Centers for Medicare & Medicaid Services
Department of Health and Human Services

November 6, 2023

Comments submitted by email, http://www.regulations.gov

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

Dear CMS Colleagues:

The Center for Medicare Advocacy (Center) submits comments on a proposed rule to establish a minimum staffing standard for nursing facilities, which was published on September 6, 2023 at 88 Fed. Reg. 61352, https://www.govinfo.gov/content/pkg/FR-2023-09-06/pdf/2023-18781.pdf.

The Center for Medicare Advocacy (Center) is a national, private, non-profit law organization, founded in 1986, that provides education, analysis, advocacy, and legal assistance to assist people nationwide, primarily the elderly and people with disabilities, to obtain necessary health care, therapy, and Medicare. The Center focuses on the needs of Medicare beneficiaries, people with chronic conditions, and those in need of long-term care and provides training regarding Medicare and health care rights throughout the country. It advocates on behalf of beneficiaries in administrative and legislative forums, and serves as legal counsel in litigation of importance to Medicare beneficiaries and others seeking health coverage. These comments are based on the Center's experiences talking with and representing Medicare beneficiaries and their families and advocates.

Overview of Concerns

COVID-19 caused the deaths of more than 200,000 nursing home residents and staff members.[1] The extraordinarily high number of deaths – nearly one-quarter of the COVID-19 deaths nationwide were nursing home residents,[2] although the 1.2 million nursing home residents[3] constitute only 0.004% of the 331 million people who live in the United States[4] – brought to public

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

[2] Centers for Disease Control and Prevention, COVID Data Tracker, https://covid.cdc.gov/covid-data-tracker/#datatracker-home

[3] KFF, "Total Number of Residents in Certified Nursing Facilities" (2023), https://www.kff.org/other/state-indicator/number-of-nursing-facility-residents/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[4] https://www.google.com/search?q=what+is+the+population+of+the+US%3F&rlz=1C1KDEC_enUS1028US1028&oq=what+is+the+population+of+the+US%3F&gs_lcrp=EgZjaHJvbWUyBggAEEUYOTIHCAEQABiABDIHCAIQABiABDIHCAMQABiABDIHCAQQABiABDIHCAUQABiABDIHCAYQABiABDIHCAcQABiABDIHCAgQABiABDIHCAkQABiABNIBCDg0NzFqMWo0qAIAsAIA&sourceid=chrome&ie=UTF-8

attention the poor quality of care in many nursing homes and led directly to President Biden's announcement of a historic nursing home reform agenda in February 2022.[5]

Staffing is the centerpiece of the President's agenda. It is therefore with dismay that we find that the proposed rule issued by the Centers for Medicare & Medicaid Services (CMS) on September 6, 2023 fails to implement the President's explicit directive to improve staffing levels in nursing homes and is, instead, a shockingly major step backwards in many ways.

The preamble to the proposed rule strongly makes the case for dramatically increasing nurse staffing levels in nursing facilities nationwide. It contains multiple sources of evidence (comments of residents, families, and staff; research literature; CMS's Request for Information; CMS's Listening Sessions; and considerably more) about the pervasive understaffing in nursing homes for decades and the devastating consequences for residents and staff. The comment letter submitted by Charlene Harrington on behalf of 79 additional geriatric nursing experts (individuals and organizations) in response to CMS's 2022 Request for Information, listed more than 110 research articles from 1977-2022 documenting better care for residents in facilities with higher staffing levels.[6] All research studies, whatever the focus and whatever measures they use, find better care for residents with more nursing staff. No study finds otherwise.

The preamble summarizes a small fraction of what CMS heard about the consequences of chronic understaffing in facilities:

> For example, residents going entire shifts without receiving toileting assistance, which can lead to an increase in falls or the development or worsening of pressure ulcers. Commenters noted that NAs barely have time to get each resident dressed, fed, and bathed; that residents lie for hours in wet and soiled diapers; that residents who need help to eat struggle to feed themselves; and that residents suffer abuse from staff and other residents because no one is watching. Commenters also shared stories of residents wearing the same outfit for a week without a change of clothing or a shower. Commenters highlighted the contribution of facility staff and attributed the lack of quality care to insufficient staffing levels.

88 Fed. Reg., 61358.

The proposed rule ignores not only the overwhelming evidence, compiled over the decades, about the consequences of understaffing on residents (and staff), but also the 2023 Abt nurse staffing study that CMS commissioned, which is filled with first-person descriptions of the harm suffered by residents and staff when facilities are inadequately staffed. **CMS provides no clinical basis for the inadequate staffing ratios and standards that it actually proposes.** The inadequate standards in the proposed rule are below the staffing levels met by facilities during the COVID-19 pandemic, have no support in the 2023 Abt staffing study (which evaluated four higher staffing levels), ignore the simulation analyses and conclusions of the 2023 Abt staffing study, and are

[5] White House, "FACT SHEET: Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Homes" (Feb. 28, 2022), https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/28/fact-sheet-protecting-seniors-and-people-with-disabilities-by-improving-safety-and-quality-of-care-in-the-nations-nursing-homes/

[6] https://www.regulations.gov/comment/CMS-2022-0069-410

arbitrary and capricious. Many of the questions and issues on which CMS seeks public comment would only weaken the already weak rule even further.

The Center sees no justification in the proposed rule supporting the low nurse staffing ratio and standards that CMS proposes if the goals of staffing ratios are (as they should be) meeting residents' actual clinical needs, minimizing delayed or omitted clinical care, and respecting residents' quality of life and rights. The proposed staffing ratios violate the mandate of the 1987 Nursing Home Reform Law that

> **It is the duty and responsibility of the Secretary to assure that requirements which govern the provision of care in skilled nursing facilities under this subchapter, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents . . . .** [7]

The inadequate staffing ratios and levels proposed by CMS fail to protect residents' "health, safety, welfare, and rights."

The Center's detailed comments are set out below, followed by a summary of our recommendations, including recommended changes to the regulatory language.

Detailed comments

1. **Nurse staffing levels for registered nurses and nurse aides must be substantially strengthened.**

The proposed staffing ratio of 3.0 hours per resident day (HPRD), comprised of .55 registered nurse (RN) hours per resident day (HPRD) and 2.45 nurse aide HPRD, is grossly inadequate and will perpetuate and intensify pervasive problems of poor care that result from inadequate staffing levels. The proposed rule contains no clinical or factual justification for such a low nurse staffing ratio.

A. The 3.0 HPRD is below the 4.1 HPRD standard identified by CMS in 2001 as the level needed to prevent avoidable harm to residents and to meet a limited number of the requirements of the 1987 Nursing Home Reform Law.

The 3.0 HPRD staffing ratio in the propose rule is substantially below the 4.1 HPRD nurse staffing ratio identified by CMS's 2001 staffing report, which was mandated by the 1987 Nursing Home Reform Law and was completed by Abt Associates, in a four-volume report, after several years of comprehensive research. As described in Abt's 2023 staffing study, the 2001 Abt report "identified a strong relationship between nurse staffing quality measures for a sample that included more than 5,000 facilities in 10 states."[8] The 2001 Report identified hours of nursing staff (by category of nurse) that were needed to prevent avoidable harm and to meet five key care requirements of the

[7] 42 U.S.C. §1395i-3(f)(1) (Medicare). The standard for Medicaid is substantively identical. 42 U.S.C. §1396r(f)(1)
[8] Abt 2023 Staffing Study, p. 63

1987 Nursing Home Reform Law.[9] Although both CMS (in the preamble, p, 61359) and Abt (in the 2023 staffing report) attempt to discount or discredit the 4.1 standard as not really calling for 4.1 HPRD of nursing time, the Center is unaware of anyone who has ever before disavowed the validity of the 4.1 HPRD standard in the 2001 report.

To the contrary, the 4.1 HPRD nurse staffing standard has been used and relied on as the gold standard for nurse staffing levels (although with the increase in resident acuity in the 20+ years since the report was issued, the 4.1 HPRD standard actually needs to be higher).

The 4.1 HPRD standard was, in fact, universally assumed to be the starting point for CMS to determine appropriate staffing ratios to implement President Biden's nursing home reform agenda and commitment to implement meaningful nurse staffing ratios.

As recently as August 2023, the American Health Care Association (AHCA), the nursing home trade association, was reporting, in its Access to Care Report, that nursing facilities could not meet the anticipated 4.1 HPRD standard. AHCA wrote: "446,715 residents may be at risk of displacement if facilities are unable to increase their workforce and must reduce their census in order to comply with a 4.1 hours per resident day staffing minimum."[10] In July 2022, AHCA estimated the cost of meeting the 4.1 HPRD standard would be $10 billion annually.[11] AHCA's increased cost estimate of $11.3 billion for compliance with an anticipated proposed rule, issued in December 2022, also assumed that CMS would be proposing a 4.1 HPRD standard.[12]

Federal prosecutors in the U.S. Department of Justice, state lawyers in Medicaid Fraud Control Units, residents' advocates, and others concerned about nursing home issues have all routinely relied on the 4.1 HPRD standard and viewed it as the appropriate, but minimum, standard for nurse staffing. CMS itself cites the 2001 report in its Technical Users' Guide (July 2023 edition) for its Five-Star Quality Rating System.[13]

CMS acknowledges in the preamble that it did not want to rely on a 22-year old nurse staffing standard from its 2001 report because the report was too old to reflect current resident needs. 88 Fed. Reg., 61359. That acknowledgement is absolutely true, but equally true is that residents have become far sicker and frailer in the 22 years since the Abt 2001 report was issued, as many more

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[9] CMS, "Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Overview of the Phase II Report: Background, Study Approach, Findings, and Conclusion" (2011), https://www.justice.gov/sites/default/files/elderjustice/legacy/2015/07/12/Appropriateness_of_Minimum_Nurse_Staffing_Ratios_in_Nursing_Homes.pdf

[10] AHCA, "Access to Care Report" (Aug. 2023), https://www.ahcancal.org/News-and-Communications/Fact-Sheets/FactSheets/Access%20to%20Care%20Report%20August%202023.pdf

[11] AHCA, "Report: Increasing Nursing Home Staffing Minimums Estimated at $10 Billion Annually" (Press Release, Jul. 19, 2022), https://www.ahcancal.org/News-and-Communications/Press-Releases/Pages/Report-Increasing-Nursing-Home-Staffing-Minimums-Estimated-at-$10-Billion-Annually.aspx

[12] AHCA, "Updated Report: Additional Funding for Workers Needed to Meet a Potential Nursing Home Staffing Minimum Mandate" (Press Release, Dec. 15, 2022), https://www.ahcancal.org/News-and-Communications/Press-Releases/Pages/Updated-Report-Additional-Funding-for-Workers-Needed-to-Meet-a-Potential-Nursing-Home-Staffing-Minimum-Mandate.aspx

[13] CMS, "Design for *Care Compare* Nursing Home Five-Star Quality Rating System: Technical Users' Guide" (Jul. 2023), https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/downloads/usersguide.pdf, at pages 6, STRIVE Study (p. 10)

alternatives to nursing home care are now available. Nursing homes' longstanding stranglehold on Medicaid long-term care dollars has been reversed. Medicaid reports that in 2014, 53% of all Medicaid long-term care spending was on home and community-based services.[14] KFF reports that in 2019, 59% of Medicaid long-term services and supports spending went to home and community-based services and 41% on nursing facilities), a stark contrast from 1995, when 82% of Medicaid spending on long-term services and supports went to nursing facilities and only 18%, to home and community-based alternatives.[15] There can be no dispute, and CMS acknowledges (88 Fed. Reg., 61371), that residents have more comorbidities and complex medical needs, are more dependent, and need considerably more nursing care in 2023 than they did in 2001.

CMS's 2001 staffing report, calling for 4.1 HPRD, should have been the starting point for the 2023 study.

B. The 3.0 HPRD in the proposed rule is below the 3.76 HPRD staffing level met by facilities during the coronavirus pandemic.

The 3.0 HPRD in the proposed rule is even lower than staffing levels met by nursing facilities during the pandemic, when staffing shortages were rampant. According to Abt's 2023 staffing report, "In 2022Q2, the mean RN staffing level in U.S. nursing homes was 0.67 HPRD, the mean LPN staffing level was 0.88 HPRD, the mean nurse aide staffing level was 2.22 HPRD, and the mean total nurse staffing level (RNs, LPNs, nurse aides) was 3.76 HPRD."[16] **The 3.0 HPRD will not improve staffing requirements, as President Biden called for in 2022, when, during the pandemic, facilities staffed at the considerably higher (although inadequate) 3.76 HPRD level.**

Abt's 2023 staffing report also described variations in staffing levels by various categories (such as ownership status and size), again, during the pandemic:

> For-profit nursing homes have lower mean staffing levels (3.57 HPRD) than non-profit (4.28 HPRD) or government nursing homes (4.19 HPRD). Larger nursing homes have lower mean staffing levels than smaller nursing homes; specifically, nursing homes with fewer than 50 residents have mean staffing levels of 4.67 HPRD, whereas nursing homes with 50 or more residents have mean staffing levels ranging from 3.51 to 3.76 HPRD across size categories.
>
> Staffing levels for freestanding nursing homes (3.71 HPRD) are much lower than staffing levels for hospital-based nursing homes (5.24 HPRD), particularly for RNs (0.63 HPRD compared to 1.60 HPRD). Nursing homes that were not part of a continuing care retirement community are lower staffed (3.69 HPRD) than nursing homes that were (4.41 HPRD).[17]

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[14] CMS, Home & Community Based Services (2014), https://www.medicaid.gov/medicaid/home-community-based-services/index.html

[15] Molly O'Malley Watts, MaryBeth Musumeci, and Meghana Ammula, KFF, "Medicaid Home & Community-Based Services: People Served and Spending During COVID-19" (Mar. 3, 2022) https://www.kff.org/report-section/medicaid-home-community-based-services-people-served-and-spending-during-covid-19-issue-brief/ ,

[16] Abt 2023 Staffing Study, p. 44

[17] *Id*., p. 45

In summary, Abt documented that **non-profit and government-owned nursing facilities already staff above the 4.1 HPRD standard.** Only for-profit facilities staff below the 4.1 HPRD level. However, even the poorest-staffed sector of the nursing home industry – for-profit nursing facilities – staffed at 3.57 HPRD during the pandemic. Clearly, all nursing facilities staffed far above the 3.0 HPRD standard proposed by CMS. **There is no basis or rationale for CMS's proposing staffing levels of 3.0 HPRD, which are *considerably below* the levels already achieved by the most poorly staffed sector of the nursing home industry.**

C. The 3.0 HPRD nurse staffing requirement in the proposed rule is below the licensed nurse staffing levels identified by Abt's 2023 report in the simulation component as necessary to minimize delayed or omitted clinical care.

The 2023 Abt staffing study's quantitative analysis includes a simulation component to determine the effect of licensed nurse staffing levels on delayed or omitted care.[18] Abt conducted observations at 20 nursing facilities, with overall ratings of four or five stars, for six core clinical tasks – medication pass, resident assessment, wound care, catheter/device care, collecting lab specimen, and ventilator management – for a total of 8,249 unique care task observations.[19] Then, using ProModel and Simul8 simulation software, which resulted in more than 339,840 replications,[20] Abt found that

- "the level of delayed and omitted care falls below 5 percent at a staffing level between three and our licensed nurses, or 1.0 to 1.4 licensed nurses HPRD."[21]

- "Delayed and omitted care reaches 0 percent in all simulation scenarios at a staffing level of seven or more licensed nurses, or 2.4 HPRD."[22]

- four licensed nurses, in a 70-resident facility, corresponding to approximately 1.4-1.7 licensed HPRD, would "reduce the simulated level of delayed and omitted care below 5 percent."[23]

Abt acknowledges that its simulation of licensed nursing staff evaluated only five types of direct clinical care tasks, which "do not fully capture the universe of clinical care needs in nursing homes that licensed nurses meet."[24]

For the CNA component of its 2023 staffing study, Abt incorporates research by Jack Schnelle and others, "Determining Nurse Aide Staffing Requirements to Provide Care Based on Resident

[18] *Id*., p. 66
[19] *Id.* Exhibit 4.16, pp. 69-70
[20] *Id*., p. 76
[21] *Id*., p. 74
[22] *Id.*, p. 74
[23] *Id.*, p. 76. The current licensed nurse staffing level is 1.45 HPRD. Abt finds that 38% of nursing facilities would need to increase their licensed nurse staffing to reach a 1.4 HPRD threshold and 71% would need to increase their licensed nurse staffing to reach a 1.7 HPRD threshold. *Id.*
[24] *Id*., p. 76

Workload: A Discrete Event Simulation Model."[25] This research developed acuity-based methods to determine how many CNAs a facility would need to provide care to residents. Researchers tested 65 different workload situations and seven workload categories based on level of dependency in activities of daily living. They concluded that facilities need between 2.8 HPRD and 3.6 HPRD for aide time, based on resident acuity, to keep the rate of care omissions below 10%.

Most significantly, Schnelle and colleagues describe their methodology as "an objective method to determine nurse aide staffing needs across a broad range of NHs with different levels of resident acuity as defined by varying ADL needs."[26] They suggest that "NHs could use this acuity-based simulation method to determine staffing needs for an individual facility."[27]

The 2023 Abt Staffing Study incorporated the Schnelle methodology into its report. Combining its own simulation numbers for licensed nursing staff with Schnelle's 2016 simulation numbers of nurse aide staffing levels, the 2023 Abt Staffing Study concludes that **"a total nurse staffing level between 3.8 HPRD and 4.6 HPRD would be adequate to keep rates of both omitted ADL and omitted clinical care below 10 percent.**"[28] At present, Abt reports that 42% of nursing facilities already have total nurse staffing above 3.8 HPRD and 13%, above 4.6 HPRD.[29]

CMS's NPRM acknowledges these results of the simulation component the Abt's quantitative analysis:

> [T]he 2022 Nursing Home Staffing Study found that a total nurse staffing level of 3.67 or 3.88 HPRD was linked with additional facilities improving quality and safety relative to current low performers, and that total nurse staffing levels between 3.8 HPRD and 4.6 HPRD (including a 1.4 licensed nurse HPRD) were linked with reductions in the amount of delayed or omitted critical care.

88 Fed. Reg., 61353.

Nevertheless, CMS completely ignores these findings, writing that its goal in the proposed rule is establishing "implementable minimum standards that can substantially improve quality and safety at all LTC facilities in the near term." *Id*. CMS also claims that its proposal requires 75% of facilities to increase their nurse staffing levels. Although CMS does not explain which part of its proposed staffing standard would be most difficult for facilities to meet, it is likely that the 24/7 RN requirement is the staffing challenge for facilities, since most facilities already provide more than 3.0 HPRD of nursing care (counting LPNs).

Regardless, CMS's shocking acknowledgement is actually an indictment of the insufficient levels of nursing staff that are provided by the majority of nursing facilities in the country. However, that

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[25] Jack F. Schnelle, L. Dale Schroyer, Avantika A. Sarah, Sandra F. Simmons, "Determining Nurse Aide Staffing Requirements to Provide Care Based on Resident Workload: A Discrete Event Simulation Model," 17 *Journal of the American Medical Directors Association* 970 (2016). Abstract available at https://www.jamda.com/article/S1525-8610(16)30358-9/fulltext
[26] *Id.* 976
[27] *Id.* 976.
[28] Abt 2023 Staffing Study, p. 76.
[29] *Id*.

fact neither justifies nor supports mandating a grossly inadequate standard going forward that would perpetuate inadequate care and fail to keep residents (and staff) safe.

D. CMS's proposed rule is based on the 2023 Abt staffing study's evaluation of flawed measures – quality measures and health inspections – not on residents' clinical need.

The primary reason that CMS proposes such an inadequate nurse staffing ratio appears to be that, contrary to all the evidence about the devastating effects of inadequate staffing on residents that CMS describes in the preamble to the proposed rule, **CMS does not base its proposed staffing ratios on residents' clinical needs and the impact on residents of insufficient staffing levels, as Abt's 2001 study did**. Moreover, CMS totally ignored the results of Abt's 2023 simulation analysis.

Instead, CMS focuses solely on the portion of the 2023 Abt staffing study that looked at how facilities compared with other facilities in their own states. CMS's staffing proposal considers two measures – quality measures (which CMS calls quality) and health inspections (which CMS calls safety), *as reported during the COVID-19 pandemic*, when staffing was at an all-time low and CMS had suspended standard and complaint surveys. Based on these data from highly atypical times, CMS then proposes raising facilities' performance on these two measures to the 50th percentile in each state.[30] Neither measure directly focuses on or evaluates residents' actual clinical needs, as the Abt/CMS study of 2001 did (or as Abt's 2023 simulation analysis does). The purpose appears to be raising the measures of the lowest performing facilities in the country to the middle level of performance in their own state. This level of mediocre performance does not fulfill CMS's statutory responsibility to assure that standards of care are "adequate to protect residents' health, safety, welfare, and rights."

The two specific measures used by Abt and CMS are not based on the actual care needs of residents and are especially problematic.

Quality measures are notoriously fraudulent. In 2014, *The New York Times* reported that the poorest quality facilities in the country were self-reporting high (but unverified) resident assessment information, which CMS automatically (and without review or audit) converted into quality measures.[31] CMS has twice recalibrated the quality measures because so many facilities reported resident assessment information that gave them a quality measure rating of four or five stars.[32] The Abt 2023 staffing study acknowledges that self-reported QM data have limitations. Among other additional shortcomings, Abt reports that QM data are not available for Medicare Advantage residents and do not capture quality of life issues that are important to residents.[33]

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[30] *Id.*, pp. 63-64

[31] Katie Thomas, "Medicare Star Ratings Allow Nursing Homes to Game the System," *The New York Times* (Aug. 24, 2014), https://www.nytimes.com/2014/08/25/business/medicare-star-ratings-allow-nursing-homes-to-game-the-system.html?searchResultPosition=1

[32] CMS, "Design for Care Compare Nursing Home Five-Star Quality Rating System: Technical Users' Guide" (Jul. 2023), https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/downloads/usersguide.pdf

[33] 2023 Abt Staffing Study, p. 65

Health inspection surveys, CMS's second measure for analysis, are overly tolerant of poor care. Surveys cite fewer deficiencies than should be cited and describe them as less serious and pervasive than they actually are. The Government Accountability Office (GAO) has issued literally dozens of reports since 1998 describing chronic, persistent weaknesses in the survey and enforcement system.[34]

Nevertheless, the 2023 Abt staffing study looks at data during the coronavirus pandemic: quality measure (QM) data and health inspection (HI) survey results from the October 2022 Nursing Home Care Compare update and PBJ staffing data from 2021 Q3-2022Q2.[35] Abt calculates the percentages of facilities exceeding the 25th and 50th percentiles in QMs and HIs, acknowledging that increased staffing was correlated with higher performance on both measures.[36]

Abt evaluated staffing for the fourth through seventh decile cutpoints for five approaches (RNs, LPNs, nurse aides, licensed nurses (RNs and LPNs), and total nurse staff (RNs, LPNs, and nurse aides.[37] Total nurse staffing would be 3.30 HPRD to 3.88 HPRD.[38] Abt assumed that facilities staffing below these thresholds would increase staffing and that facilities above these thresholds would not reduce staffing.[39] Abt did not explain why it selected the fourth through seventh deciles for analysis, as opposed to a higher decile. **CMS does not explain why it did not choose any of the (insufficient) staffing thresholds identified by Abt and why it proposes a significantly lower staffing standard.**

Abt also considered two- and four-requirements alternatives (RN and nurse aide; RN, LPN, nurse aide, total nurse staff, respectively).[40] **Again, CMS does not explain why it chose the two-requirement alternative for the proposed rule** (although it asks for comment on whether it should consider a third component to its staffing requirements (a total nurse staffing requirement)).

CMS also fails to set out any reason for choosing the 50th percentile as an appropriate level of performance. It does not explain how these proposed staffing standards fulfill its statutory responsibility "to assure that requirements which govern the provision of care . . . , and the

[34] *See,* e.g., See, e.g., the following sample of GAO reports: *Federal and State Oversight Inadequate to Protect Residents in Homes with Serious Care Violations*, T-HEHS-98-219 (Jul. 28, 1998); *Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards*, HEHS-99-46 (Mar. 18, 1999*); Enhanced HCFA Oversight of State Programs Would Better Ensure Quality*, HEHS-00-6 (Nov. 4, 1999); *More Can Be Done to Protect Residents from Abuse*, GAO-02-312 (Mar. 1, 2002); *Prevalence of Serious Quality Problems Remains Unacceptably High, Despite Some Decline*, GAO-03-1016T (Jul. 17, 2003); *Despite Increased Oversight, Challenges Remain in Ensuring High-Quality Care and Resident Safety*, GAO-06-117 (Dec. 28, 2005*); Prevalence of Serious Quality Problems Remains Unacceptably High, Despite Some Decline*, GAO-03-1016T (Jul. 17, 2003); *Some Improvement Seem in Understatement of Serious Deficiencies, but Implications for the Longer-Term Trend Are Unclear*, GAO-10-434R (Apr. 28, 2010); *Nursing Homes: Improved Oversight Needed to Better Protect Residents from Abuse*, GAO-19-433 (Jun. 2019)

[35] 2023 Abt Staffing Study, p. 40

[36] *Id.*, pp. 46-49, Exhibits 4.4 and 4.5

[37] *Id*. Exhibit 4.10, p. 56

[38] *Id.*. Exhibit 4.10, at p. 56

[39] *Id.* 56

[40] *Id.*, pp. 60-62 and Exhibit 4.13 (two requirements) and Exhibit 4.14 (four requirements)

enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents."[41]

E. Only certified nurse aides should be included in CMS's staffing ratios.

CMS uses the term "nurse aide" without qualification. The Center urges CMS to confirm explicitly that only certified nurse aides are counted in the staffing ratios. Two other categories of workers must be excluded from CMS's calculations: feeding assistants and temporary nurse aides (TNAs).

Feeding assistants are included in 42 C.F.R. §483.60, the regulation addressing food and nutrition; they are not included in the regulation addressing nursing services, 42 C.F.R. §483.35. Feeding assistants have limited training (federal rules require only eight hours). Consequently, they are allowed to perform only a single task, feeding residents "who have no complicated feeding problems."[42] They should not be counted in minimum nurse staffing requirements.

Temporary nurse aides were permitted for the first during the pandemic, when CMS waived the statutory requirements that facilities not use individuals as certified nurse aides for more than four months unless they successfully completed their state's nurse aide training requirements and passed their state's competency evaluation program.[43] The American Health Care Association promptly offered a free on-line eight-hour training program for a new category of worker for the pandemic that it called temporary nurse aides (TNAs). Many states explicitly accepted AHCA's eight-hour on-line training module as sufficient training during the pandemic and other states authorized workers with less than 75 hours of training to be employed as aides.[44]

On April 8, 20221, CMS stated in guidance that the four-month regulatory timeframe for aides working in a facility would be reinstated when the blanket waiver of nurse aide training rules, issued during the public health emergency (PHE), was lifted. However, CMS also suggested that states "consider allowing some of the time worked by the nurse aides during the PHE to count toward the 75-hour training requirement."[45] Many states accepted CMS's explicit invitation to create new options for TNAs to become fully certified nurse aides without satisfying their states' normal training requirements.

Although CMS has not sought to identify how many TNAs worked in nursing facilities during the pandemic and are currently working in nursing homes, AHCA claims that facilities lost more than 200,000 staff positions during the pandemic[46] and that more than 300,000 TNAs were trained and

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[41] 42 U.S.C. §§1395i-3(f)(1), 1396r(f)(1), Medicare and Medicaid, respectively

[42] 42 U.S.C. 1395i-3(b)(5), 1396r(b)(5), Medicare and Medicaid, respectively; regulations at 42 C.F.R. §483.60(h)(3)(i)

[43] 42 C.F.R. §483.35(d)

[44] Center for Medicare Advocacy, "Who's Providing Care to Nursing Home Residents?" (CMA Alert, Jul. 29, 2020), https://medicareadvocacy.org/whos-providing-care-to-nursing-home-residents/. Full Report, *Who's Providing Care for Nursing Home Residents? Nurse Aide Training Requirements during the Coronavirus Pandemic* available at https://medicareadvocacy.org/wp-content/uploads/2020/07/Report-Nurse-Aide-Training.pdf

[45] CMS, "Updates to Long-Term Care (LTC) Emergency Regulatory Waivers issued in response to COVID-19," QSO-21-17-NH (Apr. 8, 2021), https://www.cms.gov/files/document/qso-21-17-nh.pdf

[46] AHCA, "Data Show Nursing Homes Continue to Experience Worst Job Loss Of Any Health Care Sector" (Press Release, Jan. 19, 2023), https://www.ahcancal.org/News-and-Communications/Press-Releases/Pages/Data-Show-

many work in nursing facilities.[47] The Center urges CMS not to permit these minimally trained workers to be counted in the staffing ratios for nurse aides; only fully trained and certified nurse aides should be counted. TNAs must be given the opportunity to complete their states' training requirements and must then be required to pass their states' competency evaluation.

F. The Center's proposed staffing standard is 4.2 HPRD and it allows states to include licensed practical nurses.

Decades of research confirm that higher nurse staffing levels than most facilities currently provide are needed to provide adequate care to residents. The importance of staffing is neither disputable nor disputed.

CMS asks for public comment on requiring a total nurse staffing number, suggesting 3.48 HPRD, but providing no explanation of how it calculated such a number. 88 Fed. Reg., 61370. CMS assumes that facilities would hire nurse aides to meet a 3.48 standard. 88 Fed. Reg., 61420.

The Center supports a total nurse staffing standard. However, we believe that a total nurse staffing standard (1) must be far higher than 3.48 HPRD and (2) must recognize licensed practical nurses/licensed vocational nurses and allow facilities to include them in the licensed nurse requirements.

The Center proposes the following nurse staffing standard:

Licensed nurses (1.4 HPRD), composed of
0.75 HPRD RN
0.65 HPRD (RN or LPN/LVN)
Certified nurse aides
2.8 HPRD
Total: 4.2 HPRD

The Center proposes the following revisions to proposed §483.35(a)(1):

(i) Licensed nurses, including but not limited to a minimum of 0.75 ~~0.55~~ hours per resident day for registered nurses (RNs) and 0.65 hours per resident day of licensed nurses (RNs, licensed practical nurses (LPNs), or licensed vocational nurses (LVNs)

(ii) Other nursing personnel, in accordance with §483.71, including but not limited to a minimum total of ~~2.45~~ 2.80 hours per resident day for certified nurse aides (NAs).

This nursing standard is just 0.10 HPRD higher than the 4.10 HPRD standard that the Abt 2001 report found was necessary to prevent avoidable harm to residents and to meet some of the requirements of the 1987 Nursing Home Reform Law.

Nursing-Homes-Continue-to-Experience-Worst-Job-Loss-Of-Any-Health-Care-Sector.aspx#:~:text=Nursing%20homes%20have%20lost%20210%2C000,over%20the%20last%20nine%20months

[47] Ginger Christ, "Nursing homes rush to certify TNAs as CMS deadline looms," *Modern Healthcare* (Jun. 8, 2022), https://www.modernhealthcare.com/post-acute-care/nursing-homes-rush-certify-tnas-cms-deadline-looms

The Center's recommendations also reflect findings of the Abt 2023 Staffing Study. The Center's licensed nurse proposal is based on Abt's 2023 Staffing Study (discussed above), which applied two simulation software programs to its own observations at 20 nursing facilities to determine the levels of licensed nurses that were necessary to reduce delayed and omitted care. As noted above, Abt relied on and incorporated research by Schnelle (2016) for the CNA component of nurse staffing standards. Abt's simulation findings establish staffing standards of 3.8 HPRD and 4.6 HPRD "to keep rates of both omitted ADL and omitted clinical care below 10 percent."[48] As Abt observes, 42% of nursing facilities nationwide "currently maintain total nurse staffing above 3.8 HPRD."[49]

G. CMS's other proposed nursing standards.

The Center understands that CMS claims the 3.0 HPRD standard is only *part* of the nurse staffing requirements and that CMS has two additional components to its nurse staffing proposal: a new 24 hour a day RN requirement and a revision to existing facility assessment requirements. 88 Fed. Reg. at 61366. These additional factors add little to actual, meaningful nurse staffing requirements and are not sufficient to compensate for the inadequate 3.0 HPRD nursing staffing standard that CMS proposes.

2. 24/7 RN Requirement

The 24/7 RN requirement is not a direct care requirement. CMS mandates that RNs be onsite 24/7 but it requires only that RNs be "available to provide direct care to residents." Proposed 42 C.F.R. §483.25(b)(1). Even if RNs work only on non-nursing tasks during their entire shifts, their facility would nevertheless still meet the new 24/7 RN requirement, so long as they were physically present in the building and "available to provide direct care to residents." As proposed, the 24/7 RN requirement is too nebulous to be a real or meaningful enhancement of nurse staffing requirements that improve resident care.

In the proposed rule, CMS recognizes the critical importance of RNs to resident care. CMS describes the scope of practice for RNs, which is considerably broader than the scope of practice for other categories of nurses and affirms that the population of nursing homes today has greater care needs than earlier groups of residents:

> LTC facilities are caring for more dependent residents who require more complex basic medical care and rehabilitative services. In addition, LTC facilities are caring for a significant number of residents with dementia, depression, or other behavioral health issues. LTC facilities today have even been referred to as "mini hospitals."

88 Fed. Reg., at 61371. CMS acknowledges that, "for decades," studies and "gray literature" have recommended 24/7 RN coverage in nursing facilities. 88 Fed. Reg., 61371. It also acknowledges that the 2016 final rule did not mandate nurse staffing ratios because it did not yet have sufficient PBJ data about staffing levels in nursing facilities. *Id*. Nevertheless, it proposes only that RNs be

[48] Abt 2023 Staffing Study, p. 76
[49] *Id.*

on-site and "available" and asks for comment on whether that standard should be weakened. Our answer is firmly no; the 24/7 RN standard needs to be strengthened to ensure that RNs are actually providing direct care to residents, not just that they are present and "available" in the building.

The Center proposes revising proposed §483.35(b)(1) as follows:

> (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.

3. The Facility Assessment Process must be strengthened and must require facilities to use a prescribed methodology to determine staffing levels based on acuity.

As proposed, the revised facility assessment process provides no additional actual protection for residents. CMS enacted the facility assessment process in the 2016 final regulations that revised the Requirements of Participation as its answer to the problem of inadequate staffing and its decision not to mandate a nurse staffing ratio. As CMS now describes the agency's rationale in 2016, CMS "assumed" in 2016 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.

In a bit of magical thinking, CMS reports that the agency's

> expectation [in 2016] was that the application and development of the facility assessment requirement and competence-based staffing decisions would involve every service provided by a LTC facility and apply to all staff, including the interdisciplinary team. For example, a facility that provides dementia care would need to ensure that it has a sufficient number of staff with the necessary skill sets and competencies to care for individuals living with dementia. In addition, CMS intended for facilities to use the facility assessment as a resource and planning tool for both short-term (day-to-day) and long-term (strategic) purposes.

88 Fed. Reg., at 61373. Use of the words "expectation" and "intended" is telling. Expectations and intentions are not requirements.

Not surprisingly, the facility assessment process has largely been ignored by facilities and surveyors alike. Few F838 deficiencies are cited (158 in FY 2021; 261 in FY 2022; 173 in FY 2023) and very few at the harm or jeopardy level (4 in FY 2021; 2 in FY 2022; 3 in FY 2023), the levels at which any financial penalty is more likely to be imposed.

CMS's discussion of the facility assessment process recognizes the concern that facilities might lower their staffing levels to the minimum numbers that CMS proposes in the rule, but cites the separate "sufficient" staffing requirement and the lack of preemption of stricter state or local staffing standards. 88 Fed. Reg., at 61373.

It is magical thinking on CMS's part to believe that nursing facilities will not staff to the minimum. When CMS replaced the former Medicare Part A reimbursement system for skilled nursing facilities, Resource Utilization Groups-IV, with the new Patient Driven Payment Model (PDPM) effective October 1, 2019, the industry response was immediate. Thousands of therapists lost their jobs, as Medicare reimbursement no longer created financial incentives to provide therapy. CMS is fully aware of these changes. It reported in its 2021 proposed rule updating Medicare Part A reimbursement to skilled nursing facilities that following implementation of PDPM on October 1, 2019, physical and occupational therapy sharply declined; therapy minutes declined from 91 minutes per resident per day in FY 209 to 62 minutes per day in FY 2020, a decline of more than 30%; and concurrent or group therapy increased from 1% in prior years to 32% and 29%, respectively.[50]

The "sufficient" standard provides no protection that facilities will necessarily maintain current staff and add more staff. The "sufficient" standard has been the federal requirement for decades and it has not been effective in leading to adequate nurse staffing levels. There is no reason to believe that, going forward, the nursing home industry (which is increasingly dominated by real estate investment trusts, private owners with no accountability, and private equity firms) will treat the "sufficient" staffing mandate seriously.

In addition to strengthening the facility assessment process, and as discussed further below, CMS needs to establish explicit acuity methodologies for facilities to use in the facility assessment process in order to ensure that facilities identify their residents' acuity in a meaningful way and staff themselves accordingly.

A. Facility assessment requirements must be strengthened.

CMS proposes to redesignate facility assessment requirement as a separate regulatory provision and to strengthen its requirements. The Center comments on the proposals and makes several recommendations.

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 "consistent with and informed by individual resident assessments as required under §483.20 of this part."

Appendix PP of the State Operations Manual (SOM) includes numerous references to the facility assessment requirement – not admitting residents whose needs cannot be met (p. 185); identifying hazards and risks (p. 325); identifying physical plant hazards (p. 338); identifying residents' unique cultural characteristics (p. 436); sufficiency of staff (pp. 473, 628); identification of staff competencies (pp. 479, 483. 512); determining whether an RN is needed more than 8 hours per

[50] CMS, "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 2022, 86 Fed. Reg. 19954 (Apr. 15, 2021), https://www.govinfo.gov/content/pkg/FR-2021-04-15/pdf/2021-07556.pdf?emci=b4848c10-81ae-eb11-85aa-0050f237abef&emdi=ea000000-0000-0000-0000-000000000001&ceid=

day (p. 486); identifying residents' behavioral health needs or other serious mental disorders (pp. 498, 508); changing resident population (p. 629); involvement of governing body in facility assessment (p. 678); and the requirement itself, 42 C.F.R. §483.70(e), F838.

The current guidance for F838 in Appendix PP includes information not included in the proposed rule.

> "Although not required, facility staff are strongly encouraged to seek input from the resident/family council, residents, their representative(s), or families and incorporate that information as appropriate when formulating their assessment."[51]

> "The assessment must include or address an evaluation of the facility's training program to ensure any training needs are met for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. The assessment should also include an evaluation of what policies and procedures may be required in the provision of care and that these meet current professional standards of practice. If there are any concerns regarding training refer to §483.95. Training."[52]

These two SOM guidance recommendations should be incorporated into the final regulatory language to require (1) inclusion of residents and families and (2) evaluation of the facility's training program. The Center suggests adding a new subsection (5) to §483.71(a):

> (5) The input of the resident/family council, residents, their representative(s) or families.

The Center also suggests a new subsection (vii) to §§483.71(a)(1):

> (vii) The facility's training program to ensure any training needs are met for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles.

B. CMS must prescribe specific evidence-based methodologies, and require nursing homes to choose one of them, to evaluate the acuity of their residents during the facility assessment process for purposes of determining nurse staffing levels based on resident acuity.

CMS asks, "What steps can CMS take to support LTC facilities in predicting what their case-mix adjusted staff might be and hire in expectation of that adjusted staffing level? What resources will facilities need to proactively calculate their existing HPRD for nursing staff, and what may be needed?" 88 Fed. Reg., 61371.

The Center's answer is **that CMS must prescribe specific methodologies for nursing homes to use to evaluate the acuity of their residents during the facility assessment process.** Facilities should not use whatever tools they like to determine resident acuity and staffing needs based on acuity. CMS must (1) require facilities to use a **recognized** "evidence-based data-driven"

[51] State Operations Manual, Appendix PP, p. 680
[52] *Id*., p. 681

methodology in their facility assessment process to determine resident acuity and appropriate staffing levels and (2) identify specific approved methodologies that facilities must choose from and use.

In 2020, Charlene Harrington and colleagues developed a comprehensive methodology for determining total nursing staffing levels, based on resident acuity and incorporating Schnelle's 2016 certified nurse aide methodology.[53] The step-by-step data-driven assessment approach guides the process for determining how resident acuity should be used to establish nurse staffing levels.[54]

Step one in the five-step guide, entitled "Determine the Collective Resident Acuity and Care Needs," identifies the sources of information for determining staffing levels for a nursing facility: the facility assessment process, resident assessments and care plans, Jack Schnelle's classification system for activities of daily living (which defines seven groups),[55] and CMS Form 672 and cost report data.

Step 3 is entitled "Determine Appropriate Nurse Staffing Levels Based on Resident Acuity." Table 3 identifies recommended staffing hours per resident day for six levels of acuity:

[53] Charlene Harrington, Mary Ellen Dellefield, Elizabeth Halifax, Mary Louise Fleming, Debra Bakerjian, "Appropriate Nurse Staffing Levels for U.S. Nursing Homes," *Health Serv Insights* (Jun. 29, 2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7328494/

[54] *Id.*

[55] Schnelle JR, Schroyer I.D. Saraf A.A. Simmons SF. "Determining nurse aide staffing requirements to provide care based on resident workload: a discrete event simulation model," *Journal of the American Medical Directors Association*, 2016; 17:970-977

Table 3. Recommended nurse staffing hours per resident day for RUG-IV and PDPM group resident acuity.

	RUG-IV	PDPM GROUP	RN	LVN/LPN	AIDE	TOTAL STAFFING
Extensive services	ES3	ES3	2.39	1.69	3.60	7.68
	ES2	ES2	1.81	1.43	3.60	6.84
	ES1	ES1	1.35	0.96	3.60	5.91
		Average	1.85	1.36	3.60	6.81
Special care high	HE2/HD2	HDE2	1.20	0.99	3.60	5.79
	HE1/HD1	HDE1	1.20	0.99	3.60	5.79
	HC2/HB2	HBC2	1.53	0.70	3.20	5.42
	HC1/HB1	HBC1	1.53	0.70	3.20	5.42
		Average	1.36	0.84	3.40	5.61
Special care low	LE2/LD2	LDE2	1.20	0.99	3.60	5.79
	LE1/LD1	LDE1	1.20	0.99	3.60	5.79
	LC2/LB2	LBC2	1.53	0.70	3.20	5.42
	LC1/LB1	LBC1	1.53	0.70	3.20	5.42
		Average	1.36	0.84	3.40	5.61
Clinically complex	CE2/CD2	CDE2	1.22	0.70	3.60	5.53
	CE1/CD1	CDE1	0.96	0.78	3.60	5.34
	CC2/CB2	CBC2	0.99	0.67	3.20	4.86
	CA2	CA2	1.00	0.63	2.80	4.42
	CC1/CB1	CBC1	1.00	0.63	3.20	4.82
	CA1	CA1	1.00	0.63	2.80	4.42
		Average	1.03	0.67	3.20	4.90
Behavioral symptoms	BB2/BA2	BAB2	0.75	0.55	3.00	4.30
	BB1/BA1	BAB1	0.75	0.55	3.00	4.30
		Average	0.75	0.55	3.00	4.30
Reduced physical function	PE2/PD2	PDE2	0.75	0.55	3.60	4.90
	PE1/PD1	PDE1	0.75	0.55	3.60	4.90
	PC2/PB2	PBC2	0.75	0.58	3.20	4.53
	PA2	PA2	0.75	0.55	2.80	4.10
	PC1/PB1	PBC1	0.75	0.55	3.20	4.50
	PA1	PA1	0.75	0.55	2.80	4.10
		Average	0.75	0.56	3.20	4.51

Abbreviations: CMS, Centers for Medicare & Medicaid Services; LPN, licensed practical nurses; LVN, licensed vocational nurses; MDS, Minimum Data Set; PDPM, Patient Driven Payment Model; RN, registered nurses; RUGS IV, Resource Utilization Groups IV.
Source: RUG IV to PDPM Crosswalk from CMS *Patient Driven Payment Model, Fact Sheet: PDPM Patient* Classification (Revised 8-27-2019): see also MDS 3.0 RAI Manual v. 1.17.1 October 2019, Chapter 6.
RN and LPN Hours for Extensive, Special Care High, and Special Care Low are from the Staff Time Measurement Study (STM). ES1, ES2, and ES3 are assumed to have PDPM Nursing Function Scores between 0 and 6. RN and LPN Hours for Behavioral Symptoms & Cognitive Performance are adjusted to the minimum hours from the CMS 2001 study. CNA hours are based Schnelle et al[36] estimates of 2.8 hprd for PDPM Nursing Function Score of 15-16, 3.0 hprd for Score of 11-16, 3.2 hprd for Score of 6-14, 3.3 hprd for Score of 0-14, and 3.6 hprd for Score of 0-5.

Table 4 identifies recommended staffing hours per resident day, converted to a ratio of residents to staff, for the six levels of acuity:

Table 4. 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

Abbreviations: LPN, licensed practical nurses; LVN, licensed vocational nurses; RN, registered nurses.
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 of 24 hours per day.

CMS must require facilities to use the Harrington methodology or another recognized evidence-based data-driven methodology to identify the acuity of the facility's residents.

The Center suggests that CMS revise proposed §483.71(a) to state:

(a) The facility must assess the acuity of its residents using one of the following methodologies:

(i) the methodology developed Charlene Harrington and colleagues, "Appropriate Nurse Staffing Levels for U.S. Nursing Homes," *Health Services Insights,* Vol. 13:1-14 (2020),[56]

(ii) the 24 case-mix categories used to assess skilled nursing needs of residents in Medicare's patient-driven payment model[57] or

(iii) another recognized evidence-based data-driven methodology for identifying resident acuity identified by the facility and submitted to, and approved for use in advance, by CMS.

4. A total nurse staffing standard is necessary and CMS must identify specific standards for each type of nurse and recognize LPNs as important licensed nurses.

CMS solicits public comment on whether it should establish a total nurse staffing standard, such as 3.48 HPRD. 88 Fed. Reg. 61370. The Center's answer is yes, but the 3.48 HPRD standard suggested by CMS is far too low and has no support in the research literature or in the 2023 Abt staffing study (which does not analyze a 3.48 HPRD standard).

As recommended above, the total nurse staffing standard should be 4.2 HPRD, based on the 2023 Abt staffing study's discussion and analysis of the simulation findings, CMS's Congressionally-mandated 2001 staffing report by Abt, and expert recommendations.[58]

In addition, there must be specific staffing requirements for RNs, licensed nurses (including both RNs and LPNs), and certified nurse aides (CNAs), whose combined total would be the total nurse staffing standard of 4.2 HPRD.

Simply identifying a total number of nurse staffing hours per day, without distinguishing among the types of nurses and requiring specified numbers of hours for each, results in the replacement of higher-paid, more highly trained nursing staff (RNs) with lower-paid staff with less training (CNAs), particularly because CMS proposes no specific staffing levels for LPNs.

Research has confirmed that when states increase nurse staffing levels but fail to distinguish between the types of nurses, facilities replace more highly-trained, higher-paid nursing staff with

[56] Charlene Harrington, Mary Ellen Dellefield, Elizabeth Halifax, Mary Louise Fleming, Debra Bakerjian, "Appropriate Nurse Staffing Levels for U.S. Nursing Homes," *Health Serv Insights* (Jun. 29, 2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7328494/

[57] 88 Fed. Reg. 21316, 21323 (Apr. 10, 2023) (Table 5, urban facilities), 21323 (Table 6, rural facilities)

[58] C. Harrington, C. Kovner, M. Mezey, J. Kayser-Jones, S. Burger, M. Mohler, R. Burke, D. Zimmerman, "Experts recommend minimum nurse staffing standards for nursing facilities in the United States," *The Gerontologist* 200 Feb;40(1):5-16. Abstract at https://gerontologist.gerontologyjournals.org/cgi/content/abstract/40/1/5/

lesser-trained lower-paid nursing staff. An in-depth analysis of the impact of minimum staffing standards in California and Ohio, which changed their requirements for nurse staffing in 2000 and 2002, respectively, analyzed data from 1996 to 2006 and found that RN HPRD decreased while LPN and CNA HPRD increased in nursing facilities in both states.[59]

Researchers Min M. Chen and David R. Grabowski also found that increasing nurse staffing requirements resulted in decreases in HPRD for indirect staff, including housekeeping, food service, and activities.[60] CMS must prohibit facilities from reducing indirect staff levels through a requirement for maintenance of effort.

It is also critical that CMS explicitly recognize LPNs, who have been an essential component of nursing home staffing for decades. LPNs are frequently the category of licensed nurses who provide most direct licensed nursing care for residents and supervise CNAs, as RNs sign off on resident assessments and do paperwork. The Abt 2023 staffing study found improved performance on quality measures as the numbers of RN HPRD, LPN HPRD, and nurse aide HPRD increased.[61]

CMS's insistence that its proposed hours for RNs and aides are "only the absolute minimum floor adjusting for the average acuity across all LTC facilities, and the required hours of nursing care may be greater but never lower than the proposed minimum standards, if the acuity needs of residents in a facility requires a higher level of care," 88 Fed. Reg., 61368, reflects magical thinking, not reality. Nursing facilities will consider the RN and aide hours the required staffing levels and will adjust their staffing accordingly. To meet the proposed 2.45 HPRD for aides, facilities will replace current LPNs with aides. The Center has already heard that facilities are claiming: "3 point 0, good to go."

CMS asks if it should case-mix-adjust staffing HPRD. 88 Fed. Reg., 61371. Our answer is no. The direct care staffing standard is the minimum nursing hours that all facilities must meet, regardless of case-mix. CMS makes this point itself, writing at 88 Fed. Reg., 61369, "Compliance with the numerical minimum staffing requirement is necessary but not necessarily sufficient to meet staffing needs for every facility," "LTC facilities would be required to staff above these minimum adjusted baseline levels, as appropriate, to address the specific needs of their unique resident population," and language in proposed §483.35(a)(1)(v). Facilities must both (1) meet the mandatory minimum staffing hours for RNs and aides (and any other nursing category identified by CMS in the final rule) and (2) make case-mix adjustments in the facility assessment process, using a recognized evidence-based data-driven methodology for assessing resident acuity and need.

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[59] Min M. Chen, David C. Grabowski, "Intended and Unintended Consequences of Minimum Staffing Standards for Nursing Homes," *Health Economics*, Vol. 24, No. 7, 822-839, at 832 (July 2015), http://onlinelibrary.wiley.com/doi/10.1002/hec.3063/abstract;jsessionid=D1C94F93FE069B7A5AAC7C44F6C202D6.f02t01 (abstract).

[60] *Id.* 834 and Table IV

[61] Abt 2023 Staffing Study, p. 44, Exhibit 4.4, p. 48

5. **CMS should not grant hardship exemptions from nurse staffing ratios.**

CMS proposes to give nursing facilities a hardship exemption from nurse staffing ratios for RNs and aides when "external circumstances may prevent a LTC facility from meeting our proposed minimum staffing requirements, despite the LTC facility's best efforts." 88 Fed. Reg., 61376. **The Center opposes hardship exemptions under all circumstances. If facilities cannot meet staffing standards, they should not be providing care to vulnerable residents. The Center particularly opposes the hardship criteria that CMS proposes.**

The Center observes, first, that the "external circumstances" language identified in the preamble does not appear in the regulatory language, proposed §483.35(g). This preamble language makes clear that "external circumstances" are central to any facility's claimed need for an exemption. The language needs to be incorporated explicitly into the regulatory language to explain when an exemption may be appropriate. The Center proposes revising the opening paragraph of §483.35(g) as follows:

> (g) *Hardship Exemption from the Minimum Hours Per Resident Day Requirements.* A facility may be exempted by the Secretary from the requirements of paragraphs (a)(1)(i) and (ii) of this section **if external circumstances prevent the facility from meeting the minimum staffing requirements, despite the facility's best efforts,** and if verifiable hardship exists that prohibits the facility from achieving or maintaining compliance. The facility must meet the four following criteria to qualify for a hardship exemption.

CMS proposes to create hardship exemptions based on (1) staffing shortages during the pandemic, (2) nursing home trade associations' arguments that facilities are unable to find staff, and (3) data from the Bureau of Labor Statistics indicating that, in contrast to other health care settings, nurse staffing levels in nursing facilities have not rebounded since the pandemic. 88 Fed. Reg., 61376. These factors do not justify the exemptions that CMS proposes.

First, facilities have been understaffed for decades, as the 2001 Abt report, among many others over the years, confirmed. Blaming the pandemic for staffing shortages is inaccurate. Second, as CMS acknowledges, "comparatively low pay and difficult working conditions for nursing home workers" help explain why nursing homes, in contrast to other health care settings, have not seen their workforce return. 88 Fed. Reg., 61376. As CMS further writes:

> We recognize that LTC facility workers—disproportionately women of color—are among the lowest-paid in the country and often have to rely on public benefits despite working complex and demanding jobs. In addition, poor working conditions in LTC facilities have been found to influence the quality of care provided to residents. Investments in the care workforce, including competitive wages, are foundational to helping to retain LTC facility workers and improving health and educational outcomes. [footnote omitted]

88 Fed. Reg., 61377. Giving waivers to facilities will not address or correct the reasons for inadequate staffing that are within facilities' control. Facilities must improve wages, benefits, and working conditions (and staff at sufficiently high levels) in order to achieve a permanent, stable

workforce. To give facilities exemptions from staffing requirements perpetuates the decades-long problem of serious understaffing.

Despite CMS's strong statement of the key reasons for worker shortages in nursing facilities, CMS writes:

> Unfortunately, lack of transparency regarding nursing home finances, operations, and ownership impedes the ability to fully understand how current resources are allocated. This obscures evaluation of the industry's ability to absorb the costs of increased staffing and improved working conditions. [footnote omitted]

88 Fed. Reg., 61377. CMS's lack of knowledge about facilities' ownership and spending practices reflects the agency's ignoring, for years, the information CMS already regularly collects (including change of ownership submissions and facility cost reports). CMS's lack of knowledge about facility spending does not support a conclusion that the agency should grant facilities exemptions from staffing requirements.

CMS then claims that it is balancing the need for minimum nurse staffing standards "to ensure that residents receive safe and high-quality care" with "the need to ensure access to care, which is an important health and safety consideration." *Id.* The result of CMS's balancing is the hardship waiver proposal.

The threat of nursing home closures, implicit in CMS's comment and explicit in nursing homes' dire (but fluctuating) warnings about closures,[62] cannot obscure the real fact that nursing homes frequently close, and have closed for decades. A 2009 article studying 1,789 nursing homes closures in the six-year period between 1999 and 2005 found that 8% of facilities in operation in 1999 closed between 199 to mid-2005, reflect a 2% closure rate each year.[63] The study found "Nursing homes with higher rates of deficiency citations, hospital-based facilities, chain members, small bed size, and facilities located in markets with high levels of competition were more likely to close."[64] It also found "High Medicaid occupancy rates were associated with a high likelihood of closure, especially for facilities with low Medicaid reimbursement rates."[65] In other words, 20 years ago, facilities closed, typically, because they provided poor quality care, had low occupancy, were small facilities or hospital-based, as well as because Medicaid rates were low.

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[62] AHCA, "AHCA/NCAL Releases Statement Ahead Of U.S. House Energy & Commerce Subcommittee On Health Hearing" (Press Release, Oct. 25, 2023), https://www.ahcancal.org/News-and-Communications/Press-Releases/Pages/AHCANCAL-Releases-Statement-Ahead-Of-U-S--House-Energy-&-Commerce-Subcommittee-On-Health-Hearing.aspx (contending that the staffing rule "could **displace nearly 300,000 residents**"); AHCA, "New Report Finds Access To Nursing Home Care A Growing Crisis; **Nearly 450,000 Residents At Risk Of Displacement** Under Federal Staffing Mandate" (Press Release, Aug. 23, 2023), https://www.ahcancal.org/News-and-Communications/Press-Releases/Pages/New-Report-Finds-Access-To-Nursing-Home-Care-A-Growing-Crisis-.aspx

[63] 2 Nicholas G. Castle, John Engberg, Judith Lave, and Andrew Fisher, "Factors Associated with Increasing Nursing Home Closures," *Health Services Research* 2009 Jun; 44)3: 1088-1109, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2699923/

[64] *Id*.

[65] *Id.*

Eleven years later, a report by LeadingAge describes 555 nursing home closures between June 2015 and June 2019, representing about 4% of the facilities in operation in June 2019,[66] double the annual closure rate identified in the 2009 article. Nine states[67] accounted for more than half the closures and closures in three states[68] were concentrated in rural areas. LeadingAge also reports that nursing home occupancy declined nearly two percentage points over the four-year period it studied, "despite more than 550 nursing homes closing."[69]

The LeadingAge report describes a significant policy change at the state level – rebalancing of long-term services and supports (LTSS) – that has resulted in a higher percentage of Medicaid dollars going to home and community-based services (HCBS).[70] In fact, LeadingAge reports that since fiscal year 2013, "the majority of Medicaid LTSS dollars have gone toward HCBS across all populations."[71]

Describing Current and Future Population Trends, LeadingAge writes:

> The closure of nursing homes over the last four years may be reflective of market trends given the current population of older adults. With changes and increased availability of HCBS, older adults who may have otherwise gone to nursing homes are staying home. In addition, there is some indication from survey research that older adults prefer to live in their own homes and communities, particularly when they do not face a physical or cognitive impairment.[72]

As the Center has shown, many of the closures during the pandemic document a similar pattern – small facilities with low occupancy rates and poor records for quality of care are often the facilities that close.[73]

The four criteria for a hardship waiver proposed by CMS – location, "demonstrated good faith effort to hire and retain staff," "demonstrated financial commitment," and exclusions, 88 Fed. Reg., 61378 – are too limited to protect residents' need for care. All residents should receive high quality of care, regardless of where they live.

The location criterion is either being in a geographic area that is 20% or 40% below the national average for applicable health care staff (RN or aide) or 20 miles from the next closest facility. Proposed §483.35(g)(1), 88 Fed. Reg., 61378. This broad criterion sweeps in a large proportion of facilities, without justification. CMS presents no support or basis for the location criterion.

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[66] LeadingAge, Nursing Home Closures and Trends June 2015-June 2019, p. 3 (Feb. 2020), https://leadingage.org/sites/default/files/Nursing%20Home%20Closures%20and%20Trends%202020.pdf
[67] *Id.* 1, listing California, Illinois, Kansas, Massachusetts, Nebraska, Ohio, Oklahoma, Texas, and Wisconsin
[68] *Id*. 2, identifying Kansas, Montana, and Nebraska
[69] *Id*. 1, 3
[70] *Id.* 12
[71] *Id.*
[72] *Id*. 13
[73] CMA, "Nursing Home Closures in Iowa Exemplify General Pattern" (Report, Feb. 23, 2023), https://medicareadvocacy.org/report-nursing-home-closures-in-iowa-exemplify-general-pattern/

The effort to hire and retain staff criterion is similarly weak, requiring, among other specific points, that a facility offer wages at the prevailing rate or better. Since, as CMS acknowledges, one of the major causes of people refusing to work in nursing facilities is the poverty-level wages, the "prevailing wage" standard would not lead to any improvement in wages or staffing levels.

The demonstrated financial commitment criterion requires facilities to document "the financial resources that the LTC facility expends annually on nurse staffing relative to revenue." 88 Fed. Reg., 61378. The criterion includes no standards or basis for evaluation, making the criterion essentially meaningless.

Finally, the exclusions from exemptions provide little protection. A facility must not have failed to comply with the Payroll Based Journal requirements, must not have been a Special Focus Facility (SFF), and must not have been cited with a certain level of staffing deficiencies in the prior 12 months. *Id*.

Only a handful of facilities would be excluded from a hardship waiver under these criteria. Only 66 Special Focus Facilities exist nationwide. CMS does not even propose including the 400+ SFF candidates that meet the criteria for SFF status.

The exclusion criterion – staffing deficiencies cited at levels H, I, or J-L within the prior 12 months – applied to 44 staffing deficiencies (F725) in Fiscal Year 2023, https://qcor.cms.gov/report41snf.jsp?which=0&report=report41snf.jsp, and to 56 staffing deficiencies (F725) in FY 2022, https://qcor.cms.gov/report41snf.jsp?which=0&report=report41snf.jsp, according to qcor.cms.gov on October 3, 2023.

The Center opposes considering exemptions only when a facility is first cited as non-compliant as a result of a survey. Concerns about limiting enforcement of staffing standards to the survey process are discussed elsewhere in these comments and are equally relevant here. With respect to exemptions, however, the specific additional point is that if external factors make it temporarily impossible for a facility to meet the staffing ratios that CMS ultimately enacts in final rules, CMS should require the facility to request an exemption. The exemption process should require facilities to use the forms, procedures, and timelines that CMS specifies and should require the facility to identify the specific category(ies) of nurse whose mandatory HPRD it cannot meet. The Center proposes the following revisions to proposed §483.35(a)(1)(iii):

> (iii) The 0.55 hours per resident day for RN and 2.45 hours per resident day for NA requirement may be exempted under paragraph (g) of this section for facilities that ~~are found non-compliant~~ request an exemption from Secretary, using the forms, procedures, and timelines specified by the Secretary and are granted an exemption ~~and meet the eligibility criteria as determined~~ by the Secretary and the facility must identify the specific category(ies) of nursing staff whose mandatory HPRD it cannot meet.

The Center strongly opposes CMS's proposal that facilities provide documentation supporting their eligibility for an exemption, as set out in §483.35(g)(1)-(4), only "when requested." Proposed §483.35(g)(5). CMS should require facilities to submit all of the supporting

documentation in a format specified by CMS in all cases where facilities request an exemption. CMS should not take on faith a facility's claim that it is eligible for an exemption and should not trust that facilities are eligible and qualify for an exemption without reviewing their documentation. The Center proposes the following alternative language:

> (g)(5) Determination of Eligibility. The Secretary will determine eligibility for an exemption based on the criteria in paragraphs (g)(1) through (4) of this section. The facility must provide supporting documentation, using the forms, processes, and timeframes specified by the Secretary ~~when requested~~.

The Center also strongly opposes CMS's proposal to give facilities unlimited numbers of exemptions. Proposed §483.35(g)(6). **Exemptions should be granted for a maximum of one year.** Authorizing unlimited exemptions means that a facility could be allowed to continue providing care to residents while **never** meeting minimum staffing ratios. If a facility is unable to find sufficient staff within the year that it is granted an exemption, it should lose its certification for Medicare and Medicaid and a new owner must be required.

The Center proposes deleting the last sentence in proposed §483.35(g)(6) ("There are no limits on the number of exemptions that an eligible facility can be granted.")

There need to be additional regulatory and public reporting requirements for facilities that are granted an exemption. If a facility is given a one-year exemption, CMS should

- place a monitor in the facility to assure that residents are getting the care they need and require the monitor to submit written reports to CMS about residents' care.

- require the facility to make at least quarterly reports to CMS, documenting its good faith efforts to hire more staff and its demonstrated financial commitment, requirements proposed at §§483.35(g)(2), (3).

- post an icon on *Care Compare* informing the public that the facility has been given a one-year exemption from meeting a staffing requirement(s).

- require facilities to include on the daily staff posting, current 42 C.F.R. §483.35(g), information indicating that the facility has been granted an exemption from staffing requirements.

The Center recommends that **CMS establish criteria for rescinding the exemption** during the one-year period when

- a facility fails to report staffing data in accordance with the Provider Based Journal requirements

- a facility is not reporting its progress in working towards hiring staff

- resident care falls to dangerous levels, as determined by the monitor, or a standard or complaint survey, or otherwise. CMS or the state must seek temporary management or receivership in these circumstances.

- it fails to post a notice on its daily staff posting, current 42 C.F.R. §483.35(g), indicating that the facility has been granted an exemption from staffing requirements.

The Center supports the requirement to make publicly available the identity of facilities that receive exemptions from staffing requirements. 88 Fed. Reg., 61378. We recommend that publicly available means an icon on *Care Compare*, CMS's website for the public, indicating the exemption.

The Center proposes eliminating §483.35(g) entirely. However, assuming that CMS will permit exemptions, the Center proposes the following revisions to the regulatory language at §483.35(g):

> (g)(5) Determination of Eligibility. The Secretary will determine eligibility for an exemption based on the criteria in paragraphs (g)(1) through (4) of this section. The facility must provide supporting documentation, using the forms, processes, and timeframes specified by the Secretary ~~when requested~~.
>
> (g)(6) *Timeframe.* The term for a hardship exemption is a maximum of 1-year, ~~unless~~ and shall be rescinded if the facility becomes an SFF facility or is cited for widespread insufficient staffing with resultant resident actual harm or a pattern of insufficient staffing with resultant resident actual harm or otherwise fails to qualify for an exemption, as determined by the Secretary, and as described in (g)(8). ~~A hardship exemption may be extended on a yearly basis, after the initial 1-year period, if the facility continues to meet the exemption criteria in paragraphs (g)(1) through (4) of the section, as determined by the Secretary. There are no limits on the number of exemptions that an eligible facility can be granted.~~
>
> (g)(7) *Regulatory and public reporting requirements.* When CMS grants an exemption to a facility, it must
>
> (i) place a monitor in the facility to ensure that residents are getting the care they need and require the monitor to submit written reports to CMS about residents' care
>
> (ii) post an icon on Care Compare informing the public that the facility has been given an exemption from meeting a staffing requirement(s)
>
> (iii) require the facility to include on the daily staff posting information indicating that the facility has been granted an exemption from a staffing requirement(s)
>
> (g)(8) The Secretary may rescind an exemption when

(i) resident care falls to dangerous levels, as determined by the monitor, or a standard or complaint survey. CMS or the state must seek temporary management or receivership in these circumstances.

(ii) the facility fails to report staffing data in accordance with Provider Based Journal requirements

(iii) the facility does not report its progress in working towards hiring staff, as required by CMS

6. **Rural facilities**

CMS proposes a longer timeframe for implementation of nurse staffing standards for rural facilities. The Center opposes these longer timeframes for rural facilities. All residents are entitled to high quality of care, regardless of where they live. Moreover, the 2023 Abt staffing study found, and acknowledged, relatively minor differences in staffing levels in rural facilities, compared to urban facilities:[74]

Location	Number of nursing homes	Total nursing staff	RN	LPN	Nurse aide
Rural	4,174	3.66	0.64	0.80	2.23
Urban	10,973	3.80	0.67	0.91	2.21

Abt's 2023 report found that nurse staffing levels depend far more on factors other than rural/urban distinctions:[75]

- **ownership type**: for-profit facilities staff at 3.57 HPRD, non-profit facilities, at 4.28 HPRD, and government facilities, at 4.19 HPRD
- **facility size:** facilities with fewer than 50 residents staff at 4.67 HPRD, facilities with more than 50 residents staff at 3.51-3.76 HPRD
- **freestanding vs. hospital-based:** freestanding facilities staff at 3.71 HPRD, hospital-based facilities, at 5.24 HPRD
- **proportions of Medicaid residents**: facilities in the lowest Medicaid quartile staff at 4.33 HPRD, facilities in the highest quartile, at 3.53 HPRD
- Special Focus Facilities and candidates

CMS, correctly, is not proposing different staffing levels based on ownership status, facility size, whether the facility is freestanding or hospital-based, and whether the facility has a high or low proportion of Medicaid residents.

[74] Abt 2023 Staffing Study, p. 45
[75] *Id.*, pp. 45-46

Abt's 2023 report frankly acknowledges, "Finally, differences in staffing levels by urbanicity are not large, with average staffing levels slightly higher for nursing homes in an urban location (3.80 HPRD) than for nursing homes in a rural location (3.66 HPRD)."[76]

There is no evidence or reason to believe that residents in rural nursing facilities or underserved areas have lesser nursing needs than other residents. In fact, they are likely to have greater nursing needs, the result of decades of inadequate or insufficient health care. **Equity demands that standards of care not be lowered for poor communities.**

The issue of challenges in recruiting and retaining staff in rural and underserved areas is not new. It was addressed 40 years ago by the Institute of Medicine in its 1983 report *Nursing and Nursing Education; Public Policies and Private Actions* (1983), Chapter VI, Alleviating Nursing Shortages in Medically Underserved Areas and Among Underserved Populations.[77]Then, as now, recommendations included educational outreach (including educational loan repayment programs, strengthening local educational opportunities for people from underserved communities who are more likely to continue living in those communities), upgrading existing staff in nursing homes, and ensuring appropriate payments. Then, and now, recommendations did *not* include watering down standards for rural and other underserved areas.

A 2011 study, "Staffing Levels in Rural Nursing Homes," looked at nurse staffing at 171 nursing facilities in Colorado, Idaho, Nevada, Utah, and Wyoming, using both quantitative and qualitative research methods, including survey data collected between January 1, 2004 and June 2015. While acknowledging the difficulty of rural facilities' recruiting and retaining staff because of the small labor pool and competition within the pool, researchers found that the smallest rural facilities, with fewer than 31 beds, had the highest average RN hours per resident day, "partially attributed to the requirement than an RN must be on duty 8 hours per day, 7 days per week."[78] The federal requirement for RN staffing was effective in ensuring RN coverage.

In interviews with research staff, administrators, and directors of nursing in facilities with higher staffing levels "attributed their success to having a good reputation, being flexible, and offering individual growth opportunities (e.g., school reimbursement)."[79] The study reports:

> Despite facing competition challenges, several administrators and DONs discussed how they were trying to overcome those challenges and shared their successes in recruiting and retaining qualified staff. Some resolutions involved increasing wages or at least offering comparable wages to the competition. Several facilities were offering sign-on bonuses. Another strategy was enhancing individual growth and the work environment. Many NHs offered educational opportunities in addition to the required in-house education. CNAs wishing to become LPNs could enter a contract stating they would work for the NH for a

[76] *Id.* p. 46
[77] https://www.ncbi.nlm.nih.gov/books/NBK218556/
[78] Gail L. Towsley, Susan L. Beck, William N. Dudley, and Ginette A. Pepper, "Staffing Levels in Rural Nursing Homes," Research in gerontological nursing, 4(3), Jul. 2011: p. 1-14, https://libres.uncg.edu/ir/uncg/f/W_Dudley_Staffing_2011.pdf
[79] *Id.*

> specified amount of time in exchange for their schooling costs. One facility offered continuing education at the NH, which decreased travel and seminar costs to the staff. Some NHs developed community partnerships to recruit employees. These activities included attending job fairs, serving breakfast at CNA classes, or acting as a clinical site for aspiring CNAs and LPNs.
>
> Many administrators and DONs discussed the work environment as a major influence on their ability to recruit qualified staff. This influence included offering flexible schedules as well as facility/corporate values such as promoting teamwork, new visions, and a positive workplace that appreciated employees. Even after increasing wages, some NHs' wages still remained lower than their competitors. However, they believed other factors attributed to being able to recruit qualified staff. One DON said, "So they are still less than almost everybody around me. They aren't so much less that they appreciate the better working conditions."

Recruiting and retaining successes were also attributed to the NH's reputation. One DON told researchers, "Usually when I get people that are applying it's a positive thing…and they say, 'Oh, we hear such good things about this place.'" An administrator reported, "Because of our high HPRD, we're known as an organized facility because of the systems in place." Less tangible responses to successful recruitment strategies came in the form of luck, and a few informants attributed obtaining staff to no one particular strategy or action. One DON said, "They just come to us." Examples of these strategies or actions included a response to an advertisement in the newspaper, individuals unexpectedly walking through the door and applying for a position, and prayer.[80]

The study's authors concluded that complex labor pool challenges "require complex solutions."

> Our findings are similar to those of Kemper et al. (2008), who found that direct care workers in NHs voiced increased staffing, improved work relationships, and increased pay were the top three changes important to improving their jobs. These strategies may not be sufficient to meet the care needs of NH residents. Innovative and supportive models as suggested by the IOM (2008) should encompass better wages, better health insurance, and better pensions, as well as improved training, supervision, and mentoring. Comprehensive solutions are needed to address the concerns of quality and quantity of the long-term care workforce.[81]

The recommendations for rural facilities are the same as the recommendations for all facilities for improving staffing levels. Staff need "better wages, better health insurance, and better pensions, as well as improved training, supervision, and mentoring."

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[80] Gail L. Towsley, Susan L. Beck, William N. Dudley, and Ginette A. Pepper, "Staffing Levels in Rural Nursing Homes," *Research in gerontological nursing*, 4(3), Jul. 2011: p. 1-14, https://libres.uncg.edu/ir/uncg/f/W_Dudley_Staffing_2011.pdf

[81] *Id.*

CMS has no factual basis for proposing to give rural facilities more time to implement mandatory staffing standards. All residents need decent care, wherever they live. Appropriate staffing standards should be implemented as quickly as possible, throughout the country.

7. Implementation Timeframe

The implementation timeframes proposed by CMS are too long.

The Center's first concern about the timeframes is CMS's proposal for separate timeframes for urban and rural facilities. 88 Fed. Reg., 61380. CMS proposes to implement the three requirements – facility assessment, 24/7 RN, and staffing minimums – separately and differently for urban and rural facilities – three years following publication of a final rule for urban facilities and five years for rural facilities. As noted above, the 2023 Abt staffing report found limited differences in staffing nurse levels at urban and rural facilities and much more significant differences in staffing levels depending on ownership status, facility size, freestanding vs. hospital-based status, and proportion of Medicaid residents. None of these other more significant differences justifies separate phase-in requirements and neither does the less significant difference in urban/rural facility location.

CMS asks: Do other underserved communities similarly require longer implementation timeframes? The Center's answer is no. There is no justification for giving longer implementation timeframes for other underserved communities. Perpetuating poor quality care for underserved communities, particularly those serving racial and ethnic minorities, does not promote equity; it does the exact opposite.

The Center's second concern is the implementation schedule for nurse staffing standards. **The Center suggests a single implementation timeframe for all nursing facilities in the country – a three-year phase-in for all requirements for all facilities.**

CMS's approach to implementing the mandatory RN and aide HPRD is not phased-in; it is a lengthy delay in implementing minimum staffing standards. The Center proposes that CMS gradually increase mandatory staffing requirements each year until facilities fully meet the mandatory HPRD staffing levels. To the extent that CMS proposes specific staffing levels for specified categories of nurses, the Center suggests that specific progress be made in the first year. For example, if the final RN requirement were 0.75 HPRD, CMS should require 0.60 HPRD in year one, 0.70 HPRD in year two, and 0.75 HPRD in year three. Such an approach would put nursing homes on the path to increasing staffing levels gradually, but would require improvements each year until the full staffing mandate was met.

CMS asks about state preparations for the new staffing requirements and anticipated effects on resident health and safety. The Center cites again the Secretary's broad statutory duty under the 1987 Nursing Home Reform Law to ensure that standards of care, and their enforcement, are adequate to protect resident's health, safety, welfare, and rights. Understaffing nursing facilities harms residents' welfare and rights as well as their health and safety. The Abt 2023 staffing report acknowledges that its study did not even consider residents' rights and quality of life, which are critical to residents and critically affected by staffing levels. When CMS implements appropriate

staffing requirements in the final rule, it must avoid delay in implementation to the maximum extent possible, recognizing that any delay harms residents.

8. **Enforcement should be on two tracks: Using the survey process as the sole method of enforcing new nurse staffing standards is insufficient.**

CMS proposes to use the standard survey and enforcement system as the sole method of enforcing staffing requirements. 88 Fed. Reg., at 61365. The survey and enforcement process is a necessary, but not sufficient, response.

Direct and timely imposition of remedies – civil money penalties (CMPs) and denials of payment for new admissions (DPNA) – is needed to ensure that facilities fully and promptly comply with any staffing standards that set specific hours per resident day for designated nursing staff that CMS implements in a final rule. Enforcement of these hours-per-resident-day staffing standards complements the existing requirement that facilities provide "sufficient staffing to meet residents' needs" and can and should be separately enforced.

As noted above (footnote 34 and accompany text), the survey and enforcement process is timid and weak, failing both to cite deficiencies at all and to properly classify the scope and severity of deficiencies that it cites. The GAO has identified and reported these weaknesses for decades.

Most deficiencies are classified as no harm. Only the rare deficiency – about 5-6% of all deficiencies cited – is classified as actual harm or immediate jeopardy. Moreover, as a matter of policy, CMS typically limits enforcement to actual harm and immediate jeopardy deficiencies. (The exceptions are no-harm deficiencies that are cited at the same time as actual harm or immediate jeopardy deficiencies or, occasionally, when an extremely large number of no-harm deficiencies is cited.)

As of September 13, 2023, Qcor.cms.gov reports the follow deficiencies cited for F725, sufficient nurse staffing, for two fiscal years during the pandemic (FYs 2023 and 2022) and one year before the pandemic (FY 2018):

Fiscal year	B-C (substantial compliance)	D-F (no harm)	G-I (actual harm)	J-L (immediate jeopardy)	Total number of deficiencies
FY 2023	3	899 (93%)	32	32	966
FY 2022	2	1,068	52	41	1,164
FY 2018	3	1,012 (96%)	17	25	1,057

If this longstanding pattern of classifying most nurse staffing deficiencies as no-harm continues, there will be few staffing deficiencies and far fewer actual harm or immediate jeopardy staffing deficiencies. The staffing ratios that CMS enacts will simply not be enforced if the survey and enforcement system is the single approach to enforcement.

A second concern is that states and CMS should be enforcing the HPRD staffing standards directly and immediately, not waiting for a standard or complaint survey to identify and cite the facility's

noncompliance. Facilities submit staffing data quarterly to CMS through the Payroll-Based Journal (PBJ). A review of the data will automatically determine whether a facility met the staffing ratios mandated by CMS.

The President's reform agenda expressly recognized the need to base enforcement actions on data. The first sentence under the heading "Expand Financial Penalties and Other Enforcement Sanctions" states, **"CMS will expand the instances in which it takes enforcement actions against poor-performing facilities based on desk reviews of data submissions."** PBJ data submitted by facilities provide an appropriate opportunity to impose financial penalties based on desk review of data.

The current crisis in the survey and enforcement system makes it more critical to base some enforcement actions on data. In May 2023, the Senate Special Committee on Aging's hearing[82]and Majority Staff report[83] documented the dramatic decline in the number of standard surveys performed since the pandemic. Twenty-eight percent of the country's facilities have not had a standard survey for more than 16 months or more and one in nine facilities has not had a standard survey in two years. Witnesses testified at the May 2023 hearing about shortages of surveyors in state survey agencies and the increased risk for residents' health and safety that results. It is essential that CMS not rely solely on the survey process to determine facilities' compliance with nurse staffing standards.

The Center proposes two automatic consequences of PBJ data's documenting staffing in violations of the federal rules – an automatic civil money penalty (with the amount determined by the scope and severity of the facility's noncompliance) and denial of payment for new admissions. A prompt response to insufficient staffing will better protect residents from poor care.

CMS has experience imposing automatic CMPs against nursing facilities. CMS required facilities to report COVID-19 data to the CDC in an interim final rule with comment period published May 8, 2020.[84] In a second interim final rule with comment period, CMS imposed fines against facilities for failing to submit COVID-19 data to the Centers for Disease Control and Prevention (CDC). 42 C.F.R. §488.447(a).[85] CMS increased the federal fines for facilities' subsequent failures to report

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[82] "Residents at Risk: The Strained Nursing Home Inspection System and the Need to Improve Oversight, Transparency, and Accountability" (May 18, 2023 hearing), https://www.aging.senate.gov/hearings/residents-at-risk-the-strained-nursing-home-inspection-system-and-the-need-to-improve-oversight-transparency-and-accountability

[83] "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

[84] CMS, "Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program" (Interim final rule with comment period), 85 Fed. Reg. 27550, 27601 (May 8, 2020), https://www.govinfo.gov/content/pkg/FR-2020-05-08/pdf/2020-09608.pdf

[85] CMS, "Medicare and Medicaid Programs, Clinical Laboratory Improvement Amendments (CLIA), and Patient Protection and Affordable Care Act; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency," Interim final rule with comment period (Sep. 2, 2020), 85 Fed. Reg. 54820, https://www.govinfo.gov/content/pkg/FR-2020-09-02/pdf/2020-19150.pdf. CMS advised state survey agencies of plans to publish the interim final rule on May 6, 2020. CMS, "Interim Final Rule Updating Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes," QSO-

data to CDC, as required. 42 C.F.R. §488.447(a)(2). **A similar enforcement strategy must be employed when facilities submit PBJ information to CMS that documents their failure to meet mandated staffing ratios.**

CMS should also impose denial of payment for new admissions for facilities that fail to meet the RN and nurse aide staffing requirements (and any other specific hourly requirements mandated by CMS in the final rule). The rationale for the Center's proposal is clear. If facilities do not meet CMS's mandatory staffing levels, they should use their existing staff to provide care to current residents. Understaffed facilities should not admit additional residents whose needs they will be unable to meet, jeopardizing both current residents and new residents.

CMS's rationale for using solely the survey process for enforcing staffing standards is that the agency does not want facilities to conclude that meeting numerical requirements is enough and means the facility is in compliance with staffing requirements. CMS's view is that facilities must also meet the "sufficient" staff requirement to reflect staffing to meet resident acuity. CMS also states that it does not want facilities to interpret the staffing numbers as the ceiling, rather than, as CMS expects, the floor. 88 Fed. Reg., at 61366.

These arguments do not support CMS's decision to limit enforcement to the survey and enforcement system. CMS proposes two staffing requirements – the new HPRD requirement for RNs and CNAs (and possibly LPNs and total nurse staff, if mandates for these staff are included in the final rule) and the longstanding "sufficient staffing to meet residents' needs" standard. CMS can and should cite the immediate staffing deficiency, based on data, and impose automatic CMPs and DPNAs for failure to meet the HPRD-mandated staffing levels AND, as determined by the survey or other factors, cite and impose appropriate penalties for the "sufficiency" requirement. The two nurse staffing requirements are complementary and both can and should be enforced on separate tracks.

9. The Medicaid Institutional Payment Transparency Reporting Provision, §§438.72, 442.43, must be significantly revised to focus on transparency for all Medicare and Medicaid payments that facilities receive for resident care.

CMS proposes to require states, in four years, to report annually to CMS the percent of Medicaid payments, including those paid by managed care organizations and prepaid inpatient health care plans, for direct care workers (including not only nursing staff, but also therapists, social workers, feeding assistants, activities staff, others providing clinical services, and more) and for support workers (including housekeepers, janitors, groundskeepers, food service or dietary workers, drivers, and more), including salary, benefits, and the employer share of payroll taxes. Each state must also maintain a website to make the information publicly available.

The statutory authority for this proposal is the Medicaid requirement at 42 U.S.C. §1396a(a)(30) that state plans must "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the

20-29-NH (May 6, 2020), https://www.cms.gov/files/document/qso-20-29-nh.pdf. Pages 4-5 of the memorandum describe enforcement for F884, 42 C.F.R. 483.80(g)(1)-(2).

geographic area." When nearly every nursing facility in the country voluntarily participates in Medicaid, this requirement is already plainly met. Rates must already be sufficiently high to secure facilities' participation in Medicaid.

The real concern about public reimbursement rates is that facilities do not spend sufficient portions of their reimbursement on care for residents, but, instead, divert large portions of their reimbursement elsewhere, often to profits.

New York State nursing facilities' lawsuit challenging the state law that established a direct care ratio and limited profits to 5%[86] demonstrates how money is diverted from resident care to private profit.[87] Plaintiff facilities claim that if New York's law had been in effect in 2019, they would have had to return $824,000,000 to the state ($511,000,000 attributed to the direct care ratio requirement and $313,000,000 attributed to the limitation on profits). In other words, by their own calculations, New York State nursing facilities spent $824 million (in 2019) on spending not related to resident care and excess profits, as those terms are defined by the state's 2021-2022 budget law.

Related party transactions are also strong evidence of resources diverted to expenses unrelated to patient care. Paying related companies (companies under common ownership) for nursing home services, often at inflated prices, is a common practice in the industry. Multiple reports and articles document that facilities that engage in related party transactions both provide poorer care to residents and are highly profitable for their owners.

Twenty years ago, an investigative report by *U.S. News & World Report*, "The New Math of Old Age; Why the nursing home industry's cries of poverty don't add up," found considerable related-party and self-dealing transactions in the nursing home industry, involving facilities' sending profits to their corporate parent, paying rent to related companies, and paying management or consulting fees to related parties.[88] Many "costs" are actually profits by another name.

The New York Times reported in January 2018, that nearly three-quarters of all nursing facilities in the country buy goods and services, such as therapy services, management services, medications, and rent, often at inflated prices, from companies that they own and control and that as a result of these related party transactions, facilities are able to hide profits as the cost of doing business.[89] Kaiser Health News journalist Jordan Rau described two New York owners whose family trusts took $40 million of the $145 million that their facilities received as reimbursement over an eight-year period – a 28% profit margin. Facilities engaging in related party practices have fewer nurses and aides to provide care to residents, "higher rates of patient injuries and unsafe practices," and twice as many complaints as other facilities.

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[86] New York State Budget for State Fiscal Year 2021-22, §2828 (Residential health care facilities; minimum direct resident care spending), https://www.nysenate.gov/legislation/laws/PBH/2828

[87] *Home for the Aged of the Little Sisters of the Poor v. Mary T. Bassett*, No. 1:21-cv-01384 (BKS/CFH) (N.D.N.Y., filed Dec. 29, 2021), https://medicareadvocacy.org/wp-content/uploads/2022/01/Nursing-homes-NY-nh-case-21-cv-1384-BKS-CFH-complaint-U.S.-District-Court-NYND-2.pdf

[88] Christopher H. Schmitt, "The New Math of Old Age; Why the nursing home industry's cries of poverty don't add up," *U.S. News & World Report* (Sep. 30, 2002)

[89] Jordan Rau, "Care Suffers as More Nursing Homes Feed Money Into Corporate Webs," *The New York Times* (Jan. 2, 2018), https://www.nytimes.com/2018/01/02/business/nursing-homes-care-corporate.html?searchResultPosition=9

In December 2020, Debbie Cenziper and colleagues at *The Washington Post* documented the self-dealing of California's largest nursing home operator, Brius Healthcare Services, whose nursing facilities paid $103 million to related companies in 2018 for supplies, administrative services and financial consulting, and rent, among other services.[90] Care at many Brius facilities was so poor that, in 2014, then-California Attorney General Kamala Harris took an unprecedented step of filing an emergency motion in bankruptcy court in an effort to persuade the court not to give Brius additional facilities. Harris's motion called the company a "'serial violator of rules within the skilled nursing industry.'"

The *Naples Daily News* reported in 2018 that Consulate Health Care, then, the largest nursing home operator in Florida and sixth largest operator in the country (with 210 facilities and 22,059 beds in 21 states), founded in 2006 and owned by the Atlanta-based private equity firm Formation Capital, designed its facilities "to appear cash-strapped."[91] The article described the chain's individual facilities as "essentially empty shells, they pay rent, management and rehabilitation service fees to Consulate or Formation Capital-affiliated companies." One Consulate facility paid $467,022 in management fees and $294,564 in rent to two companies owned by Consulate and Formation Capital. Forty-eight of Consulate's 77 Florida nursing facilities had one or two stars on the federal website, then called Nursing Home Compare.

In 2022, Eleanor Laise reported in *MarketWatch* that Ephram Lahasky, one of the largest private nursing home operators in the country, charged increasingly large amounts for rent at a Connecticut nursing facility that he co-owned, which the state had placed in court-ordered receivership in 2019:

> The state reported in a court filing that the facility did not have sufficient funds for "'payroll, food, medical supplies and other necessary services.'" The facility paid "sharply increasing amounts of rent to a related party [where Lahasky is a principal], according to cost reports filed with the state," with rent increasing from $633,000 in 2017 to $1.1 million in 2018. Lahasky said, "'If you own the real estate and the operations, you're allowed to charge yourself whatever you want in rent,'" adding "'I never got a dollar from that facility.'"[92]

New York State Attorney General Letitia James sued four of Centers Health Care's New York nursing homes, alleging that Respondents committed financial fraud, misused public funds,

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[90] Debbie Cenziper, "Profit and Pain: How California's largest nursing home chain amassed millions as scrutiny mounted," *The Washington Post* (Dec. 31, 2020), https://www.washingtonpost.com/business/2020/12/31/brius-nursing-home/

[91] Ryan Mills and Melanie Payne, "Neglected: Florida's largest nursing home owner represents trend toward corporate control," *Naples Daily News* (May 31, 2018), https://www.naplesnews.com/story/news/special-reports/2018/05/31/floridas-largest-nursing-home-owner-part-growing-national-trend/581511002/

[92] Eleanor Laise, "'All you hear about is the bad stuff': Ephram Lahasky has a new investment model for America's nursing homes. Regulators have questions," *MarketWatch* (Mar. 23, 2022), https://www.marketwatch.com/story/all-you-hear-about-is-the-bad-stuff-ephram-lahasky-has-a-new-investment-model-for-americas-nursing-homes-regulators-have-questions-11648041864?mod=mw_latestnews

neglected residents, grossly understaffed the facilities, and converted to their own profit more than $83 million in Medicare and Medicaid reimbursement.[93]

The trade press also recognizes the desirability of ancillary businesses to private operators. The president and founder of Evans Senior Investments told *Skilled Nursing News*, "If they have their own pharmacy or they have their own therapy company, it allows them to push more revenue under the master umbrella and it makes the economics that much more attractive to be able to pay these aggressive prices."[94] He also recognized that so-called management fees are another major source of revenue: "The difference between the management fee, which is standardized at 5%, and 1.5% of 2% it actually costs to run these facilities is extremely 'accretive' when underwriting facilities as a buyer."[95]

Instead of focusing on whether Medicaid rates are high enough, CMS should focus on its statutory responsibility under the Nursing Home Reform Law:

> (f) Responsibilities of Secretary relating to nursing facility requirements
> (1) General responsibility
> It is the duty and responsibility of the Secretary to assure that requirements which govern the provision of care in nursing facilities under State plans approved under this subchapter, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and **to promote the effective and efficient use of public moneys**. [bold font supplied]

42 U.S.C. §1396r(f)(1). The Medicare portion of the Nursing Home Reform Law is substantively identical. 42 U.S.C. §1395i-3(f)(1).

The transparency proposal by CMS not only ignores its own legal obligations to protect residents and make sure that public funding is effectively and efficiently used, it also

- is unnecessarily complex

- excludes Medicare payments entirely (focusing solely on Medicaid). It inappropriately excludes reporting of payments "for which Medicaid is not the primary payer," 88 Fed. Reg., 61386. CMS's reasons for excluding Medicare payments for dually eligible residents is that including Medicare would be "outside the scope of this data collection," 88 Fed. Reg., 61387. Medicare is outside the scope of the data collection only because CMS defines the scope of the data collection to include solely Medicaid.

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[93] The Attorney General's Verified Petition in People of the State of New York v. Abraham Operations Associations LLC (N.Y. Supreme Court, N.Y. County, Jun. 28, 2023) is at https://ag.ny.gov/sites/default/files/court-filings/centers-filed-petition.pdf; the Attorney General's Press Release, "Attorney General James Sues Owners and Operators of Four Nursing Homes for Financial Fraud and Resident Neglect"(Jun. 28, 2023) is at https://ag.ny.gov/press-release/2023/attorney-general-james-sues-owners-and-operators-four-nursing-homes-financial

[94] Alex Zorn, "New SNF Buyers Drive Busy Acquisition Market as Regulatory Future Remains Uncertain," *Skilled Nursing News* (May 4, 2022), https://skillednursingnews.com/2022/05/new-snf-buyers-drive-busy-acquisition-market-as-regulatory-future-remains-uncertain/

[95] *Id.*

- may not include all Medicaid payments to facilities.

In response to CMS's request for comment on various issues in the proposed transparency provisions, the Center suggests that

1. CMS include Medicare payments in order to give a more accurate and complete understanding of how much Medicare and Medicaid reimbursement facilities receive and how they spend the public funding

2. CMS include Medicaid base payments, supplemental payments, and any other payments made by or through the state's Medicaid program to determine how much Medicaid actually pays nursing facilities. The Medicaid and CHIP Payment and Access Commission (MACPAC) describes information about Medicaid payment rates as "limited." MACPAC finds that (1) states' base payments vary widely, from 62-182% of the national average, (2) some states do not include resident contributions to their care when reporting states' base payments, (3) 23 states made supplemental payments of $3.4 billion in 2019, and (4) **states may also adjust rates based on resident acuity, area wages, and other factors**.[96] **All of the Medicaid payments must be included to get an accurate understanding of Medicaid payments to facilities.**

3. CMS count Medicaid beneficiaries' contributions to their care because they are part (and often a substantial part) of the "Medicaid" reimbursement that facilities receive (since Medicaid-supported residents are required, by post-eligibility rules, to contribute all of their income towards care except for specified exclusions, including personal needs allowance and maintenance needs of spouse or family.[97])

The Center supports complete transparency in how facilities spend all of the reimbursement they receive and also believes that financial accountability is essential. **Accountability is achieved by requiring facilities to spend designated portions of their reimbursement on direct care for residents.**

In the proposed rule for home and community-based services (HCBS) in the Medicaid program, 88 Fed. Reg. 27960 (May 3, 2023), https://www.govinfo.gov/content/pkg/FR-2023-05-03/pdf/2023-08959.pdf, CMS proposed both financial transparency and financial accountability.

First, the HCBS proposed rule 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). Second, in proposed §441.311, Reporting Requirements, at proposed §441.311(e), CMS requires States to report to CMS about HCBS spending, "at the time and in the form and manner specified by the CMS." Third, in proposed §441.313, website

[96] MACPAC, "Estimates of Medicaid Nursing Facility Payments Relative to Cost" (Issue Brief, Jan. 2023), https://www.macpac.gov/wp-content/uploads/2023/01/Estimates-of-Medicaid-Nursing-Facility-Payments-Relative-to-Costs-1-6-23.pdf

[97] *See* 42 C.F.R. §435.832, medically needy, 42 C.F.R. §483.725, post-eligibility rules for SSI states

transparency, CMS requires, at 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 to report spending to CMS "in the form and manner specified by CMS," and require CMS to publish these results on the CMS website.

The requirements in the proposed HCBS rule are far more comprehensive than the limited transparency that CMS proposes for nursing facilities in the proposed rule at issue here.

First, with respect to nursing facilities, CMS confirms that it is not requiring specified portions of reimbursement to be spent on direct care staff, writing,

> As we discuss below, we are not proposing a minimum percentage of Medicaid payments for nursing facility services and ICF/IID services that must be spent on compensation to direct care workers and support staff. We do not have adequate information at this time to determine such a minimum percentage, nor what impact requiring a minimum percentage would have on Medicaid institutional payments.

88 Fed. Reg., 61384. CMS's further explanation is that CMS is just beginning to learn from PBJ data about the "relationships between staffing hours and staff compensation in nursing facilities that service Medicaid residents;" that States have different payment rate methodologies; and that the proposed transparency rule is "a necessary step in gathering and making publicly available more information about Medicaid institutional payments that can aid in further analyses, which in turn can inform future policy development and potential rulemaking." 88 Fed. Reg. 61384.

The Center is unaware of any comparable information about HCBS that CMS already had that supported the comprehensive accountability provisions in the proposed HCBS rule. CMS should impose an explicit accountability requirement in the final nurse staffing rule. At the very least, CMS must commit itself to publishing a proposed rule for financial accountability for nursing facilities, once the transparency requirements are implemented.

The four-year delay is excessive. The Center proposes a uniform three-year implementation deadline for all requirements.

Recommendations

The Center's recommendations are:

- Mandate a staffing standard of at 4.2 HPRD, comprised of specific HPRD for each type of nurse:
    - Licensed nurses of 1.4 HPRD composed of
        - 0.75 RN HPRD
        - 0.65 HRPD (licensed nurses, RNs, LPNs, or LVNs, as facilities choose)

- 2.8 CNA HPRD

- Require that the 24/7 RN actually provide direct care to residents, not just that the RN "be available."

- Confirm in regulatory language that states and localities may provide higher staffing standards than the federal regulations require (88 Fed. Reg., 61373).

- Do not create separate staffing standards for rural and other underserved facilities.

- Do not enact any exemptions from staffing requirements. However, if CMS authorizes exemptions, it must

    - limit exemptions to a single year
    - establish criteria, procedures, processes, and timelines for facilities to apply for an exemption
    - establish criteria for rescinding the exemption during the one-year period when the facility fails to comply with CMS requirements or when resident care falls to dangerous levels (as determined by the monitor, a complaint or standard survey, or otherwise)
    - require quarterly reporting by facilities of their progress in hiring staff
    - impose a monitor at any facility with an exemption from staffing requirements
    - post an icon on *Care Compare* to indicate that a facility has received an exemption
    - require facilities to publicly display on their daily staff posting that they have received an exemption

- Revise the enforcement process to authorize immediate civil money penalties and denials of payment for new admissions for facilities reporting on Payroll-Based Journal submissions that they are not meeting mandated staffing hours per resident day, by nurse category.

- Limit the phase-in for all nurse staffing requirements for all nursing facilities to three years.

- Revise the Medicaid Institutional Payment Transparency Reporting Provision to

    - include Medicare, all Medicaid payments made by the state (however they are described and categorized) and all residents' contributions to Medicaid charges, as required by Medicaid's post-eligibility rules

- Commit to conduct a formal evaluation of implementation of a final staffing rule in order to determine whether and how staffing levels increased and the impact of the final rule on resident care. CMS's current commitment, at 88 Fed. Reg., 61353, is only to continue examining staffing thresholds. CMS writes:

    > Should subsequent data indicate that additional increases in staffing minimums would be warranted and feasible, we anticipate that we will revisit the minimum

staffing standards to shift them toward the higher ranges supported by the evidence, such as those described above, with continued consideration of all relevant factors.

88 Fed. Reg., 61353. This statement is too vague. CMS must commit to conducting a formal evaluation of the final staffing rule, publishing the results of its evaluation three years after the final rule goes into effect, and **increasing staffing standards if the evaluation shows that resident care has not improved and that higher staffing standards are needed.**

Proposed changes to regulatory language:

483.35 Nursing Services
(a) (i) Licensed nurses, including but not limited to a minimum of 0.75 ~~0.55~~ hours per resident day for registered nurses (RNs) and 0.65 hours per resident day of licensed nurses (RNs, licensed practical nurses (LPNs), or licensed vocational nurses (LVNs)

(ii)Other nursing personnel, in accordance with §483.71, including but not limited to a minimum total of ~~2.45~~ 2.80 hours per resident day for certified nurse aides (NAs).

483.35(a)(1)(iii) The 0.55 hours per resident day for RN and 2.45 hours per resident day for NA requirement may be exempted under paragraph (g) of this section for facilities that are ~~found non-compliant~~ request an exemption from Secretary, using the forms, procedures, and timelines specified by the Secretary and are granted an exemption ~~and meet the eligibility criteria as determined~~ by the Secretary and the facility must identify the specific category(ies) of nursing staff whose mandatory HPRD it cannot meet.

§483.35(a)(7) The federal rules do not preempt higher staffing standards that States and local jurisdictions mandate.

483.35(b)
(1)~~Except when waived under paragraph (e) or)f) of this section~~, ~~t~~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.

483.35(g) Hardship Exemption
(g) *Hardship Exemption from the Minimum Hours Per Resident Day Requirements.* A facility may be exempted by the Secretary from the requirements of paragraphs (a)(1)(i) and (ii) of this section **if external circumstances prevent the facility from meeting the minimum staffing requirements, despite the facility's best efforts,** and if verifiable hardship exists that prohibits the facility from achieving or maintaining compliance. The facility must meet the four following criteria to qualify for a hardship exemption.

(g)(5) Determination of Eligibility. The Secretary will determine eligibility for an exemption based on the criteria in paragraphs (g)(1) through (4) of this section. The facility must provide supporting documentation, using the forms, processes, and timeframes specified by the Secretary ~~when requested~~.

(g)(6) *Timeframe.* The term for a hardship exemption is a maximum of 1-year, ~~unless~~ and shall be rescinded if the facility becomes an SFF facility or is cited for widespread insufficient staffing with resultant resident actual harm or a pattern of insufficient staffing with resultant resident actual harm or otherwise fails to qualify for an exemption, as determined by the Secretary, and as described in (g)(8).. ~~A hardship exemption may be extended on a yearly basis, after the initial 1-year period, if the facility continues to meet the exemption criteria in paragraphs (g)(1) through (4) of the section, as determined by the Secretary. There are no limits on the number of exemptions that an eligible facility can be granted.~~

(g)(7) *Regulatory and public reporting requirements.* When CMS grants an exemption to a facility, it must

(i) place a monitor in the facility to ensure that residents are getting the care they need and require the monitor to submit written reports to CMS about residents' care

(ii) post an icon on Care Compare informing the public that the facility has been given an exemption from meeting a staffing requirement(s)

(iii) require the facility to include on the daily staff posting information indicating that the facility has been granted an exemption from a staffing requirement(s)

(g)(8) The Secretary may rescind an exemption when

(i) resident care falls to dangerous levels, as determined by the monitor, or a standard or complaint survey. CMS or the state must seek temporary management or receivership in these circumstances.

(ii) the facility fails to report staffing data in accordance with Provider Based Journal requirements

(iii) the facility does not report its progress in working towards hiring staff, as required by CMS

483.71(a) Facility assessment

(a) The facility must assess the acuity of its residents using one of the following methodologies:

(i) the methodology developed Charlene Harrington and colleagues, "Appropriate Nurse Staffing Levels for U.S. Nursing Homes," *Health Services Insights,* Vol. 13:1-14 (2020)[98]

[98] Charlene Harrington, Mary Ellen Dellefield, Elizabeth Halifax, Mary Louise Fleming, Debra Bakerjian, "Appropriate Nurse Staffing Levels for U.S. Nursing Homes," *Health Serv Insights* (Jun. 29, 2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7328494/

(ii) the 24 case-mix categories used to assess skilled nursing needs of residents in Medicare's patient-driven payment model or

(iii) another recognized evidence-based data-driven methodology for identifying resident acuity identified by the facility and submitted to, and approved for use in advance, by CMS.

Additional proposed revisions to proposed §473.71

(a)(1)(vii) The facility's training program to ensure any training needs are met for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles.

(a)(5) The input of the resident/family council, residents, their representative(s) or families.

Conclusion

In February 2022, President Biden made a commitment to improve staffing levels in nursing facilities to protect residents and workers. CMS must honor and implement that commitment. We cannot go backwards. CMS must implement and effectively enforce meaningful nurse staffing standards.

Facilities in both urban and rural areas already meet far higher nurse staffing standards than CMS proposes.

During the pandemic, in the second quarter of 2002, nursing facilities staffed at 3.76 HPRD, composed of

RN: 0.67 HPRD
LPN: 0.88 HPRD
Aide: 2.22 HPRD

Even the lowest staffed sector of the nursing home industry – for-profit facilities – provided 3.6 HPRD during the pandemic.

Non-profit facilities currently provide 4.28 HPRD and government nursing facilities, 4.19 HPRD, already exceeding a 4.1 HPRD standard.

The Abt 2023 Staffing Study found that 42% of facilities currently staff above 3.8 HPRD, including 13% of facilities that staff above 4.6 HPRD.

The Abt 2023 Staffing Study (simulation component) found that staffing between 3.8 HPRD and 4.6 HPRD would be adequate to keep rates of both omitted ADL and omitted clinical care below 10%.

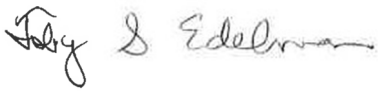
CMS must implement and fully enforce nurse staffing standards to ensure that residents receive the care and services they need to maintain their highest practicable physical, mental, and psychosocial well-being. CMS must implement its statutory duty and responsibility

> **to assure that requirements which govern the provision of care in skilled nursing facilities under this subchapter, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys.**

We cannot go backwards.

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

Sincerely,



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