CMS Request for Information on Revising Requirements for Long Term Care Facilities to Establish Mandatory Minimum Staffing Levels

On April 15, 2022, Centers for Medicare & Medicaid Services (CMS) issued a Request for Information (RFI) regarding the implementation of a minimum staffing standard in nursing homes. The RFI poses seventeen questions and solicits public comment. For decades, advocates for nursing home residents have fought for a minimum staffing standard. To help facilitate and encourage responses to the RFI in support of a minimum staffing standard, advocates from National Consumer Voice for Quality Long-Term Care, Long Term Care Community Coalition, Center for Medicare Advocacy, Justice in Aging, and California Advocates for Nursing Home Reform have created this draft outline. We encourage you to comment. Please share your own experience and opinion, and use any information in this outline to help support your comments. It is not necessary for you to respond to each question. Most importantly, CMS needs to hear your voice in support of this necessary protection for nursing home residents.

We fully support the Administration's plan to set mandatory minimum staffing levels. The 1987 Nursing Home Reform Law gives the Secretary full authority to set minimum staffing standards. The Reform Law requires that the Secretary assure that facilities provide each resident with high quality care and that Medicare and Medicaid payments are spent on care and not diverted to profits, management fees, and inflated payments to self-related parties. These broad and important powers provide the Secretary with clear authority to set minimum staffing standards.

Staffing is a complex issue, with multiple interrelated factors affecting staffing levels. Setting minimum staffing levels is essential to improving quality of care for residents, but it is not sufficient. Staff, especially certified nursing assistants, need better wages and benefits, more training, better working conditions, more respect and better treatment from employers, less discrimination against women of color and immigrants, and more. Some of these staffing issues will require additional federal regulations. Other issues require actions by parties other than CMS.

The implementation of a minimum staffing standard will be the most important and significant increase in protections for nursing home residents in decades. We applaud the Secretary for taking this necessary step and provide feedback to the Request for Information questions below.

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

- Evidence:
    - 2001 study from the Centers for Medicare & Medicaid Services (CMS) found a clear association between nurse staffing ratios and nursing home quality of care. It established the importance of having a minimum of 0.75 Registered Nurse (RN) hours per resident day (hprd), 0.55 Licensed Vocational Nurse (LVN)/Licensed Practical Nurse (LPN) hprd, and 2.8 (to 3.0) Certified Nursing Assistant (CNA) hprd, for a total of 4.1 nursing hprd to prevent resident harm and jeopardy.[1]
    - The minimum standard was verified in a 2004 observational study,[2] and later confirmed in a simulation study finding that between 2.8 and 3.6 CNA hprd were needed to ensure adequate care to residents with varying staffing care needs.[3]
    - Some experts have recommended higher minimum staffing standards (a total of 4.55 hprd), with adjustments for resident acuity (nursing need) or case-mix. [4]
- Benefits:
    - Many studies have found a strong relationship between nursing staffing levels and improved quality of care in terms of both process and outcome measures.[5] [6] [7] [8] [9]
    - The strongest relationships are between RN staffing levels and quality measures.[10]
    - Studies have shown that higher nurse staffing levels are associated with improved resident outcomes, including: better functional improvement,[11] [12] [13]and reduced incontinence,[14] urinary tract infections and catheterizations,[15] [16] [17] [18] pain,[19] pressure ulcers,[20] [21] [22] [23] [24] [25] weight loss and dehydration,[26] [27] [28] [29] use of antipsychotics,[30] [31] restraint use,[32] [33] [34] infections,[35] [36] falls,[37] [38] rehospitalization and emergency department use,[39] [40] [41] [42]missed care,[43] [44] adverse outcomes,[45] and mortality rates.[46] [47] Higher staffing levels are strongly associated with fewer deficiencies.[48] [49] [50]
    - Low staffing levels are associated with COVID-19 infections and deaths. Insufficient staffing leads to greater infection control violations which lead to greater risk of spread and death. Infection control deficiencies are more common at homes with fewer nurses and aides than at facilities with higher staffing levels, based on an analysis of data from the past two regular inspection periods.[51]

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

- Resident factors are the most important determinant of what the staffing levels should be. The minimum staffing levels should be established for residents with the lowest care needs, assessed using the MDS 3.0 assessment forms.
- Nursing facilities are expected to increase the staffing levels as their resident care needs or acuity increases (The Medicare prospective payment system (PPS) adjustment for resident acuity is based on this principal[52]). Many state Medicaid programs also pay based on resident acuity.[53]
- All facilities regardless of size should have a full-time director of nursing seven days a week (rather than the current five days required) who is a registered nurse. As facilities grow in size, the administrative nursing requirements should increase commensurate with the size.
- A recent study focused on CNAs, who provide 90% of bedside care, found that nursing homes need to adjust CNA staffing for acuity.[54] Average nurse aide staffing should vary between 2.8 hprd for the lowest level of resident acuity to 3.6 hprd for the highest level of resident acuity to maintain a rate of care omissions below 10 percent.
- Federal regulations require nursing homes to conduct a facility self-assessment regarding what resources and qualified staff are needed to meet patient needs and to carry out all functions at the facility level. This analysis must consider: "the number, acuity and diagnoses of the facility's resident population" and must be updated at least annually (42 C.F.R. §483.70(e)).

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

- A 2022 study comparing actual NH staffing with the 2001 CMS minimum staffing standard found that 95 percent of NHs failed to meet all the recommended minimum staffing levels (4.10 hours per resident day (hprd)).
- [55] They estimated that the cost to attain the recommended minimum staffing was $7.25 billion based on current wage rates and stated that this cost represents only **4.2% of the $172.2 billion** of national NH expenditures in 2019.
- Bowblis (2022), using data from the 1995/97 Staff Time Measurement (STM) studies as a benchmark for minimum staffing, found that 60 percent did not meet the minimum for total nursing staff. He estimated the costs of meeting staffing minimums would be $500,000 on average for those not meeting the standard or a total of $4.9 billion annually.[56]
- Though these authors argued that many Medicaid reimbursement rates are too low for nursing homes to increase their staffing without additional funds, **there is widespread evidence that most nursing homes have adequate resources to increase their staffing levels without additional Medicaid resources.**[57] [58] [59] A study recently showed that most major publicly traded NH companies were highly profitable, even during the

pandemic.[60] Another study of Ensign, the second largest publicly-traded nursing home chain in the US, made high profits during the COVID pandemic while keeping its staffing levels low and having large COVID-19 resident infections and deaths.[61]

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

- Yes: For-Profit Chains and Non-Chains Often Have Lower Staffing and Poor Quality:
    - For-profit nursing home companies generally have poorer quality indices and deficiencies (for violations of regulations) than nonprofit and government facilities.[62] [63]
    - Studies show staffing levels, as a quality indicator, are lower in for-profit nursing homes.
    - For-profit owners have been found to frequently cut nurse staffing, especially RN staffing, and reduce wages, benefits, and pensions to maximize profits, compared to nonprofit and government facilities, which provide higher staffing and quality care.[64]
    - For-profit nursing homes reported an average of 16 percent fewer staff than nonprofits, after accounting for differences in resident needs in 2017. There was 1 RN for every 28 residents in nonprofits and 1 for every 43 in for-profit nursing homes.[65]
    - Homes with the highest profit margins have been found to have the worst quality in the US.[66]
    - Nursing home chains have more quality and compliance problems than other nursing homes.[67] The largest for-profit chains have lower RN and total nurse staffing hours than non-profit facilities and government facilities and have more deficiencies, which is not surprising considering their low staffing and high acuity levels. [68] [69]
    - Non-profit nursing homes (compared to for-profits) have fewer 30-day hospitalizations and greater improvement in mobility, pain, and functioning.[70]
    - Private equity (PE) companies have been found to increase costs and reduce staffing. Private equity firms with funds from private investors use loans to acquire nursing homes, usually with the idea of investment for 3-7 years, during which the company seeks to make profits when it sells the company. A GAO study found that private equity investments resulted in increasing the costs for facilities and capital, along with higher profit margins compared to other for-profit or nonprofit homes.[71]
    - A recent study of PE buyouts of nursing homes from 2000 to 2017 showed robust evidence of declines in resident health and compliance with care standards related to cuts to front-line nursing staff and higher bed utilization compared to acquisitions by non-PE corporates and chains.[72] Evidence suggests that staffing by PE companies varies based on geographic competition.[73]
    - For-profit nursing home companies have developed increasingly complex corporate ownership structures, with most having a separate property company

from the operating company.[74] [75] [76] Some nursing homes have as many as 7-8 layers of companies in control. The complexity of interlocking corporations is designed to protect operating companies from litigation by moving assets into a separate company. A recent study of Ensign, a large chain, showed that the highly profitable publicly traded company had 430 corporate entities to manage its 228 nursing homes and senior facilities.[77] The complexity is also designed to shield parent companies from liability and reduce regulatory oversight.

- Growth in Related-Party Transactions Hides Profits. By contracting with related-party individuals and organizations for services that include management services, nursing and therapy services, lease agreements, and loans, facilities are able to siphon money out of the facilities as expenses and hide the profits through these third-party contractors.
- A study[78] by Kaiser Health News found that nearly three-quarters of US nursing homes (more than 11,000) have related-party business transactions. Many homes contract out basic functions like management or rent their own building from a sister corporation.
- Contracts with related companies accounted for $11 billion of nursing home spending in 2015 — a tenth of their costs — according to Medicare cost reports.
- Homes that did business with related-party companies employed 8 percent[79] fewer nurses and aides, were 9 percent more likely to have hurt residents or put them in immediate jeopardy of harm, and had 53 substantiated complaints for every 1,000 beds, compared with 32 per 1,000 beds at independent homes.[80]
- For-profit nursing homes utilize related corporations more frequently than nonprofits. For-profit homes with related party contracts had 10 percent higher fines, received 24 percent more substantiated complaints from residents, and had 4 percent lower than at independent for-profits.[81]

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

- One of the most significant barriers to successful recruitment and retention of staff is job quality, which can be measured by facility staff turnover. CMS estimates that the average staff turnover for a nursing home is 52.6% annually.[82] Studies show that high turnover in nursing homes leads to poorer outcomes for nursing home residents.[83] In order to retain and attract new workers, facilities must address the issues that lead to turnover. Most commonly, high turnover is the result of poor wages and benefits, lack of training, poor management, lack of career advancement, and workloads.[84] By directly addressing these issues, nursing homes will reduce turnover, attract new workers, and, importantly, provide better quality care to residents.

A. Wages and Benefits

1. Wages

- CNAs
  - $14.48 is median wage in 2020; $24,200 median income
  - 34% rely on some kind of public assistance
  - 41% live in low-income households[85]
- RNs
  - Median annual wage in nursing homes is $72,420. For hospitals it is $78,070.[86]

2. Paid leave

- One study showed 64% of nursing home staff stated they did not have paid leave.[87]
- Sick staff cannot afford to not work and fear losing their jobs, and resultingly end up going to work sick. This phenomenon was particularly damaging during the COVID-19 pandemic, where infected staff were the primary driver of COVID-19 infection in nursing homes.[88]

3. Health Insurance

- Only 62% of CNAs have health insurance through their employer. An additional 25% have Medicaid, and 13% have no coverage at all.[89]

Strategies to Address Issues

- A Leading Age study estimated raising wages of CNAs would reduce turnover and stabilize the workforce.[90] The Leading Age report estimated that costs associated with increased wages would be offset by gains in productivity.
- All direct care staff must be paid a living and competitive wage.
- Nursing homes must be required to provide health insurance and paid leave benefits.

B. Workloads

- High workloads directly contribute to high staff turnover.[91]
- Understaffing leads to overwhelming workloads that result in residents not receiving necessary care and also to staff burnout. As a result, the problem of understaffing is perpetuated.
- CMS research has established the importance of having a minimum of 2.8 CNA hprd for each resident.[92] Accordingly, CNAs should not have more than 6 residents on the day and evening shifts to care for and no more than 13 residents at night. However, on average, CNAs in nursing homes provide care to 13 residents per shift.[93] 1 in 10 CNAs in the USA are responsible for 17 or more residents.[94]

Strategies to Address Issues

- Increasing direct care staffing by addressing the issues that contribute to turnover will reduce staff workloads and increase staff retention.

C. Training

In addition to leading to high turnover, inadequate training results in poor health outcomes for residents.

- Tailored and ongoing training programs improve job satisfaction and reduce turnover.[95]
- CNAs reporting high-quality training are more likely to work in states requiring additional initial training hours and were more satisfied with their jobs than those with low-quality training.[96]
- A 2008 study by the Institute on Medicine (IOM) found the current minimum federal training requirements for CNAs to be inadequate, leading not only to poor health outcomes for residents, but also increased turnover in staff. The study recommended significant increases in the training requirement to at least 120 hours. [97]

- A recent report from the National Academy of Science, Engineering, and Medicine came to the same conclusion as the 2008 IOM report. [98] The report also recommended that state and federal government should provide free access to entry-level and continuing education training programs, and that nursing homes should pay workers for attending these training.

Strategies to Address Issue

- CMS should raise the required minimum training hours from 75 to 120 hours.
- Direct care staff should have access to free entry level training and continuing education classes. The time spent by direct care staff attending trainings should be paid for by nursing homes.

D. Career Advancement and CNA Empowerment

There is little opportunity for career advancement in nursing homes, particularly for people of color. By providing workers, particularly CNAs with opportunities for career growth, nursing homes will increase retention.

- 58% of CNAs are people of color.[99] However, the number of people of color in higher-level positions, such as LPNs or RNs decreases as the educational requirements increase.[100]
- Empowerment of CNAs and career opportunities can reduce staff turnover and increase care quality. [101]

- CNA empowerment was a main focus of the report issued by the National Academies of Science, Engineering, and Medicine, which found that increasing opportunities for CNAs could lead to a reduction in staff turnover. The report noted that CMS 2016 revised regulations for nursing homes required that CNAs be part of the interdisciplinary team and involved in care planning.[102]

Strategies to Address Issue

- Nursing homes must provide more career advancement opportunities for direct care staff through sponsoring training and education.
- CNAs must be incorporated into care planning and given a more prominent role in care teams assigned to provide care to residents.

E. Administrators/Leadership

On average, nursing home administrators last little more than a year before leaving their positions.[103] A variety of factors contribute to administrator turnover, including burnout, lack of resources, and difficulty with corporate management.[104]

Regardless of the causes, high turnover in administrative staff has been shown to be associated with high turnover in direct care staff. Chaos in management and administration will inevitably contribute to higher turnover among direct care staff and poor health outcomes for residents. [105]

Strategies to Address Issue

- To incentivize stability in management, CMS should incorporate administrator turnover into its value-based purchasing program.
- CMS should require all nursing home administrators to have, at a minimum, a bachelor's degree and training in topics relevant to their role.[106] For instance, the National Association of Long Term Care Administrator Boards offers both accreditation and continuing education programs designed specifically for nursing home administrators.

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

When facilities are unable to obtain adequate staff, CMS must require the facility to cease new admissions until the facility is able to meet the staffing requirement. Inadequate staffing is a threat to the health and well-being of residents.

Why and for what reason is CMS applying a good faith effort assessment? If CMS is suggesting that it may apply a good faith determination as to whether a minimum staffing standard should be waived, we strongly oppose any such waiver.

If CMS is considering applying a good faith measure to an assessed penalty, we suggest that any such measure be used infrequently, and only in instances of emergencies. Any good faith metric must be based on empirical data and should include a facility documenting its efforts to hire new staff and to retain staff through the investment in high quality jobs.

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

- Turnover is the primary barometer of how nursing homes are treating staff. Currently, CMS estimates that the average annual turnover rate is 52.6%. CMS recently began posting turnover rates on Care Compare, which is an important step in furthering transparency for consumers. CMS should continue to explore ways to incentivize the reduction of turnover rates, including using facility turnover rate as a measure in the SNF Value Added Purchasing Program.
- The use of agency staff has been associated with poorer health outcomes for nursing home residents.[107] Additionally, long-term use of agency staff may be indicative of a facility's failure to address underlying job quality issues in a facility. However, there may be instances where agency staff is needed, such as emergencies or pandemics. CMS should continue to monitor the use of agency staff and investigate its impact on resident care.

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

- Only direct care nursing staff should be included in the minimum staffing standard. The landmark 2001 CMS study looked at only RNs, LPNs, and CNAs to determine what staffing levels were necessary to ensure care quality was not compromised.
- There is no evidence that any other nursing home staff, including feeding assistants, social workers, and other mental health workers, are able to replace the care provided by RNs, LPNs, and CNAs. While we support the creation of standards for social workers and other mental health staff, those standards should be separate from a minimum staffing standard.
- CMS must not group together RNs, LPNs, and CNAs into a single care expectation. CMS, itself, has acknowledged the important role that each nursing group provides. That is why in 2001, and in most studies since then, minimum recommendations have been made based on each nursing category. Failure to do this will result in facilities using the least costly nursing options, CNAs, to fulfill the minimum obligation. This was proven true in states that failed to designate hours per nursing category.[108]

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

- Administrative time should be counted separately from minimum resident care standards. CMS recommends a minimum of 4.1 hprd of direct resident care, which does not factor in administrative or non-clinical responsibilities. The purpose of hprd standards is to ensure residents receive CNA and nursing care to prevent illness or death related to lack of direct care.[109]
    - Direct care involves direct contact with residents to "provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being."[110]
- Current regulations allow Directors of Nursing (DON) to serve as charge nurse only if there are sixty or less occupied beds.[111] Meanwhile, several states with minimum staffing standards require an additional RN if the RN on staff is subject to administrative duties.[112] Current staffing requirements recognize that administrative duties can inhibit time towards resident care. Thus, any additional minimum staffing requirement should not include administrative duties as part of direct resident care.
    - Also note, Green House model nursing facilities remove administrative responsibilities from clinical staff and report fewer hospitalizations, infections, and deaths – this leads to more support for requirements just around direct care and separating administrative responsibilities to ensure residents' needs are met.[113]

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

- Recommend using both minimum nursing hprd and nurse to resident ratios. As previously stated, hprd clarifies the direct care hours residents require to meet their basic needs and prevent negative outcomes.[114] However, solely relying on hprd is confusing for staff, residents, and families in determining whether a facility has adequate staffing. RN/CNA to resident ratios is a clearer way to identifying staffing capacity.
- RNs should also be onsite 24-hours per day – nursing facilities inherently require skilled nursing care suggesting higher level of care than nurse aides. Nursing facilities house populations with highest needs and complex medical issues which require RN experience.[115] Additionally, as noted in Question 1, higher levels of RN care are associated with better health outcomes for residents.[116]

    - Additionally, nurse aides provide the bulk of resident care but may need supervision for certain tasks like medication administration or wound care. If an RN is not available to provide supervision around the clock, then residents will suffer from delayed care.
    - Due to CMS waiver and workforce shortage, many nurse aides did not receive full 75 hour+ training during the COVID pandemic – which magnifies the need for a full-time RN to support aides when there is a gap in knowledge/training/experience.
- Unclear exactly what non-nursing duties would entail. As previously stated, minimum hprd staffing standards should not include administrative duties. While RNs and nurse aides should have training on non-nursing requirements like residents' rights and cultural competency, those should not count as part of residents' direct care hours.
    - There is generally greater confusion and lower morale when nursing duties are conflated with non-nursing responsibilities[117]
    - However, given increasing complexities of residents, non-nursing specialists, like social workers, should be included in nursing home staff, but not counted towards nursing or direct care hours.

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

- Recommend using the quantitative 4.1 hprd as a minimum standard, in combination with the qualitative requirement that facilities must have to meet residents' needs. 4.1 hprd provides a clear baseline for direct resident care but does not address the needs of residents with increased acuity.
    - Including "sufficient nursing staff" on top of the minimum hprd clarifies that many residents will need beyond 4.1 hprd in order to be sufficient.[118]
- CMS should utilize facility assessments to determine number of residents, and number of residents with specialized needs requiring higher staffing standard of 5.6 – 6.8 total hprd
    - Facilities should use MDS data to help determine resident acuity for purposes of minimum staffing requirements since the MDS forms captures resident's functional and health status.[119]
- Overtime restrictions should not be considered for purposes of establishing minimum staffing standards. Facilities should recruit and train a high number of direct care workers without relying on a small number of workers with significant overtime.

Overworked nursing home staff results in high rates of burnout and turnover, in addition to physical injury.[120]

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

- Several studies have shown that a state's implementation of minimum staffing standards led to increased nursing hours, better health outcomes, and a reduction of deficiencies.[121]
- Quality of care improves from minimum staffing requirements primarily because residents experience fewer adverse outcomes (fewer pressure sores, restraints, and deficiencies, less extensive COVID outbreaks, and less mortality overall) and experience more positive outcomes (restoration of functioning, increased nutritional intake, and increased vaccination rates).[122]
- Minimum staffing levels must set a standard for each type of staff (CNAs, LVNs, and RNs); otherwise, minimum levels are achieved by hiring the least expensive, lowest skilled staff.[123]

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

- Only the District of Columbia has set a minimum staffing standard that meets the recommended standard of 4.1 hprd. [124] The majority of states - 29 - require less than 3.5 hprd, with 15 of those states falling below 2.5 hprd.[125] Accordingly, CMS should not rely on state models to implement staffing standards.
- Although CMS should not rely on state approaches, it should learn from mistakes made by states when implementing staffing standards. California, Ohio, and Florida, when implementing minimum standards, failed to specify minimums for each category of direct care staff (RN/LPN/CNA). As result, all three states experienced a decline in RN hours after the minimum was implemented.[126]
- Prohibiting paid feeding assistants as substitutes for CNAs raises the quality of care.

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

- Yes, a requirement for 24/7 RNs is long overdue. There is almost universal agreement in support.[127] [128]
- Plenty of studies demonstrate that more RNs leads to better care. The strongest positive relationships between staffing and positive resident outcomes are in RN staffing.[129]
- The care improvements for residents related to increased RN staffing saves Medicare and Medicaid money by reducing hospitalizations and the need for other expensive medical interventions.[130].

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

- An unintended consequence has been the substitution of lesser trained licensed nurses (licensed practical nurses substituted for registered nurses). In Ohio and California, ratios for RNs, LPNS, and RNs were not separately mandated. As a result, RN hours decreased, while less skilled nursing staff hours increased.[131] To prevent these unintended consequences, nurse staffing ratios must identify the different categories of nursing staff. In addition, CMS must not be allowed to shift non-nursing tasks to nurses or to reduce the work hours of non-nursing staff, such as housekeeping, food services workers, and activities.
- There is also evidence that alternative care settings are able to meet minimum staffing standards. For instance, researchers of the Green House Model[132] found that even though Shahbazim performed non-nursing tasks, "residents in GH [Green House] homes received approximately 0.4 more hprds (24 minutes) of direct care time from a Shahbazim than residents in traditional SNF settings." Their conclusion that "The GH model allows for expanded responsibilities of CNAs in indirect care activities and more time in direct care activities and engaging directly with residents" suggests that alternative care settings, like Green Houses, can meet any minimum staffing standards that CMS might enact, without any need for accommodation.[133]

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

- A minimum nurse staffing standard must be met by all facilities. There is no evidence or reason to believe that residents in rural nursing facilities or underserved areas have lesser nursing needs than other residents. While additional efforts are needed to increase the numbers of nurses working in rural and underserved areas, these efforts should not undermine the need for appropriate staffing levels as a mandate for all facilities, regardless of location. This issue of challenges in recruiting and retaining staff in rural and underserved areas is significant, but not new. It was addressed nearly 40 years ago by the Institute of Medicine, whose recommendations included educational outreach (including educational loan repayment programs, strengthening local educational opportunities for people from underserved communities who are more likely to continue living in those communities), upgrading existing staff in nursing homes, and ensuring appropriate payments. [134]
- In interviews with research staff, administrators, and directors of nursing in rural facilities with higher staffing levels "attributed their success to having a good reputation, being flexible, and offering individual growth opportunities (e.g., school reimbursement)." The study concluded that complex labor pool challenges "require complex solutions": "better wages, better health insurance, and better pensions, as well as improved training, supervision, and mentoring."[135]

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

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

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

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

> The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable

physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).")

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

Citations/Endnotes

[1] 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.

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