California Association of Long Term Care Medicine
Promoting quality patient care through medical leadership and education

November 6, 2023

Centers for Medicare & Medicaid Services
Submitted electronically
https://www.regulations.gov/commenton/CMS-2023-0144-0001

Re: CMS-3442-P, Medicare Program

Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting 88 Fed. Reg. 61352 (Sept 6, 2023)

Dear CMS Administrator and Brooks-LaSure and CMS Colleagues:

CALTCM is the medical voice for long term care in California. We advocate for quality patient care, representing physicians, nurse practitioners, physician assistants, nurses, pharmacists, social workers, and others who provide care to the residents of nursing homes. We achieve our mission through education and policy.

The COVID-19 pandemic has been particularly devastating to older adults living in nursing homes and the staff that compassionately care for them, with over 200,000 deaths in nursing homes across the country.[1] However even prior to the pandemic, our members have recognized myriad issues that impede quality care in nursing facilities. For many years we have observed dedicated administrators and directors of nursing struggle under financial pressures. Low wages and limited benefits have made finding and maintaining staff challenging. Studies have shown that understaffed nursing homes are correlated with poorer clinical quality.[2]

We strongly support CMS's effort to establish minimum staffing standards for NHs, but we recommend higher mandatory minimum staffing standards than CMS has proposed. We also support specific guidelines for staffing levels based on resident acuity. The regulations as proposed have potential negative unintended consequences. If unchanged, we will risk normalizing staffing levels that continue to deliver poor quality of care and outcomes. Substantial improvement in the quality of care at NHs will not be realized unless these standards are revised and strengthened. We also believe that staffing mandates alone will not maximize opportunities to bring about improvement in the quality of care in our nation's nursing homes. We are submitting the following specific comments.

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[1] https://www.kff.org/policy-watch/over-200000-residents-and-staff-in-long-term-care-facilities-have-died-from-covid-19/
[2] Harrington, C. et al. Appropriate Nurse Staffing Levels for U.S. Nursing Homes. (Health Services Insights, June, 2020).

I. Addressing the Proposed Staffing Minimums

1. The Importance of A Minimum Staffing Standard

We agree with CMS's statement that there is strong evidence that setting mandatory minimum staffing levels can improve the quality of care for long term care facilities (LTCFs) which we refer to as nursing homes (NHs). Our support is based on evidence that includes that (1) sufficient numbers of well-trained, well-compensated, and well-treated staff are essential to provide residents with high quality of care and quality of life and to protect their health and safety; (2) adequate and appropriate staffing will improve the quality of jobs for NH nursing staff; and (3) requiring minimum staffing levels will ensure that public funds are used appropriately to provide sufficient staff and prevent/reduce the diversion of funds to profits.

The implementation and enforcement of a nursing staffing standard is vital to the physical, mental, and psychosocial well-being of NH residents and the safety and well-being of the staff. It is therefore important to ensure that a staffing standard is implemented with as little delay as possible to ensure that residents receive the safe quality care they deserve and that has been paid for. Most NH residents are elderly (83% being more than 65 years old[3]), disabled, with complex care needs and multiple co-morbidities[4]. Many are unable to perform the most basic activities of daily living ("ADLs") that include bathing, eating, drinking, dressing, going to the toilet and transferring[5], without assistance from NH staff. Facilities need adequate staffing levels to meet residents' needs. If not, the residents will have an increased risk of poor outcomes.

Research reveals a strong relationship between residents' care outcomes that increase positively with higher nursing staff hours, and negatively with lower nursing staff hours.[6] [7] [8] [9] This relationship was tragically illustrated during COVID-19 where low staffing levels were associated with infections and many of the over 200,000 deaths of NH residents and staff. [10] [11] [12] [13]

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[3] Centers for Disease Control. Nursing home residents, by selected characteristics and length of stay, Table IX. Atlanta, GA, 2016. https://www.cdc.gov/nchs/data/series/sr_03/sr03_43-508.pdf

[4] Co-morbidities are diseases or medical conditions that are simultaneously present within a patient.

[5] Transferring means being able to either walk or move oneself from a bed to a wheelchair and back again.

[6] 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.

[7] Schnelle, J.F., Schroyer, L.D., Saraf, A.A., and Simmons, S.F. Determining nurse aide staffing requirements to provide care based on resident workload: A discrete event simulation model. *J. American Medical Directors Association*. 2016: 17:970-977.

[8] Dellefield, M.E., Castle, N.G., McGilton, K.S., & Spilsbury, K. The relationship between registered nurses and nursing home quality: An integrative review (2008-2014). *Nursing Economic$*, 2015: 33 (2):95-108 and 116.

[9] Castle, N. Nursing home caregiver staffing levels and quality of care: A literature review. *Journal of Applied Gerontology, 2008: 27*: 375-405.

[10] White, E. M., Aiken, L. H., & McHugh, M. D. Registered nurse burnout, job dissatisfaction, and missed care in nursing homes. *Journal of the American Geriatrics Society*, 2019: *67*(10), 2065-2071.

[11] Li, Y., Temkin-Greener, H., Shan, G., & Cai, X. (2020). COVID-19 infections and deaths among Connecticut nursing
home residents: Facility correlates. *Journal of American Geriatrics Society, 68*(9), 1899–1906. https://doi.org/10.1111/jgs.16689

[12] 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.

[13] 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.

In addition to benefiting NH residents, enacting a sufficient federal minimum staffing standard would improve the quality of jobs for NH nursing staff by helping to alleviate the poor working conditions that overburdened NH staff suffer. When a facility is short-staffed, nursing staff are unable to care for residents without significant delays and omissions in care and consequently suffer stress, moral distress, and burnout that in turn leads to high turnover and chronic vacancies.[14] Reducing turnover will have a significant impact on the existing workforce shortages.

Research has shown that in the absence of national NH staffing standards, many facilities, especially for-profit facilities, have routinely maintained low levels of staffing.[15] Establishing federal staffing standards may ensure that facilities provide adequate care to residents, but this is contingent upon what staffing standards are established. We believe such standards should be set to protect **all** residents.

2. The Importance of the Nursing Skill Mix (RN + LPN/LVN + CNA).

Residents in NHs require healthcare services that are typically clinically complex and labor intensive, requiring both manual labor and intellectual effort. Because of the unique nature of these services, care is optimally provided using a nursing skill mix consisting of registered nurses (RNs), licensed vocational/practical nurses (LPN/LVNs), and certified nursing assistants (CNAs).

Each type of nursing staff uniquely contributes to achievement of desired care outcomes through their performance of specific care processes. RNs are critically important to the overall quality of NHs because they are responsible for the co-ordination and overall delivery of care including problem solving, assessing, planning, implementing, and evaluating residents' care plans. RNs are responsible for management and supervision of LPN/LVNs and CNAs and collaborate with other interdisciplinary team members, such as physicians, social workers, and rehabilitation staff regarding care goals and interventions. Additionally, RNs are responsible for implementation of new or modified regulatory requirements. For example, any effective chain-wide implementation of policies and procedures needs to be tailored to the unique physical layout of a facility and the collective competencies of its nursing staff.

LPN/LVNs provide practical care and are licensed to undertake tasks that vary by state but usually include tasks such as administering medications and treatments. These are activities that CNAs are not trained to do and are not within their scope of practice. Not including LVNs/LPNs within the staffing standards confers unnecessary ambiguity to the mix of direct care staffing. Nursing homes and extended care settings in the United States employ 4.4 percent of the country's RNs, compared with 27.5 percent of the country's LPN/LVNs (down from 31.7 percent in 2017).[16]

[14] White, E. M., Aiken, L. H., & McHugh, M. D. Registered nurse burnout, job dissatisfaction, and missed care in nursing homes. *Journal of the American Geriatrics Society*, 2019: *67*(10), 2065-2071.

[15] Hawk T, White EM, Bishnoi C, Schwartz LB, Baier RR, Gifford DR. Facility characteristics and costs associated with meeting proposed minimum staffing levels in nursing homes. JAGS. 2022; 1-10. doi:10.1111/jgs.17678

[16] The National Academies of Sciences, Engineering, and Medicine (NASEM), Board on Health Care Services, Health and Medicine Division, Committee on the Quality of Care in Nursing Homes. *The national imperative to*

While the LPN/LVN is not an equivalent substitute for the RN, they are an important part of the nursing home workforce.

CNAs are primarily responsible for assisting residents with activities of daily living such as eating, dressing, transferring and toileting. To perform these services effectively, CNAs are required to understand how their caregiving contributes to the resident's achievement of care goals as described in the resident-centered plan of care.

3. Staffing Standard for RNs 24-hours Per Day

CMS is proposing that: (1) 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 that is available to provide direct resident care.

We strongly support this CMS proposed requirement for 24-hour RN staffing in all NHs and appreciate the CMS rationale of using research literature to support this regulation. This recommendation has been strongly supported by many experts and organizations for many years.[17] [18] [19] [20] [21] [22]

We strongly recommend that the Director of Nursing (DON) and other administrative nurses should have their administrative time counted separately from RNs providing direct care 24 hours a day, 7 days a week in the proposed regulation. Under the federal regulations, the DON may also serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents (§483.35(b)(3)). While there is no evidence to support lowering licensed staffing requirements for facilities under 60 beds, we believe that CMS should consult with nursing and long term care medicine experts in order to determine a realistic approach to this issue. **We recommend that all direct care RNs be located in each NH and not off-site or on call, although we support further research into the efficacy of utilizing telehealth to provide such services.**

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improve nursing home quality: honoring our commitment to residents, families, and staff. 2022. Washington, DC: The National Academies Press. https://nap.nationalacademies.

[17] Harrington, C., Kovner, C., Mezey, M., Kayser-Jones, J., Burger, S., Mohler, M., Burke, B., and Zimmerman, D. Experts Recommend Minimum Nurse Staffing Standards for Nursing Facilities in the U.S. *The Gerontologist*. 2000: 40 (1):5-16.

[18] Institute of Medicine. *Keeping patients safe: transforming the work environment of nurses.* Washington, DC: National Academy of Medicine, 2004.

[19] American Nurses' Association. Nursing staffing requirements to meet the demands of today's long term care consumer recommendations from the Coalition of Geriatric Nursing Organizations (CGNO). Position Statement 11/12/14. www.nursingworld.org

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

[21] Kolanowski A, Cortes TA, Mueller C, Bowers B, et al. A call to the CMS: Mandate adequate professional nurse staffing in nursing homes. *AJN.* March, 2021: 121 (3):22-25.

[22] The National Academies of Sciences, Engineering, and Medicine (NASEM), Board on Health Care Services, Health and Medicine Division, Committee on the Quality of Care in Nursing Homes. *The national imperative to improve nursing home quality: honoring our commitment to residents, families, and staff.* 2022. Washington, DC: The National Academies Press. https://nap.nationalacademies.

Larger facilities should increase nursing requirements commensurate with their size. For facilities with over 100 beds, we believe there should be two direct care RNs on duty 24-hours per day, seven days per week in addition to a DON and an ADON on the day shift seven days a week. **For every 100 beds, NHs should be required to add another RN 24-hours per day, so that a facility with 300 beds for example, would be required to have 3 direct care RNs 24-hours per day in addition to the administrative RNs and DONs.**

We strongly oppose waiver provisions for RN and licensed nurse staffing that are not outcomes based. The current CMS waivers potentially undermine the health and safety of residents, in addition to normalizing the delivery of substandard care. Instead, NHs must be required to not admit residents when adequate RN and licensed staffing are not available.

To add an additional RN 24 hours a day for every extra 100 beds as we recommend, would increase costs over these estimates. However, we consider that these costs would represent a justifiable investment given that resulting improvements in care (such as reduced admissions to hospital) would lead to savings.

4. **Minimum Staffing Levels for RNs**

CMS is proposing a requirement for (i) Licensed nurses, including but not limited to a minimum 0.55 RN hours per resident day (hprd) for registered nurses (RN). CMS's proposal to set the minimum RN staffing standard at 0.55 hprd is better than not having a standard, but this minimum is not consistent with the existing evidence-based literature, which supports **a direct care RN standard of 0.75 RN hprd.**

CMS selected 0.55 RN hprd for its minimum standard, which is the median level (in the 50th decile) for RN staffing in US NHs even though the national average for RNs reported by the 2023 Abt Study was 0.67 hprd. CMS should incorporate the findings from the 2023 Abt study and the clinical considerations from previous research studies, where 0.75 RN hprd as a minimum.

Quality Outcomes. The 2023 Abt Staffing Study showed that higher levels of RN staffing have a strongly beneficial impact on NH quality of care.[23] Importantly, Abt's Exhibit 4.7 below shows that facilities that staff at 0.55 RN hprd are less than 50% likely to meet the minimal expected quality standards. This standard is unacceptable.

[23] Abt Associates. Nursing Home Staffing Study Comprehensive report. Report prepared for the Centers for Medicare & Medicaid Services. June 2023. *https://edit.cms.gov/files/document/nursing-homestaffing-study-final-report-appendix-june-2023.pdf*

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

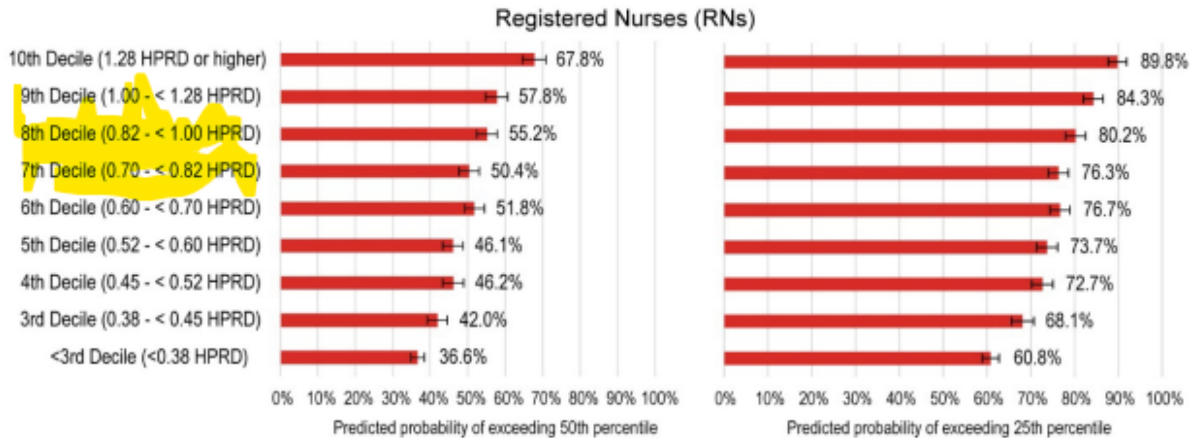
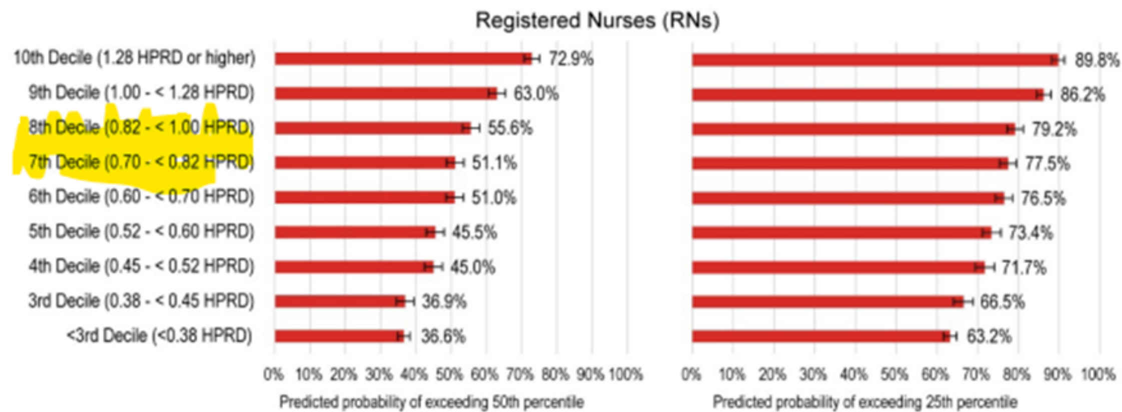


Exhibit 4.7 from the report shows that **facilities that had RN staff at 0.70 to 0.82 RN hprd, at 0.82 to 1.0 RN hprd, at 1.0-1.28, and at 1.28 to 2.8 RN hprd all had a probability of having significantly higher than average quality outcomes. All of these levels were significantly better than the proposed 0.55 RN hprd quality outcomes for residents.**

It is noteworthy that Abt assumed facilities with average quality measures had acceptable quality and yet it is common knowledge that most of the “average” quality facilities in the US have unacceptably poor quality based on research and reports by experts, residents, families, and advocates. In addition, quality measures are based on unaudited, self-reported data. If Abt had set higher standards for quality measures (above the average NH) as they should have done, it would have likely shown that 0.55 RN hprd is not a minimally acceptable standard of quality.

Safety Outcomes. The 2023 Abt Staffing Study showed that higher levels of RN staffing have a strongly beneficial impact on NH safety. Exhibit 4.9 from the Abt report (below) shows that **facilities with staffing at 0.70 to 0.82 RN hprd, with 0.82 to 1.0 RN hprd, and with 1.26 RN hprd had significantly higher than average predicted probabilities of exceeding the minimum acceptable level for safety. Facilities with only 0.55 RN hprd staffing do not meet the minimal acceptable level for safety at the 50th percentile.**

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



It should be noted that the 2023 Abt study used deficiency data based on atypical data from the time of the public health emergency during the COVID-19 pandemic. For example, these data included staffing levels at a time of increased absenteeism and high vacancies and the use of survey deficiency scores from a time when surveys were suspended or infrequent and therefore not reliable or representative. If CMS had examined the safety measures prior to the pandemic, it is likely they would have shown more significant differences in safety outcomes with 0.75 RN hprd.

Abt Simulation Study. The 2023 Abt Staffing Study conducted a limited simulation study of licensed nursing to look at omitted care. While the study did not separate LPN/LPNs and RNs, **it found that facilities needed 1.4 licensed nursing hprd to keep omitted and delayed care below 10%. The other level of care examined by Abt was 1.0 hprd of licensed care, but that level would result in 19% omitted or delayed care.** The simulation model supports the need for 0.75 RN hprd as part of the total 1.4 licensed nursing hprd.

.55 RN hprd Below the National Average Staffing. It is also important to point out that the CMS proposed 0.55 RN hprd minimum is below the national average RN staffing levels reported in the 2023 Abt Staffing study (see Table below).[24] CMS should consider setting a level of 0.75 RN hrpd to bring all RN staffing up to a level supported by evidence-based research. A request to increase RN staffing from a national average of 40 minutes per resident day (0.67 hprd) up to 45 minutes (0.75 hprd) would simply increase average RN staffing by 5 minutes a day for residents. However, it could improve the quality of care and safety of residents.

[24] Abt Associates. Nursing Home Staffing Study Comprehensive report. Report prepared for the Centers for Medicare & Medicaid Services. June 2023. *https://edit.cms.gov/files/document/nursing-homestaffing-study-final-report-appendix-june-2023.pdf*

Exhibit 4.2: Average Staffing Levels by Nursing Home Characteristics (in hprd)

	Number of Nursing Homes	Total	RN	LPN	Nurse Aide
All	15,147	3.76	0.67	0.88	2.22

The results from the Abt study found a 0.75 RN hprd minimum standard would provide more acceptable quality and safety. We therefore encourage CMS to increase its proposed minimum RN standard to 0.75 hprd.

5. **Minimum Staffing Standard for Total Licensed Nursing (RN +LPN) hprd**

We strongly urge CMS to add a specific minimum requirement of 1.4 licensed nursing hours per resident day (hprd). CMS appears to have assumed that NHs will retain their existing LPN/LVNs and simply hire more RNs and NAs as needed to meet the new CMS requirements. As CMS noted in its background section for the regulations, currently LPNs are hired as substitutes for RNs, in part because they are on average, $9 per hour less expensive than RNs.[25] NHs are more than likely to replace LPN/LVNs with RNs rather than hire additional RNs at an estimated $44 per hour.

It is unfortunate that in the 2023 Abt nurse staffing study LPN/LVN hours did not demonstrate a statistically significant correlation with measurable improvements in quality and safety measures. However, that should not be used to not set a minimum for LPN/LVNs, or licensed nursing. **CMS new standards must demonstrate the importance of the work that LPNs perform.** Although LPNs need to work under the supervision of RNs and do not have the extensive training that RNs have, they are essential to providing medications and treatments to residents. Without adequate LPN/LVN hprd, and with limited RN hprd, many residents would have delayed or omitted medications and treatments that could certainly result in harm and jeopardy to their health, safety and well-being.

Because the proposed 0.55 RN hprd minimum is below the level of RNs needed based on expert opinion and research, it is absolutely essential that the new regulations ensure adequate LPN/LVN care is provided.

Rather than adding a minimum standard for LPN/LVNs to the current proposal, we recommend that CMS set a minimum standard of 1.4 licensed (RN and LPN/LVN) hprd. We make this recommendation of a 1.4 minimum licensed nursing hprd based on evidence-based research studies.

First, the study on appropriate staffing for Centers for Medicare & Medicaid Services (CMS) in 2001 found a clear association between nurse staffing ratios and NH quality of care. Specifically, the study established the importance of having a minimum of 0.75 RN hours per resident day (hprd), 0.55 LPN/LVN hprd, and 2.8 (to 3.0) CNA hprd, for a total of 4.1 nursing

[25] Ibid.

hprd to prevent harm and jeopardy for long stay residents.[26] When added together, the total licensed nursing hours recommended 20 years ago as a minimum was 1.3 hprd. The CMS 2001 minimum standard has been endorsed by professional associations and experts over the past 20 years.[27] [28] [29] [30] [31]

CMS's NH staffing data from the payroll-based data system shows that NHs with higher averages of nursing hours and higher RN hours per resident day have higher overall quality ratings, better health inspection ratings, and fewer instances of abuse.[32] The 2023 Abt study of staffing found that as NH staffing levels increase, there is a continuous improvement in turnover rates and quality (e.g., fewer hospitalizations). There is no ceiling on improvements as staffing increases.

CMS should incorporate the findings from the 2023 Abt Nurse Staffing Study which conducted a simulation model for licensed nurses (RNs and LPN/LVNs).[33] Although the simulation study was limited in several ways, it had important findings. The simulation study only modeled 5 licensed nursing tasks out of hundreds of tasks that nurses carry out. Moreover, the study failed to consider the amount of time that nurses must spend on interrupted care because of urgent or emergent unplanned care that is needed by residents. The study also wrongly included 30 minutes for paid lunch breaks which nurses often do not receive. Therefore, the findings were an undercount of needed licensed nursing hours.

Despite the simulation model being very limited, Abt found that licensed staffing levels of 1.4 to 1.7 licensed nurse hprd were needed to eliminate delayed and omitted clinical care below 10 percent. They found that a level of licensed nurse at 1 hprd resulted in delayed or omitted care of 19 percent, which is completely unacceptable. This research clearly shows the importance of having total licensed nurses be at least a minimum of 1.4 hprd.

Since this is the most recent study data, we urge CMS to establish this minimum requirement. Not only will it protect the health and safety of residents, it will prevent NHs from laying off LVN/ LPNs, which would be an unintended consequence of the proposed

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[26] 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.
[27] American Nurses' Association. Nursing staffing requirements to meet the demands of today's long term care consumer recommendations from the Coalition of Geriatric Nursing Organizations (CGNO). Position Statement 11/12/14. www.nursingworld.org
[28] Coalition of Geriatric Nursing Organizations (CGNO). Nursing staffing requirements to meet the demands of today's long-term care consumer recommendations, 2013. http://nadona.org/pdfs/CGNO%20Nurse%20Staffing%20Position%20Statement%201%20page%20summary.pdf
[29] Institute of Medicine. *Keeping patients safe: transforming the work environment of nurses.* Washington, DC: National Academy of Medicine, 2004.
[30] Kolanowski A, Cortes TA, Mueller C, Bowers B, et al. A call to the CMS: Mandate adequate professional nurse staffing in nursing homes. *AJN.* March, 2021: 121 (3):22-25.
[31] Harrington, C., Schnelle, J.F., McGregor, M., Simmons, S.F. The need for minimum staffing standards in nursing homes. *Health Serv Insights*. 2016: 9:13-19.
[32] Zheng, Q., Williams, C.S., Shulman, E.T., White, A.J. Association between staff turnover and nursing home quality – evidence from payroll-based journal data. *JAGS.* 2022: 07 May 2022, https://doi.org/10.1111/jgs.17843
[33] Abt Associates. Nursing Home Staffing Study Comprehensive report. Report prepared for the Centers for Medicare & Medicaid Services. *https://edit.cms.gov/files/document/nursing-homestaffing-study-final-report-appendix-june-2023.pdf.*

regulations and a disaster for care. This level will prevent delays and omissions in care and protect the health and safety of residents.

6. Minimum Staffing Levels for Nursing Assistants and Certified Nursing Assistants

CMS is proposing a minimum total of 2.45 hours per resident day for nurse aides (NA). **We strongly urge CMS to establish a minimum staffing standard for CNAs of 2.8 hprd rather than 2.45 CNA hprd.** As part of the 2001 Abt study for CMS, a simulation model of CNAs established the minimum number of staff necessary to provide five basic aspects of daily care in a facility with different levels of resident acuity. The results found that the minimum threshold for CNA staffing is 2.8 hprd to ensure consistent, timely care to residents.[34]

Further, this minimum standard was verified in a 2004 observational study of residents in 21 NHs that found NHs that staffed above 2.8 CNA hours per resident day (hprd) performed better on 13 of 16 care processes compared to lower staffed homes.[35] This minimum threshold was later confirmed in Schnelle and colleagues' 2016 simulation study which found that 2.8 CNA hprd were needed to ensure adequate care to residents with the lowest staffing care needs. Residents with moderate care needs required 3.2 CNA hprd and residents with the highest care needs required 3.6 CNA hprd [36].

Schnelle and colleagues' 2016 simulation study found that NHs need to adjust CNA staffing for acuity.[37] Based on five ADLs and seven workload categories, 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.[39]

The Schnelle study showed that a minimum of 2.8 NA hprd was needed to maintain rates of omitted ADL care below 15 percent. For the lowest resident workloads, this converts to 1 CNA for every 7 residents on the day and evening shifts and 1 CNA to 11 residents at night. For the heaviest resident workloads, 3.6 CNA hprd converts to 1 CNA for 5.5 residents on days and evenings, and 1 CNA to 11 residents on nights. The Schnelle et al simulation study in 2016 is considered the gold standard study.

CMS proposed only 2.45 hprd of CNA care per day stating that "staffing below 2.45 hprd for CNAs did not improve safety and quality care." The 2023 Abt Staffing study showed, however, that higher CNA staffing at 2.8 hprd substantially improved both safety and quality. The 2023 Abt Study, upon which the 2.45 hprd is based, documents that there continues to be significant increases in safety outcomes above the 2.45 hprd level.

Importantly, the 2016 Schnelle Study found that CNA staffing at a level of 2.45 hprd would result in 15 percent omitted care for residents with the lowest acuity needs. Omitted basic care by CNAs can result in serious harm and jeopardy to residents such as weight loss, dehydration, pressure

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[34] 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.
[35] 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.
[36] 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. *JAMDA*. 2016; 17:970-977.
[37] Schnelle JF, Schroyer LD et al. 2016.

ulcers, urinary tract infections, loss of physical functioning, and many other problems that can lead to injury and even death.

We urge CMS to adopt a minimum CNA standard of 2.8 hprd which is based on scientific research and expert opinion. The goal is to improve the quality of resident care and to protect their health and safety.

It should be noted that CMS refers to Nursing Assistants (NAs) instead of Certified Nursing Assistants (CNAs). **CMS should be using the term CNAs since this is the federal requirement. Nursing assistants are required to meet certification standards within a specified period. NHs are not allowed to rely on NAs to provide basic care unless they meet the training requirements as required. We strongly oppose the use of other uncertified and untrained staff.**

7. **Minimum Staffing Standards For Total Nursing Staff Are Needed**

We strongly urge CMS to strengthen the proposed minimum staffing standard to include both licensed nurses as discussed above and a minimum for total nursing hours per resident day (hprd). We recommend a minimum staffing standard of 4.2 total nursing hprd to include 0.75 registered nurses (RNs) hprd, 1.4 licensed nurse (total RNs and licensed practical or vocational nurses (LPNs/LVNs) hprd, and 2.8 certified nursing assistants (CNAs) hprd.

As currently written, the CMS proposed regulations would require a minimum of 3.0 total nursing hours (based on the combination of 0.55 RN hprd and 2.45 NA hprd). This is fundamentally inadequate and unacceptable as a minimum standard. If CMS fails to set a specific minimum standard for licensed nurses, NHs are likely to reduce their LPN/LVN hours in order to save money. This could have calamitous results. Having a total minimum licensed nursing standard would require NHs to maintain an overall minimum nursing standard.

CMS claims the 3.0 hrpd is not a minimum staffing standard because facilities will still be required to have to have sufficient staff to meet the residents' needs. CMS has relied on this "sufficient" language for decades, and it has not been proven to be an effective means of assuring adequate staffing levels. This is one of the reasons why President Biden had to propose a minimum staffing standard. The sufficient standard has not worked for a variety of reasons, including poor enforcement, lack of knowledge about resident acuity, and inadequate specificity of the standards.

As proposed, CMS is implementing a low floor for CNA and RN care, assuming the rest will all be worked out by the enforcement system. This is impractical, especially give the data and reports showing that state survey agencies are understaffed and over worked, with widespread backlogs. A Senate Aging report from earlier this year detailed the critical staffing shortages in state survey agencies.[38]

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[38] US Senate Committee on Aging. Uninspected and Neglected: Nursing Home Inspection Agencies are Severely Understaffed, Putting Residents at Risk.
https://www.aging.senate.gov/imo/media/doc/UNINSPECTED%20&%20NEGLECTED%20-%20FINAL%20REPORT.pdf

CMS's 3.0 hprd minimum standard would allow for a reduction in total staffing to levels below the pre-pandemic national staffing averages (March 2019) that were 0.69 RN hprd, 0.87 LPN/LVN hprd, 2.31 CNA hprd and 3.87 total nursing hprd and post pandemic (May 2022), the national staffing averages were RN hprd of 0.68, LPN/LVN hprd of 0.88, CNA hprd of 2.20, for a total of 3.76 hprd.[39] **We therefore consider that without a minimum standard for all nursing staff, the proposed ruling presented is incomplete and could have serious unintended consequences which will exacerbate, rather than ameliorate the jeopardy that too many residents face every day to their health and safety.**

There is ample research evidence showing the need for a higher minimum standard of 4.2 total nursing hprd. In 2001, a CMS commissioned report gave minimum staffing recommendations to prevent harm and jeopardy to residents as RN 0.75, LPN/LVN 0.55 and CNA 2.80 hprd, for a total of 4.10 hprd. It is accepted that NH residents care needs are now more complex than they were 20 years ago.[40]

Indeed, a statement in the 2022 NASEM report quoted in this proposed ruling, identifies the need for increased staffing because "…the types of residents and the complexity of their needs have changed dramatically." Yet, the findings from the CMS 2001 study and the increased acuity of NH residents since 2001 were not closely examined in the 2023 Abt Staffing Study[41] which underpins the CMS proposed regulations. This is despite the fact that the standard of 4.10 as established in the federal government's own published research is being consistently relied upon by federal and state officials looking to enforce safe care and to determine whether adequate and appropriate staffing is being provided.

As noted above, the 2001 Abt study on appropriate staffing for CMS found a clear association between nurse staffing ratios and NH quality of care. Specifically, the study established the importance of having a minimum standard of 4.1 total nursing hprd to prevent harm and jeopardy

[39] CMS, Nursing Home Compare 5-Star data). CMS. Nursing homes including rehab services. Provider Files. Data Archives. March 2019 and May 2022. https://data.cms.gov/provider-data/archived-data/nursing-homes
[40] 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.
[41] Abt Associates. Nursing Home Staffing Study Comprehensive report. Report prepared for the Centers for Medicare & Medicaid Services. June 2023. *https://edit.cms.gov/files/document/nursing-homestaffing-study-final-report-appendix-june-2023.pdf*

for long stay residents.[42] The CMS 2001 minimum standard has been endorsed by professional associations and experts over the past 20 years.[43] [44] [45] [46] [47]

The 2023 Abt NH Staffing Study simulation study found that a total nurse staffing level of 1.4 to 1.7 licensed nursing hours was needed just to complete 5 licensed nursing tasks out of dozens of tasks that nurses need to complete. Total nurse staffing levels including 1.4 licensed nurse hprd were linked with reductions in the amount of delayed or omitted clinical care to less than 10 percent. This is the maximum threshold that the federal government should tolerate -- or the consequence will be that delayed and omitted care will continue to be common in many parts of the industry.

In addition to the 2023 Abt simulation models supporting a licensed nurse requirement of 1.4 to 1.7 hprd, the Schnelle simulation models showed a minimum need of 2.8 NA hprd for the lowest acuity residents and 3.6 NA hprd for high acuity residents. Together, these studies show that in order to avoid unacceptable levels of omitted and delayed care, CMS must require total minimum nursing hours of 4.2 hprd to 5.3 hprd, of which 1.4 hprd is licensed nursing and 2.8 hprd is CNA care.

Proposing a minimum standard of 4.2 total nursing hprd including 0.75 RN hprd, 1.4 licensed nursing hours, and 2.8 CNA hprd is financially feasible. A recent study by the industry showed 25 percent of NHs met a minimum standard of 4.1 total nursing hprd, 31 percent met the 0.75 RN hprd, 85 percent met the 0.55 LPN/LVN hprd, and 11 percent met the 2.8 hprd CNA thresholds. The estimated cost for achieving the proposed federal minimums across SNFs nationwide would require an estimated additional $7.25 billion annually. This amount only was a 4.2 percent of overall national NH spending, and would cost approximately $16 per resident per day.[48]

8. CMS Must Correct statements in the Proposed Regulations About Resident Acuity

The CMS proposed minimum staffing regulations are designed to establish a minimum floor for NH staffing. As such, **CMS must clarify that CMS minimum staffing levels are considered to be only for residents with the lowest acuity needs.** Beyond the minimum standards, the Nursing Home Reform Act of 1987, OBRA requires that each NH must provide:

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[42] 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.
[43] American Nurses' Association. Nursing staffing requirements to meet the demands of today's long term care consumer recommendations from the Coalition of Geriatric Nursing Organizations (CGNO). Position Statement 11/12/14. www.nursingworld.org
[44] Coalition of Geriatric Nursing Organizations (CGNO). Nursing staffing requirements to meet the demands of today's long-term care consumer recommendations, 2013. http://nadona.org/pdfs/CGNO%20Nurse%20Staffing%20Position%20Statement%201%20page%20summary.pdf
[45] Institute of Medicine. *Keeping patients safe: transforming the work environment of nurses.* Washington, DC: National Academy of Medicine, 2004.
[46] Kolanowski A, Cortes TA, Mueller C, Bowers B, et al. A call to the CMS: Mandate adequate professional nurse staffing in nursing homes. *AJN.* March, 2021: 121 (3):22-25.
[47] Harrington, C., Schnelle, J.F., McGregor, M., Simmons, S.F. The need for minimum staffing standards in nursing homes. *Health Serv Insights*. 2016: 9:13-19.
[48] Hawk T, White EM, Bishnoi C, Schwartz LB, Baier RR, Gifford DR. Facility characteristics and costs associated with meeting proposed minimum staffing levels in nursing homes. JAGS. 2022; 1-10. doi:10.1111/jgs.17678

> "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).

The CMS proposed regulations regarding facility assessments stress that nursing homes must do acuity assessments and staff the needs of all residents. CMS, however, offers no guidance on how to meet the needs of residents with higher acuity. Essentially, facilities are expected to have "sufficient" staff, without CMS providing guidance on what the staffing for acuity should be. This lack of guidance is a continuance of the status quo, where "sufficient" staff remains undefined. This practice has not worked, which is why President Biden made his historic announcement regarding a minimum staffing standard.

There is a blueprint for acuity, as CMS already has a system for assessing acuity for the Medicare Prospective Payment System, using the Patient Driven Payment Model (PDPM). PDPM assigns different levels of payment to providers based upon the acuity and care needs of residents. Although CMS pays NHs based on resident acuity, it does not require facilities to staff based on acuity and does not dedicate the acuity payments to nursing care.[49]

The CMS language in the NPRM is very confusing because on p. 61369, it states that

> "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."

CMS is inaccurately equating their minimum staffing standard with "average acuity." The implication here is that the standard is based on average acuity, but it is not. It is based on the lowest care needs and in our opinion is inadequate for that purpose. There is nothing in the record or any study that supports 3.0 total nursing hprd as sufficient staffing to meet the average acuity level or even the lowest acuity level.

CMS also says "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." (NPRM, p. 61370). This language gives the impression that staffing at 3.0 HPRD will meet the acuity needs of the average nursing home resident." CMS could NOT build an acuity adjustment into the 3.0 hprd standard, because it has no relation to acuity and could lead to an increase in unacceptably low staffing levels.

CMS should correct these statements to clarify that the minimum staffing is only for the lowest acuity residents. Higher acuity residents are expected to have higher than minimum staffing.

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[49] *Centers for Medicare & Medicaid Services (CMS). 42 CFR Part 413 and 483 [CMS-1765-F and CMS-3347-F] RIN 0938-AU76 and 0938-AT36 Medicare Program; Prospective Payment System and Consolidated Billing for Nursing homes; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2023;* https://www.federalregister.gov/public-inspection/2022-16457/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities

We encourage CMS to establish clear, standardized guidelines for increasing staffing levels depending upon resident acuity which we discuss in the facility assessment section of these comments.

II. Addressing Minimum Nurse Staff Level Waivers and Hardship Exemptions

CMS proposed a regulation that: (iii) The 0.55 hours per resident day for RN and 2.45 hours per resident day for CNA requirement may be exempted under paragraph (g) of this section for facilities that are found non-compliant and meet the eligibility criteria as determined by the Secretary.

We strongly oppose any waiver provisions for RN and licensed nurse staffing that are not related to outcomes and urge CMS to eliminate the proposed waiver provisions. The current CMS waivers are not evidence-based and could potentially undermine the health and safety of residents. Instead, CMS should place a ban on new admissions if adequate RN and licensed staffing are not available.

CMS has proposed the following*:* (g) Hardship Exemption from the Minimum Hours Per Resident Day Requirements*.* CMS proposed that a facility must meet the four following criteria to qualify for a hardship exemption: (1) *Location* - in an area where (i) supply of healthcare staff 20 percent below the national average or 40 percent below the national average provider-population ratio for nursing workforce; or (ii) The facility is at least 20 miles from another long-term care facility, as determined by CMS. The facility must demonstrate good faith efforts by offering the prevailing wages, demonstrate the amount the facility expends on nurse staffing relative to revenue, with exclusions and a determination of eligibility. The exemption time frame is 1 year with no limits on the number of exemptions that an eligible facility can be granted.

We strongly oppose the CMS proposed hardship exemptions. A NH resident in a rural or underserved area has the same needs and deserves the same care as one in an urban setting. A staffing standard based on evidence should not be altered because of location or the financial source for care.

While there may be local reasons why a NH has difficulty in recruiting staff, the use of waivers/exemptions will undermine safe staffing levels and jeopardizes the health and safety of residents. We appreciate that this proposed ruling provides for four criteria that all must be met before an exemption is granted (p. 61354). However, giving waivers or exemptions from minimum staffing levels, puts residents in danger and staff under strain. It is sanctioning staffing below a level where safe care can be provided. **Where staffing is too low to meet residents' care needs, admissions should be stopped until appropriate staffing levels are present.**

Exemptions not only jeopardize the residents but also the nursing staff who are subject to injuries and stress when workloads are too heavy. It also undermines the current wages and benefit levels by allowing facilities not to have to pay prevailing wages or wages that are competitive with other entry level jobs. It also has a negative impact on staff turnover rates.

1. CMS Should Require NHs To Improve Job Quality

The argument that exemptions/waivers are needed because there are no workers available is not supported by Abt's recent report. Providing facilities with waivers/exemptions from the proposed

staffing standard will put residents in danger and leave workers set up to fail. The provision of waivers/exemptions from new staffing standards would put NH residents at risk by perpetuating substandard care and poor working conditions for staff. The assumption that there is a shortage of workers rather than a lack of quality jobs, underlies the inclusion of waivers/exemptions from adhering to staffing standards in this proposed rule:

> "We determined, in the same spirit as the existing waiver process, to propose exemptions intended to address *underlying workforce unavailability concerns*, especially in rural and other underserved areas, while balancing the need for efforts by LTC facilities to recruit staff and improve quality of care."(61377, emphasis added).

Rather than providing waivers/exemptions, these communities would be better served by supporting and encouraging NHs to improve the quality of NH jobs. Low compensation, few if any benefits, inadequate training, and career paths, makes these low status jobs. A challenging culture includes inadequate support, appreciation, respect and recognition and gender and racial inequalities in an industry where many workers are women of color. They have experienced racism and discrimination across their lives, leading to inequalities and disparities. In addition, onerous workloads, and high rates of injury lead to a lack of safety and poor working conditions. Who would choose to work in a place where they are undervalued and underappreciated?

The top 10 reasons for direct care workers (that includes CNAs) leaving their jobs are: lack of respect; low salary/lack of benefits; difficulty of the job; staff shortages; personal health/family concerns; lack of appreciation; lack of resources; lack of good relationship with supervisor; lack of teamwork; lack of trust with clients/families; and not being informed of changes made.[50] Finding solutions to these problems is essential to providing adequate and appropriate staffing. Identified solutions include: good management practices that include adequate staffing; conveying recognition and respect through fair wages; improving job quality and working conditions; free and fair choice to join a union, [51] mandating diversity, equity and inclusion (DEI) training to counteract systemic and structural racism; implementing an interdisciplinary care team approach that involves listening to all team members; consistent, supportive supervision; consulting with workers as "experts by experience"; predictable shifts with worker-centered scheduling and consistent assignments.[52]

There is no rationale or substantial evidence for providing waivers. The 2023 Abt study shows that staffing in rural and urban NHs was almost identical. We strongly oppose the granting of multiple waivers. No facility should be operating below standards. Allowing large numbers of NHs to obtain waivers and exemptions undermines the regulations, defeats the purpose of a minimum standard, and places residents at significant risk.

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[50] PHI Would you stay? Rethinking Direct Care Job Quality 2020. https://www.phinational.org/wp-content/uploads/2020/10/Would-You-Stay-2020-PHI.pdf
[51] The White House. Fact sheet protecting seniors and people with disabilities by improving safety and quality of care in the nation's nursing homes. February 28, 2022. https://www.whitehouse.gov/ briefing-room/statements-releases/2022/02/28/fact-sheet-protectin g-seniors-and-people-with-disabilities-by-improving-safety-and-qu ality-of-care-in-the-nations-nursing-homes/.
[52] PHI Would you stay? Rethinking Direct Care Job Quality 2020. https://www.phinational.org/wp-content/uploads/2020/10/Would-You-Stay-2020-PHI.pdf

2. Hardship Exemptions For For-Profit NHs Should Not Be Allowed

Staffing levels are significantly lower in for-profit nursing homes. Indeed, comparing nurse staffing levels of non-profit (29% of NHs) versus for-profit (71% of NHs) from the 2023 Abt Staffing study, shows that on average, non-profit NHs' staffing is higher than for profits by a factor of 1.23 (Exhibit 4.2 below).[53]

Exhibit 4.2 Average Staffing Levels by Nursing Home Characteristics (in hprd)

		Nursing Homes	Total	RN	LPN	Nurse Aide
All		**15,147**	**3.76**	**0.67**	**0.88**	**2.22**
Ownership	**For-Profit**	**10,748**	**3.57**	**0.57**	**0.89**	**2.10**
	Non-Profit	**3,439**	**4.28**	**0.91**	**0.86**	**2.50**
	Govern-ment	**959**	**4.19**	**0.83**	**0.87**	**2.49**

These numbers support the conclusion that for-profit NHs are understaffed because the for-profit owners deliberately keep their staffing low to maximize profits. One study found that staffing levels in for-profit nursing homes, including nursing home chains, had 16 percent fewer staff than nonprofits after accounting for differences in residents' needs in 2017.[54] Nurse staffing wages, benefits, and pensions (especially for RNs) are major costs for nursing homes and are often cut by for-profit owners who are motivated to maximize profits. Private equity (PE) companies, representing about 9 percent of nursing home owners in 2015, have excelled at extracting profits from nursing homes by reducing staffing and services. PE buyouts of nursing homes from 2000 to 2017, when compared to acquisitions by non-PE companies, resulted in declines in resident health and regulatory compliance related to cuts to front-line nursing staff.[55] PE ownership increased short-term mortality of Medicare patients by 10 percent (or 20,000 lives) and resulted in declines in resident well-being, staffing and quality standards.[56]

The current proposal favors for-profit facilities over non-profit facility owners. This is certainly not equal treatment and jeopardizes the health and safety of residents. If most of the non-profit and government facilities can achieve higher staffing, then why shouldn't CMS require all the for-profit facilities to meet a minimum staffing level?

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[53] Abt Associates. (2023). Nursing Home Staffing Study Comprehensive report. Report prepared for the Centers for Medicare & Medicaid Services. *https://edit.cms.gov/files/document/nursing-homestaffing-study-final-report-appendix-june-2023.pdf*
[54] Harrington C, Olney B, Carrillo H, Kang T. Nurse staffing and deficiencies in the largest for-profit chains and chains owned by private equity companies. *Health Serv Res*. 2012; 47(1 pt I):106–128.
[55] Gupta A, Howell ST, Yannelis C, Gupta A. Does private equity investment in healthcare benefit patients? Evidence from nursing Homes. Philadelphia, PA: Wharton School. February, 2020.
[56] Gupta A, Howell ST, Yannelis C, Gupta A. Does private equity investment in health care benefit patients? Evidence from nursing homes. Chicago, IL: Becker Friedman Institute, Working Paper 2021-20, February 2021.

3. CMS Should Require NHS To Pay Competitive Wages and Living Wages

CMS is proposing that NHs can receive hardship waivers for demonstrating "good faith" efforts to hire and retain staff, part of which is described as "…offering the prevailing wages." Prevailing wages are those comparable to what other NHs pay in an area and CMS presumes that paying prevailing wages are sufficient.

Low wages, low benefits and heavy workloads are the primarily cases of shortages of workers and high nursing turnover rates. RNs in nursing homes receive much lower wages than those for hospital RNs).[57] 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. How can NHs complain that they cannot attract and retain RNs when they are not paying comparable wages to hospitals? Ironically, the CMS PPS Medicare payment system uses hospital wages when calculating the annual Medicare SNF payment rates, and yet NHs are not paying that rate.[58]

Most NH resident care is provided by nursing assistants who make minimum wages (averaging $16.90 per hour and an annual income of $35,160 in 2022). [59] Nursing assistant wages in nursing homes are lower than wages in hospitals which at $18.18 per hour in 2022. They are also less than for comparable entry level jobs for retail sales persons and customer service representatives. Altogether, 12 percent of nursing home workers live below 100 percent of the federal poverty level, while 38 percent live in low-income households.[60] As a result, many nursing home staff work in more than one facility, which was found to be a factor that increased the spread of COVID-19 between facilities during the pandemic.[61]

In nursing homes, 15 percent of nursing assistants do not have health insurance and 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.[62]

NHs must offer wages that are at least competitive with hospital wages and other jobs that require comparable skills and living wages. CMS should require that NHs pay 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." Research shows that raising the pay of direct care workers to the living wage would translate into meaningful wage gains for the lowest-paid aides, improve productivity, and have a significant effect on the overall economy.[63] [64]

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[57] Bureau of Labor Statistics. Occupational Employment and Wages, May 2022 29-1141 Registered Nurses. https://www.bls.gov/oes/current/oes291141.htm
[58] CMS PPS
[59] Bureau of Labor Statistics. Occupational Employment and Wages, May 2022. 31-1131 Nursing Assistants. https://www.bls.gov/oes/current/oes311131.htm
[60] PHI. Direct care workers in the United States. Key Facts. Bronx, NY: PHINational. October 2022. https://www.phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-2/
[61] Centers for Disease Control and Prevention. COVID-19 in a long-term care facility – King Country, Washington, February 27-March 9, 2020. *Morbidity and Mortality Weekly Report.* 2020: 69, March 18.
[62] PHI, Ibid.
[63] Weller C, Almeida B, Cohen M., Stone R. Making care work pay. Leading Age, September 2020.
[64] Massachusetts Institute of Technology. (2020). Living Wage Calculator. Cambridge, MA: MIT, 2020.

By giving hardship exemptions, CMS is contributing to the nursing staffing shortages because NHs do not have to pay competitive wages. CMS should not allow any exemptions to staffing minimums. If CMS does issue waivers, it should require NHs to demonstrate they are paying competitive wages on par to those in the community and at hospitals, as well as a living wage, and not simply wages prevailing wages comparable to what other NHs pay in an area.

4. Hardship Exemptions Should Not Be Allowed for Rural NHs

The CMS proposed regulations states "We were also concerned that some LTC facilities, especially those in rural and underserved areas, might find complying with such a requirement especially challenging" (61372).

The purpose of a staffing standard is to ensure that NH residents are provided with the care they need and that has been paid for. Therefore, delaying implementation of these new standards in rural or other underserved areas is allowing residents in these facilities to continue to live in substandard conditions longer than necessary. In addition, low staffing levels lead to overburdened staff that cannot succeed in caring for their residents leading to stress, moral distress, burnout, and turnover.

There is no evidence that rural NHs are not able to meet the same standards as urban NHs. The 2023 Abt Report states (p. 32): "Particularly in rural areas and for NHs with fewer financial resources, respondents reported concerns about having a limited staffing pool to draw from and not being able to offer competitive wages to recruit and hire new staff to meet a minimum requirement."[65] However, there were only 2 rural NHs in the qualitative sample and yet undue weight is given to statements like these. Exhibit C, 18 "Demographics of Nursing Homes Participating in Site Visits" notes that zero rural NHs were included (n=16).

Findings from the recent Abt study (2023) commissioned by CMS do not support the assumption that staffing for rural NHs is scarcer than for urban NHs.[66] The study determined that on average, staffing in rural settings was very similar to urban settings (Exhibit 4.2, see below). Indeed, CNA staffing was on average slightly higher than urban settings, RNs about the same (0.03 hprd lower) and LPN/LVNs 0.11 lower. The report concluded, "…differences in staffing levels by urbanicity are not large, with average staffing levels slightly higher for NHs in an urban location (3.80 HPRD) than for NHs in a rural location (3.66 HPRD)."

Available at https://livingwage.mit.edu/.
[65] Abt Associates. (2023). Nursing Home Staffing Study Comprehensive report. Report prepared for the Centers for Medicare & Medicaid Services. *https://edit.cms.gov/files/document/nursing-homestaffing-study-final-report-appendix-june-2023.pdf*
[66] Ibid.

Exhibit 4.2 Average Staffing Levels by Nursing Home Characteristics (in hprd)

		Number of Nursing Homes	Total	RN	LPN	Nurse Aide
All		**15,147**	**3.76**	**0.67**	**0.88**	**2.22**
Location	Rural	4,174	3.66	0.64	0.80	2.23
	Urban	10,973	3.80	0.67	0.91	2.21

It is also apparent that the percentage of staff increases needed to reach 0.55 RN hprd and 2.45 CNA hprd are lower in rural areas (RNs by 1.7% and CNAs by 1.5%) than urban homes (61412, Table 23).

Therefore, we see no reason for hardship considerations or waivers or delays in implementation requirements for rural NHs. We strongly oppose exemptions for rural areas.

5. The CMS Proposed Hardship Exemption for Location Should Be Eliminated or Revised

CMS is proposing a hardship exemption in areas where the supply of RNs and NAs is not sufficient to meet geographical area needs based on either a medium of 20 percent the national average or a low of 40 percent of below the national average supply. **We do support this exemption but if CMS does allow an exemption, it should only be in areas with the lowest supply of 40 percent below the national average.**

CMS proposed a hardship exemption for facilities that are at least 20 miles from another NH but offers no clear basis for selecting 20 miles in rural areas. Staff in rural areas are used to driving long distances to work and they do not face the traffic that urban areas have. **A 30-40 mile limit is more reasonable than 20 because that would be about 30 to 40 minutes of commuting time. A commuting time of 30-40 minutes is very common for urban areas, even though the distance may be much less than 20 miles.**

Rural areas do not have the population density to support many NHs in a given area. This needs to be a consideration in setting distance criteria. The CMS proposed criteria of 20 miles between facilities implies that the US should establish a standard of having a NH every 20 miles. This would result in adding thousands of more NHs, which are not needed or feasible.

Even though the US population of older and disabled people has steadily increased over the years, the total number of NH residents has steadily declined (from 1.39 million in 2009 to 1.33 million in 2016). Correspondingly, the average occupancy rate declined from 83.7 percent in 2009 to 80.8 percent in 2016 although these vary across states.[67] Occupancy rates declined even

[67] Harrington, C., Carrillo, H., Garfield, R., Musumeci, M, and Squires, E. *Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009 Through 2016*, KFF (Apr. 3, 2018), https://www.kff.org/medicaid/report/nursing-facilities-staffing-residents-and-facility-deficiencies-2009-through-2016/

further during the pandemic to as low as 75% in July 2020.[68] NH occupancy rates continue to be low across most parts of the US – only an average of 76 percent based on CMS Nursing Home Compare data for July 2023. The decline in occupancy rates suggests an excess supply of nursing home beds in many areas so that some facilities and beds could be downsized or closed. **We strongly recommend that CMS eliminate the distance criteria for determining hardship or raise the distance substantially.**

6. CMS's Hardship Exemption for Good Faith Effort to Hire and Retain Staff Should be Revised.

CMS has not developed criteria for a "good faith effort" so that this will be impossible to monitor as stated. Recognizing that the shortages of direct care workers are directly tied to poor quality jobs, **CMS should require NHs to use the PHI "5 Pillars of Direct Care Job Quality" for CNAs in order to recruit and retain staff as a way to define "good faith effort."[69]**

1. Quality training is needed. It should be person-centered and condition-specific to improve the quality of care for residents. PHI recommends that the training is competency-based, adult learner centered, and culturally and linguistically appropriate.
2. Fair compensation is needed to ensure that CNAs receive a living wage. Wages need to be competitive with jobs where work is similarly challenging, and include benefits for health insurance, paid sick leave, family and medical leave, and retirement savings.
3. Quality supervision and support is needed for CNAs. This can be developed by providing nurse supervisor training on communication, coaching, problem-solving, and empowerment to better support CNAs and recognize their achievements.
4. Respect and recognition of CNAs is needed to empower and integrate CNAs into interdisciplinary care teams and organizational decision-making.
5. Real opportunity for career pathways is needed to retain workers, leverage their skills and expertise, and maximize their contributions to resident care and outcomes.

Improvements in job quality have been shown to have strong benefits for retaining direct care workers and improving the quality of NH care. This effort would negate the need for hardship exemptions for NHs. **If NHs cannot demonstrate that they have met all 5 criteria for hiring and retention, they should not receive a hardship waiver.**

CMS monitors NH nursing staff turnover rates through the PBJ reporting system. Currently, the average nursing staff turnover is very high at 52 percent. **An easy way for CMS to measure a good faith effort is to establish a minimum staff turnover rate. We believe that if staff turnover rates for RNs and/or CNAs and other nursing staff is higher than 35 percent, a NH should not meet the good faith effort requirement for an exemption.**

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[68] Flynn, B. Leading Age. *Nursing home closures and trends June 2015-June 2019.* Washington, DC: Leading Age. February, 2020

[69] PHI. "The 5 Pillars of Direct Care Job Quality." Accessed September 30, 2023. https://www.phinational.org/resource/the-5-pillars-of-direct-care-job-quality/; PHI. 2021. Caring for the Future: The Power and Potential of America's Direct Care Workforce. Bronx, NY: PHI. https://www.phinational.org/wp-content/uploads/2021/01/Caring-for-the-Future-2021-PHI.pdf.

PHI has also developed a report for changing federal policy priorities for the direct care workforce that would address the underlying staffing shortages. We urge CMS to adopt these important, detailed, and practical policy recommendations.[70]

7. CMS Should Change its Medicare NH PPS Rates for Nursing to Ensure Equity in Payments for Rural NHs

The problems and challenges of recruiting and retaining staff in rural NHs were addressed about 20 years ago by the Institute of Medicine.[71] Rural NHs are subject to the same recruitment and retention issues that all US NHs experience due to the poor quality of jobs (described above). In addition, the key issue of low compensation for rural NH nursing staff is exacerbated by the Medicare PPS reimbursement system which reimburses NHs for nurse staffing at a lower rate in rural areas than in urban areas - See Table 5 and 6 in the CMS Medicare Program: Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities proposed for 2023.[72]

Specifically, the highest PDPM nursing rate is $437.41 in urban areas and only $417.91 in rural areas. The lowest PDPM nursing payment rate is $70.62 in urban areas and only $67.47 in rural areas. This builds in inequities especially since NHs are competing for nursing staff with other nursing facilities and hospitals throughout the state. One way to mitigate this problem is to eliminate the lower Medicare payment rates for rural areas as part of the PPS payment regulations. **CMS should have the same payment rates for rural as for urban areas but require NHs to pass these wages through to their workers. This would be the strongest method to improving rural disparities and eliminating rural shortages.**

8. CMS's Requirement for "Financial Commitment" Must Be Defined and Monitored

In order to obtain a hardship waiver, CMS wants NHs to demonstrate a financial commitment through documentation what is spent annually on nurse staffing relative to revenues. This is vague and without benchmarks it cannot be monitored.

CMS has issued guidelines for HCBS programs that require states to spend 80% of HCBS payments on direct care, require States to report spending to CMS "in the form and manner specified by CMS," and require CMS to publish these results on the CMS website. In addition, four states (New Jersey, New York, Massachusetts, and Pennsylvania) have passed legislation requiring a percentage of NH revenues to be spent on direct care services, with limitations on

[70] PHI. 2021. Federal Policy Priorities for the Direct Care Workforce. Bronx, NY: PHI. https://www.phinational.org/wp-content/uploads/2021/07/Federal-Policy-Priorities-for-the-Direct-Care-Workforce-2021-PHI.pdf.
[71] Institute of Medicine. *Keeping patients safe: transforming the work environment of nurses.* Washington, DC: National Academy of Medicine, 2004.
[72] Centers for Medicare & Medicaid Services (CMS). 42 CFR Part 413 and 483 [CMS-1765-F and CMS-3347-F] RIN 0938-AU76 and 0938-AT36 Medicare Program; Prospective Payment System and Consolidated Billing for Nursing homes; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2023; *https://www.federalregister.gov/public-inspection/2022-16457/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities*

administrative costs, property costs, and profits.[73] By limiting administrative costs and profit taking, nursing homes can reallocate its revenues to nursing, ancillary, and support services.

We strongly urge CMS to adopt a requirement that NHs must demonstrate that at least 80 percent of revenues are spent on direct care services. CMS should place a ceiling on the combined administrative costs and profits of each nursing home and its related parties, and parent companies of 20 percent of net revenues per year. This should also limit expenditures for capital costs, leases, and management fees. This combined maximum should be on all net revenues regardless of funding source including Medicare and Medicaid. Expenditures over the ceiling should be forfeited proportionately to the payers at the end of each year. If a NH cannot demonstrate that at least 80 percent of revenues are spent on nursing and direct care services, NHs should NOT be allowed a hardship exemption.

9. CMS Must Require Documentation and Be Fully Responsible for Any Exemptions Issued

Although we oppose hardship exemptions, if CMS does allow such exemptions, there must be documented evidence for any exemptions. We were surprised to read the CMS statement that supporting documentation for exemptions is only required when requested (42 CFR 483.35(g)(5). CMS must take full responsibility for issuing any hardship exemptions and for the effect of those exemptions on residents and staff working conditions. **It is unacceptable that NHs could request an exemption and then self-certify that each NH meets CMS exemption criteria. CMS should review of all documentation by NHs requesting a hardship exemption prior to an exemption being issued by CMS.**

If there are hardship exemptions, CMS should administer these at the national level rather than at the state level. This will ensure that any waivers issued would be uniform in their implementation.

10. Waivers/Exemptions for Staffing Means That There is No Effective Standard

In summary, we conclude that the provision of exemptions/waivers from meeting the new staffing standard is unacceptable, and that this applies to all NHs including those that are in rural areas and those that are for-profit. We have noted above, that Abt's 2023 study has established that there is no evidence of a significant difference between rural and urban NHs nurse staffing levels. The same solutions to improve recruitment and retention described above would apply to all NHs wherever they are located. The consequences of providing exemptions/waivers for any NH would be the same: it would put residents at greater risk and undermine staffing wages and benefits as well as working conditions.

It is our recommendation that the only justifiable reason for an exemption or waiver is if a NH consistently demonstrated that they outperform their peers on measureable and reported standards that clearly demonstrate that they are meeting the needs of those they serve and work in their facilities. If CMS believes that exemptions or waivers are

[73] Long Term Care Community Coalition. *LTCCC Policy Brief: Direct care minimum spending laws.* 2022; March. https://nursinghome411.org/wp-content/uploads/2022/03/LTCCC-Policy-Brief-NY-Direct-Care-Min.-Spending-Ratio.pdf

necessary, then a composite of existing quality goals (that have been shown in the literature to be related to nurse staffing) should be the justification for those exemptions/waivers. If facilities are preforming well on outcomes such as hospital readmission rates, nurse turn-over, facility acquired injuries, anti-psychotic medication use, at their current staffing ratios then there is logical justification to give them a waiver.

III. The Role of The Facility Assessment in Ensuring Adequate Staffing

Section § 483.71 Facility Assessment. CMS proposes that "The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment.

This echoes conclusions from the report of the independent Coronavirus Commission for Safety and Quality in NHs established by CMS in April 2020.[74] One of the recommendations of this Commission was: Principle Recommendation 6A: Mobilize resources to support a fatigued NH workforce and assess minimum care standards. This recommendation specifically called for CMS to:

> "Issue guidance based on recent research that defines updated, acuity-adjusted, evidence-based, person-centered minimum care standards. These standards should specify hours of care per resident per day during normal and emergency operations alike and require NHs to adhere to these standards."

1. We Support a Facility Assessment Requirement, But The Existing CMS Requirement Is Not Effective

While we strongly support a CMS facility assessment requirement, CMS first adopted the facility assessment requirement as part of its 2016 updated Conditions of Participation. Since the requirement was implemented in 2017, there is no evidence that facilities are generally complying with the regulation or that the requirement has been enforced, and no evidence that the regulation has had any impact on increasing staffing levels in NHs. In fact, the nurse staffing levels have been basically flat since the regulation was introduced. Moreover, multiple studies have shown that the average NH is not meeting the minimum staffing standards recommended by experts.

[74] Centers for Medicare and Medicaid Services. *Coronavirus Commission for Safety and Quality in Nursing Homes*. Baltimore, MD; 2020 Apr 30. https://www.cms.gov/files/document/covid-final-nh-commission-report.pdf

Poor NH quality has been associated with low nurse staffing levels, particularly low RN staffing.[75] [76] In 2017-18, about 75 percent of NHs almost never met the CMS expected RN staffing levels based on resident acuity.[77] Other studies show that most NHs failed to meet the CMS 2001 recommended minimum staffing levels in 2019 (4.1 total hprd), including 0.75 RN hprd) [78] [79] and staffing levels recommended by experts based on acuity in 2017.[80] Heavy workloads, low wages and benefits, and poor working conditions have been associated with persistent staff dissatisfaction, shortages, and high staff turnover levels.[81]

The result is too many residents living at risk of harm and jeopardy with the realities of delayed and omitted care that include hunger, loneliness, and inadequate personal hygiene, harm, injuries, and deaths of residents.[82] If facilities are not even meeting minimum staffing levels, they certainly are not adjusting their staffing to consider resident acuity.

There is also little evidence that NHs are adjusting their staffing for acuity even though they are being paid for higher acuity in their Medicare PPS payment rates.

2. CMS Does Not Account For How Staffing Levels Are Set in Most For-Profit Facilities

When CMS first established the facility assessment requirement in 2016, CMS stated that it "assumed" that facilities "already conducted some type of facility assessment and resources required as part of their normal strategic planning." 88 Fed. Reg., at 61373. CMS's 2016 "goal" was aligning regulations "with current clinical practice" and allowing "flexibility to accommodate multiple care delivery models to meet the needs of diverse populations that receive services in these facilities." 88 Fed. Reg., at 61373. Although clearly, this should be the way facilities assess their staffing needs, this was an unfounded assumption by CMS.

The proposed regulation doesn't account for the fact that most for-profit NHs, including large chains, and facilities owned by private equity companies, investors, and real estate investors, are given an annual operating budget by the owner or the operating or managing

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[75] The National Academies of Sciences, Engineering, and Medicine (NASEM), Board on Health Care Services, Health and Medicine Division, Committee on the Quality of Care in Nursing Homes. *The national imperative to improve nursing home quality: honoring our commitment to residents, families, and staff.* 2022. Washington, DC: The National Academies Press. https://nap.nationalacademies.

[76] Office of the Inspector General. Some nursing homes' reported staffing levels in 2018 raise concerns; Consumer transparency could be increased. *HHS OIG Data Brief*. August, 2020. Washington, DC. OEI-04-18-00450.

[77]Geng F, Stevenson, DG, Grabowski DC. Daily nursing home staffing levels highly variable, often below CMS expectations. *Health Aff*. 2019; 38 (7):1095-1100.

[78] 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.

[79] Bowblis, JR. The need for an economically feasible nursing home staffing regulation: evaluating an acuity-based nursing staff benchmark. *Innovations in Aging.* 2022; 6(4)1–11. https://doi.org/10.1093/geroni/igac017

[80] Harrington C, Dellefield M, Halifax E, Fleming M, Bakerjian D. Appropriate nurse staffing levels for US nursing homes. *Health Serv.* 2020;13:1-14.

[81] Bishop CE, Squillace MR, Meagher J, Anderson WL, Wiener JM. Nursing home work practices and nursing assistants' job satisfaction. *The Gerontologist.* 2009; 49 9 5), 611–622. https://doi.org/10.1093/geront/gnp040

[82] White, E. M., Aiken, L. H., & McHugh, M. D. Registered nurse burnout, job dissatisfaction, and missed care in nursing homes. *Journal of the American Geriatrics Society*, 2019: *67*(10), 2065-2071.

entity. The budget dictates how much the facility will spend on nursing, ancillary and support services. In addition, the budget is likely to specify spending on property costs, administration, and profits. In this situation, the facility administrator and the DON must operate within these parameters or risk termination. Therefore, the DON often has no discretion in setting staffing based on a facility assessment that adjusts for resident acuity. The existing guidance perpetuates the myth that for-profit NHs set staffing based on acuity and resident care needs.

Other hospital-based distinct part facilities, non-profits, and government facilities may also have detailed budgets. However, they may give the facility administrator and the DON greater input and flexibility in setting nurse staffing based on resident acuity. These facilities generally have staffing at higher levels than minimum standards, and some appear to adjust for resident acuity.

3. CMS Has Undertaken Limited Enforcement of Existing Facility Assessment Requirements

There is little evidence that CMS survey and certification programs are enforcing existing facility assessment requirement regulations. To ensure staffing is adequate to meet residents' needs CMS needs to enforce its own facility self-assessment requirements to determine 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). The assessment conducted by the facility must include information from stakeholders such as residents, families, councils, and representatives (§483.35(a)(1)-(2)). The facility assessment process has been ignored by facilities and surveyors alike.[83] Few F838 deficiencies are cited (158 in FY 2021; 261 in FY 2022; 173 in FY 2023) and, of course, very few at the harm and jeopardy level where financial penalties are likely to be imposed (4 in FY 2021; 2 in FY 2022; 3 in FY 2023).

While we support greater specificity as required under the proposed CMS requirements for the facility assessment of staffing needs, we continue to believe that the **amended facility assessment regulation will have essentially no impact unless there is increased specificity in the requirement along with strong enforcement of the requirements.**

4. CMS Must Establish New Detailed Guidelines For Facility Assessments

We recommend that CMS issue detailed guidelines on how to link resident acuity to setting staffing levels in order to meet resident needs. Resident acuity is 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. Residents' care needs are adequately assessed using the MDS 3.0 assessment forms.

As resident care needs or acuity increases, NHs are expected to increase the staffing levels. This is the entire principle upon which the Medicare prospective payment system (PPS) adjustment

[83] Edelman, T. Center for Medicare Advocacy. Comments to CMS on Minimum Staffing Standards. Washington, DC: October, 2023.

for resident acuity is based,[84] as shown in the CMS PPS reimbursement regulations. Why would CMS adopt a Medicare payment system based on resident acuity and then not require NHs to staff based on the acuity that Medicare has paid for? Many state Medicaid programs also pay based on resident acuity.[85]

We recommend that CMS give the following specific guidelines to NHs on how to set acuity that are based on expert recommendations by Harrington and colleagues.[86]

Step 1: Determine the Collective Acuity Level of the Residents
A facility's acuity level should be based upon the average resident acuity for whom care is being provided. In other words, it is not necessary to determine whether all residents individually receive a certain number of hours of nursing care per day, but rather whether the facility, as a whole, is adequately staffed to account for the facility's collective acuity level.

Each NH is required to use the Minimum Data Set (MDS) resident assessment form and to calculate a summary of nursing PDPM scores for each resident, and submit the data to CMS. The resident acuity data are used by CMS in calculating each facility's Medicare reimbursement rates.

NHs should use the CMS guide to convert the PDPM nursing codes into casemix categories for the six major PDPM nursing case-mix groups. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/Downloads/hippsuses.pdf

Each facility should create a spread sheet that lists the nursing PDPM summary score for each resident. In addition, the spread sheet could indicate any special problems or care needs of the resident that should be considered in establishing staffing levels. The resident listings should be separate for each unit because of the wide variability across some units. The facility should then add all the scores for each resident and divide by the number of residents (census) to calculate the average nursing PDPM score for each unit and for the facility.

We recommend that each NH be required to calculate the average summary nursing PDPM acuity score every quarter or more frequently if there has been any major change in acuity levels. This summary score should be calculated for each unit and the entire facility.

Step 2: Examine Other Factors that May Influence Staffing Needs Relative to Acuity
At this point, the NH should examine the factors identified in these 2023 CMS proposed regulations that might have a favorable or negative impact on staffing levels. This includes all the guidelines listed in the regulations that might impact on the amount of nursing time needed to

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[84] *Centers for Medicare & Medicaid Services (CMS). 42 CFR Part 413 and 483 [CMS-1765-F and CMS-3347-F] RIN 0938-AU76 and 0938-AT36 Medicare Program; Prospective Payment System and Consolidated Billing for Nursing homes; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2023; https://www.federalregister.gov/public-inspection/2022-16457/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities*
[85] Medicaid and CHIP Payment and Access Commission (MACPAC). State's Medicaid fee-for-services nursing facilities payment policies. 2021. Washington, DC: MACPAC.
[86] 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.

provide care to residents. These factors include the training and experience of staff, the facility structure, and many other considerations.

Step 3: Determine Each Facility's Actual Per-Resident Per Day Staffing Levels
Each facility should calculate its actual staffing hprd for RNs, LPN/LVNs, and CNAs per day for each unit. NHs are required to maintain records documenting staffing levels on a per-patient-per-day basis. Most of this information is maintained, reported, and summarized in daily posted staffing reports, facility payroll data, and summary staff reports. These calculations should, of course, be consistent with the daily staffing reports sent to CMS on the Payroll Based Journal (PBJ) reporting system.

Step 4: Use A Specific Guideline to Determine Staffing Based on Resident Acuity
After determining the acuity and staffing levels for the respective units, the facility should determine how many staff by type would be needed to carry out all the care activities. The question of adequate staffing is primarily focused on each facility's aggregate acuity for each unit and overall facilities.

The PDPM scores are divided into six resident overall groupings or categories. The lowest acuity category is the behavioral symptoms group and the highest acuity category is the extensive services group.

After the average PDPM nursing score is computed for each unit and the facility, it should be compared with CMS suggested staffing times. **We strongly recommend that CMS adopt the staffing time guidelines for each PDPM developed by Harrington and colleagues and shown on the Table below.**[87]

[87] 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.

Table 1. Average Recommended Nurse Staffing Hours Per Resident Day Converted to Staffing Ratios

	Average Hours Per Resident Day				Ratio of Residents to Staff And Hours Per Resident Day							
Acuity	RN	LVN/LPN	AIDE	TOTAL		RN Ratio to Residents	RN hprd	LVN/LPN Ratio to Residents	LPN hprd	AIDE Ratio to Residents	AIDE hprd	Total Nursing hprd
Extensive Services	1.85	1.36	3.60	6.81	Day	9	0.89	14	0.57	5.5	1.45	
					Evening	14	0.57	18	0.44	5.5	1.45	
					Night	20	0.40	25	0.32	12.0	0.67	
					Total		**1.86**		**1.34**		**3.58**	6.77
Special Care High	1.36	0.84	3.40	5.61	Day	14	0.57	24	0.33	5.5	1.45	
					Evening	17	0.47	28	0.29	6.0	1.33	
					Night	25	0.32	36	0.22	13.0	0.62	
					Total		**1.36**		**0.84**		**3.40**	5.61
Special Care Low	1.36	0.84	3.40	5.61	Day	14	0.57	24	0.33	5.5	1.45	
					Evening	17	0.47	28	0.29	6.0	1.33	
					Night	25	0.32	36	0.22	13.0	0.62	
					Total		**1.36**		**0.84**		**3.40**	5.61
Clinically Complex	1.03	0.67	3.20	4.90	Day	18	0.44	30	0.27	6.0	1.33	
					Evening	22	0.36	34	0.24	6.5	1.23	
					Night	36	0.22	42	0.19	13.0	0.62	
					Total		**1.03**		**0.69**		**3.18**	4.90
Behavioral Symptoms	0.75	0.55	3.00	4.30	Day	28	0.29	38	0.21	7.0	1.14	
					Evening	30	0.27	40	0.20	7.0	1.14	
					Night	40	0.20	56	0.14	11.5	0.70	
					Total		**0.75**		**0.55**		**2.98**	4.29
Reduced Physical Function	0.75	0.56	3.20	4.51	Day	28	0.29	38	0.21	6.0	1.33	
					Evening	30	0.27	40	0.20	6.5	1.23	
					Night	40	0.20	56	0.14	13.0	0.62	
					Total		**0.75**		**0.55**		**3.18**	4.49

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.

Estimates include administrative care nurses (Director of Nursing, Assistant Director of Nursing, Director of Staff Development (or about 0.24 hprd for 100 residents), the MDS Coordinator, supervisors, direct care nurses, plus an RN on duty 24 hours per day.

Based on time study data and simulation research, [88] the minimum RN staffing levels should be 0.75 RN hours per resident day (hprd) for the lowest acuity resident. This translates into a ratio of 1 RN for direct care to 28 residents on the day shift; 1 RN to 30 residents on evenings; and 1 RN to 40 residents at night. For the highest acuity, the amount of RN time was estimated to be 1.85 RN hprd. This would be 1 RN for 9 residents in the day, 1 RN to 14 residents in the evening, and 1 RN to 20 residents at night.

For LPN/LVNs, the lowest acuity residents would receive 0.55 LPN hprd per day. This converts to a ratio of 1 LPN/LVN for 38 residents on the day shift, 1 LPN/LVN to 40 residents on the evening, and 1 LPN/LVN to 56 residents at night. For the highest acuity residents, the LPN/LVN hprd would be 1.36 LPN hprd. This would result in 1 LPN/LVN to 14 residents on days, 1 LPN/LVN to 18 residents in evenings, and 1 LPN/LVN to 20 residents at night.

[88] 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.

Schnelle and colleagues' 2016 simulation study found that the lowest acuity residents should have 2.8 CNA hprd and 3.6 for the highest acuity residents[89] to maintain a rate of care omissions below 10 percent.[39] For the lowest resident workloads, this converts to 1 CNA for every 7 residents on the day and evening shifts and 1 CNA to 11 residents at night. For the heaviest resident workloads, 3.6 CNA hprd converts to 1 CNA for 5.5 residents on days and evenings and 1 CNA to 11 residents on nights.

Step 5: Evaluate and Adjust Staffing If Care Problems Are Identified by Federal and State Deficiencies and Complaints, Quality Measures, Missed or Omitted Care, Adverse Events or Quality Problems

The final step should be a quarterly review of evidence to determine if the facility has established the appropriate staffing level for each unit and the facility. These include:

Federal and State Deficiencies and Complaints. Low staffing may be reflected in consumer complaints about poor quality care by residents and advocates, including families, resident councils and ombudsmen. These may be substantiated or unsubstantiated by state agency surveyors. Deficiencies and citations given by state surveyors for violations of quality regulations are clear evidence of quality problems which are often directly related to understaffing.

CMS Quality Measures. CMS developed resident quality measures using data from the MDS assessments submitted by NHs to CMS and reported on the Medicare NH Compare website that are related to staffing levels. These quality measures currently include: pressure ulcers, urinary tract infections, decline in physical functioning, decline in mobility, overuse of antipsychotics, and falls with injuries. Most quality measures, self-reported by the facility, are not audited and therefore may be inaccurate. The CMS quality measures based on claims data are more accurate than self-reported quality measures. These include the percent of residents who: were readmitted to the hospital; were successfully discharged to the community; and had outpatient emergency department visits. Poor quality measures are evidence of inadequate staffing levels.

Missed or Omitted Care. Another important source of information about the adequacy of staffing may come directly from reports by facility nursing staff about their workload and inability to complete their assignments including basic care, communications, and timeliness of care. Missed or omitted care has been found to be associated with adverse events including: pressure ulcers, medication errors, new infections, and IVs running dry or leaking. Missed nursing care has also been found to be associated with poor patient safety culture and patient falls, a patient safety indicator. Staffing levels, not surprisingly, predict missed nursing care and can explain the relationship between staffing levels and patient outcomes. Common missed care includes care planning, comforting/talking with

[89] Schnelle JF, Schroyer LD et al. 2016.

residents, providing adequate resident surveillance, and resident/family teaching. Missed care would indicate that the staffing adjustments for acuity are not adequate.[90] [91]

Adverse Events and Quality Problems. NHs are required to develop program feedback, data systems and monitoring of quality of care (§483.75(c)(a). Each facility must: (1) obtain and use feedback and input from staff, residents, and others to identify problems and opportunities for improvement; (2) identify, collect, and use data and information from all departments to develop and monitor performance indicators; (3) develop, monitor, and evaluate performance indicators, and (4) monitor adverse events. Facility reports on problems with quality of care, quality of life, and safety problems may indicate that the staffing levels for acuity are inadequate.

Once this evaluation of problems is complete, CMS should require facilities to take these findings into account in revising their unit and facility staffing levels to ensure that each resident has adequate staffing to meet its needs.

5. CMS Should Require the NH Director of Nursing to Certify and Document the Facility Assessment Process

The DON is responsible for NH staffing and administration of nursing services. We further urge that CMS regulations should state that the DON is responsible for completing the facility assessment and signing a document certifying the assessment. The DON should be responsible for determining if the facility lacks adequate staffing and shall have the authority to place a hold on new admissions until the DON considers that the facility has adequate staffing.

6. CMS Should Require Each NH Medical Director To Be Engaged in the Facility Assessment Process

CMS collects PBJ data from each facility quarterly that should identify the NH DON and Medical Director. In addition, at the time of the annual survey, CMS presently has an "Entrance Conference Worksheet" (FORM CMS–20045 (11/2020) that is filled out by the surveyor upon beginning a survey. It includes the collection of information regarding full-time DON coverage and the name of the Resident Council President. CMS now includes the Medical Director in the "List of key personnel" requiring location and phone numbers. The NH Administrator is asked to make the Medical Director aware of the survey and offer an opportunity to the Medical Director to provide feedback to the survey team.

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[90] Kalisch BJ, Tschannen D, Lee KH. Do staffing levels predict missed nursing care? *Int J Qual Health Care*. 2011;23:302-308.
[91] Hessels AJ, Paliwal M, Weaver SH, Siddiqui D, Wurmser T. Impact of patient safety culture on missed nursing care and adverse patient events. *J Nurs Care Qual*. 2019;34:287-294.

In the context of the appropriate engagement of the facility medical director, this is also an opportunity for CMS to collect DON and medical director information in order to create a directory that could be effectively utilized during emergencies and/or disasters.

Furthermore, the NH medical director should have expertise related to the complexity and acuity of residents and should be involved in this aspect of the Facility Assessment. **Therefore, it would be appropriate and beneficial to have the Medical Director, who (by §483.75(i)) is responsible the implementation of resident care policies and the coordination of medical care in the facility, to also sign off on the Facility Assessment.**

7. CMS Needs to Strengthen Enforcement of the Facility Assessment To Ensure Staffing is Adjusted to Meet Resident Case-Mix Needs

The CMS Proposed §483.71 largely is the same as the current requirement, §483.70(e), with the exceptions of §483.71(b)(1)-(5) and new language in §483.71(a)(1)(ii) saying that the assessment must use "evidence-based data-driven methods" and be "consistent with and informed by individual resident assessments as required under §483.20 of this part."

We strongly recommend that CMS adopt the methodology recommended by Harrington and colleagues (2020) described above as a guideline to assess whether staffing is adequate or develop a similar methodology, to give facilities clear staffing guidelines linked to resident acuity.

CMS should make both detailed and average nursing PDPM acuity levels available on its Nursing Home Compare website each quarter along with the PBJ data, and this should replace its current "casemix adjusted" data on its website. Facilities that fail to adjust staffing levels to meet its resident acuity levels should be identified publicly.

In addition, CMS may also use surveyors to evaluate compliance with the facility assessment requirement. Most facilities are not complying with the current rules because at least 75 percent of facilities do not meet even minimum recommended staffing levels. **In order to ensure enforcement, CMS should classify consistent non-compliance with this requirement at the level of immediate jeopardy and require a hold on new admissions until compliance is achieved.**

IV. NH Surveys and Enforcement

CMS proposed the following regulation: (iv) Determinations of compliance with hours per resident day requirements will be made based on the most recent available quarter of PBJ System data submitted in accordance with § 483.70(p) of this part. (v) Compliance with minimum hours per resident day for RN and CNA should not be construed as approval for a facility to staff only to these numerical standards. Facilities must ensure there are adequate staff with the appropriate competencies and skills sets necessary to assure resident safety and to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment at § 483.71 of this part.

1. The CMS Central Office Should Implement Automatic Mandatory Enforcement

We strongly recommend that the CMS central office should monitor the PBJ staffing data and identify all facilities that are not in compliance with all of the federal staffing standards. Facilities that have consistently large drops in staffing on weekends and holidays and other dangerously low staffing should be identified. Citations should be automatically issued by CMS from the central office for failure to comply with staffing regulations.

Automatic holds on new admissions should also be used by the CMS central office for any serious non-compliance with staffing standards until a NH is back in compliance with the minimum staffing requirements for at least 6 consecutive days.

Residents need to be protected by strict CMS enforcement of staffing standards and should not have to wait for an annual survey report to ensure enforcement. Timing for surveys range from 9-15 months by which time the resident may have received months of poor care and may no longer be in a facility. It is an unacceptable delay in enforcement to only rely on surveys.

2. CMS Must Strengthen Its State Survey Enforcement to Ensure Adequate Staffing Levels

Failure to have “sufficient” staff to meet resident needs can result in enforcement action by CMS. NHs, however, rarely face consequences for understaffing, because CMS mischaracterizes almost all staffing deficiencies (over ninety-six percent) as not causing harm.[92] Even when CMS finds that there are staffing deficiencies and that they pose an “immediate jeopardy” to residents, NHs are often not sanctioned. A review of staffing deficiencies found 1,465 in 2019 of which only 36 were reported as causing harm and 20 as immediate jeopardy. Deficiencies for staffing dropped to 280 (1.5 percent of facilities) in 2020, with only 5 causing harm and 12 for immediate jeopardy.[93]

States’ surveyors have failed to monitor staffing and issue appropriate sanctions. Because of this, we urge CMS to establish more detailed guidelines to state surveyors on monitoring staffing levels.

In addition, state surveyors should be instructed to require a hold on new admissions for any NH until the NH is back in compliance with the minimum staffing requirements for at least 6 consecutive days.

As noted above, CMS should not only automatically sanction facilities for failure to meet minimum staffing requirements but also for failure to adjust staffing to meet the resident acuity care needs. Violations should be made available on the CMS Nursing Home Compare website along with data on CMS penalties and enforcement actions.

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[92] Edelman, T. *Staffing deficiencies in nursing facilities: rarely cited, seldom sanctioned.* Washington, CD: Center for Medicare Advocacy, 2014. http://www.medicareadvocacy.org/staffing-deficiencies-in-nursing-facilities-rarely-cited-seldom-sanctioned/

[93] Edelman, T. *Nurse staffing deficiencies.* Washington, DC: Center for Medicare Advocacy, 2019. https://www.medicareadvocacy.org/report-nurse-staffing-deficiencies/ http://www.medicareadvocacy.org/staffing-deficiencies-in-nursing-facilities-rarely-cited-seldom-sanctioned/ Edelman, T.S. Improving nurse staffing levels in nursing facilities: Strategies, approaches, recommendations. Center for Medicare Advocacy September 30, 2020.

Moreover, CMS needs to revise its Survey and Certification guidelines to identify staffing as the root cause of many quality problems that residents experience. Each survey should prioritize examining whether staffing is adequate. Surveyors are often instructed to only cite the resident problems (for example, pressure ulcers) that are identified, even though the underlying cause of the problem is recognized as low staffing. **The CMS guidelines should instruct surveyors to issue citations for both the resident problems that they identify *and* for inadequate staffing that more than likely led to the poor resident outcomes.**

V. Managed Care

CMS has proposed that 2. Section 438.72 is added to subpart B to read as follows: § 438.72 Additional requirements for long term services and supports. *Nursing facilities services and services delivered in Intermediate Care Facilities for Individuals with Intellectual Disabilities.* If the State includes nursing facility and/or ICF/IID services in their MCO or PIHP contracts, the State must include requirements in these contracts imposing obligations on the MCO or PIHP to the extent necessary to comply with the reporting requirements in § 442.43 of this subchapter, and must comply by the first rating period for contracts with MCOs or PIHPs beginning on or after the effective date specified in § 442.43(f) of this subchapter.

We support stronger reporting requirements for all facilities contracted with MCOs. MCOs and PIHPs should be required to separately report the number of residents and days of care for Medicare and Medicaid MCO and PIHP NH residents as well as enrollees who pay privately.

VI. Medicaid Institutional Payment Transparency Reporting Provision

CMS is proposing requirements for state Medicaid programs to identify, at the facility level, the percent of Medicaid payments spent on compensation to: (i) Direct care workers at each nursing facility; (ii) Support staff at each nursing facility; (iii) Direct care workers at each ICF/ IID, and (iv) Support staff at each ICF/IID.

We strongly support increased Medicaid payment transparency requirements. Medicare cost reports already require SNFs to report wages and benefits for some categories of workers. In fact, the Abt Staffing Study used the cost report data to calculate average wages and benefits for RNs, LPN/LVNs, and CNAs in its study.

Medicaid wage and benefit data are available in some states while Medicaid financial data are not available in other states.[94] While it would be ideal to have more detailed information on wages and benefits, we do not believe that most state Medicaid programs have this information available without developing a more comprehensive financial reporting system.

[94] Medicaid and CHIP Payment and Access Commission (MACPAC). Nursing Facility Fee-for-Service Payment Policy. Issue Brief. Washington, DC: MACPAC. 2019; December. https://www.macpac.gov/publication/nursing-facility-payment-policies/

1. CMS Should Adopt the Medicaid Transparency Recommendation by MACPAC

We strongly urge CMS to implement the Medicaid transparency recommendations of the 2023 Medicaid and CHIP Payment and Access Commission (MACPAC).[95] MACPAC has conducted recent studies of Medicaid nursing facility payments and cost data and has identified extensive problems with the lack of transparency. Unless Medicaid programs are required to provide more comprehensive data on rates and payments as well as expenses, CMS will not be able to draw any useful conclusions from this one proposed transparency requirement.

The MACPAC recommendations, described above, call for state Medicaid programs to make nursing facility (NF) payment and cost data publicly available in a standard format.[96] Such data should include Medicaid annual payment rates for each specific NH. The reports should include:

- **Base Medicaid payments, supplemental payments, managed care directed payments, and beneficiary contributions to their share of costs.**
- **The amount of provider contributions to the non-federal share of Medicaid payments to calculate net payments to providers.**
- **Expenses for wages and benefits separately for nursing, ancillary, and support services as well as administrative staff and other employees.**
- **Expenses for direct care including staffing costs for nursing, ancillary, and support services**
- **Expenses for administration, property, and profits.**
- **Detailed expenses for related party transactions, real estate ownership, and disallowed costs.**

Thus, we strongly urge CMS to revise this proposed regulation to implement all the recommendations of MACPAC for improving Medicaid nursing facility transparency.

2. CMS Should Adopt Stronger Medicaid NH Financial Accountability Requirements

Medicaid rates have been considered to be inadequate by the nursing industry for many years. While there is little evidence that this is the case, the rates are subject to debate. Because of the lack of overall nursing home financial transparency and accountability of nursing homes and their parent companies and related party companies, it is difficult to know whether Medicaid rates cover the costs for Medicaid residents.

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[95] Medicaid and CHIP Payment and Access Commission (MACPAC). Principles for Assessing Medicaid Nursing Facility Payment Policies, Chapter 2. March 2023 Report to Congress on Medicaid and CHIP. https://www.macpac.gov/wp-content/uploads/2023/03/Chapter-2-Principles-for-Assessing-Medicaid-Nursing-Facility-Payment-Policies.pdf
[96] Ibid.

For-profit nursing homes have better financial performance than non-profit facilities by having higher revenues and total profit margins.[97] [98] Nursing homes have many ways to make money (called hidden profits) such as by contracting with their own related party companies (with shared ownership) including separate companies that provide management, staffing, therapy, pharmacy, and property leases and real estate companies.[99] About three-fourths of nursing homes reported a total of $11 billion in related party transactions in 2015.[100] See also a new report on dubious related-party transactions by The Consumer Voice.[101]

In 2023, the NASEM Committee concluded that NHs may be using related-party and unrelated party entities to hide profits because of inadequate financial transparency and inaccurate and incomplete cost reporting. The Committee urged policy changes to improve transparency and accountability. [102] One study of California NHs found that NHs with related-party transactions were more likely to report lower profit margins,[103] suggesting that the use of related-party organizations may be a successful way to hide profits.

The New York State Attorney General recently filed a lawsuit against four NHs for multiple fraudulent schemes to divert government funds through related-party real estate arrangements, unnecessary and exorbitant loans with inflated interest rates, phony fees paid to companies they and their family members own, and paying themselves inflated salaries for work that was not performed. The lawsuit alleges that the diversion of funds led to shortages of staffing and significant resident neglect, harm, and humiliation.[104]

3. CMS Should Require Medicaid Programs to Assure That At Least 80 percent of Revenues Are Spent on Direct Care Services

The CMS proposed regulations discuss the value and importance of ensuring accountability for spending government resources by setting a requirement for direct care spending. CMS, however, failed to include a requirement for state Medicaid programs to set requirements of NH direct care spending.

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[97] GAO 2010 U.S. Government Accountability Office. *Nursing Homes: Complexity of Private Investment Purchases Demonstrates Need for CMS to Improve the Usability and Completeness of Ownership Data.* GAO-10-710. Washington, D.C.: GAO, 2010. Accessed May 15, 2012. Available at http://www.gao.gov/products/GAO-10-710

[98] Weech-Maldonado R, Laberge A, Pradhan R, Johnson CE, Yang Z, Hyer K. Nursing home financial performance: The role of ownership and chain affiliation. *Health Care Man Rev.* 2012, 37 (3):235-245.

[99] Harrington, C., Ross, L. & Kang, T. Hidden owners, hidden profits and poor nursing home care: A case study. *International J. Health Services.* 2015: 45 (4): 779-800.

[100] Rau J. Care suffers as profits rise. *New York Times.* January 7, 2018. https://www.nytimes.com/2018/01/02/business/nursing-homes-care-corporate.html

[101] The National Consumer Voice. *Where do the billions of dollars go? A look at nursing home related-party transactions.* The Consumer Voice. Washington, DC, 2023. https://theconsumervoice.org/news/detail/latest/new-report-nursing-homes-funnel-dollars-through-related-party-companies

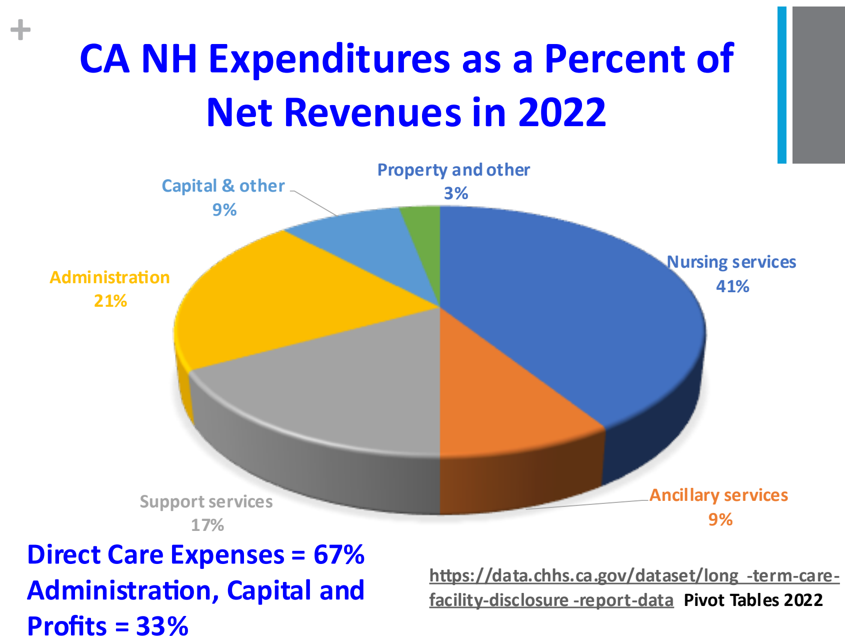
[102] The National Academies of Sciences, Engineering, and Medicine (NASEM), Board on Health Care Services, Health and Medicine Division, Committee on the Quality of Care in Nursing Homes. *The national imperative to improve nursing home quality: honoring our commitment to residents, families, and staff.* 2022. Washington, DC: The National Academies Press. https://nap.nationalacademies.

[103] Harrington CA, Hailer L, Mollot RJ, Mukamel DB. Examining California nursing home profitability and related factors before and during the COVID-19 pandemic. JAGS. 2023; Apr 7, DOI: 10.1111/jgs.18356.

[104] New York Attorney General James. Attorney General James sues owners and operators of four nursing homes for repeated financial fraud and resident neglect. New York. 2023. https://ag.ny.gov/press-release/2023/attorney-general-james-sues-owners-and-operators-four-nursing-homes-financial

We recommend that CMS issue a guideline to state Medicaid programs to set a requirement that at least 80 percent of Medicaid NH revenues should be spent on direct care services, excluding administrative costs, property costs and profits. Four states (New Jersey, New York, Massachusetts, and Pennsylvania) have passed legislation requiring a percentage of NH revenues to be spent on direct care services, with limitations on administrative costs, property costs, and profits.[105] For example, New York's legislation required at least 70 percent of total operating expenses for direct care, including 40 percent for resident-facing staffing, and limited profits to no more than 5 percent of expenses. These states require NHs to return funds that exceed the state limits.[91]

Based on California NH cost report data that are available on line, California NHs spent only 67 percent of total NH revenues (including Medicaid, Medicare, and other payers) on direct care expenditures in 2022, while 33 percent was spent on administration (which include Medicaid provider fees), property, and profits.[106] See the table below:



A recent study of US 2019 NH cost report data found that nationally, NHs spent a total of 66 percent of revenues on direct care services compared to 34 percent for administration, capital, and profits.[107] This is strong evidence that NHs are not being financially accountable for ensuring that government funds are spent on services and not on administration, capital, and profits. It also gives strong support for setting a 80 percent requirement for direct care spending.

[105] Long Term Care Community Coalition. *LTCCC Policy Brief: Direct care minimum spending laws.* 2022; March. https://nursinghome411.org/wp-content/uploads/2022/03/LTCCC-Policy-Brief-NY-Direct-Care-Min.-Spending-Ratio.pdf
[106] California Health Care Access and Information. Long Term Care Cost Report Pivot Tables, 2022. https://data.chhs.ca.gov/dataset/long-term-care-facility-disclosure-report-data 2
[107] Harrington, C., Mollot RJ, Braun RT, and Williams, D. United States' Nursing Home Finances: Spending, Profitability, and Capital Structure. *International J. of Social Determinants of Health and Health Services,* In Press.

We also want to point out setting a minimum for Medicaid spending is not sufficient because NHs can shift expenditures to other payers. CMS should set a minimum direct care spending requirement for all payers including Medicare and Medicaid.

Moreover, CMS has issued a HCBS proposed rule that calls for a direct care ratio, requiring, at proposed §441.302(k)(3)(i), that "At least 80 percent of all payments with respect to services at §440.180(b)(2) through (4) must be spent on compensation for direct care workers." Direct care workers are defined at proposed §441.302(k)(1)(ii)(A)-(G). In proposed §441.311, Reporting Requirements, in §441.311(e), CMS requires States to report to CMS about the HCBS spending, "at the time and in the form and manner specified by the CMS:"

In addition, CMS proposed HCBS regulations require that Medicaid programs must report to CMS annually on the percent of payments for certain services, as specified in §441.302(k)(3)(i), that are spent on compensation for direct care workers, at the time and in the form and manner specified by CMS. The State must report separately for each service and, within each service, must separately report services that are self-directed. Third, the in proposed §441.313, website transparency, CMS proposed §441.313(b), that "CMS must report on its website the results of the reporting requirements specified at §441.311 that the State reports to CMS." Finally, in proposed §447.203(b)(1), CMS requires State agencies to publish payment rates on a website that is accessible to the public in a "payment rate transparency publication."

These proposals, together, require states to spend 80% of HCBS payments on direct care, require. States are required to report spending to CMS "in the form and manner specified by CMS," and require CMS to publish these results on the CMS website.

CMS should adopt these same comprehensive requirements for Medicaid and Medicare NH spending.

VII. CMS Should Adopt New Medicare Cost Report Transparency, Accountability, and Enforcement Requirements

Ironically, the new CMS proposed regulations are focused on improving state Medicaid financial transparency and accountability. These regulations fail to adopt changes in Medicare financial transparency and accountability.

The Medicare Payment Advisory Commission states that Medicare nursing home payments are too high: the 2019 profit margin on Medicare spending was 11.3 percent and has remained over 10 percent for the past 20 years.[108] Unfortunately, the focus of Medicare rate setting has been almost entirely on controlling costs rather than ensuring quality. Medicare prospective payments are based on estimated costs and not on acutal expenditures. This system allows nursing homes to keep staffing and operating expenses low in order to maximize profits.

Because of these concerns, the Commission and Office of the Inspector General called for a redesign of the payment system based on patient characteristics rather than on services provided. In October 2019, CMS changed its Medicare PPS reimbursement system for nursing homes to a

[108] Medicare Payment Advisory Commission (MedPac). *Report to the Congress: Medicare Payment Policy.* Washington, DC: MedPac, March 2023.

Patient Driven Payment Methodology (PDPM) for nursing and other services. The PDPM system has resident case-mix adjusted components for therapies, non-therapy ancillary, and nursing services.[109] The CMS PDPM payment methodology was primarily designed for payment and not specifically to promote high quality staffing nor to assure that nursing homes meet the federal regulatory requirements.

The Affordable Care Act (ACA, 2010) required detailed Medicare nursing home cost reports, including expenditures for staff wages and benefits and separated costs for direct and indirect care, capital costs, and administrative costs that include owners' profits.[110] Medicare cost report data are not audited and penalties are not issued for failure to report. In other words, the Medicare prospective payment system allocates funds for expected costs but does not impose audit requirements and ensure that funds are expended as allocated. The GAO recommended that CMS take steps to ensure that cost data are reliable and made readily accessible to public stakeholders.[111] Audits of cost reports are needed and penalties should be instituted for inaccurate nursing home ownership and cost data.

1. **CMS Should Establish Stronger Medicare Financial Transparency Requirements**

We strongly urge CMS to improve reporting on the Medicare cost report, CMS Form 2540, for Skilled Nursing Facilities (SNFs). We also urge CMS to fully implement the statutory requirements of Section 6104 of the Affordable Care Act (ACA) which requires SNFs to separately report expenditures for wages and benefits for different types of direct care staff and to categorize all expenditures for direct care services (including nursing, therapy, and medical services), indirect care (including housekeeping and dietary services), capital assets (including building and land costs), and administrative services.

The proposed changes would significantly improve the usefulness of Medicare SNF cost reports to CMS and improve public transparency regarding how taxpayer funds are being spent. We also urge CMS to accelerate the implementation of the Administration's forward-looking NH initiatives announced on February 28, 2022. Among other provisions these initiatives, called for:

> "Expand[ing] Financial Penalties and Other Enforcement Sanctions. CMS will expand the instances in which it takes enforcement actions against poor-performing facilities based on desk reviews of data submissions, which will be performed in addition to on-site inspections…. CMS will also use data, predictive analytics, and other information processing tools to improve enforcement."

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[109] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. 2019. 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 2020. *Federal Register.* Proposed Rule 4/25/2019. https://www.federalregister.gov/documents/2019/04/25/2019-08108/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation

[110] Patient Protection and Affordable Care Act (ACA) (PL. 11-148). Signed by President Barack Obama on March 23, 2010. See also Wells J, Harrington C. *Implementation of Affordable Care Act provisions to improve nursing home transparency and quality.* Kaiser Commission on Medicaid and the Uninsured: Washington, DC, 2013.

[111] U.S. Government Accountability Office (US GAO). (2016). *Skilled nursing facilities: CMS should improve accessibility and reliability of expenditure data.* GAO-16-700. Washington, D.C.: GAO, September

The intended purpose of ACA Section 6104 is to provide a clear, detailed, and accurate picture of how taxpayer funding for skilled care in SNFs is being spent. Notably, the current cost reporting form does not require SNFs to disclose how much revenue was received from each source (i.e., Medicaid, Medicare Advantage, managed care, Medicaid managed care, self-pay, and other private insurers and programs). The suggested modifications enumerated below are laid out in an accompanying Excel spreadsheet sample template (hereafter referred to as the "Addendum"). Such reporting would provide needed information on revenue received by payor and would reveal whether these payments are sufficient. Notably, Medicare cost reporting regulations at 42 C.F.R. 413.20 (d) provide scope for this reporting by requiring reporting of "amounts of income received by source and purpose."

Implementing more useful reporting requirements would also improve transparency and accountability regarding how Medicare payments to SNFs are being used for care of residents in certain key functional categories. Cost reporting is not only about accountability; it can also inform rate setting.

For these reasons, we recommend incorporating the following suggestions into an Addendum to the current Medicare cost reporting form. To further ensure accuracy and completeness, we recommend that an Addendum be signed under penalty of perjury by appropriate NH officials, including the facility Administrator and the CFO.

Bed days by payor. Medicare, Medicaid, Medicare Advantage or managed care, Medicaid managed care, self-pay, and other payors classified into three categories; inpatient days, bed hold days, and leave of absence days.

Revenue received by payor. Medicare, Medicaid, Medicare Advantage or managed care, Medicaid managed care, self-pay, and other payers, calculated as: gross routine, less contractual adjustments or deductions, net revenue, and ancillary gross revenue for inpatient and outpatient services, less ancillary contractual adjustments or deductions, net ancillary revenue, total net patient revenue, total non-health revenue, and total revenue.

Patient Driven Payment Model (PDPM) Rate Codes. Effective October 1, 2019, CMS began using the Patient Driven Payment Model (PDPM) to categorize the needs of SNF patients in a covered Part A stay. The 25 PDPM groups represent specific sets of patient characteristics (acuity), sometimes referred to as case-mix groups, which Medicare uses to make payment determinations. We recommend that the Medicare cost report addendum include the total number of patient days in each PDPM group by payor (Medicare, Medicaid, Medicare Advantage or managed care, Medicaid managed care, self- pay, and other payors). This would replace the current RUG score detail, which is only disclosed for Medicare bed days – an incomplete data set.

Direct Care Nursing Hours. In addition to the paid hours currently included on the cost reports, nursing service expenditures should include the following information: actual worked nursing hours (i.e., productive hours, excluding vacation and sick leave) by nursing category: direct care nursing hours (RNs, LVNs/LPNs, CNAs, including, certified medication technicians, restorative aides, nursing aides in training); nursing administration; agency nursing hours.

Therapy Hours. Actual therapy hours provided should be reported by type as follows: physical therapy, occupational therapy, speech therapy, respiratory therapy, agency therapy hours.

Support Services. Costs for housekeeping, dietary, and all other basic operating costs.

Administrative Costs (overhead). Administrative costs should include home office costs, the facility's business offices (for instance, administration, admissions, and medical records). Administrative costs consist of salaries, wages and benefits, retirement costs, retirement plan administrative costs paid to external organizations, health and other insurance costs, the employer portion of payroll taxes for FICA, Medicare, and unemployment insurance. In addition, this section should include office supplies, office expenses, licensing fees, quality assurance fees, liability insurance, general business insurance, association dues, legal costs, other special purpose cost centers and non-reimbursable cost centers.

The administrative costs should be clearly summarized in a straightforward manner. In the attached sample excel spreadsheet template, we suggest four columns: (1) for administrative costs specific to the facility; (2) for administrative costs allocated to the facility by a management company or home office; (3) for the administrative costs incurred by additional disclosable parties (see comment in *Disallowed Costs* below); and (4) for totals. For consistency and comparability, this schedule should have pre-loaded line items and space for additional categories.

Property and Capital Costs. These costs include land, land improvements, buildings, fixtures, building and leasehold improvements, fixed and movable equipment, property tax, property insurance, lease and rental charges, and interest on land, property, and equipment. The schedule should have three columns (1) for the home office and management company; (2) for the facility; and (3) for the total.

Disallowed Costs. Once the inclusion of reporting from additional disclosable parties are defined in a final regulation issued by CMS, we recommend that the Medicare cost report addendum discussed here be simultaneously modified with the addition of a new schedule. Briefly, each additional disclosable party would detail revenue collected from the facility concerned, along with the cost of any goods and/or services sold to the SNF, the administrative expenses charged, and profit realized from providing these goods and/or services.

Related Party Costs. In addition, CMS should amend its Medicare SNF cost reports to collect more detail on related party transactions, real estate ownership transactions, and show disallowed payments from SNFs. This would ensure greater accountability for the spending of public monies.

In summary, we recommend that Medicare SNF cost reports require a detailed organizational chart outlining the organization's corporate structure. These should include all additional disclosable parties once CMS has issued a final regulation defining them. Each entity would be defined by their legal name, DBA ("doing business as") name, state of incorporation, date of incorporation, owner/member names, ownership percentages down to the individual(s), and changes in ownership.

2. CMS Should Require NHs to Submit Audited Medicare Cost Reports to Ensure Accuracy

The CMS Medicare cost report requirements should be amended to require each skilled nursing facility provide annual consolidated financial report inclusive of data from operating entities (license holders) and all organizations and entities related by common ownership or control. Related entities include but are not limited to home offices, management organizations, staffing, therapy, supply, pharmaceutical, consulting, insurance, banking and investment entities, parent companies, holding companies and sister organizations. Management companies and property

companies that are not related by ownership should also be required to provide a full financial report annually.

The CMS Medicare cost reports should require that each nursing home submit an annual consolidated financial report prepared by a certified public accounting firm within six months of the end of each fiscal year. The annual financial audit report should be prepared using Generally Accepted Accounting Principles (GAAP) as well as the Financial Accounting Standards Board's (FASB) financial reporting requirements. Statements should be prepared using the accrual basis and include an income statement, a balance sheet, statement of changes in equity and a cashflow statement. Management companies and property that are not related by ownership should also provide a full financial report prepared by a certified public accounting firm within six months of the end of each fiscal year, including copies of their contractual agreements with the nursing facility operating company.

A combined financial and oversight system should be established by CMS to conduct annual joint Medicare and Medicaid audits including home office and related party payer audits, in order to administer the medical loss ratio ceiling for administrative costs and profits. As part of the audit oversight, CMS should be given full access to IRS filings of all the entities involved in the nursing home operation.

3. CMS Needs to Enforce Its Medicare SNF Cost Report Transparency Requirements

CMS needs to develop two types of enforcement for cost report transparency: 1) enforcement for failing to file, for late filings, and for submitting incomplete and/or inaccurate information, and 2) enforcement for providing false information on a cost report. The first issue is governed by 42 C.F.R. 405.371(d)(1), stating: "If a provider has failed to timely file an acceptable cost report, payment to the provider is immediately suspended in whole or in part until a cost report is filed and determined by the Medicare contractor to be acceptable." This language is also reflected in Section 10.2 of the Medicare Financial Management Manual, and addresses instances where the cost report does not include certain required information, or the provided information is obviously inaccurate. The remedy here is the enforcement of the temporary suspension of payments. We recommend substantial/meaningful fines for violations to deter non-compliance.

Finally, to further improve accuracy, CMS could consider establishing a "reward system" for finding and reporting errors that is paid for from fines levied against the facilities for submitting inaccurate cost reports. If a suspected error or falsification is substantiated, a reporter (e.g., an auditor, attorney, or other members of the general public) could be paid a modest fee.

4. CMS Should Establish A Direct Care Expenditure Requirement for NHs

Under the Affordable Care Act, insurers must spend a certain percentage of their premium on health care claims or quality improvement, set at 85 percent for the large group market and called

a medical loss ratio (MLR). In 2019, insurers were reported to owe rebates to 11.2 million enrollees of about $2.46 billion ($219 per person).[112]

The nation's nursing homes have high administrative costs and profits. California nursing home cost reports showed a total of 67 percent on direct care services and 33 percent of net nursing home revenues were spent on administration and profits in 2010, not counting the hidden profits from third party contracts.[113]

As noted earlier, based on 2022 California NH cost report data that are available on line, California NHs spent only 67 percent of total NH revenues (including Medicaid, Medicare, and other payers) on direct care expenditures, while 33 percent was spent on administration (which include Medicaid provider fees), property, and profits.[114]

A recent study of US 2019 NH cost report data found that nationally, NHs spent a total of 66 percent of revenues on direct care services compared to 34 percent for administration, capital, and profits.[115] This is strong evidence that NHs are not being financially accountable for ensuring that government funds are spent on services and not on administration, capital, and profits. It also gives strong support for setting a 80 percent requirement for direct care spending.

We also want to point out setting a minimum for Medicaid or Medicare spending is not sufficient because NHs can shift expenditures to other payers. CMS should set a minimum direct care spending requirement for all payers including Medicare and Medicaid.

A medical loss ratio (the proportion of revenues spent on clinical services versus administration and profits), similar to that imposed at the federal level for private health insurance companies by the Affordable Care Act, could be imposed on nursing homes.[116] Since the vast majority of nursing home revenues are from Medicare and Medicaid, the total amount of administration and profits could be limited to 10-15 percent of net income annually. A medical loss ratio of 20 percent could save payers billions and ensure that funds are used for services.

As noted above, CMS has issued guidelines for HCBS programs that require states to spend 80% of HCBS payments on direct care, require States to report spending to CMS "in the form and manner specified by CMS," and require CMS to publish these results on the CMS website.

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[112] Keith, K. ACA round-up: record-high medical loss ratio rebates, pass-through funding, preventive services. *Health Affairs Blog.* November 17, 2020. See also https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2019-Rebates-by-State.pdf

[112] New Jersey. Assembly, No. 4482, 219th Legislature. *Establishes minimum wage requirements for certain long-term care facility staff; establishes direct care ratio requirements for nursing homes; requires nursing home care rate study.* 2020-09-16, executive: Approved P.L.2020, c.89. https://fastdemocracy.com/bill-search/nj/219/bills/NJB00038520/

[113] Harrington, C., Ross, L., Mukamel, D., and Rosenau, P. Improving the Financial Accountability of Nursing Facilities. Report prepared for the Kaiser Commission on Medicaid and the Uninsured, Washington, DC: Kaiser Commission on Medicaid and the Uninsured, June, 2013. http://kff.org/medicaid/report/improving-the-financial-accountability-of-nursing-facilities/

[114] California Health Care Access and Information. Long Term Care Cost Report Pivot Tables, 2022. https://data.chhs.ca.gov/dataset/long-term-care-facility-disclosure-report-data 2

[115] Harrington, C., Mollot RJ, Braun RT, and Williams, D. United States' Nursing Home Finances: Spending, Profitability, and Capital Structure. *International J. of Social Determinants of Health and Health Services,* In Press.

[116] Patient Protection and Affordable Care Act (ACA) (PL. 11-148). Signed by President Barack Obama on March 23, 2010.

CMS should be adopting these same comprehensive requirements for Medicare NH spending.

As noted above, four states (New Jersey, New York, Massachusetts, and Pennsylvania) have passed legislation requiring a percentage of NH revenues to be spent on direct care services, with limitations on administrative costs, property costs, and profits.[117] By limiting administrative costs and profit taking, nursing homes can reallocate its revenues to nursing, ancillary, and support services.

We strongly urge CMS to adopt a requirement that Medicare NHs must demonstrate that at least 80 percent of revenues are spent on direct care services. This would place a ceiling on the combined administrative costs and profits of each nursing home and its related parties, and parent companies of 20 percent of net revenues per year. This combined maximum would be on all net revenues regardless of funding source including Medicare and Medicaid. Expenditures over the ceiling would be forfeited proportionately to the payers at the end of each year. Financial controls should also limit expenditures for capital costs, leases, and management fees.

VIII. CMS Cost Estimates Fail to Place Costs in the Context of Potential Savings and Overall NH Revenues

CMS has noted that the government can save money with higher staffing because of improved quality outcomes. This includes savings from reduced rehospitalizations, pressure ulcer complications, and other clinical problems cause by understaffing.

1. CMS Should Report the Relationship Between Higher Staffing and Quality and NH Profitability

CMS should point out that there have been research studies that show that NHs can be more profitable when they have higher staffing and higher quality outcomes. Weech-Maldonado and colleagues pointed out that there is a strong business case to be made for higher quality NH care.[118] One study by Park and colleagues showed that NHs that improved their reported performance on NH Compare improved their financial performance,[119] and another study by Mukamel and Spector found there are some quality regimens that are associated with lower costs.[120] A recent study by Harrington and colleagues looking at the profitability of California NHs in 2019 and 2020 also found that NHs with high quality outcomes were more profitable.[121]

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[117] Long Term Care Community Coalition. *LTCCC Policy Brief: Direct care minimum spending laws.* 2022; March. https://nursinghome411.org/wp-content/uploads/2022/03/LTCCC-Policy-Brief-NY-Direct-Care-Min.-Spending-Ratio.pdf

[118] Weech-Maldonado R, Pradham R, Dayama N, Lord J, Gupta S. Nursing home quality and financial performance: is there a business case for quality? *Inquiry*. 2019;56:1-10.

[119] Park J, Konetzka RT, Werner RM. Performing well on nursing home report cards: does it pay off? Health Serv Res. 2011;46(2): 531-554. doi:10.1111/j.1475-6773.2010.01197.

[120] Mukamel DB, Spector WD. Nursing home costs and risk adjusted outcome measures of quality. Med Care. 2000;38(1):78-89. doi:10.1097/00005650-200001000-00009

[121] Harrington CA, Hailer L, Mollot RJ, Mukamel DB. Examining California nursing home profitability and related factors before and during the COVID-19 pandemic. *JAGS.* 2023; Apr 7, DOI: 10.1111/jgs.18356.

Another study of 12 NH administrators in one state in 2023 reported that 7 of 12 NHs reported that by investing in higher staffing, affordable health insurance, activities to increase staff morale, and paid time off, these NHs were able to stabilize their staff, improve their star ratings, and become more profitable.[122]

2. **CMS Should Revise Its Cost Estimates for Increased Staffing**

We believe the CMS minimum staffing cost estimates are inaccurate because of faulty assumptions that CMS made. **We urge CMS to revise the cost estimates for the staffing. CMS failed to put these staffing cost considerations or "industry burden" into perspective. CMS needs to show the staffing costs relative to the current total NH revenues and expenditure and to those projected into the future.**

The CMS Costs for Adding 24-Hour RN Coverage Are Inaccurate. CMS and Abt used inaccurate assumptions to estimate the costs of increasing RN coverage to 24 hours in the proposed CMS regulations. Although only 22.5% of NHs would need to hire additional staff, the Abt Study and CMS proposal assumed that NHs would keep their existing LPN/LVN staff and hire additional RNs. LPN/LVNs are currently estimated to cost about $9 per hour less than an RN.[123] It is more than likely that NHs will simply reduce their LPN/LVN hours to pay for additional RN hours to meet the standard. As a result, the cost to a facility would be only $9 more per hour, which is four times lower than the costs estimated by CMS ($35-$44 per hour). Instead of the CMS' estimate of $3.47 billion, the actual costs for 24-hour RN coverage will be substantially lower. See also the cost estimates by the Long Term Care Community Coalition showing that the overall costs for 24-hr RN staffing is minimal.[124]

CMS RN 0.55 hprd Requirement Cost Estimates Are Inaccurate. The CMS proposal assumed that in meeting the standard of the 0.55 hprd RN minimum, NHs would keep their existing LPN staff and hire additional RN hours. However, only a small percentage of NHs would need to hire additional RN hours. NHs currently use cheaper LPNs (estimated to cost about $9 per hour less) to substitute for RNs. To meet the regulations, NHs will substitute an RN for an LPN, which would cost only $9 more per hour. See the recent cost estimates conducted by nursing home industry representatives.[125] CMS should therefore have calculated the actual RN costs to be $9 per hour (the difference between and RN and LPN wage) which would be only 20 percent of costs estimated. Moreover, the proposed regulations should have pointed out that 30% of NHs that do not meet the RN level are within 6 minutes of meeting the 0.55 hprd.

CMS Cost Estimates for 2.45 NAs hprd Are Inaccurate. CMS incorrectly assumed that all NHs would retain their existing nursing staff and add new NAs. Unless CMS establishes

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[122] Farrell, D. Study of NH administrators show you get what you pay for. Oaklan, CA: 2023.
[123] Abt Associates. Nursing Home Staffing Study Comprehensive report. Report prepared for the Centers for Medicare & Medicaid Services. June 2023. *https://edit.cms.gov/files/document/nursing-homestaffing-study-final-report-appendix-june-2023.pdf*
[124] Long Term Care Community Coalition (LTCCC). 24-hour registered nurses in nursing homes: Essential and affordable. New York, LTCCC, September 2023. https://nursinghomoe411.org/costs-24-hour-rn/
[125] 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

adequate minimum standards for licensed nurses, many NHs will simply convert LPNs to CNAs, this would result is a substantial savings to a facility. A CNA was estimated to cost $21 per hour and an LPN cost is $35 per hour. By converting an LPN to a CNA, each facility would save $14 per hour, and replacing LPNs with RNs would increase costs by only $9 per hour. Without a requirement for minimum LPN/LVN hprd, NHs could actually have no additional costs or make savings by meeting the proposed additional RN and CNA minimum requirements. Thus, the CMS cost estimates for NAs are inaccurate.

Cost Estimates Are Minimal for Meeting a 4.2 Total Nursing hprd Standard, with 0.75 RN hprd, 1.4 Licensed Nursing hprd, and 2.8 CNA hprd. We consider that a minimum standard of 4.2 total nursing hprd including 0.75 RN hprd, 1.4 licensed nursing hours, and 2. 8 CNA hprd is financially feasible. A recent study by the industry showed 25 percent of NHs met a minimum standard of 4.1 total nursing hprd, 31 percent met the 0.75 RN hprd, 85 percent met the 0.55 LPN/LVN hprd, and 11 percent met the 2.8 hprd CNA thresholds. The estimated cost for achieving the proposed federal minimums across SNFs nationwide would require an estimated additional $7.25 billion annually. This amount only was a 4.2 percent of overall national NH spending, and would only cost approximately $16 per resident per day.[126]

3. CMS Must Put Its Staffing Cost Estimates into Context of Total NH Revenues

CMS collects national expenditure data for NHs and makes national cost projections. The most recent CMS national expenditure projection data for Nursing Care Facilities and Continuing Care Retirement Communities is shown in the table below.

Nursing Care Facilities and Continuing Care Retirement Communities – CMS Projections

	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031
Total Expenditures	181314	193609	201363	206128	215574	224838	234968	246308	257974	270394	283272
Out of pocket	44391	47845	51542	53322	54706	55914	57347	59292	61092	63292	65471
Health Insurance	117952	126560	129471	131508	138592	145586	153151	161079	169467	178280	187532
Private Health Insurance	16281	19056	20191	21192	22234	23297	24502	25942	27359	29000	30673
Medicare	40589	43064	41700	42638	46827	50285	54089	58159	62436	66757	71384
Medicaid (Title XIX)	54267	57058	58447	57888	59244	61414	63836	66185	68810	71619	74534
Other Health Insurance	6815	7381	9133	9790	10287	10589	10723	10794	10862	10903	10941
Other Third Party Payers and Programs	18972	19204	20350	21299	22276	23339	24470	25937	27415	28822	30270

https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected Data in millions.

These data show that total NH/CCRC expenditures were expected to be $201 billion in 2023 with $41.7 billion paid by Medicare and $58 billion paid by Medicaid in 2023.

CMS projected the total annual costs of their proposed minimum nurse staffing requirement (Table 20) would be $4 billion in year 4, $5 billion in 5 and $5.7 billion in year 10. CMS should put these numbers in context, showing these costs would be only about 2 percent of total spending in 2028.

Even projected costs for implementing the recommended standard of 4.2 total nursing hprd, 0.75 RN hprd, 1.4 licensed nursing hprd, and 2.8 CNA hprd would increase costs by

[126] Hawk T, White EM, Bishnoi C, Schwartz LB, Baier RR, Gifford DR. Facility characteristics and costs associated with meeting proposed minimum staffing levels in nursing homes. JAGS. 2022; 1-10. doi:10.1111/jgs.17678

only and estimated 4 percent of total expenditures. CMS needs to show the potential costs relative to NH expenditures. Therefore, we argue that, when put in the context of total on-going costs, these minimum staffing standards are truly feasible.

4. **Minimum Staffing Standards Are Not an Unfunded Mandate**

CMS seems to be questioning whether new minimum staffing standards are unfunded mandates, but there is no evidence that the proposed minimum standards are an unfunded mandate, and we do not believe this is the case. As the average staffing levels in NHs at this time have higher staffing than the proposed minimums under the current funding system, other NHs should be able to increase their staffing too. However, many for-profit NHs are diverting government funds away from direct care and into property, profits, and administrative costs. By allowing some NHs to have low staffing levels, the government is supporting the misuse of public funds. There is no evidence that NHs cannot absorb the costs to meet the proposed staffing minimums.[127]

Sincerely,

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[127] Harrington, C., Mollot RJ, Braun RT, and Williams, D. United States' Nursing Home Finances: Spending, Profitability, and Capital Structure. *International J. of Social Determinants of Health and Health Services,* In Press.