

November 6, 2023

Submitted electronically via regulations.gov

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

Re: Medicare and Medicaid Programs: Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting [CMS-3442-P; RIN 0938-AV25], 88 Fed. Reg. 61352 (September 6, 2023).

Dear Administrator Brooks-LaSure:

The Center for Law and Social Policy (CLASP) appreciates the opportunity to comment on the proposed rule to establish nurse staffing standards for nursing homes that participate in Medicare and Medicaid.

CLASP is a national, nonpartisan, nonprofit advancing anti-poverty policy solutions that disrupt structural, systemic racism and remove barriers blocking people from economic justice and opportunity. With deep expertise in a wide range of programs and policy ideas, longstanding relationships with anti-poverty, child and family, higher education, workforce development, workers' rights, and economic justice stakeholders, and over 50 years of history, CLASP works to amplify the voices of directly impacted workers and families and help public officials design and implement effective programs. CLASP takes a racial equity-based, systemic approach to improving job quality, particularly for marginalized workers in occupationally segregated industries. Family-sustaining wages, benefits, access to paid sick days, paid family and medical leave, and stable work schedules, minimum staffing levels are fundamental components of job quality.

We strongly support the Administration's initiative to improve the quality of care in nursing homes. For decades, health researchers, geriatricians, nurses, and other clinical experts have recommended minimum nursing staffing requirements to improve the quality of care at nursing homes; a wide range of peer-reviewed literature demonstrates the causal connection between staffing and quality of care in nursing homes.ⁱ As far back as 2001, the Center for Medicare & Medicaid Services (CMS) noted the "strong and compelling" evidence for having minimum staffing levels, even in an economy with a chronic workforce shortage.ⁱⁱ Moreover, a blue-ribbon panel convened by the National Academy of Science, Engineering, and Medicine (NASSEM) noted in its 2022 report that increasing overall nurse staffing has been a consistent and longstanding recommendation for improving the quality of care in nursing homes.ⁱⁱⁱ

There is a pressing need for national nursing home staffing standards for certified nursing assistants—certified nurse aides (CNAs), licensed practical nurses (LPNs), and registered nurses (RNs) who provide direct care to residents. The continued pattern of poor staffing and the significant variability in the nurse-to-resident ratios across facilities and states increases the

likelihood of residents receiving unsafe and low-quality care, particularly during a public health crisis.^{iv} All residents, regardless of zip code, are entitled to appropriate professional nursing care.

This Notice of Proposed Rulemaking (NPRM) sets a minimum nursing staffing standard; it does not create a ceiling on staffing or impose a “one-size-fits-all” solution. Furthermore, the NPRM does nothing to change the moral and legal obligations to provide resident-centered care. The 1987 Nursing Home Reform Act (NHRA) required all nursing homes to provide “nursing services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.”^v Facilities with a higher acuity case mix would still be required to staff at a level appropriate to meet the needs of those residents. Thus, a minimum staffing standard sets a floor for care, not a ceiling.

Less discussed but equally important—and ultimately related to care quality—is the impact of inadequate staffing on direct care workers themselves. Nurse staffing has been a chronic problem that preceded the pandemic.^{vi} With the average CNA earning just over \$17/hour,^{vii} it remains difficult for facilities to find people willing to undertake such physically and emotionally draining work—work with a significant risk of injury that is heightened by understaffing.

While a variety of factors, such as wage levels and employment benefits, contribute to job quality, it is clear that understaffing leads to stress, burnout, and physical and moral hazard. Workers are often forced to make impossible choices about how to prioritize the various care needs of their residents. The intense pace of work from understaffing also prevents nursing home workers from being able to care for themselves. Understaffing isolates individual workers, often keeping them from being able to organize around their job strain. It can also create fear of changing workplace conditions because they know there isn’t another worker to replace them and care for their patients.

It is not coincidental, however, that marginalized workers have historically been overrepresented within the nursing sector. Although nursing home workers care for the most vulnerable members of our society, their work is largely undervalued as a result of systemic racism, sexism, and xenophobia that obscures the value of care work. This is especially true for CNAs, who provide the bulk of hands-on care to residents—CNAs are 90 percent women, 58 percent BIPOC workers, and 20 percent immigrant workers.^{viii} As a result, this workforce is grossly underpaid, overworked, undervalued, and experiences some of the highest rates of workplace injury, at almost three times the rate of the typical US worker.^{ix}

The labor market disequilibrium is even more evident in the poor retention rate of direct care staff. On average, nursing homes lose more than half their direct care staff annually.^x Chronic turnover not only diminishes the quality of care – since the average direct care worker is less experienced and not as familiar with the needs of particular residents – but creates an endless cycle of turnover, understaffing, and increased job strain due to the extra burden placed on existing staff from CNAs to RNs.

The labor market difficulties facing the sector are solvable, as shown by the difference in staffing between for-profit facilities and nongovernmental nonprofit facilities. Average staffing for the latter already meets or exceeds the 4.1 hours per resident day standard identified in the 2001 study by Abt Associates.^{xi} Both receive the same reimbursement from public programs. The

difference is how they allocate revenue. The Administration should not forego policies that would improve the quality of care simply because one industry segment — for-profit facilities — refuses to address a workforce problem of its own creation.

We commend the Administration for proposing minimum nursing staffing standards. The NPRM represents a paradigm shift in nursing home oversight to promote quality of care. At the same time, we strongly urge CMS to strengthen the proposed minimum nurse staffing standard, as detailed below. These proposed changes will increase the likelihood that facilities meet the requirements of the NHRA and increase both job quality for care workers and quality of life for residents.

Recommended Changes

Staffing Minimums

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

Additionally, we suggest including LPNs in the rule, and adopting requirements for which types of nurses are required. In the rule as it currently stands, without a total nurse staffing hours per resident day (HPRD), some nursing homes may choose to staff in such a way as to only comply with the CNAs and RN HPRD minimums, potentially decreasing other types of nursing staff, such as LPNs. Similarly, in the current rule, nursing homes could meet the 0.55 RN HPRD and fill the rest of the staff with CNAs, leading to a lower skill mix. A total nurse staffing HPRD would safeguard against this behavior.

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

- The care provided by a CNA should be 2.8 HPRD; and
- The care provided by a licensed nurse should be set at 1.4 HPRD, with 0.75 of that provided by an RN and 0.65 of that provided by a licensed practical nurse (LPN)

These staffing levels are more protective of residents and direct care staff and, consequently, are more likely to meet both the statutory goals of the NHRA and the goals of the NPRM.

Additionally, the aforementioned staffing levels are consistent with the goal of establishing a minimum nursing staffing standard that avoids unacceptable levels of omitted and delayed care and reduces the likelihood of compromised care — goals articulated in the 2001 Abt study and echoed by the 2023 Abt study.

It is worth noting that the suggested RN level is taken directly from the simulation study conducted by Abt as part of the 2023 study.^{xii} The suggested CNA level is taken from the authoritative work of Professor John Schnelle^{xiii} and cited approvingly by the 2023 Abt study;

the 2023 Abt study did not conduct a simulation study for CNAs. In both cases, these are the staffing levels needed to keep delayed or omitted care below 10 percent; they are also staffing levels supported by qualitative analysis in the 2023 study. These staffing standards are reasonable and achievable when nongovernmental nonprofit homes average 4.19 HPRD, according to the latest CMS data.^{xiv}

Waivers and Exemptions

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

To the extent that waivers exist, they should be limited in number and frequency. A facility should only be granted a waiver if it has demonstrated clearly identifiable progress on nursing staffing, including documenting a reduction in turnover and an increase in wages. To promote high-road employers, CMS should define “prevailing wage” to be consistent with both its usage in federal programs, as well as through looking at collectively bargained wage rates as a source of data on competitive wage levels. This also means including benefits in the determination of prevailing wage. Demonstrations of a good-faith effort to hire sufficient nursing staff should include evidence that the facility has offered what constitutes a living wage for that community.

Any facility granted a waiver should be under more intense scrutiny. For example, survey frequency should be increased, and CMS and state survey agencies could appoint an independent entity to monitor the facility’s performance. Demonstrations of a good-faith effort to hire sufficient nursing staff should also include data demonstrating turnover rates below a certain threshold, as proof that hardship is not caused by poor working conditions.

Finally, any waiver that is granted should be prominently displayed on the Nursing Home Compare website, along with a warning about the possible consequence of nursing understaffing. A similar notice should be required to be posted in the nursing facility and provided to any individual seeking admission to the facility.

Enforcement and Assessment

We appreciate the fact that the success of any nurse staffing standard relies on the enforcement regime backing it up. We urge CMS to consider policy opportunities to bolster the current state survey and certification process. Currently, CMS’s proposed rule does not propose specific enforcement policies or assessment methods. Having more specific requirements for assessment can better ensure compliance and allow positive results to be replicated. For example, CMS can require each facility to develop a facility-wide staffing plan, with CMS guiding what that plan can look like to help facilities determine acuity adjusted HPRD for each nursing staff type. By requiring that facilities demonstrate use of their guide in the development of their plan, CMS can better ensure compliance.

Another way to approach assessments is through meaningful and protected inclusion of worker input. Workers are the true experts of their workplaces, and often have information of conditions that administrators do not have access to. CMS can center worker voice by requiring the creation of an assessment committee that includes representatives from all levels of nursing staff. In doing so, explicit language should be included prohibiting intimidation or retaliation of workers participating in the assessment process.

Transparency

We applaud CMS for seeking to increase the transparency of Medicaid reimbursement; at the same time, we think facilities should be required to show how much of their total revenue goes to resident care. Specifically, reporting requirements should include both the percentage of revenue spent on direct care workers and support staff as well as median hourly wages for each category of employees. Further, the data should be disaggregated by job duty since wages for different types of direct care workers and support staff are incredibly wide-ranging. Just posting broad categorical percentages or median hourly wages for a range of job classifications does not provide transparency as to how each type of worker is actually compensated. We also believe that nursing homes should be required to detail other expenses, including any payments to related parties and revenue from *all* payer sources that is spent on compensation. This transparency could also be furthered by the implementation of an Interested Parties Advisory Group (IPAG) made up of consumers, workers, and other stakeholders. A strong nurse staffing standard and greater financial transparency in the sector are necessary prerequisites for any discussion of greater nursing home reimbursement.

Conclusion

We heartily applaud the Administration for taking up the critical issue of nurse staffing in nursing homes. This is a critical issue as nursing homes continue to care for an increasing number of residents with high acuity. Finally, as a workforce primarily made up of marginalized workers, improving staffing ratios is a critical means of moving towards racial and gender equity.

CMS's initial efforts to define an appropriate minimum nurse staffing standard culminated in the 2001 Abt study, which sought to answer the critical question of whether staffing ratios were necessary to achieve high-quality of care for residents. The answer then and now is a resounding "yes." But staffing ratios can be meaningful and effective only if they are designed to ensure that residents actually receive the care they need. We urge CMS to accept our recommendations and publish a final rule that requires appropriate staffing ratios. We also urge CMS to consider this proposed rule as its own floor in attaining better job quality and care in nursing homes. This rule should be considered the start of a larger set of nursing home reforms at the systems level, following the recommendations laid out in the NASEM report.

Sincerely,

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The Center for Law and Social Policy (CLASP)

ⁱ *Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2023; Request for*

Information on Revising the Requirements for Long-Term Care Facilities To Establish Mandatory Minimum Staffing Levels (CMS-1765-P, 87 Fed. Reg. 22720 (April 15, 2022). See also Castle, N. (2008). *Nursing Home Caregiver Staffing Levels and Quality of Care: A Literature Review*. *J. of Applied Gerontology*, 27: 375- 405; Dellefield, M.E., Castle, N.G., McGilton, K.S., & Spilsbury, K. (2015). *The Relationship Between Registered Nurses And Nursing Home Quality: An Integrative Review* (2008-2014). *Nursing Economic*, 33 (2):95-108 and 116.; Castle, N.G. & Anderson, R.A. (2011). *Caregiver Staffing in Nursing Homes and Their Influence on Quality of Care*. *Medical Care*, 49(6):545-552.; Castle, N., & Engberg, J. (2008). *Further Examination of the Influence of Caregiver Staffing Levels on Nursing Home Quality*. *Gerontologist*, 48: 464-76.; Schnelle, J.F., Simmons, S.F., Harrington, C., Cadogan, M., Garcia, E., & Bates-Jensen, B. (2004). Relationship of Nursing Home Staffing to Quality Of Care? *Health Services Research*, 39 (2):225-250.

ⁱⁱ 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.

ⁱⁱⁱ 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.

^{iv} Medicare and Medicaid Programs: Minimum Staffing Standards for Long Term Care Facilities and Medicaid Institutional Payment Transparency Reporting, 88 *Fed. Reg.* 61353 (September 6, 2023).

^v 42 U.S.C1396r, 42 U.S.C. 1395i-3, 42 CFR 483.

^{vi} Munday, R., *Chronic Understaffing in Nursing Homes and the Impacts on Healthcare*, *Nurse Journal*, July 6, 2023. Available at <https://nursejournal.org/articles/chronic-understaffing-in-nursing-homes/>. See also Rau, J., 'It's Almost Like a Ghost Town.' *Most Nursing Homes Overstated Staffing for Years*, *New York Times*, July 17, 2018. Available at <https://www.nytimes.com/2018/07/07/health/nursing-homes-staffing-medicare.html?auth=linked-google1tap>. See also Quinton, S., *Staffing Nursing Homes Was Hard Before The Pandemic. Now it's Even Tougher*, *Fierce Health*, May 18, 2020. Available at <https://www.fiercehealthcare.com/hospitals-health-systems/staffing-nursing-homes-was-hard-before-pandemic-now-it-s-even-tougher>.

^{vii} *Direct Care Workers in the United States: Key Facts 2023*, PHI National. Available at <https://www.phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-2023/#:~:text=Key%20Takeaways&text=Between%202021%20and%202031%2C%20the,care%20workers%20were%20only%20%2423%2C688>.

^{viii} Bryant, N., Cimarolli, V., et al, *Organizational Factors Associated with Certified Nursing Assistants' Job Satisfaction during COVID-19*. *J Appl Gerontol*. 2023 Jul; 42(7): 1574-1581. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9908517/pdf/10.1177_07334648231155017.pdf

^{ix} Campbell, S., “*Workplace Injuries and the Direct Care Workforce*,” PHI, April 2018.

^x *Nursing Home Staff Turnover Above 50%, LTCCC Alert*. Available at <https://nursinghome411.org/alert-staffing-q4-2022/#:~:text=Nursing%20homes%20are%20turning%20over,with%20worse%20quality%20of%20care.> *High Staff Turnover at U.S. Nursing Homes Poses Risks for Residents' Care*, Reed Abelson, *New York Times*, August 21, 2021. <https://www.nytimes.com/2021/03/01/health/covid-nursing-homes-staff-turnover.html>. 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 Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7992115/>.

^{xi} *Nursing Home Staffing Study Comprehensive Report*, Abt Associates, June 2023. Available at

<https://www.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf>

^{xii} *Nursing Home Staffing Study Comprehensive Report*, Abt Associates, page 76, June 2023. Available at

<https://www.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf>

^{xiii} Schnelle, J.F., Schroyer, L.D., Saraf, A.A., Simmons, S.F., *Determining Nurse Aide Staffing Requirements to Provide Care Based on Resident Workload: A Discrete Event Simulation Model*, *J Am Med Dir Assoc*, 2016 Nov 1;17(11):970-977. Available at <https://pubmed.ncbi.nlm.nih.gov/27780572/>.

^{xiv} *Better Staffing is Achievable A Look at For-Profit versus Non-Profit Nursing Homes*, National Consumer Voice for Quality Long-Term Care, September 29, 2023. Available at https://theconsumervoice.org/uploads/files/issues/Better_Staffing_Is_Achievable.pdf.