request for Information¹¹ from CMS, Consumer Voice submitted detailed comments¹² and recommendations, which called for a strong minimum staffing standard based on clinical evidence that ensured all nursing home residents received adequate care.

ⁱ Although discussed much further later in the comments, it is important to note that this minimum was composed of .75 HPRD of registered nurse (RN) care, .55 HPRD of licensed practical nurse (LPN) care, and 2.8 HPRD of certified nursing assistant care (CNA).

Staffing Matters

As CMS notes in the NPRM, it is indisputable that there is a strong relationship between higher staffing levels in nursing homes and better health outcomes for nursing home residents.¹³ In Consumer Voice's response to CMS' Request for Information last year, we provided dozens of citations to research that shows that nursing homes with higher staffing provide better quality care.¹⁴ Inadequate staffing in nursing homes is the fundamental driver of poor health outcomes for residents.

Workforce Challenges and Transparency and Accountability in Finances

Much has been made of workforce shortages in the nursing home sector over the past several years. CMS has clearly designed this NPRM to accommodate the assumed belief that there are not enough workers to staff nursing homes, especially in rural areas. Notably, these same concerns were brought up in the 2001 Study, which characterized the time as one of "workforce shortages."¹⁵

However, a closer look reveals that nursing homes are experiencing a job quality crisis. The average annual turnover of direct care staff is over 53.5% according to data from CMS.¹⁶ Another recent study estimated the national average for staff turnover to be 128%.ⁱⁱ Thus, the inability to retain staff is a critical factor in any apparent staffing crisis. The factors contributing to high staff turnover in nursing homes are well documented: poor wages and benefits, lack of training, bad management, lack of career advancement, and impossible workloads.¹⁷ Poor job quality has plagued nursing home workers for years, yet the nursing home industry has done little to address these underlying problems.

A 2016 article in the Journal of Nursing Home Research revealed that "Nursing homes have one of the highest occupational illness and injury rates in the United States (higher than coal mines, steel and paper mills, warehousing, and trucking)."¹⁸ The article notes several causes for the high rate of direct care worker injuries such as: high staff turnover; lack of proper equipment; and staff shortages. The report finds that these multiple factors are interconnected and, "This results in a vicious cycle as staff shortages result in overworked staff which in turn leads to higher injury rates which results in increasing staff turnover and shortages."¹⁹

Another factor contributing to difficulties attracting and keeping staff is low wages. The median annual income for a certified nursing assistant (CNA) is \$25,748,²⁰ which, according to the Massachusetts Institute of Technology living wage calculator, is 39% lower than the wage needed to support a single person with one child living in rural Pennsylvania.²¹ Forty percent (40%) of CNAs rely on public assistance.²²

ⁱⁱ 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.

The effects of poor wages and poor job quality fall heavily on women, particularly women of color. Ninety percent of CNAs are women.²³ Fifty-six percent of CNAs are people of color. Low wages perpetuate poverty among nursing home direct care staff.

Despite these dismal job characteristics, a look at current staffing data²⁴ shows that thousands of homes throughout the country are providing sufficient staffing, in excess of CMS' proposed standard. A large majority of these homes are non-profit.

Consumer Voice's analysis of staffing levels reveals a stark contrast between staffing in for-profit homes versus non-profit homes.ⁱⁱⁱ On average, non-profit nursing homes staff 23% higher than for-profit homes.²⁵ This fact was confirmed in the 2023 Abt Staffing Study (2023 Study), which found that non-profit, non-government operated homes staffed at, on average, 4.28 hours per resident day (HPRD).²⁶ In contrast, for-profit homes staff at an average of 3.57 HPRD, or 43 minutes less than non-profit, non-government run homes.²⁷ The 2023 Study notes that for-profit homes will have a much more difficult time meeting a staffing standard than non-profit homes.

Despite this vast chasm in staffing levels, the 2023 Staffing Study and Abt Associates do not investigate why these disparities exist. Why do non-profit homes staff more than 20% higher than for-profit homes? Instead of exploring this issue, CMS has suggested a staffing standard that gives tacit approval to for-profit nursing homes staffing their facilities at woefully low levels.

Consumer Voice strongly believes that there must be increased transparency and accountability in how nursing homes spend the tens of billions of taxpayer dollars they receive each year. It is well documented how nursing homes, particularly for-profit homes, employ a vast array of accounting practices that allow them to siphon billions of dollars each year through a web of related companies^{iv} that they own.²⁸²⁹³⁰ There is little to no accountability for how this money is spent. One nursing home chain's facilities paid their owners nearly \$124 million in "Home Office Costs" from 2018 to 2020.³¹ There is no information, however, describing what constitutes "home office costs," nor evidence that CMS has determined these costs to be reasonable and prudent, as required by federal guidance.³² Unsurprisingly, residents in this chain's facilities were receiving, on average, forty minutes less of direct care each day than necessary to prevent compromised care.³³ Nearly 75% of nursing homes use related parties³⁴.

To illustrate the results of these financial arrangements, Consumer Voice looked at staffing and cost reports for a series of nursing homes in North Carolina,^v all owned by the same for-profit company. The chart below shows the profits and losses reported by these homes on their Medicare cost reports for the years 2020-2022.

ⁱⁱⁱ Consumer Voice's analysis separated for-profit companies from all other homes, including government-run homes.

^{iv} Related party companies are companies with which nursing homes do business but have common ownership and control.

	Reported Profit or Loss			Total P/L
	2020	2021	2023	
Carolina Rivers Nursing & Rehab				
Harmony Hall Nursing	\$ 151,085.00	\$ (289,635.00)	\$ 40,635.00	\$ (97,915.00)
Riverpoint Crest Nursing & Rehab	\$ 843,336.00	\$1,546,175.00	\$2,254,259.00	\$ 4,643,770.00
River Trace Nursing	\$ 518,831.00	\$1,603,565.00	\$2,557,642.00	\$ 4,680,038.00
Premier Nursing and Rehab	\$1,781,188.00	\$2,243,371.00	\$4,325,992.00	\$ 8,350,551.00
Grantsbrook Nursing	\$ (864,127.00)	\$1,518,577.00	\$2,573,917.00	\$ 3,228,367.00
Cherry Point Bay Nursing	\$ 591,301.00	\$1,040,645.00	\$1,269,195.00	\$ 2,901,141.00
Croatan Ridge Rnursing	\$ 561,227.00	\$1,514,300.00	\$ 504,101.00	\$ 2,579,628.00
	\$ (187,900.00)	\$ 291,987.00	\$ 809,308.00	\$ 913,395.00
			Total	\$ 27,198,975.00

For the three-year period, the total profit made by these homes was nearly \$27.2 million. During that same time, these nursing homes paid to related party companies \$53.652 million dollars, \$11 million of which were “home office costs.” We do not know how much of those payments were profit to the related companies.

During that same period, these are the average wages these facilities reported on their Medicare cost reports.

Average Wages 2020-2022		
CNA	RN	LPN
\$14.27	\$28.40	\$23.59

While tens of millions of dollars in profits were flowing to owners, a CNA working in one of these homes was making \$14.27 per hour. RNs were being paid \$28.40, or only 65% of the national RN average wages according to the 2023 Staffing Study.³⁵ It comes as no surprise then, to see that staffing in these eight facilities is grossly inadequate, with average total staffing at 3.32 HPRD, almost an hour below the levels documented in these comments to keep residents safe.

When nursing home owners and operators divert money away from workers to profits, the result is poverty level wages, high turnover, and poor care for residents. With clear data that this practice is common across the country, it should not be assumed that for-profit facilities will be challenged to meet a staffing standard.

Requiring nursing homes to spend money on direct care to meet a minimum staffing standard is a critical step in creating better jobs and reducing turnover. Nursing homes will be forced to spend Medicare and Medicaid dollars on workers in order to reduce turnover and meet minimum standards. At the same time, Consumer Voice urges CMS to increase requirements holding nursing homes accountable for how

they spend taxpayer dollars, as well as increasing scrutiny of Medicare and Medicaid cost reports to determine how money is being spent, particularly on related party transactions.

The 2023 Staffing Study

After President Biden announced that his administration would implement a minimum staffing standard, CMS commenced a new staffing study. The study^{vi}, “Nursing Home Staffing Study, June 2023” (“2023 Study”) was conducted by Abt Associates, the same organization that conducted the “2001 Study”.³⁶ Because CMS relies on the 2023 Study in its NPRM, Consumer Voice will address several significant concerns about the study.

As noted previously, CMS conducted its 2001 Study, in part, to determine what staffing levels were necessary to conform with federal law.³⁷ Similarly, the 2023 Study’s goal was to determine “the level and type of staffing needed to promote acceptable quality and safety, so that residents are not at substantially increased risk of not receiving the safe and quality care they deserve.”³⁸

Despite the similarity in goals of both the 2001 Study and 2023 Study, the methodology and recommendations from the 2023 Study focus more on improving the quality of the very worst performing facilities while forgoing the more systemic goal of protecting all residents from being at a “substantially increased risk of not receiving the safe and quality care they deserve.”³⁹

For instance, the study authors created two measures to gauge quality and safety in nursing homes. These measures were derived from Care Compare^{vii} ratings. The Care Compare measures are relative in that they do not gauge clinical outcomes but measure one facility’s performance against all other facilities. It is a classic bell curve purposefully designed to have one-half of homes on each side of the median performing home.⁴⁰ Next, the study authors declared that they were going to establish thresholds for high-quality care at the 25th and 50th performance percentiles. In other words, the home that performed average on the quality and safety scores (50th percentile) were considered the benchmark for high-quality care^{viii}. The 2023 Study does not explain why these levels are considered acceptable or high quality. Yet higher performance percentiles were not examined. CMS justifies these levels in the NPRM by stating that these thresholds were “similar to other CMS nursing home improvement quality initiatives such as Value-Based Purchasing.”⁴¹

The goal of the Value-Based Purchasing Program is to “provide an incentive to LTC facilities for improving quality of care provided to residents.”⁴² This goal differs greatly from the goals of both the NHRA, and the

^{vi} The study was eventually published online by CMS at <https://www.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf>.

^{vii} Care Compare is a website maintained by CMS that provides certain information on each nursing home in the United States. CMS uses a five-star system to rate homes based on staffing, health inspections, and a quality metric. There is also an overall score based on a composite of the three measures. <https://www.medicare.gov/care-compare/>

^{viii} In the NPRM, CMS refers to its proposed staffing standard as providing high-quality care. (NPRM, p. 61369).

2023 Study itself, which is not seeking to provide incentives for improvement but to “determine the level and type of staffing needed to promote acceptable quality and safety.”⁴³ It is unclear why the principles of the Value-Based Purchasing Program would apply in this regulatory setting.

This focus on “improvement” is likely why the 2023 Study seems to purposefully avoid higher staffing levels. As documented in detail in our comments below, the 2023 Study continuously found evidence of a substantial increase in the likelihood of better quality and safety outcomes at higher staffing levels but failed to explore these levels or suggest them to CMS.

This practice is best illustrated in the recommendations the 2023 Study made to CMS regarding CNA care. The 2023 Study offered four CNA staffing levels, 2.15 HPRD (“Low”), 2.25 HPRD (“Medium”), 2.35 HPRD (“High”) and 2.45 HPRD (“Highest”).⁴⁴ Yet, the study, as noted by CMS in the NRPM, found that “staffing below 2.45 HPRD for [C]NAs did not improve safety and quality care for LTC facility residents.”⁴⁵ The 2023 Study provided CMS with three CNA staffing levels that would have no impact on resident care. This failure to provide CMS with other options for higher staffing levels will be discussed in more detail below.

This approach to minimum staffing conflicts directly with NHRA’s goal that nursing homes provide sufficient nursing staff to “attain or maintain the highest practicable physical, mental, and psychosocial well-being of **each** resident.”⁴⁶

Fortunately, while the 2023 Study’s recommendations are inadequate when compared to the statutory requirements, the study itself does provide support for a strong minimum standard, which will be discussed in detail below.

Consumer Voice strongly supports the requirement that a registered nurse be present twenty-four hours per day, seven days per week. CMS should require that the nurse be providing care, not “available” to provide care.

Consumer Voice strongly supports CMS’ proposal to require a nursing home to have an RN on staff twenty-four hours per day seven days per week.⁴⁷ Many studies have demonstrated that higher RN staffing levels result in better outcomes for residents, including:

- Increased functional improvement;^{48 49 50}
- Reduced incontinence;⁵¹
- Reduced urinary tract infections and catheterizations;^{52 53 54 55}
- Reductions in pain,⁵⁶ pressure ulcers;^{57 58 59 60 61 62} weight loss and dehydration,^{63 64 65 66} use of antipsychotics,^{67 68} restraint use,^{69 70 71} infections,^{72 73} falls,^{74 75} rehospitalization and emergency department use,^{76 77 78 79} missed care,^{80 81} adverse outcomes,⁸² and mortality rates.^{83 84}
- Higher RN staffing levels are strongly associated with fewer deficiencies.^{85 86 87}

Studies conducted during the COVID-19 pandemic found that increased staffing levels, including higher RN levels, led to fewer deaths from COVID-19.^{88 89 90}

In its 2022 report, *The National Imperative to Improve Nursing Home Quality*, the National Academy of Sciences, Engineering, and Medicine recommended the on-site direct care coverage of an RN (in addition to the director of nursing), at a minimum of 24 hours per day, 7 days per week.⁹¹ Additionally, the Academy recommended that the number of RNs present be adjusted for acuity and case-mix. This need for a twenty-four-hour RN presence has also been endorsed by the nursing home industry.⁹² Nursing facilities house populations with high needs and complex medical issues that require RN experience.⁹³

The NASEM report in recommending 24-hours per day, 7 days per week coverage stated that the RN coverage should be “direct care” and in addition to the director of nursing (DON)⁹⁴. We urge CMS to incorporate this requirement into the proposed regulation. As worded, the current proposal only requires an RN to be “on-site” and “available to provide direct care”.⁹⁵ This language will result in RNs whose only duties are administrative (DONs or Assistant DONs) being counted towards the requirement. It is not the presence of an RN in a facility that results in better outcomes for residents, but the actual provision of direct care by the RN.

We recommend that CMS change the proposed language to:

Except when waived under paragraph (e) or (f) of this section, the facility must have a registered nurse on site 24 hours per day, for 7 days a week who is providing direct resident care.

The proposed .55 RN HPRD minimum standard is too low and will place nursing home residents at risk of harm.

As noted above, decades of research, including the 2023 Staffing Study, demonstrate the relationship between better health outcomes and higher RN staffing levels. Small changes in RN staffing levels can have a huge impact on resident health outcomes. One study⁹⁶ found that an increase of just twenty minutes in RN staffing levels resulted in 22% fewer COVID-19 cases, and 26% less deaths. RNs are critically important to nursing home residents’ well-being.

Despite this evidence, CMS has proposed a minimum staffing standard for RNs that is too low. CMS’s justification for this RN level is that it is higher than every state’s minimum RN staffing standard.⁹⁷ However, and importantly, CMS has proposed a minimum standard well below the current national average of .67 HPRD of RN care.⁹⁸ This proposed standard could result in driving the national average down.

CMS relies on the 2023 Study to support its .55 HPRD RN proposal. CMS notes that its 2023 Study first identified a “statistically significant difference in safety and quality” at .45 HPRD of RN care.⁹⁹ Notably, this

level is the lowest level of RN care proposed by the 2023 Study.¹⁰⁰ However, according to CMS, the .45 HPRD RN requirement is associated with state RN minimums, which are in turn associated with “increased risk for unsafe and poor-quality care”.¹⁰¹ To avoid this relationship to state staffing standards, CMS added on .1 HPRD.¹⁰² This justification is not based on clinical outcomes or evidence but is merely to be higher than state standards.

The other justification CMS provides for the .55 RN HPRD is that it will result in a “large majority” of facilities having to increase their RN levels.¹⁰³ While .55 RN HPRD may result in many facilities having to raise their RN staffing levels, this does not mean that residents in those facilities will be receiving high-quality care. Rather, it is a symptom of how poorly nursing homes are currently staffed. Just because many facilities will have to raise their staffing levels does not mean that the level to which staffing is raised should be considered sufficient or high-quality care.

CMS does not explain why it adopted the lowest level of RN care proposed by the 2023 Study instead of a higher and safer level. In the 2023 Staffing Study, CMS is presented with four RN staffing level options, .45 RN HPRD (Low), .52 RN HPRD (Medium), .60 HPRD (Higher), .70 HPRD (Highest).¹⁰⁴ (2023 Study, p. xiv) While CMS relies on the 2023 Study to establish a “baseline” of .45 RN HPRD (before adding on .1 HPRD), there is no explanation as to why it did not consider the higher RN levels presented. The 2023 Study clearly documents better quality and safety outcomes as RN staffing levels are increased.¹⁰⁵ In fact, quality and safety outcomes increase nearly 10% between the “Low” and “Highest” levels proposed by the 2023 Study.¹⁰⁶ Yet there is no explanation from CMS as to why the lowest RN staffing level was used.

The 2023 Study included a simulation component looking at the levels of licensed nurse care necessary to reduce delayed and omitted care.¹⁰⁷ It is the only aspect of the 2023 Study that was based on observation by the study authors of actual direct care. The 2023 Study found that four licensed nurses per 70 residents were needed (1.4 HPRD) to keep delayed and omitted care below 10%.^{ix, 108} The 2023 study found that reducing licensed nursing to 1.0 HPRD, or three licensed nurses per 70 residents, would result in 19% delayed or omitted care.¹⁰⁹ It is worth noting that the current median licensed nursing level in the United States is 1.45 (HPRD).¹¹⁰

CMS has proposed a licensed nurse staffing level that the 2023 Study documented would result in 62.1% to 85.8% delayed or omitted care.¹¹¹ This rate of delayed and omitted care is too high. This high level of omitted care is the result, in part, of CMS failing to provide a staffing standard for LPNs, even though LPNs are included in the analysis of delayed or omitted care. Further, it is not acceptable to assume that nursing homes will provide licensed nursing over the .55 RN minimum, despite CMS’s claims to the contrary. There is no evidence for this assumption.

^{ix} We note that even a level of omitted and delayed below 10% is high. However, Abt estimated that the actual level of omitted care would be 2.5% (2023 Study, p. 74).

To properly protect all residents and reduce omitted or delayed care, CMS should implement a 1.4 HPRD licensed nursing staffing standard, of which .75 HPRD must be made up of RN care.

In 2001, CMS released the results of a multi-year study¹¹² (“2001 Study”) that looked at staffing minimums in nursing homes. The study found that to avoid compromised care nursing home residents needed, at a minimum, 4.1 HPRD of direct nursing care. This 4.1 HPRD standard was composed of .75 RN, .55 LPN, and 2.8 CNA HPRD.¹¹³ Since 2001, these numbers have served as the gold standard for staffing minimums and have been endorsed by multiple experts and organizations. Just recently, a study¹¹⁴ documented how nursing homes that staffed below the 2001 Study standard of .75 RN HPRD had a two times greater probability of resident COVID-19 infections.

The 2023 Study supports an RN staffing level of .75 RN HPRD, if not higher. Notably, the “Highest” recommendation made by Abt for RN care was .70 HPRD.¹¹⁵ Yet, Abt’s own analysis shows that quality and safety gains continued at .82 RN HPRD.¹¹⁶ In fact, there is nearly a 10% increase in quality and safety outcomes from .70 RN HPRD to .82 HPRD. (See Exhibit 1. These charts are taken directly from the 2023 Staffing Study).¹¹⁷ Despite these significant increases, neither Abt nor CMS examine nor entertain these higher levels. Instead, CMS has proposed a staffing level that is 27% lower than the 2001 recommended RN level.

Exhibit 1

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

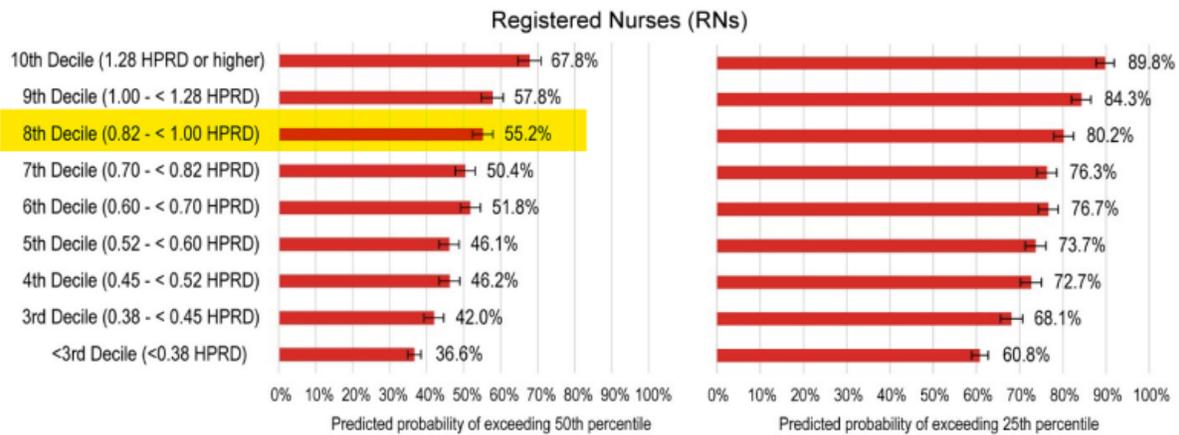
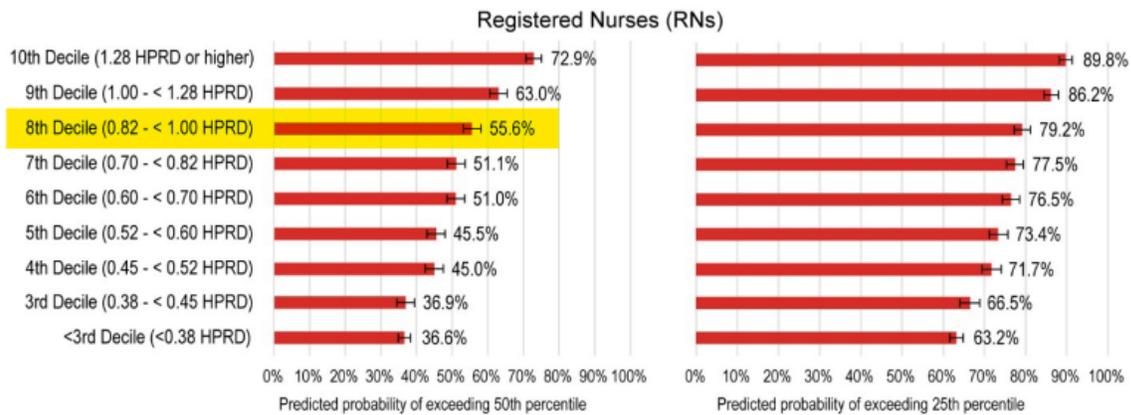


Exhibit 4.9: Predicted Probability of Exceeding Minimum Acceptable Standards for Weighted Health Inspection Survey Score Across Case-Mix-Adjusted Nurse Staffing Deciles, by Staff Type



The 2001 Study found that residents need, at least .75 RN HPRD to avoid compromised care.¹¹⁸ In the NPRM, CMS states that the 2001 study was conducted to determine:

- 1) [W]hether there is a nurse staffing ratio above which no additional improvements in quality are observed; and
- 2) [W]hat nurse staffing thresholds are minimally necessary to provide care processes consistent with the Omnibus Budget Reconciliation Act (OBRA) of 1987 optimal standards.¹¹⁹

This fact should have resulted in CMS and the 2023 Staffing Study investigating the 2001 Staffing Study levels to gauge their continued relevancy.

In the NPRM, CMS states that the:

“The 2001 study also reported that ‘minimum staffing levels at any level up to these thresholds are associated with incremental quality improvements, with the greatest benefits as these thresholds are approached.’ In other words, 4.1 HPRD was the highest HPRD...beyond which no further improvement in safety and quality are observed.”¹²⁰ (emphasis in original).

CMS uses this language to dismiss the 2001 study, because there were improvements in health and safety outcomes before 4.1 HPRD, and therefore 4.1 HPRD was just the maximum level. However, CMS seems to overlook the critical finding from the 2001 Study that at levels below 4.1 HPRD care in nursing homes is compromised. It is undeniable that as staffing increases in nursing homes, so do quality and safety outcomes. However, that fact cannot serve as the defining principle of a minimum staffing standard, otherwise, any staffing increase would be sufficient. The goal of a staffing minimum must be to ensure that care in nursing homes is “consistent with the Omnibus Budget Reconciliation Act (OBRA) of 1987 optimal standards.”¹²¹

Nevertheless, the 2023 Study shows strong support that the staffing levels from the 2001 Study are still relevant and critical to resident safety, particularly .75 HPRD RN requirements.

As noted previously, and demonstrated in Exhibit 1, the 2023 Study showed significant increases in the likelihood of positive safety and quality outcomes at .82 RN HPRD. This factor alone should have resulted in both the authors of the 2023 Study and CMS considering a higher RN staffing level, particularly as these higher levels supported the 2001 study. At the .82 RN HPRD level, quality and safety outcomes increase significantly. Why were these levels not examined? Instead, the study's authors stopped their analysis at .70 RN HPRD.

The simulation study conducted by the authors of the 2023 Study that examined omitted and delayed care also supports a higher RN staffing level. The simulation study found that 4 licensed nurses (1.4 HPRD of licensed nurse care) per every 70 residents were needed to keep the rate of omitted and delayed care below 10%.¹²² In fact, this level would virtually eliminate delayed and omitted care as it pertains to RNs. In contrast, CMS has proposed a licensed nurse minimum standard of .55 RN HPRD. Their own study demonstrates that at this staffing level of .55 RN HPRD, rates of delayed and omitted care could be as high as 85.6%.¹²³

The 1987 Nursing Home Reform Act (NHRA) requires that a skilled nursing facility must provide “nursing services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.”¹²⁴ The RN staffing level proposed by CMS falls far short of this goal. In the absence of any requirement that facilities provide additional licensed nurse care, residents could be subject to delayed and omitted care between 62.1% and 85.8%.¹²⁵ It is clear this result would be violative of the NHRA.

Notably, if CMS’s alternative “total minimum” of 3.48 HPRD were adopted, (assuming that the additional .48 HPRD was licensed care), it would still result in 19% delayed or omitted care daily for residents.¹²⁶ This level of care could result in 266,000 nursing home residents receiving delayed or omitted care each day. This amount of delayed or omitted care is unacceptable and contrary to the NHRA.

A staffing level of .75 RN HPRD is supported by the 2023 Study, the 2021 Study, and other evidence. However, to ensure that residents do not go without care and are not subjected to delayed care, CMS should implement a total licensed staffing standard of 1.4 HPRD. CMS should require that at least .75 HPRD of the total licensed staffing standard be composed of RN care. At this level of licensed nurse staffing, residents will receive care commensurate with the mandates of the NHRA.

Importantly, this licensed nurse requirement will allow facilities flexibility to use LPN/LVNS to meet the portion of the 1.4 HPRD total not composed of the .75 HPRD RN minimum. LPNs are critical to nursing home care in that they provide critical services such as providing medications and other treatments,

tasks that are not within a CNAs scope of practice. They support RNs in their work. Additionally, they are less expensive than RNs. By allowing LPN hours to go towards the 1.4 HPRD licensed nurse requirement, CMS will be providing facilities with the flexibility to meet the standard.

The minimum standard proposed by CMS of 2.45 HPRD of CNA care is too low and will result in unacceptable levels of harm and omitted care to residents.

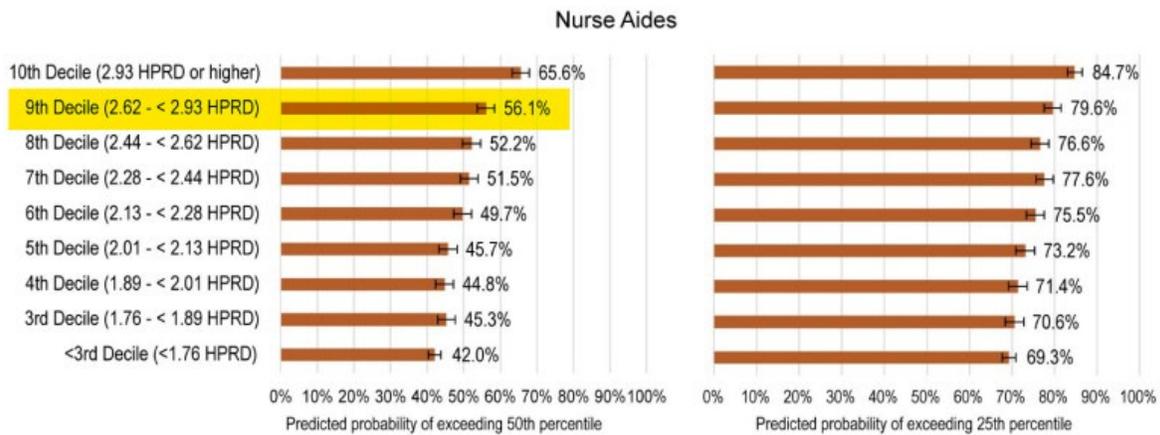
CNAs provide the vast majority of direct care each day to nursing home residents.¹²⁷ CNAs help residents with aspects of daily living, such as bathing, eating, dressing, and transferring.¹²⁸ When facilities have inadequate CNA staff, the quality of life for residents is degraded, resulting in residents waiting hours to be fed, dressed, have adult diapers changed, or have their call bell answered. CNAs are critical to the health and well-being of nursing home residents.

CMS has proposed a CNA HPRD staffing minimum that would place all residents at risk of harm. CMS relies solely on the 2023 Study in its proposal to establish a 2.45 CNA HPRD.¹²⁹ In selecting the 2.45 HPRD, CMS ignores significant evidence that this will result in significant levels of omitted care for residents. The justification offered by CMS for this staffing level is not based on the requirement in OBRA '87 that all nursing homes must provide "nursing services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident."¹³⁰ Instead, CMS justifies this level of care by stating it is higher than all state minimum HPRD requirements.¹³¹ This metric is not one on which a staffing standard should be based.

Critically, the 2023 Study failed to consider and propose CNA staffing levels higher than 2.45 HPRD, despite noting that research has shown that nursing home residents need at least 2.8 HPRD of CNA care each day to keep omitted care below 10%.¹³² The 2023 Study continued to find statistically significant differences in resident safety at CNA staffing levels beyond 2.45 HPRD.

2.45 CNA HPRD was the first level at which the 2023 Study detected a positive relationship between CNA care and the likelihood of positive health and safety outcomes.¹³³ Yet, the study results show that the likelihood of better safety outcomes continued at levels beyond the 2.45 HPRD. As (Exhibit 2) documents, significant increases in the likelihood of better safety outcomes occur at 2.62 HPRD and higher.¹³⁴ The failure to examine and propose higher levels to CMS limited the choices from which CMS could choose.

Exhibit 2



The 2023 Study offered four CNA staffing levels for CMS to consider: 2.15 HPRD (Low), 2.25 HPRD (Medium), 2.35 HPRD (Higher), and 2.45 HPRD (Highest).¹³⁵ The 2023 Study offered these levels, despite the study finding that three of these levels had no impact on the likelihood of better quality and safety outcomes.¹³⁶ Even CMS notes that “staffing below 2.45 HPRD for CNAs did not improve safety and quality care for LTC facility residents.”¹³⁷

In its recommendations to CMS regarding the RN staffing levels, the 2023 Study offered four RN staffing levels, all of which increased the likelihood of better quality and safety outcomes.¹³⁸ The first level recommended, .45 RN HPRD, was the level at which the study first observed a positive relationship with quality and safety outcomes, similar to the 2.45 CNA HPRD.¹³⁹ Importantly, the .45 HPRD was used as the **lowest** RN recommendation to CMS, and the three subsequent levels suggested were all higher.¹⁴⁰

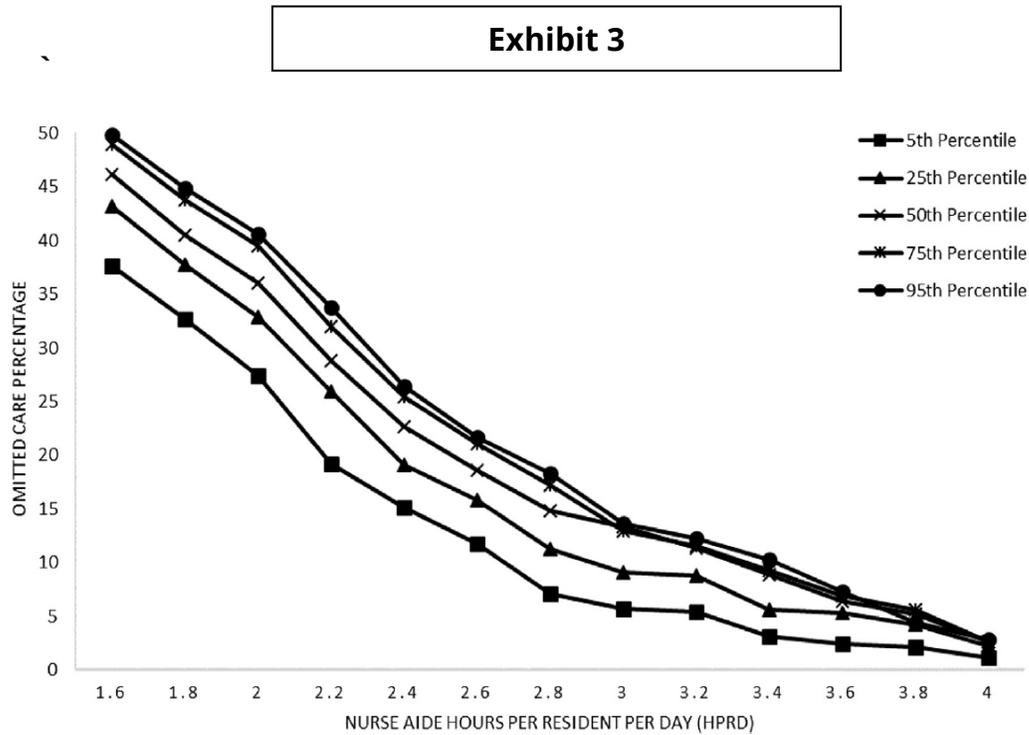
Rather than offering CMS four CNA staffing levels that would increase quality and safety outcomes, the 2023 Study proposed three of four CNA staffing levels that would have no positive impact on residents. Essentially, CMS had only one choice, 2.45 CNA HPRD to choose from, since the other levels were shown to have no impact on care quality. Similar to the RN HPRD, the 2023 Study should have used the 2.45 HPRD as the “Low” recommendation, while the “Medium” should have been 2.62 HPRD, and the highest 2.93 HPRD^x.

The 2023 Staffing Study did not conduct a simulation study to determine the CNA HPRD necessary to reduce omitted care. Instead, the study relied on “The Schnelle Study” from 2016.¹⁴¹ The Schnelle study found that, based on resident acuity, each nursing home resident needed 2.8 to 3.6 CNA HPRD to keep omitted care below 10%¹⁴² The 2.8 HPRD represented the lowest acuity facilities, or the 5th percentile, while the 3.6 HPRD represented the highest acuity facilities, or 95th percentile. The chart below

^x In the 2023 Study, there were only three CNA levels that had documented positive impact on quality and safety.

demonstrates that to get omitted care below 10% for the average acuity homes (50th percentile), roughly 3.6 HPRD CNA was necessary.

Importantly, the Schnelle study offers us a look into the levels of omitted care for 2.45 CNA HPRD, the proposed level by CMS. As the chart below demonstrates for the lowest acuity homes (5th percentile), omitted care would be at or near 15%.¹⁴³ As a resident's acuity rises, so does omitted care. The nursing homes with average acuity, according to the Schnelle Study, would experience between 20-25% omitted care daily at the proposed 2.45 CNA HPRD level. This level of omitted care would amount to 20-25% of residents residing in an average nursing home going without care every day.



It is important to point out that these omitted care levels for CNAs are completely omitted from the recommendations to CMS in the 2023 Staffing Study.¹⁴⁴ While the study authors offer omitted care levels for all four suggested staffing levels, these are only for licensed nurses.¹⁴⁵ The omitted care numbers would increase dramatically if the study correctly used the Schnelle Study omitted care levels. As a result, CMS and the public may think that the staffing levels suggested by the CMS study account for all omitted care, when in fact, the proposed levels would result in in over 15% omitted care.

To ensure resident safety and to reduce levels of delayed and omitted care, CMS should adopt a CNA HPRD minimum of at least 2.8 HPRD.

As noted previously, the 2023 Staffing Study continues to show a positive relationship between higher CNA staffing levels and safety outcomes beyond the 2.45 HPRD. For instance, there is an increase in the likelihood of positive safety outcomes of 8.4% between the 2.44 HPRD and 2.62 HPRD levels.¹⁴⁶ (However, the greatest increase in the likelihood of better safety outcomes is from 2.62 HPRD to 2.93 HPRD, with an increase of 16.9%.¹⁴⁷

The 2001 Staffing Study found that, at a minimum, nursing home residents require 2.8 CNA HPRD to avoid compromised care.¹⁴⁸ Importantly, the 2.8 CNA HPRD was later confirmed in another study¹⁴⁹, which showed that nursing homes that staff over 2.8 CNA HPRD performed better on 13 out of 16 care processes when compared with lower-staffed nursing homes. The level of staffing was again confirmed in the Schnelle Study in 2016.¹⁵⁰ As discussed supra, the Schnelle Study found that, for the lowest acuity homes, 2.8 CNA HPRD was necessary to keep omitted care below 10%.

Similarly, to the RN staffing levels, CMS disregards the 2001 Staffing Study when proposing the 2.45 HPRD. Yet over twenty years ago this study determined that residents needed 2.8 HPRD to avoid compromised care.

Taken in conjunction with the 2001 Study, the Schnelle Study, and the 2023 Study, a minimum CNA HPRD of 2.8 HPRD should be adopted by CMS. 2.8 HPRD would keep the level of omitted care below 10% for the lowest acuity homes, contribute to the reduction of compromised care, and result in the increased likelihood of better quality and safety outcomes.

CMS should use the term CNA, not NA.

Consumer Voice expresses concern that throughout the NPRM, CMS refers repeatedly to nursing assistants or NAs. The 2023 Staffing Study did not consider staffing levels for any category of nursing staff other than CNAs, LPNs, and RNs. We are concerned that CMS is using the term NA to indicate a broader group of nursing home workers other than CNAs. We strongly oppose the inclusion of any staff in a minimum staffing standard that are not CNAs, LPNs, or RNs AND providing direct care to residents. CMS has no scientific or empirical basis upon which to create a minimum staffing standard composed of any class of direct care staff other than CNAs, LPNs, and RNs.

CMS must provide detailed regulations and guidance on staffing to resident acuity levels.

CMS devotes significant space to discussions of acuity in the NPRM. The NPRM makes clear that any staffing minimum is just that, a minimum and nursing homes will be required to staff according to the

acuity needs of all residents.¹⁵¹ The proposed regulations regarding facility assessments stress that nursing homes must conduct acuity assessments and provide staff to meet the needs of all residents.¹⁵² Notably, this has been the staffing model (sufficient staff) for decades and has resulted in the disparate levels of staffing and care we see across the country today.

Despite the NPRM's emphasis on acuity, CMS provides no guidance as to what staffing to acuity requires. Absent regulatory guidance from CMS on acuity, we will be continuing the status quo, where facilities determine what it means to have "sufficient" staff.

Staffing to meet a resident's needs is the central tenet of the Nursing Home Reform Act of 1987, OBRA. Although mentioned previously, it is worth noting the language of that law again. Each nursing home must provide:

"nursing services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of **each resident.**" 42 U.S.C. § 1395i-3(b)(4)(A)(i).

Each nursing home must provide enough direct care staff to meet the acuity needs of each resident every day and on every shift. A minimum staffing standard is just a floor. CMS acknowledges the varying acuity needs of residents in its' Medicare Prospective Payment System, the Patient Driven Payment Model (PDPM), which assigns different levels of payment to providers based on the care needs of residents. Although CMS pays nursing homes based on resident acuity, it does not use the PDPM framework to establish or enforce staffing requirements or to ensure that facilities actually use Medicare dollars to provide that level of care.

In a landmark 2020 paper¹⁵³, researchers assigned staffing level needs to the PDPM system acuity levels by using the 2001 staffing standard, along with the Schnelle study on CNA staffing levels. The study proposed six separate minimum staffing levels, each of which corresponded to an acuity level in the PDPM. 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 (MDS) assessment forms to determine the level of care for each resident. Then, the MDS data is used to determine care needs and payment levels under the PDPM system. CMS has stopped short of prescribing a staffing system based on acuity, despite having the means to do so. We urge CMS to adopt the model illustrated in the 2020 paper or to develop a similar model where each acuity level has been prescribed.

The need for an acuity model is highlighted by CMS's poorly worded language in the NPRM, which will confuse and mislead nursing homes. The troubling language occurs on page 61369 of the NPRM.

“Additionally, the proposed staffing levels require all facilities to meet at least this minimum floor, **even if the facility has below average acuity**, given that resident population can shift more rapidly than staffing plans; **most facilities have either an average acuity or higher** of resident population; and as noted above, the evidence can also support a higher range of staffing.”

First, it is important to point out that “most” facilities cannot be average or higher. That is not how averages work. The average home will be in the middle, while the rest of the homes will be divided evenly above or below that average. Despite this error, CMS is implying in this paragraph that the 3.0 HPRD proposed staffing minimum is synonymous with “average acuity.” Again, later in the NPRM on page 61370, CMS states “based on the needs of its resident population, an individual facility may need to maintain levels of HPRD...that surpasses the proposed minimum nursing staffing HPRD.” This language gives the impression that staffing at 3.0 HPRD will meet the acuity needs of the average nursing home resident. That is not accurate.

The staffing levels proposed by CMS and suggested by the 2023 Study were based on quality measures and health inspection ratings and how facilities performed compared to each other on these ratings. The two performance thresholds of 25% and 50% were chosen based on value-based purchasing models (cite) and not on clinical outcomes. No determinations were made regarding average acuity, and the staffing minimum is in no way designed to address the “average acuity” of a resident.

The association is incorrect and will lead facilities to conclude that the average acuity resident needs are met if they meet CMS’ proposed staffing standard. CMS should correct this presumption in the final rule.

The proposed time frames for rural facilities are too long and will harm residents in rural facilities. Additionally, CMS should phase in implementation.

Consumer Voice does not support the proposed implementation timeframes for rural facilities.¹⁵⁴ Much has been made of the concern about the impact on rural facilities, yet the 2023 Staffing Study found that staffing in rural and urban facilities is almost identical.¹⁵⁵

	# of Facilities	RN	LPN	CNA	Total
Urban	10,973	.67	.91	2.21	3.80
Rural	4,174	.64	.80	2.23	3.66

While there are challenges to many parts of the healthcare sector in hiring and retaining various levels of staff, we do not find evidence that this challenge is significantly different for rural homes as compared to urban and suburban employers. CMS is proposing to allow nursing homes in rural areas to implement the minimum standard five years from the implementation of the final rule.¹⁵⁶ This timeframe means that

many residents will continue to reside in nursing homes with inadequate staffing for seven more years.^{xi} The amount of time is unacceptable. All residents deserve and are entitled to have their needs met, regardless of whether they live in rural or urban areas.

We urge CMS to reduce the implementation time for rural facilities to be commensurate with the urban timeframes. Additionally, CMS should phase in implementation by creating reasonable benchmarks for increasing staffing that are spread over that timeframe. Failing to do so will result in some nursing homes waiting until the last minute to staff their facilities, which will be extremely difficult. Phasing in the implementation will also ensure residents begin to feel the benefit of adequate staffing sooner.

As proposed, CMS would be creating two levels of resident care based on geography. While staffing shortages may be an issue in some areas, it is an issue in urban and rural areas as evidenced by the 2023 Study. CMS is proposing to treat residents who reside in one-third^{xii} of the country's nursing homes differently than their urban counterparts. We urge CMS to make the implementation of the rule identical, regardless of whether the facility is rural or urban, and to phase in implementation.

On the proposed twenty-mile radius, Consumer Voice does not find data supporting the idea that distances beyond 20 miles specifically hinder an employer's ability to attract and hire needed staff. While transportation is a particular challenge to lower-income workers in rural areas, the Brookings Institute found similar challenges faced by workers in urban areas. For example, in a rural area, the need to own, insure, and maintain a vehicle is much more pronounced due to the lack of public¹⁵⁷ transportation. In urban areas, public transportation is usually available, but other costs like housing, are far higher than in rural areas. In other words, both sets of workers, rural and urban, face challenges and Consumer Voice does not believe there is a reason to single out rural areas as particularly difficult areas for nursing home staff recruitment.

CMS cannot rely solely on enforcement of the staffing standard through the survey process.

There is little in the NPRM regarding enforcement of the minimum staffing standard and the twenty-four hour, seven-days-per-week RN requirement. However, Consumer Voice opposes CMS's proposal to enforce the staffing standard solely through the survey process. For nursing home residents to be assured of adequate care, CMS must take proactive steps to use additional methods to ensure compliance, including quarterly monitoring of staffing levels. CMS has access to facility-level staffing data and is in a unique position to monitor and enforce the staffing standard on an ongoing basis. Adequate staffing is a matter of life and death. It does not make sense to allow inadequate staffing to go unchecked until a survey is completed. This practice could result in residents waiting months for the standard to be enforced, and during that time, suffer preventable harm and neglect.

^{xi} While the timeframe is unclear, it will be months before this final rule is implemented. In addition, as proposed, the standard will be assessed during a general survey, which could result in another fifteen months after the five-year implementation period is in place.

^{xiii} According to the 2023 Study, there are 10,973 "urban" homes and 4,174 "rural homes. (2023 Study p. 45).

CMS is well aware of the obstacles facing state survey agencies, including flat funding, workforce shortages, and backlogs.¹⁵⁸ This past year, the Senate Aging Committee released a report, “Uninspected and Neglected”, that found state survey agencies to be stretched to the brink. According to the study, 31 state survey agencies have surveyor vacancy rates at 20% or higher.¹⁵⁹ One in nine nursing homes had not undergone an annual inspection in over two years.¹⁶⁰ These shortages are, in part, attributable to flat funding from Congress for survey and enforcement for the past ten years.¹⁶¹ These stark facts also support CMS taking a more proactive role in enforcement by frequently using the payroll-based journal data to ensure compliance with a minimum staffing standard. CMS must take a central role in monitoring staffing data, issuing penalties, and addressing critical staffing situations when they arise.

While the NPRM does acknowledge that CMS has “been moving towards more data-driven enforcement,” it suggests that because a required standard will be a minimum, it will be important to have state survey agencies assessing the overall staffing of a facility.¹⁶² While Consumer Voice agrees that nursing homes must staff to residents’ acuity, this fact does not mean CMS cannot enforce a minimum standard at the same time using data.

The staffing levels suggested by Consumer Voice in these comments ensure that levels of delayed or omitted care are not at unacceptable levels. Facilities that staff below these suggested levels will be providing inadequate care, including unacceptable rates of omitted or delayed care. In these instances, there will be no need for state surveyors to do a facility-wide acuity assessment, because the facility is not even meeting the minimum standard. While an acuity assessment will be necessary to ascertain compliance for facilities that exceed the minimum standard, it will not require an assessment to ascertain whether a facility is meeting the minimum standard. CMS and state surveyors can enforce both a staffing minimum and staffing to resident acuity independent of each other.

CMS notes that in 2022 over 1,000 facilities were cited for insufficient staffing.¹⁶³ According to [qcor.cms.gov](https://www.cms.gov), in fiscal year 2022, there were 1,164 citations for inadequate staffing, but 1,068 (92%) of these violations were found to be “no harm.” State survey agencies routinely ignore inadequate staffing unless they can discover some actual physical harm to residents. This practice cannot continue. Inadequate staffing is harmful to residents.

CMS must use strong remedies to enforce the minimum staffing standard and resulting care issues from inadequate staffing, including denial of payments for new admissions and automatic civil monetary penalties. The minimum staffing standard proposed in our comments is designed to significantly reduce instances of delayed or omitted care. Facilities that do not meet the minimum are providing inadequate care, thus CMS must not continue to pay facilities for new admissions until the facility has documented its ability to provide staffing at the minimum level. It is intolerable for CMS to recognize that a facility does not meet a staffing standard, but then allow that facility to admit new residents and put them at risk of harm and poor care.

To ensure compliance CMS should implement automatic CMPs for failing to meet the staffing standard. CMS should develop a system that flags facilities that are consistently operating at levels below the staffing minimum and assess a penalty. This practice will ensure that facilities are focused on adequate staffing throughout the year, and not just at the time of the annual survey, as so often happens today. It is impermissible to allow facilities to face no penalties until an annual survey is completed. During that time, residents are suffering in facilities providing inadequate care.

Too often, nursing home residents face dehumanization because of policies that condone bad care. CMS must acknowledge that inadequate staffing places all residents at risk of harm and use a robust enforcement strategy to ensure compliance.

The costs of properly staffing to a minimum standard are a small fraction of the annual revenues for nursing homes.

Consumer Voice will not address, in-depth, the cost estimates made by CMS in the NRPM, as we feel the staffing levels associated with these costs are insufficient. Additionally, as proposed, the costs do not account for the likelihood that many, if not most, nursing homes will simply reduce their LPN hours to meet the CNA or RN minimums. As a result, many facilities will likely save money when they reduce their LPN numbers to meet the proposed CNA requirements.

By collecting national expenditure data, CMS is able to make expenditure projections by year. According to CMS's most recent projections, the total amount of expenditures from all payment sources for nursing facility care and continuing care retirement communities will be \$224 billion in 2026¹⁶⁴, the year that these regulations would likely go into effect. The \$224 billion includes \$50.28 billion in Medicare spending and \$61.41 billion in Medicaid spending. Importantly, the \$224 billion will be revenues to these industries.

A recent study¹⁶⁵ by the nursing home industry found that it would cost \$7.25 billion dollars annually to meet the 4.1 HPRD standard, as proposed by the 2001 Study. By 2026, this will amount to 3.2% of the \$224 billion in revenues of the nursing home and continuing care retirement community industries. Under the industry cost study estimates, it would cost nursing homes approximately \$16 more per day per resident to meet recommended minimum staffing levels.

Critically, there are billions of dollars that go unaccounted for each year that are funneled through related party transactions and other questionable accounting practices.¹⁶⁶ CMS does not hold nursing homes accountable for the tens of billions of taxpayer dollars they receive each year. Yet, the NPRM focuses heavily on costs and feasibility. We cannot just assume that new money is needed to implement a minimum standard. CMS must take immediate action to ensure transparency and accountability of federal dollars going to nursing homes.

Hardship exemptions should not be allowed. CMS should not permit and endorse the provision of care to nursing home residents that places them at heightened risk of harm or death.

Consumer Voice opposes hardship exemptions for facilities that claim they are unable to meet the minimum staffing standard. The staffing levels proposed in Consumer's Voice comments keep delayed and omitted care below 10% and are documented to have significant positive impacts on quality and safety outcomes. Allowing nursing homes to staff below these proposed levels would place residents at a heightened risk of harm due to high rates of omitted and delayed care and would compromise health and safety outcomes. CMS cannot create a two-tiered health system where some residents are living safely, while others are subjected to dangerous and unhealthy conditions.

The fact that CMS is considering issuing exemptions highlights how impractical it is to base a staffing standard on anything other than clinical outcomes and research. How do you balance the needs of a resident to be safe and receive quality care with the interests of ease of visitation and access to family? Why is it acceptable to have a facility operate at a level that harms residents rather than closing down? CMS asks nursing home residents, their families, and their supporters to make these untenable choices between living in a facility providing care at levels that are documented to hurt residents and other non-medical considerations.

With this Consumer Voice position in mind, we offer the following comments, should some sort of hardship exemption remain in the final rule.

If there are to be any exemptions to safe and high-quality staffing levels, the exemption should only be six months. During that time, facilities should be under heightened scrutiny from CMS and state surveyors. In addition, facilities should be required to:

- Create a specific staffing plan to get them into compliance. This plan should be separate from the facility assessment and must be approved by CMS. The staffing plan should require achievable benchmarks that facilities are required to report on quarterly.
- Be subject to a survey three months after the exemption is granted.

CMS must issue a ban on payments for new admissions to facilities out of compliance with staffing requirements. CMS should not allow a facility to admit new residents when they have demonstrated that they are incapable of meeting the care needs of current residents. The ban on payment for new admissions must not be lifted until the facility has documented that it is meeting the minimum standard.

CMS should initiate enforcement actions including citations for under-staffing at the resident harm level and a directed plan of correction for facilities that are not meeting the staffing requirements. While a waiver is active facilities must not be allowed to discharge residents to reduce census to meet the staffing standard. CMS should issue specific guidance to survey agencies requiring increased scrutiny of involuntary discharges during the exemption period.

At a maximum, any renewals of hardship exemptions should extend the waiver for one additional six-month period if the nursing facility has documented progress in addressing inadequate staffing.

Location-based exemptions should be removed from the final rule.

Consumer Voice recommends that CMS remove the provision that allows nursing homes to meet the location prong of the exemption criteria by showing there is not another facility within twenty miles. It is clear from the NPRM that CMS had no empirical support for treating residents in rural facilities differently from other nursing home residents, let alone establishing a twenty-mile radius requirement.

CMS claims that this considers the effect distance has on family visitation and participation in care.¹⁶⁷ If this is CMS's concern, why would it not base the exemption on time? For individuals driving in rural areas it will be much quicker to travel twenty miles than individuals traveling, for instance, five miles, in some urban areas. Traveling long distances is a fact of life in rural areas. CMS has no evidence to show that having a twenty-mile radius will alleviate the staffing needs or travel burden on residents' families. This provision should be removed.

CMS asks whether it should use 20% or 40% below the national average when gauging supposed shortages in certain geographical areas. Because CMS has no evidence to support either number, it should refrain from issuing a regulation based on this measure. CMS offers no evidence or support that the proposed measures are appropriate when determining the availability of nursing staff in a certain nursing home. CMS is simply assuming it does. Instead, CMS should study whether the proposed metropolitan statistical area (MSA) measure correlates with nursing home staffing and then make a decision as to its efficacy as a predictor of staffing in nursing homes. Until then, CMS should not implement this provision.

CMS Should Require NHs To Pay Competitive Wages and Living Wages

The draft regulation proposes that facilities could be granted hardship waivers for demonstrating "good faith" efforts to hire and retain staff, part of which is described as "...offering at least prevailing wages."¹⁶⁸ Prevailing wages are those comparable to what other nursing facilities pay in an area and CMS presumes that paying prevailing wages are sufficient.¹⁶⁹

Low wages, low benefits, and heavy workloads are the primary causes of worker shortages and high nursing turnover rates. RNs in nursing homes receive much lower wages than hospital-employed RNs.¹⁷⁰ The Bureau of Labor Statistics reports that RNs in hospitals made an average of \$43.56 per hour compared to RNs in NHs who made only \$37.11 per hour or 15 percent less. Nursing facilities must also

compete with non-nursing facility employers in the area to attract staff. Despite the fact that the CMS PPS Medicare payment system uses hospital wages when calculating the annual Medicare SNF payment rates, many nursing facilities do not pay that rate.¹⁷¹

The majority of resident care is provided by Certified Nursing Assistants (CNA) who are paid low wages (averaging \$16.90 per hour and an annual income of \$35,160 in 2022).¹⁷² CNA wages in nursing homes are lower than wages in hospitals which were \$18.18 per hour in 2022. They are also less than for comparable entry-level jobs for retail salespersons and customer service representatives.¹⁷³ Altogether, 12 percent of nursing home workers live below 100 percent of the federal poverty level, while 38 percent live in low-income households.¹⁷⁴

Additionally, 34 percent of workers require some form of public assistance, including Medicaid, food, and cash assistance. Many employees do not have sick leave and therefore cannot afford to stay home from work which contributed to the spread of COVID-19.¹⁷⁵

CMS must require nursing homes seeking a waiver from the regulations to offer wages that are at least competitive with hospital wages and other jobs that require comparable skills, otherwise, nursing homes will continue to lose workforce to hospitals. CMS should require that nursing facilities pay workers a “living wage” which is one that would “enable a full-time worker to pay for their family’s basic housing, food, transportation, and health care needs out of their own earnings, without the need to rely on public assistance.”¹⁷⁶ Research shows that raising the pay of direct care workers to the living wage would translate into meaningful wage gains for the lowest-paid CNAs, improve productivity, and have a significant effect on the overall economy.^{177 178} A study conducted by the non-profit nursing home industry found that increasing wages for workers would pay for itself in care quality gains.¹⁷⁹

By failing to implement wage requirements, CMS will be contributing to the nursing staffing shortages because nursing homes will be able to avoid paying competitive wages. If CMS does issue waivers, it must require facilities to demonstrate they are offering and paying competitive wages on par to those in hospitals, as well as a living wage. In order to reduce turnover, this demonstration must be for all workers, not just for potential new hires. The use of “prevailing wage” will simply perpetuate the shortages already present in nursing homes.

CMS also asks for input on staff retention efforts facilities must pursue to be eligible for a staffing requirement exemption. Staff turnover is a chronic and severe problem across the long-term care industry. Reasons for turnover include low wages, inflexible work schedules, lack of job safety, lack of career advancement opportunities, lack of paid time off and other benefits, and a culture of disrespect for direct care staff.¹⁸⁰ For a facility to qualify for an exemption, it must submit a specific plan that addresses these, and any other facility-specific factors not listed here with strategies they will undertake during the exemption period to reasonably reduce the facility turnover rate.

This plan must include documenting that a facility is:

- Offering training programs for all staff that ensure competency for particular positions.
- Increasing and documenting increases in wages and benefits.
- Implementing and documenting strategies to reduce worker injuries.
- Providing an input channel (one-on-one meetings with supervisor, written surveys, or other methods to gather staff input) for staff to tell nursing home operators what would keep them at their jobs.

Demonstrated financial commitment must be defined with specific measures included.

CMS proposes to require that nursing homes demonstrate a “financial commitment” to staffing by documenting the “financial resources that the LTC facility expends annually on nurse staffing relative to revenue”.¹⁸¹ Little more is offered as to what “financial commitment” means. Later, CMS seems to indicate that this could be some sort of minimum spending threshold for direct care staff and asks what this threshold should be.¹⁸²

Consumer Voice strongly supports holding nursing homes accountable for dedicating necessary funds towards providing care for residents, which includes the implementation of a minimum spending threshold on direct care spending. As noted in the NPRM, CMS recently proposed a similar requirement of 80% for home health agencies providing Medicaid-funded home and community-based services.¹⁸³

The NPRM admits that the “lack of transparency, regarding nursing home finances, operations, and ownership impedes the ability to fully understand how current resources are allocated.”¹⁸⁴ Consumer Voice agrees and has repeatedly called for increased transparency and accountability for how nursing homes¹⁸⁵ spend taxpayer dollars. As the agency responsible for ensuring taxpayer dollars are going towards resident care, CMS must take steps to understand how nursing homes currently spend the tens of billions of Medicare and Medicaid dollars they receive annually.

The NPRM seems to imply that the opacity of nursing home finances is unsolvable or inevitable. CMS could solve this problem, however, by auditing cost reports, determining legitimate expenditures, and requiring increased disclosure and complete transparency in spending. When a facility is part of a chain, this disclosure must be for all facilities in the chain through a consolidated cost report.

In the meantime, to determine whether a nursing home is demonstrating a financial commitment to staffing, CMS will need to undertake a facility-by-facility examination that includes, but is not limited to:

- Reviewing of Medicare and Medicaid cost reports for the previous three years for accuracy of submitted data;

- Requiring the submission of three years of federal and state tax returns;
- Require increased disclosure from related party companies, including:
 - The services provided, the actual costs of providing services and proof that they were reasonable and prudent purchases.
 - Profits to the related party companies.
 - Salaries paid to related party owners.
- Complete disclosure of executive salaries and bonuses.

Until we have actual financial transparency in nursing home finances, it will be extremely difficult to determine the actual costs of providing high-quality care, let alone make a determination of how much of each dollar should go toward direct care. The only entity that is capable of providing system-wide financial transparency in nursing homes is CMS. CMS must acknowledge this fact and take steps to address it.

The categories of facilities not eligible for exemption should be expanded and include, at a minimum, nursing homes on the Special Focus Facility nominee list.

Facilities that are included on the Special Focus Facility (SFF) list or are on the list of nominees for that list should not be granted any exemptions from staffing requirements. The purpose of the SFF, as described by CMS¹⁸⁶ is to end “yo-yo” compliance by homes that have a much higher number, usually over a longer period of time, of citations than the majority of facilities. The SFF program has three possible expected outcomes: achieving regulatory compliance; promising progress toward compliance; or termination from Medicare and Medicaid.

Homes on the SFF nominee list have equivalent quality issues to those in the SFF program but have not been entered into SFF status solely because of the limited number of slots; the 88 slots on the list are based solely on funding.¹⁸⁷ If the SFF list for a state is already fully populated, no more facilities can be added, even though they meet the criteria. These quality issues should also prevent SFF nominee homes from receiving any staffing exemptions.

Additional comments on exemptions.

In addition to a ban on payments for new admissions, nursing facilities receiving exemptions from meeting the minimum staffing should be ineligible for state Quality Improvement Payment Programs (QIPP) programs and CMS’s Value-Based Purchasing Program.

Further, facilities that have waivers should be required to post this fact in their facility and disclose it to all current and future residents. CMS must make the public aware of the facilities not meeting minimum staffing standards and those that have received waivers or exemptions, by posting this fact on Care Compare.

Any waiver/exemption process must include a rigorous and comprehensive review to ensure that only those facilities truly facing hardship would be granted such an exemption.

In sum, Consumer Voice strongly opposes CMS's plan to treat nursing home residents differently based on speculative criteria such as rurality. There is little to no evidence that rural facilities will have a hard time meeting a staffing standard. Instead, CMS's own commissioned study shows that profit status, not location, is the biggest determinant of staffing. Lost in the discussion of rurality are the residents who live in these nursing homes. The proposed exemptions will perpetuate disparities in care for rural nursing home residents and for residents living in for-profit homes.

Consumer Voice supports increased facility assessment requirements but notes that the provisions rely heavily on a broken enforcement system.

Consumer Voice supports the updated facility assessment guidelines but notes that their success depends significantly on state survey agency enforcement. Since CMS first introduced the facility assessment requirement in 2017, there has been little evidence that facilities are complying with the regulation or that it has had any impact on increasing staffing levels. Each nursing facility is required to conduct a facility assessment to determine what resources are necessary to care for residents day-to-day, and during emergencies.¹⁸⁸ Since its implementation, there has been no discernible difference in staffing levels, and Consumer Voice continues to hear from residents, families, and long-term care ombudsmen about staffing shortages, particularly on nights and weekends. Further, enforcement data shows that from fiscal year 2021 to fiscal year 2023 there were only 592 violations issued regarding the facility assessment process. Only ten of these were cited at a level where a financial penalty is likely to be imposed.

This lack of enforcement will undermine CMS' proposed changes in the NPRM. As noted elsewhere, CMS' proposed standard relies heavily on requiring facilities to staff to each resident's acuity level. To ensure compliance, state surveyors will need to spend significant amounts of time reviewing staffing plans, making acuity determinations, and then ascertaining whether the facility is staffed to the appropriate levels. While this may sound innovative and new, it is the continuance of the status quo. Currently, facilities are required to have "sufficient staff" to meet the care needs of every resident. Despite this requirement, most nursing homes fail.

In order to ensure that facilities are properly assessing acuity and staffing to each resident's needs, CMS must provide guidance that establishes acuity levels. As discussed previously, CMS must adopt an acuity scale for staffing that is easily understood, and that can be applied by nursing homes and enforcement agencies. Unless CMS provides this guidance, it will be simply continuing the current failed system of requiring "sufficient staff."

Decades of inadequate staffing have made clear that unless nursing homes are compelled to implement staffing levels, the vast majority of them will not. New language on acuity and staffing simply adds another layer of vague guidance that facilities will choose to interpret their own way. Whether facilities are compliant will fall upon overburdened state survey agencies that will make their own acuity determinations, which will differ nationally. CMS places too much reliance on a regulatory system that has failed residents for years. To ensure residents are having their acuity needs met, CMS must establish acuity levels facilities are required to meet according to a resident's needs.

Consumer Voice supports the inclusion of direct care staff in the development of and updates to the facility assessment provisions.

The inclusion of direct care staff in the development and updating of facility assessments will provide valuable input on the day-to-day needs and activities of residents as well as detailed and realistic information about the staff needed to address these needs. In many facilities, direct care staff have little to no access to resident assessment or care plan information and are left to discover on their own resident needs and preferences. To ensure this new provision is met, CMS will need to publish specific guidance on which types of staff and how many are expected to participate as well as a process to document their participation. CMS must require state survey agencies to provide guidance and training to surveyors to ensure the inclusion of direct care staff.

Consistency between facility assessments and individual resident assessments is important but should include staff needs to address resident goals, preferences, and priorities, not just care needs and deficits.

The draft rule would require the facility assessment be consistent with resident assessments on functional needs, types of diseases, conditions, physical and behavioral health issues, cognitive disabilities, overall acuity, and other pertinent facts in the resident population.¹⁸⁹ While Consumer Voice sees this consistency of information as a good step toward identifying clinical needs and the resources to meet those needs, we note that the requirement is framed completely around resident needs and deficits. The facility assessment should also include a staffing plan that provides enough person-power to get to know residents as whole persons (understanding their goals, preferences, and priorities for life) not only to address their clinical needs. Additional staff may be needed to assist residents in attaining and maintaining their highest practicable physical, mental and psychosocial well-being.

In addition to the requirement that an assessment be completed at least annually, more needs to be done to monitor and enforce completion of facility assessments and measure staffing adequacy as compared to identified needs.

The draft rule also clarifies that the facility assessment is to be completed at least annually, or more often as needed to address significant changes in resident acuity and needs and the staff skill sets needed to address those needs. Consumer Voice finds this requirement reasonable on its face, but again questions how CMS or states will monitor compliance. Additionally, it is not clear what the response from CMS or the state will be if a facility fails to complete the assessment timely or if actual staffing resources fall short of those identified in the assessment document.

The addition of a requirement that the facility assessment address behavioral health needs and noting the importance of staff competencies and skill sets are elements Consumer Voice supports.

Consumer Voice supports a focus on night and weekend staffing and staffing by residential unit but recommends updates to the PBJ system to capture staffing trends.

Consumer Voice supports the focus on addressing staff shortages on nights and weekends.¹⁹⁰ While this and the language requiring facilities to match employee competencies and skill sets to identified resident needs support improved staffing numbers and types of staff¹⁹¹, Consumer Voice recommends that CMS review the Payroll-Based Journal (PBJ) system to conduct analysis of night and weekend staffing trends and to better reveal the true 24-hour staffing levels at homes.

The proposed rule would require facilities to account for staffing in specific residential units within the building and by specific work shifts and to document and then adjust that assessment of staffing needs upon significant changes in the resident population.¹⁹² Consumer Voice supports the intent of this provision and encourages CMS to require this data be reviewed by state survey teams as they determine whether the nursing home has the requisite staff needed to meet residents' needs.

Stronger monitoring and enforcement are needed to ensure the facility assessment is current and addresses recruitment, retention, and contingency planning. Surveyors will need specific guidance to provide adequate enforcement.

Consumer Voice supports linking staffing recruitment and retention strategies as well as staffing contingency planning, below the level of emergency planning, to the facility assessment.¹⁹³ Consumer Voice recommends that CMS explore the availability and feasibility of a nearly real-time technology platform for facilities to create and update their facility assessment, which would be accessible to surveyors to review at any time. Surveyors would need training and access to the technology to monitor and review the facility assessment prior to survey visits to be able to properly track and enforce the use

of the tool as a mechanism to address these important factors in establishing staffing levels. In the interim, however, CMS should require a review of the facility's recruitment, retention, and contingency planning, as well as the facility assessment, during the facility's annual survey, and when investigating complaints relating to insufficient staffing levels.

Payment transparency reporting must include all revenue and provide more detail on expenditures.

While Consumer Voice supports transparency in how nursing homes use Medicare and Medicaid dollars, the proposed Medicaid transparency provisions will do little to help achieve this goal. It is wrong to only address Medicaid spending on staff. Most facilities are Medicare and Medicaid providers, and to analyze Medicaid spending in isolation will give an incomplete and distorted picture of workforce spending. This partial disclosure will be of little use to the public, as it keeps hidden the rest of nursing home finances.

To be effective in learning where public dollars are spent in the nursing home industry, any transparency effort must include Medicaid and Medicare, along with other sources of funds such as out-of-pocket payments by residents and long-term care insurance payments. Further, given the complex and often opaque nature of nursing home ownership, related parties, and all of the entities with an ownership or control interest in a nursing home or corporation, all of these entities must be examined to get a true picture of where various profit centers are and how much of the payments to nursing homes are going to profits as compared to care and services for residents. We also believe that CMS should collect the information from Medicaid and Medicare cost reports directly, using one standard format, and not rely on state agencies to provide spending information. We strongly urge CMS to implement the Medicaid transparency recommendations of the 2023 Medicaid and CHIP Payment and Access Commission (MACPAC).¹⁹⁴

While Consumer Voice believes that the proposed regulation will do little to shine a light on workforce spending, we offer the following comments and suggestions.

The definition of compensation should include the array of items employers may provide.

We support requirements for states to report on compensation for direct care workers and support staff. Poor compensation is one of the most cited reasons for high turnover among nursing facility staff, and in particular, workers providing direct care. We support the definition of compensation including salaries, wages, benefits like health insurance and sick leave, and the share of the employer's payroll taxes for direct care workers and support staff.¹⁹⁵

The definition of direct care worker must be limited to nursing staff (RN, LPN, and CNA) who are providing direct care.

We are concerned with the broad scope of workers that would be included in the transparency and reporting requirements.¹⁹⁶ First, we recommend limiting the definition of direct care workers to registered nurses, licensed practical nurses, nurse practitioners, or clinical nurse specialists, and certified nurse aides (CNAs) who provide direct care to residents. These categories of workers provide a significant amount of direct care to residents and are the primary subject of this NPRM as it pertains to minimum staffing ratios. While it is helpful to know the amounts spent on all nursing home staff, spending on nursing staff is more in line with the central purpose of this rule. All other workers listed in this section should be reported under a different category of workers.

We also recommend that the definition of support staff be broadened to include administrative staff, along with services like housekeeping, laundry, food service, and others. A new category named ancillary staff should be added to include physicians, speech, and occupational therapists, therapy aides, and pharmacy staff, who provide direct service to residents but should not be counted as direct care staff, which should be limited to nursing jobs. Practitioners and their supporting staff who provide services to residents are an important part of overall care plans but must be separated from nursing staff. Including these ancillary personnel in direct care staff data would skew the data and artificially inflate the count of staff actually providing direct resident care.

In addition to differentiating direct care workers from other workers listed, we strongly recommend that wages reported for these direct care workers should be assessed distinctly based on the job duties. There is a significant wage disparity even among our proposed narrower definition of direct care workers. For example, average nursing facility LPN or LVN pay is \$28.10/hour,¹⁹⁷ RN pay in nursing facilities averages \$37.11,¹⁹⁸ while average CNA pay is \$14.41/hour.¹⁹⁹ Aggregating these amounts would not provide transparency since it would give little insight into the adequacy of wages for distinct nursing categories. For instance, CNAs face particularly high turnover rates (55% in 2020)²⁰⁰ due in large part to poor compensation. Failing to identify wages by nursing category would give little insight into the sufficiency of CNA wages. Therefore, we strongly recommend disaggregating the reported data by specific job duties.

We support the inclusion of third-party contracted staff in mandatory reporting requirements to achieve better transparency. However, nursing home ownership structures have become extremely complicated. As noted in comments to earlier proposed rulemaking on nursing facility ownership and additional disclosable parties, organizations can engage with facilities in a variety of ways including complicated related-party (additional disclosable parties) transactions.²⁰¹ Thus, we recommend expanding this definition to include "all individuals or entities, providing services under contract, subcontract, or other related agreement, in whole or in part, with an organization or provider that provides goods or services to the facility through contract, subcontract, or other related agreement, in-whole or in-part. This applies regardless of whether the individual receives a W2 from either the contracted organization or the facility."

We recommend keeping the terminology “direct care staff” for the categories of nurses, nurse practitioners, and certified nurse aides identified above. We also recommend including staff who support residents’ ability to transition out of the facility into the reporting requirements only if they are in a separate category and not included as direct care workers. These staff are providing important services to improve the residents’ health, safety, and autonomy but the job duties vary much more than the direct care workers identified above. Relatedly, these workers should not be included in the minimum staffing ratios discussed earlier in the proposed rule.

The definition of support staff should include staff who have a role supporting residents but are not providing direct care.

We support the broad definition of support staff stated in the proposed rule. However, support staff workers should not be included with direct care workers like RNs, LPNs, and CNAs. All reporting requirements for these groups of workers should be distinct and disaggregated based on job duty.

A new category of ancillary staff should be added and include licensed therapy providers, therapy staff, pharmacists, and others who provide a service to residents outside of direct care.

Nursing homes employ or contract with multiple other types of providers such as physical, occupational, and speech therapists and aides who support their work, pharmacists, and other specialties. These employees or contractors should be reported under a new category of ancillary staff to account for the work they do directly with residents separately from the direct care reporting required. These staff perform important functions but do not provide daily nursing care and therefore must be accounted for separately.

Reporting on the various types of staff and contractors should be detailed and disaggregated so that valuable analysis is possible.

Comprehensive reporting on all workers that can be disaggregated easily for analysis is useful for determining Medicaid spending among nursing facilities. However, the proposed rule is very weak in achieving true transparency despite efforts to identify the many categories of nursing home workers. By limiting the reporting requirements just to Medicaid, facilities are able to obscure millions of Medicare and other dollars from any meaningful direct care spending requirements. We strongly urge CMS to expand this rule, not just to include more categories of workers, but to also include other payors, like Medicare and private payers, to truly assess the percentage of facilities’ spending that is actually going to workers providing crucial care to residents.

Reporting requirements must include both base and supplemental payments.

We strongly recommend reporting requirements apply both to base and supplemental payments, preferably in a single report. This would provide the most accurate assessment of how much facilities are spending on workers. Further, there is nothing to suggest payment rates would change drastically from year to year since that would require changes to the state plan. Therefore, including both payments provides greater clarity. We also support requiring reporting at least annually for both Fee-For-Service and managed care delivery systems to better observe trends in worker compensation across facilities.

Exemption from reporting could be allowed for swing bed hospitals from reporting requirements.

Consumer Voice does not object to an exemption for swing bed hospitals, as cost reporting requirements for these entities are encompassed in hospital reporting systems.

Exclusions from Medicaid payment reporting should not be allowed.

We do not support excluding reporting payments when Medicaid is not the primary payer. While Medicaid is a major payor for nursing home residents, facilities bill millions of dollars in claims each year to Medicare on behalf of residents.²⁰² Unless the reporting requirements extend to other payors, there is no transparency as to whether these Medicare dollars are being spent on workers providing direct care to residents.

We do recommend including beneficiary expenses, like Medicaid cost sharing, in the reporting requirements. Consumer Voice does not support any exclusion for providers with low Medicaid revenues or few Medicaid beneficiaries. These are Medicaid-affiliated expenses that go towards the facilities' total reimbursement and should be counted.

We also recommend no exclusion for providers with low Medicaid revenues as this could disincentivize providers from taking Medicaid beneficiaries. This could be especially problematic for facilities with distinct part certification, where they could limit the number of beds in the facility to a particular threshold, such that it would be included in the reporting.

Reporting at the facility level must be detailed and include pay ranges for staff median hourly wages.

We strongly support facility-level reporting. Facilities have huge variations in staffing and pay, requiring individual reports to assess adequate compensation across facilities. We also strongly support additional

median hourly compensation data in addition to the percentage of Medicaid spending going to direct care workers and staff. The total percentage provides only a small piece of information, coupled with hourly earnings, the reported percentages provide much better context. The amount paid is relevant to determining whether the facility's staffing woes might be related to poor payment. Similar to the discussion above, median hourly wages should be disaggregated by job duty and not just the categories identified in the NPRM, to better differentiate between higher and lower-paid workers within each category.

Proposed methodology for reporting payments must be disaggregated by job duties and include both fee for service and managed care spending.

We recommend that at a minimum, the data reported is disaggregated so it can be analyzed more accurately based on each specific job duty. Furthermore, we also recommend reporting both median wages and the range of wages that is offered for new staff. Providing a range would provide greater insight into whether facilities are underpaying new hires, which suggests an insincere effort to add staff.

We support making per diem rates for Fee-For Service (FFS) delivery systems public. The reported per diem rates should be based on a statewide average and include both base and supplemental payments to increase transparency and provide a complete picture of Medicaid spending. Relatedly, we strongly recommend that managed care delivery systems be required to report contracted rates for facilities. Limiting reporting requirements just to FFS does not provide accurate transparency, particularly as managed care systems continue to grow.

We support requiring a minimum percentage of all revenue payments to be spent on direct care workers and support staff. A minimum threshold is very necessary so long as it is coupled with other appropriate transparency measures. CMS must conduct a detailed study to determine the appropriate percentage of revenues that must be used for direct care and services. Several reports, including a recent MACPAC report,²⁰³ have shown that facilities are adept at maximizing profits by cutting essential resident services like quality staffing and engaging in complex corporate structures, including related party transactions. In order to be proper stewards of funds, CMS should ensure funds are going directly towards resident care. Therefore, a minimum threshold, coupled with other transparency mechanisms,²⁰⁴ is an appropriate starting point.

Website reporting should be centralized at state agencies and include accessibility elements.

Consumer Voice proposes the website include contact information for the state Medicaid agency for members of the public to contact with questions about the data.²⁰⁵ The provisions requiring non-English language, oral interpretation in all languages, auxiliary aides and services, and toll-free TTY/TDY services

are not only in keeping with legally required and generally accepted accessibility standards but are a key part of making information about nursing home spending truly transparent.

We support the accessibility requirements of one website with all the data and information related to reporting requirements. This makes accessing data much easier and more accurate than external links to managed care websites. We strongly support at least a quarterly review with an added requirement that missing or inaccurate information is remedied within two weeks of the review. Delayed reviews can lead to the publication of misrepresented data, which hampers transparency initiatives if the information is not available or accurate. Further, the longer the period of time for review, the greater the likelihood of inaccurate information which will take longer to correct. We support the requirement of prominent language indicating additional assistance is available at no cost, with clear instructions for requesting assistance or additional accommodation³³.

The timeline for implementation should be shortened to three years and we support the establishment of the interested parties advisory group.

We recommend three years instead of four years to implement the reporting requirements to FFS and managed care delivery systems. Much of the reporting data is available or could be easily obtained. Given the importance of these transparency reporting requirements, a quicker implementation period is necessary. We also support the establishment of an interested parties' advisory group to consult on nursing facility and ICF rates to better gain stakeholder perspectives in rate setting.

Conclusion

The implementation of a minimum staffing standard will only achieve the goals of the NHRA of 1987 if it ensures that all nursing home residents are safe and receiving quality care. As proposed, CMS's staffing standard only addresses the worst-performing homes by attempting to raise their staffing levels to the median-performing home, according to data from Care Compare. Thus, hundreds of thousands of nursing home residents will continue to experience high rates of delayed or omitted care, and not receive the benefits of better quality and safety.

The staffing standard proposed in Consumer Voice's comments is achievable but will require CMS to take an active role in ensuring that Medicare and Medicaid dollars are spent on resident care. Thousands of nursing homes currently provide staffing at the levels proposed in our comments. These homes are in every state and are in rural and urban areas. CMS must not build a staffing standard based on unsupported industry claims about inadequate staffing and inadequate funding. Instead, CMS, as the NHRA requires, must focus on the needs of residents to ensure they are receiving necessary care. The avenue to a strong staffing standard is clear when it is based on scientific evidence. We urge CMS to

reject the unsupported assumptions that have diluted the proposed standard, and to fulfill its duty to ensure all nursing home residents are living in safe and healthy environments.

Thank you for the opportunity to submit comments on this proposed rule.

Sincerely,

Lori Smetanka, Executive Director
lsmetanka@theconsumervoice.org

Sam Brooks, Director of Public Policy
sbrooks@theconsumervoice.org

¹ 42 C.F.R. § 483.35

² 88 Fed. Reg. 61359.

³ Centers for Medicare & Medicaid Services, Abt Associates Inc. *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes. Report to Congress: Phase II Final*. Volumes I–III. Baltimore, MD: CMS, 2001.

⁴ 42 C.F.R. § 483.35(a)

⁵ Abt Associates. Nursing Home Staffing Study Comprehensive report. Report prepared for the Centers for Medicare & Medicaid Services. June 2023, p. 45

⁶ Priya Chidambaram, “Over 200,000 Residents and Staff in Long-Term Care Facilities Have Died From COVID-19” (KFF, Feb. 3, 2022), <https://www.kff.org/policy-watch/over-200000-residents-and-staff-in-long-term-care-facilities-have-died-from-covid-19/>

⁷ Li, Y., H. Temkin-Greener, G. Shan, and X. Cai. 2020. COVID-19 infections and deaths among Connecticut nursing home residents: Facility correlates. *Journal of the American Geriatrics Society* 68(9):1899–1906.

⁸ Gorges, R. J., and R. T. Konetzka. 2020. Staffing levels and COVID-19 cases and outbreaks in U.S. nursing homes. *Journal of the American Geriatrics Society* 68(11):2462–2466

⁹ Konetzka, R. T., E. M. White, A. Pralea, D. C. Grabowski, and V. Mor. 2021. A systematic review of long-term care facility characteristics associated with COVID-19 outcomes. *Journal of the American Geriatrics Society* 69(10):2766–2777.

¹⁰ <https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/28/fact-sheet-protecting-seniors-and-people-with-disabilities-by-improving-safety-and-quality-of-care-in-the-nations-nursing-homes/>

¹¹ 87 Fed. Reg. 22720 (April 15, 2022).

¹² https://theconsumervoice.org/uploads/files/issues/CV_RFI_Responses_6.10.22.pdf

¹³ 88 Fed. Reg. 61416

¹⁴ https://theconsumervoice.org/uploads/files/issues/CV_RFI_Responses_6.10.22.pdf

¹⁵ Centers for Medicare & Medicaid Services, Abt Associates Inc. *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes. Report to Congress: Phase II Final*. Volumes I–III. Baltimore, MD: CMS, 2001.

¹⁶ <https://data.cms.gov/provider-data/>

¹⁷ Bryant, Olalya Ayanna, "Employee Turnover in the Long-Term Care Industry" (2017). Walden Dissertations and Doctoral Studies. 3389, <https://scholarworks.waldenu.edu/dissertations/3389>; Al-Hussami, M., et al, “Nurses' turnover intentions.” *Int J Nurs Pract*, 2014 20: 79-88. <https://doi.org/10.1111/ijn.12124>; Negarandeh R. Enhancing transition to workplace. *Nurs Midwifery Stud*. 2014 Apr;3(1):e17554. doi: 10.17795/nmsjournal17554. Epub 2014 Apr 17. PMID: 25414894; PMCID: PMC4228524. National Academies of Sciences, Engineering, and Medicine. 2022. *The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Families, and Staff*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/26526>.

¹⁸ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7278261/>

¹⁹ Id.

²⁰ *Direct Care Workers in the United States, Key Facts*, PHI National, 2023 <http://www.phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-3/>

²¹ <https://livingwage.mit.edu/counties/42063>

²² *Direct Care Workers in the United States, Key Facts*, PHI National, 2023 <http://www.phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-3/>

²³ *Direct Care Workers in the United States, Key Facts*, PHI National, 2023 <http://www.phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-3/>

²⁴ https://theconsumervoice.org/uploads/files/issues/Better_Staffing_Is_Achievable.pdf

²⁵ https://theconsumervoice.org/uploads/files/issues/Better_Staffing_Is_Achievable.pdf

²⁶ Abt Associates. Nursing Home Staffing Study Comprehensive report. Report prepared for the Centers for Medicare & Medicaid Services. June 2023, p. 44

²⁷ Id.

²⁸ Rau, Jordan, *Care Suffers as More Nursing Homes Feed Money Into Corporate Webs*, NY Times, Jan, 2, 2018.

-
- ²⁹ Hammond, Bill, *Following the Money: An analysis of 'related company' transaction in New York's nursing home industry*, Empire Center, July 5, 2022. <https://www.empirecenter.org/publications/following-the-money-2/>
- ³⁰ *Where Do the Billions of Dollars Go? A Look at Nursing Home Related Party Transactions*, Consumer Voice, 2023. <https://theconsumervoicereport.org/uploads/files/issues/2023-Related-Party-Report.pdf>
- ³¹ Id.
- ³² Ctrs. For Medicare & Medicaid Servs, U.S. Dept of Health & Hum. Servs., Program Manuals Sec 2102.3 (Rev. 454).
- ³³ Id.
- ³⁴ viii "These Administrative Actions Would Improve Nursing Home Ownership And Financial Transparency In The Post COVID-19 Period", Health Affairs Blog, February 11, 2021. DOI: 10.1377/hblog20210208.597573
- ³⁵ Abt Associates. Nursing Home Staffing Study Comprehensive report. Report prepared for the Centers for Medicare & Medicaid Services. June 2023, p. 97
- ³⁶Centers for Medicare & Medicaid Services, Abt Associates Inc. *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes. Report to Congress: Phase II Final*. Volumes I–III. Baltimore, MD: CMS, 2001.
- ³⁷ 88 Fed. Reg. 61359
- ³⁸ Abt Associates. Nursing Home Staffing Study Comprehensive report. Report prepared for the Centers for Medicare & Medicaid Services. June 2023, p. viii
- ³⁹ Id.
- ⁴⁰ <https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcompliance/downloads/usersguide.pdf>
- ⁴¹ 88 Fed. Reg. 61362.
- ⁴² Id. at 61366.
- ⁴³ Abt Associates. Nursing Home Staffing Study Comprehensive report. Report prepared for the Centers for Medicare & Medicaid Services. June 2023, p. vii.
- ⁴⁴ Id. at xiv.
- ⁴⁵ Id. at 61363.
- ⁴⁶ 42 U.S.C. § 1395i-3(b)(4)(A)(i).
- ⁴⁷ Id. at 61428.
- ⁴⁸ Horn, S.D., Sharkey, S.S., Hudak, S., Smout, R.J., Quinn, C.C., Yody, B. and Fleshner, I (2010). Beyond CMS Quality Measure Adjustments: Identifying Key Resident and Nursing Home Facility Factors Associated with Quality Measures. *J. American Medical Directors Association*. 11 (7):500-5.
- ⁴⁹ Alexander, G.L. 2008. An Analysis of Nursing Home Quality Measures and Staffing. *Quality Management in Health Care*. 17 (3):242-51.
- ⁵⁰ Horn, S.D., Buerhaus, P., Bergstrom, N., Smout, R.J. (2005). RN staffing time and outcomes of long-stay nursing home residents: pressure ulcers and other adverse outcomes are less likely as RNs spend more time on direct patient care. *Am J Nurs*. 105(11):58-70.
- ⁵¹ Dorr, D.A., Horn, S.D., & Smout, R.J. (2005). Cost analysis of nursing home registered nurse staffing times. *J. of Amer Geriatrics Society*, 53: 840-845.
- ⁵² Castle, N.G. & Anderson, R.A..
- ⁵³ Horn, S.D., Buerhaus, P. et al.
- ⁵⁴ Dorr et al.
- ⁵⁵ Wan, T.T.H., Zhang, N.J. & Unruh, L. (2006). Predictors of resident outcome improvement in nursing homes. *Western J. Of Nursing Research*. 28 (8):974-993.
- ⁵⁶ Castle, N.G. & Anderson, R.A..
- ⁵⁷ Castle, N.G. & Anderson, R.A..
- ⁵⁸ Alexander, G.L
- ⁵⁹ Horn, S.D., Buerhaus, P. et al.
- ⁶⁰ Dorr et al.
- ⁶¹ Lin, H. (2014). Revisiting the relationship between nurse staffing and quality of care in nursing homes: An instrumental variables approach. *J. of Health Economics*, 37: 13-24.
- ⁶² Horn, S.D., Bender S.A., Ferguson, M.L., Smout, R.J. et al (2004). The national pressure ulcer long-term care study: Pressure ulcer development in long-term care residents. *J. American Geriatrics Society*, 52: 359-367.
- ⁶³ Horn, S.D., Buerhouse, P. et al.

- ⁶⁴ Simmons, S.F., Schnelle, J.F. (2004). Individualized feeding assistance care for nursing home residents: staffing requirements to implement two interventions. *J Gerontol A Biol Sci Med Sci*. 59(9):M966-73.
- ⁶⁵ Simmons, S.F., Keeler, E., Zhuo, X., Hickey, K.A., Sato, H.W., Schnelle, J.F. (2008). Prevention of unintentional weight loss in nursing home residents: a controlled trial of feeding assistance. *J Am Geriatr Soc*. Aug;56(8):1466-73.
- ⁶⁶ Horn, S.D., Bender S.A. et al.
- ⁶⁷ Horn, S.D., Bender S.A. et al.
- ⁶⁸ Phillips, L.J., Birtley, N.M., Petroski, G.F., Siem, C., Rantz, M. (2018). An observational study of antipsychotic medication use among long-stay residents without qualifying diagnoses. *J. Psychiatry Mental Health Nursing*. 25(8):463-474.
- ⁶⁹ Castle, N.G. & Anderson, R.A
- ⁷⁰ Wan, T.T.H., et al,
- ⁷¹ Park, J. and Stearns S.C. (2009). Effects of state minimum staffing standards on nursing home staffing and quality of care. *Health Serv Res*. 44(1):56-78.
- ⁷² Uchida-Nakakoji, M., Stone, P. W., Schmitt, S. K., & Phibbs, C. S. (2015). Nurse workforce characteristics and infection risk in VA Community Living Centers: A longitudinal analysis. *Medical Care*, **53**, 261–267.
- ⁷³ Trivedi, T.K., DeSalvo, T., Lee, L., Palumbo, A., Moll, M., Curns, A., Hall, A.J., Patel, M., Parashar, U.D., Lopman, B.A. (2012). Hospitalizations and mortality associated with norovirus outbreaks in nursing homes, 2009-2010. *JAMA*. Oct 24;308(16):1668-75.
- ⁷⁴ Leland NE, Gozalo P, Teno J, Mor V. (2012). Falls in newly admitted nursing home residents: a national study. *J Am Geriatr Soc*. 60(5):939-45.
- ⁷⁵ Spector, W., Shaffer, T., Potter, D.E., Correa-de-Araujo, R., Rhona Limcangco, M. (2007). Risk factors associated with the occurrence of fractures in U.S. nursing homes: resident and facility characteristics and prescription medications. *J Am Geriatr Soc*. 55(3):327-33.
- ⁷⁶ Xing, J., Mukamel, D. B., & Temkin-Greener, H. (2013). Hospitalizations of nursing home residents in the last year of life: Nursing home characteristics and variation in potentially avoidable hospitalizations. *Journal of the American Geriatrics Society*, **61**, 1900–1908.
- ⁷⁷ Spector, W.D., Limcangco, R., Williams, C., Rhodes, W., Hurd, D. (2013). Potentially avoidable hospitalizations for elderly long-stay residents in nursing homes. *Med Care*. 2013 Aug; 51(8):673-81.
- ⁷⁸ Min, A. and Hong, H.C. (2019). Effect of nurse staffing on rehospitalizations and emergency department visits among short-stay nursing home residents: A cross-sectional study using the US nursing home compare database. *Geriatr Nurs.*, 40 (2):160-165
- ⁷⁹ Konetzka, R.T., Spector, W. & Limcangco, M.R. (2007). Reducing hospitalizations from long-term care settings. *Medical Care Research & Review*, 65:40-66.
- ⁸⁰ Simmons, S.F., Durkin, D.W., Rahman, A.N., Choi, L., Beuscher, L., Schnelle, J.F. (2013). Resident characteristics related to the lack of morning care provision in long-term care. *Gerontologist*. 53(1):151-61.
- ⁸¹ 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.
- ⁸² Konetzka, R.T., Stearns, S.C., Park, J. (2008). The staffing-outcomes relationship in nursing homes. *Health Serv Res*. 43(3):1025-42.
- ⁸³ Trivedi, T.K., et al.
- ⁸⁴ Tong PK. (2011). The effects of California minimum nurse staffing laws on nurse labor and patient mortality in skilled nursing facilities. *Health Econ*. 20(7):802-16.
- ⁸⁵ Harrington C., Zimmerman D., Karon S.L., Robinson J., Beutel P. (2000). Nursing Home Staffing and Its Relationship to Deficiencies. *Journal of Gerontology Series B: Psychological Science and Social Science*. 55(5): S278-87.
- ⁸⁶ Castle, N.G., Wagner, L.M., Ferguson, J.C. & Handler, S.M.. (2011). Nursing home deficiency citations for safety. *J. Aging and Social Policy*, 23 (1):34-57.
- ⁸⁷ Kim, H., Harrington, C. & Greene, W. (2009). Registered nurse staffing mix and quality of care in nursing homes: A longitudinal analysis. *Gerontologist*, 49 (1):81-90.
- ⁸⁸ Li, Y., H. Temkin-Greener, G. Shan, and X. Cai. 2020. COVID-19 infections and deaths among Connecticut nursing home residents: Facility correlates. *Journal of the American Geriatrics Society* 68(9):1899–1906.

-
- ⁸⁹ Gorges, R. J., and R. T. Konetzka. 2020. Staffing levels and COVID-19 cases and outbreaks in U.S. nursing homes. *Journal of the American Geriatrics Society* 68(11):2462–2466
- ⁹⁰ Konetzka, R. T., E. M. White, A. Pralea, D. C. Grabowski, and V. Mor. 2021. A systematic review of long-term care facility characteristics associated with COVID-19 outcomes. *Journal of the American Geriatrics Society* 69(10):2766–2777.
- ⁹¹ National Academies of Sciences, Engineering, and Medicine. 2022. *The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Families, and Staff*.
- ⁹² <https://www.ahcancal.org/Advocacy/Documents/24-Hour-RN.pdf>
- ⁹³ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7328494/>
- ⁹⁴ National Academies of Sciences, Engineering, and Medicine. 2022. *The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Families, and Staff*.
- ⁹⁵ 88 Fed. Reg. at 61428.
- ⁹⁶ Li, Y., H. Temkin-Greener, G. Shan, and X. Cai. 2020. COVID-19 infections and deaths among Connecticut nursing home residents: Facility correlates. *Journal of the American Geriatrics Society* 68(9):1899–1906.
- ⁹⁷ 88 Fed. Reg. at 61363.
- ⁹⁸ Abt Associates. *Nursing Home Staffing Study Comprehensive report*. Report prepared for the Centers for Medicare & Medicaid Services. June 2023, p. 44
- ⁹⁹ 88 Fed. Reg. 61363.
- ¹⁰⁰ Id.
- ¹⁰¹ Id.
- ¹⁰² Id.
- ¹⁰³ Id.
- ¹⁰⁴ Abt Associates. *Nursing Home Staffing Study Comprehensive report*. Report prepared for the Centers for Medicare & Medicaid Services. June 2023, p. xiv
- ¹⁰⁵ Id. at 52 and 55
- ¹⁰⁶ Id.
- ¹⁰⁷ Id. at 66.
- ¹⁰⁸ Id. at 74.
- ¹⁰⁹ Id.
- ¹¹⁰ Id. at xv.
- ¹¹¹ Id. at 74.
- ¹¹² Centers for Medicare & Medicaid Services, Abt Associates Inc. *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes. Report to Congress: Phase II Final*. Volumes I–III. Baltimore, MD: CMS, 2001.
- ¹¹³ Id.
- ¹¹⁴ Harrington, C., Ross, L., Chapman, S., Halifax, E., Spurlock, B., and Bakerjian, D. Nursing staffing and coronavirus infections in California nursing homes. *Policy, Politics, & Nursing Practice*. 2020: 21 (2) 174-186.
- ¹¹⁵ Abt Associates. *Nursing Home Staffing Study Comprehensive report*. Report prepared for the Centers for Medicare & Medicaid Services. June 2023, p. xiv
- ¹¹⁶ Id.
- ¹¹⁷ Id. at ps. 52 and 55.
- ¹¹⁸ Centers for Medicare & Medicaid Services, Abt Associates Inc. *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes. Report to Congress: Phase II Final*. Volumes I–III. Baltimore, MD: CMS, 2001.
- ¹¹⁹ 88 Fed. Reg. 61359
- ¹²⁰ Id.
- ¹²¹ Id.
- ¹²² Abt Associates. *Nursing Home Staffing Study Comprehensive report*. Report prepared for the Centers for Medicare & Medicaid Services. June 2023, p. 74
- ¹²³ Id.
- ¹²⁴ 42 U.S.C. § 1395i-3(b)(4)(A)(i).
- ¹²⁵ Abt Associates. *Nursing Home Staffing Study Comprehensive report*. Report prepared for the Centers for Medicare & Medicaid Services. June 2023, p. 74
- ¹²⁶ Id.

¹²⁷ Campbell, S., A. D. R. Drake, R. Espinoza, and K. Scales. 2021. *Caring for the future: The power and potential of America's direct care workforce*. New York: PHI.

¹²⁸ Id.

¹²⁹ 88 Fed. Reg. 61363.

¹³⁰ 42 U.S.C. § 1395i-3(b)(4)(A)(i).

¹³¹ 88 Fed. Reg. 61363.

¹³² Abt Associates. *Nursing Home Staffing Study Comprehensive report*. Report prepared for the Centers for Medicare & Medicaid Services. June 2023, p. 76.

¹³³ Id. at 51 and 54.

¹³⁴ Id. at 55

¹³⁵ Id. at xiv.

¹³⁶ Id. at 51 and 54.

¹³⁷ 88 Fed. Reg.

¹³⁸ Abt Associates. *Nursing Home Staffing Study Comprehensive report*. Report prepared for the Centers for Medicare & Medicaid Services. June 2023, p. xiv.

¹³⁹ Id. at 51 and 54.

¹⁴⁰ Id. at xiv.

¹⁴¹ Id. at 76.

¹⁴² Id. 61363.

¹⁴³ Schnelle, J. F., Schroyer, L. D., Saraf, A. A., & Simmons, S. F. (2016). Determining nurse aide staffing requirements to provide care based on resident workload: A discrete event simulation model. *Journal of the American Medical Directors Association*, 17(11), 970–977. <https://doi.org/10.1016/j.jamda.2016.08.006>

¹⁴⁴ Abt Associates. *Nursing Home Staffing Study Comprehensive report*. Report prepared for the Centers for Medicare & Medicaid Services. June 2023, p. xiv.

¹⁴⁵ Id.

¹⁴⁶ Id. at 55.

¹⁴⁷ Id.

¹⁴⁸ Centers for Medicare & Medicaid Services, Abt Associates Inc. *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes. Report to Congress: Phase II Final*. Volumes I–III. Baltimore, MD: CMS, 2001.

¹⁴⁹ Schnelle, JF, Simmons, SF, Harrington, C, Cadogan, M, Garcia, E, Bates-Jensen, B. Relationship of nursing home staffing to quality of care? *Health Serv Res*, 2004; 39 (2):225-250.

¹⁵⁰ Schnelle, J. F., Schroyer, L. D., Saraf, A. A., & Simmons, S. F. (2016). Determining nurse aide staffing requirements to provide care based on resident workload: A discrete event simulation model. *Journal of the American Medical Directors Association*, 17(11), 970–977. <https://doi.org/10.1016/j.jamda.2016.08.006>

¹⁵¹ 88 Fed. Reg. 61369.

¹⁵² 88 Fed. Reg. 61429.

¹⁵³ Harrington, C., Dellefield, M., Halifax, E., Fleming, M., and Bakerjian, D. Appropriate nurse staffing levels for US nursing homes. *Health Services Insights*. 2020; 13:1-14. Jun 29;13:1178632920934785. doi: 10.1177/1178632920934785. eCollection 2020

¹⁵⁴ 88 Fed. Reg.61381.

¹⁵⁵ Abt Associates. *Nursing Home Staffing Study Comprehensive report*. Report prepared for the Centers for Medicare & Medicaid Services. June 2023, p. 45

¹⁵⁶ 88 Fed. Reg.61381.

¹⁵⁷ Brookings Metropolitan Policy Program. *Commuting to Opportunity: The Working Poor and Commuting in the United States*. February 2008, p.2

¹⁵⁸ <https://www.aging.senate.gov/imo/media/doc/UNINSPECTED%20&%20NEGLECTED%20-%20FINAL%20REPORT.pdf>

¹⁵⁹ Id.

¹⁶⁰ Id.

¹⁶¹ Id.

¹⁶² 88 Fed. Reg. 61367.

¹⁶³ Id. at 61368.

¹⁶⁴ <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected>

¹⁶⁵ Hawk T, White EM, Bishnoi C, Schwartz LB, Baier RR, Gifford DR. Facility characteristics and costs associated with meeting proposed minimum staffing levels in skilled nursing facilities. *J Am Geriatr Soc.* 2022; 1-10. doi:10.1111/jgs.17678

¹⁶⁶ *Where Do the Billions of Dollars Go? A Look at Nursing Home Related Party Transactions*, Consumer Voice, 2023. <https://theconsumervoice.org/uploads/files/issues/2023-Related-Party-Report.pdf>

¹⁶⁷ 88 Fed. Reg. 61380.

¹⁶⁸ 88 Fed. Reg. 61428.

¹⁶⁹ 88 Fed. Reg. 61354

¹⁷⁰ <https://www.bls.gov/oes/current/oes291141.htm>

¹⁷¹ <https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf>

¹⁷² <https://www.bls.gov/oes/current/oes311131.htm>

¹⁷³ <https://www.bls.gov/oooh/office-and-administrative-support/customer-service-representatives.htm>

¹⁷⁴ <https://www.phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-2/>

¹⁷⁵ Id.

¹⁷⁶ Id.

¹⁷⁷ Weller C, Almeida B, Cohen M., Stone R. Making care work pay. *Leading Age*, September 2020.

¹⁷⁸ <https://livingwage.mit.edu/>

¹⁷⁹ <https://leadingage.org/wp-content/uploads/drupal/Making%20Care%20Work%20Pay%20Report.pdf>

¹⁸⁰ <https://www.phinational.org/wp-content/uploads/2021/07/Federal-Policy-Priorities-for-the-Direct-Care-Workforce-2021-PHI.pdf>,

p. 7.

¹⁸¹ 88 Fed. Reg. 61380.

¹⁸² 88 Fed. Reg. 61381.

¹⁸³ Id.

¹⁸⁴ 88 Fed. Reg. 61378

¹⁸⁵ <https://theconsumervoice.org/news/detail/all/gao-report-finds-transparency-gaps-in-private-equity-nursing-home-ownership>,

<https://theconsumervoice.org/news/detail/all/comments-to-cms-on-its-notice-of-proposed-rule-making>;

<https://theconsumervoice.org/news/detail/all/increase-scrutiny-of-nursing-home-finances>

¹⁸⁶ <https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcompliance/downloads/sffbackground.pdf>

¹⁸⁷ <https://www.cms.gov/files/document/qso-23-01-nh.pdf>

¹⁸⁸ 42 CFR 483.71

¹⁸⁹ 88 Fed. Reg. 61425.

¹⁹⁰ Id.

¹⁹¹ 88 Fed. Reg. 61424

¹⁹² 88 Fed. Reg. 61425.

¹⁹³ Id.

¹⁹⁴ <https://www.macpac.gov/publication/nursing-facility-payment-policies/>

¹⁹⁵ 88 Fed. Reg. 61424.

¹⁹⁶ 88 Fed. Reg. 61424, 61425.

¹⁹⁷ <https://www.bls.gov/oes/current/oes292061.htm>

¹⁹⁸ <https://www.bls.gov/oes/current/oes291141.htm>

¹⁹⁹ <https://www.phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-3/>

²⁰⁰ <https://academic.oup.com/gerontologist/article/60/8/1436/5878040?login=false>

²⁰¹ "These Administrative Actions Would Improve Nursing Home Ownership And Financial Transparency In The Post COVID-19 Period", *Health Affairs Blog*, February 11, 2021. DOI: 10.1377/hblog20210208.597573

x Ctrs. for Medicare & Medicaid Servs, U.S. Dep't. of Health & Hum. Servs., *Program Manuals §2102.3 (Rev. 454)*

²⁰² <https://www.kff.org/medicare/issue-brief/amid-the-covid-19-pandemic-medicare-spending-on-skilled-nursing-facilities-increased-more-than-4-despite-an-overall-decline-in-utilization/>

²⁰³ <https://www.macpac.gov/wp-content/uploads/2023/01/Estimates-of-Medicaid-Nursing-Facility-Payments-Relative-to-Costs-1-6-23.pdf>

²⁰⁴ <https://justiceinaging.org/wp-content/uploads/2023/04/Justice-in-Aging-Comments-on-Disclosures-of-Ownership-for-Nursing-Facilities-.pdf>

²⁰⁵ 88 Fed. Reg. 61425.