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November 6, 2023

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

Re: Medicare and Medicaid Programs: Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting [CMS-3442-P; RIN 0938-AV25].

Dear Administrator Brooks-LaSure:

The American Federation of Labor and Congress of Industrial Organizations (AFL-CIO) welcomes the opportunity to respond to the recent Notice of Proposed Rulemaking (NPRM) that would establish minimum staffing standards for long-term care facilities. The AFL-CIO is a voluntary, democratic federation of 60 affiliated unions representing more than 12.5 million workers in all sectors of our economy. The AFL-CIO is committed to fairness in the workplace and health security for working people and their families. Our core mission is to ensure that working people are treated fairly and respectfully, that our hard work is rewarded with family-supporting wages and benefits, and that our workplaces are safe. We also provide an independent voice in politics and legislation for working women and men and make their voices heard in corporate boardrooms and the financial system.

The AFL-CIO commends the Administration for addressing the issue of staffing in long-term care facilities. This proposed rule has the potential to improve the quality of care for millions of union retirees who are or will need care in such facilities; it has the potential to improve working conditions for the tens of thousands of union members working in nursing homes; and it has the potential to increase accountability for the tens of billions of dollars in public funding that nursing homes receive every year. While we offer suggestions for improving this NPRM, we applaud the Administration for having the political courage to take on this contentious issue and for taking bold action to address a long-ignored problem.

Background

This NPRM represents a long-overdue change in nursing home[1] oversight. As far back as 2001, the Center for Medicare & Medicaid Services (CMS) noted the "strong and compelling" evidence for having minimum staffing levels, even in an economy with a chronic workforce shortage.[2] A blue-ribbon panel convened by the National Academy of Science, Engineering, and Medicine (NASEM) noted in its 2022 report that increasing overall nurse staffing has been a consistent and longstanding recommendation for improving the quality of care in nursing homes.[3]

These recommendations are based on decades of peer-reviewed research demonstrating a causal relationship between nurse staffing and quality outcomes, much of it reviewed in a Request for Information published by the agency in June 2022.[4] This research showed that improved staffing reduced pressure ulcers, emergency department visits, re-hospitalizations, and incidents of COVID. In contrast, lower levels of staffing has been shown to adversely impact resident safety, personal hygiene and the overall quality of life for residents.[5, 6] More recent data from CMS also shows that homes with higher levels of staffing have higher overall ratings, better health inspections, and fewer instances of abuse.[7]

Many people first noticed the relationship between staffing and resident outcomes during the COVID-19 pandemic when inadequate staffing led to the deaths of more than 200,000 workers

[1] The staffing requirement of the proposed rule applies to nursing homes and skilled nursing facilities, which we will refer to generically as nursing homes or facilities.

[2] Centers for Medicare & Medicaid Services, Abt Associates, *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes. Report to Congress: Phase II Final*. Volumes I–III. Baltimore, MD: CMS, 2001. Available at https://theconsumervoice.org/uploads/files/issues/CMS-Staffing-Study-Phase-II.pdf.

[3] National Academies of Sciences, Engineering, and Medicine. 2022. *The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Families, and Staff*. Washington, DC: The National Academies Press.

[4] CMS-1765-P, Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2023; Request for Information on Revising the Requirements for Long-Term Care Facilities to Establish Mandatory Minimum Staffing Levels, 87 Fed. Reg. 22720 (Apr. 15, 2022), https://www.govinfo.gov/content/pkg/FR-2022-0415/pdf/2022-07906.pdf.

[5] *The Nursing Home Staffing Study Comprehensive Report*, Abt Associates, June 1, 2023. Available at https://www.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf. CMS refers to this as the 2022 Abt study, which we assume is because the report summarizes research activities between June and December 2022. We are referring to it by its publication date. For an overview of the literature, see also Harrington, C., et al., *Experts Response to Minimum Staffing Proposal*, submitted October 24. Available at https://www.regulations.gov/comment/CMS-2023-0144-9587.

[6] For an overview of the literature, see Harrington, C., et al., *Experts Response to Minimum Staffing Proposal*, submitted to this docket on October 24, 2023. Available at https://www.regulations.gov/comment/CMS-2023-0144-9587.

[7] *Staffing Matters*, The National Consumer Voice for Quality Long Term Care, https://theconsumervoice.org/uploads/files/issues/Staffing-Matters.pdf

and residents.[8] But as the literature shows, the research linking better staffing and improved care goes back many years.[9]

Improved staffing will be a tremendous benefit for workers who provide the bulk of the hands-on care. The work of a certified nursing assistant (CNA) is emotionally draining and physically difficult, even at the most well-staff facility. Inadequate staffing, however, makes the work of a CNA particularly challenging by adding a layer of moral injury – the pain that direct care workers feel when they cannot provide the care they are trained and want to provide, but are prevented from doing so as a result of inadequate staffing. The average CNA provides care for 13 residents per shift and one in 10 CNAs cares for 17 or more residents[10]; during COVID, CNAs report being responsible for 20 or even 30 residents. A CNA with that workload cannot possibly respond promptly to someone in pain or someone who needs help with activities of daily living. CNAs know this and their frustration is a major reason that so many leave the bedside to work in other occupations.[11]

For workers, inadequate staffing often leads to physical injury. According to 2021 data from BLS shows that working in a nursing home is one of the most dangerous jobs in America – more

[8] Chidambaram, P., *Over 200,000 Residents and Staff in Long-Term Care Facilities Have Died From COVID-19*, Feb. 03, 2022 (Kaiser Family Foundation). Available at https://www.kff.org/policy-watch/over-200000-residents-and-staff-in-long-term-care-facilities-have-died-from-covid-19/

[9] Notable studies include Harrington, C. J., Carrillo, H., Garfield, R., and Squires, E., *Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009 Through 2016*. Kaiser Family Foundation. April 3, 2018. Available at https://www.kff.org/report-section/nursing-facilities-staffing-residents-and-facility-deficiencies-2009-through-2016-staffing-levels/. Trivedi, T.K., DeSalvo, T., Lee, L., Palumbo, A., Moll, M., Curns. A., Hall, A.J., Patel, M., Parashar, U.D., and Lopman, B.A., *Hospitalizations and Mortality Associated with the Norovirus Outbreaks in Nursing Homes, 2009-2010*. JAMA (2012). Oct 24; 308 (16):1668-75. Available at https://jamanetwork.com/journals/jama/fullarticle/1380392#:~:text=We%20estimated%20that%20norovirus%20outbreaks,study%20during%202009%20and%202010.. Castle, N.G., *Nursing Home Caregiver Staffing Levels and Quality of Care: A Literature Review*. J. Journal of Applied Gerontology (2008), 27: 375-405. Available at https://www.researchgate.net/publication/245771093_Nursing_Home_Caregiver_Staffing_Levels_and_Quality_of_CareA_Literature_Review. Uchida-Nakakoji, M., Stone, P.W., Schmitt, S.K., and Phibbs, C.S., *Nurse Workforce Characteristics and Infection Risk in VA Community Living Centers: A Longitudinal Analysis.* Medical Care (2015), 53, 261-267. Available at https://pubmed.ncbi.nlm.nih.gov/25634087/. Xing, J., Mukamel, D.B., and Temkin-Greener, H., *Hospitalizations of Nursing Home Residents in the Last Year of Life: Nursing Home Characteristics and Variation in Potentially Avoidable Hospitalizations*. Journal of the American Geriatrics Society (2013), 61, 1900-1908. Available at https://pubmed.ncbi.nlm.nih.gov/24219191/.

[10] *High Staff Turnover – A Job Quality Crisis in Nursing Homes*, The National Consumer Voice for Quality Long-Term Care, September 8, 2022. Available at https://theconsumervoice.org/news/detail/all/nh-staff-turnover-report.

[11] Squillace, M. R., Bercovitz, A., Rosenoff, E., and Remsburg, R. *An Exploratory Study of Certified Nursing Assistants Intent to Leave*, ASPE, September 22, 2008. Available at http://aspe.hhs.gov/daltcp/reports/2008/intent.pdf. See also Reinhardt, J. P., Franzosa, E., Mak, W., and Burack, O. *In Their Own Words: The Challenges Experienced by Certified Nursing Assistants and Administrators During the COVID-19 Pandemic*. J Appl Gerontol. 2022 Jun; 41(6):1539-1546. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8958287/. *See also* Paulin, E., Inside the "Staffing Apocalypse" Devastating U.S. Nursing Homes, AARP, June 9, 2022. Available at https://www.aarp.org/caregiving/health/info-2022/labor-shortage-nursing-homes.html. *See also* Sick, N. *Strategies to Improve the Certified Nursing Assistant Workforce Crisis*. Urban Institute, January 31, 2023. Available at https://www.urban.org/urban-wire/strategies-improve-certified-nursing-assistant-workforce-crisis.

dangerous than working in a foundry or a prison.[12] Dangers include injuries from lifting and repositioning residents, accidental chemical and drug exposure, and intentional workplace violence. These risks are more likely to be serious in a facility that is understaffed – where workers cannot get the help they need from co-workers or take the precautions that are needed when handling dangerous chemicals.[13] For workers, the lack of adequate staffing makes their job far more dangerous and difficult than it needs to be.

A robust minimum staffing standard would also be one of the most helpful policy measures this Administration can take to address the racial inequities in a healthcare system where women and people of color routinely perform the most dangerous and poorly paid jobs.[14] CNAs, the workforce that provides the bulk of the hands-on care, are 91% women, 56% people of color, and 21% immigrants. They are poorly compensated, earning just over a median wage of $17.06/hour in 2022[15] – an amount that is far below a living wage in most communities.[16] As the NRPM notes, almost half of the direct care workforce live in or near poverty (defined as less than 200% of the federal poverty line) and rely on public assistance. A staffing standard that nudges the labor market to increase wages for direct care workers would be a small but significant step in undoing the damaging economic legacy of a discriminatory culture.

A strong staffing standard will have a similar impact on racial inequities involving nursing home residents. Over the years, numerous studies have shown that facilities with low levels of staffing have a disproportionate number of people of color.[17] Minimum staffing standards will improve the quality of care for these residents who, in many cases, are the unknowing victims of racial discrimination.

Current Law

Federal staffing requirements are minimal. Nursing homes participating in Medicare or Medicaid must have a registered nurse (RN) on duty for eight consecutive hours and licensed nursing staff

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[12] Data from *Highest Incidence Rates of Total Nonfatal Occupational Injury and Illness Cases, 2021,* part of the Survey of Occupational Illness and Injury, U.S. Bureau of Labor Statistics. Available at https://www.bls.gov/iif/nonfatal-injuries-and-illnesses-tables.htm.

[13] *Report of the Committee on the Adequacy of Nursing Staff in Hospitals and Nursing Homes*, Wunderlich, G.S., Sloan, F., Davis, C.K., eds. Institute of Medicine, Washington (DC): National Academies Press; 1996. Available at https://pubmed.ncbi.nlm.nih.gov/25121200/. *See also* Campbell, S., *Workplace Injuries and the Direct Care Workforce*, PHI, April 2018. Available at https://www.phinational.org/wp-content/uploads/2018/04/Workplace-Injuries-and-DCW-PHI-2018.pdf. Walton, A.L., Rogers, B., *Workplace Hazards Faced by Nursing Assistants in the United States: A Focused Literature Review*, Int. J. Environ. Res. Public Health 2017, 14(5), 544. Available at https://pubmed.ncbi.nlm.nih.gov/28534859/.

[14] Dill, J., and Duffy, M., *Structural Racism and Black Women's Employment in the US Health Care Sector*, Health Affairs, Vo. 41, No. 2, February 2022. Available at https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01400.

[15] Direct Care Workers in the United States: Key Facts 2023, PHI, September 2023. Available at https://www.phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-2023/.

[16] Glasmeier, A.K, 2023 Living Wage Calculator, MIT, February 1, 2023. Available at https://livingwage.mit.edu/articles/103-new-data-posted-2023-living-wage-calculator.

[17] Carlson, E., Selassie, G., *Racial Disparities in Nursing Facilities — and How to Address Them*, Issue Brief, Justice in Aging, September 2022. Available at https://justiceinaging.org/wp-content/uploads/2022/09/Racial-Disparities-in-Nursing-Facilities.pdf. See also *Experts Spotlight Systemic Racism in U.S. Nursing Homes and Call for Action*, Center for Medicare Advocacy, April 2021. Available at https://medicareadvocacy.org/systemic-racism-in-nursing-homes/.

present 24 hours a day.[18] There is no requirement that a facility increase its staffing as the number or acuity of residents increases. Federal law simply requires that a facility provide "sufficient" staff to meet the nursing needs of its residents.[19] This vague federal standard leaves far too much discretion to facility operators – as evidenced by the fact that less than 20% of facilities would meet the standard proposed in the NPRM.[20] A regulatory regime that has allowed individual facilities to define what constitutes a "sufficient" level of staffing has failed both residents and workers.

Current staffing levels are also troubling in terms of fiscal accountability. Medicare's Patient-Driven Payment Model, designed to take into account the individualized needs, characteristics, and goals of each patient, requires facilities to evaluate therapies and other medical care a resident may need.[21] The result is that facility administrators develop staffing plans and know the acuity of each Medicare beneficiary. Yet, federal rules do little to ensure that such funds are used to provide residents with the hands-on care they need. Facilities are guaranteed payment, but residents have no assurance of adequate staffing.

Scope of the Problem

Inadequate staffing at nursing homes has been a widespread and chronic problem in this country. In 2022, more than 1,000 facilities were cited for inadequate staffing.[22] Staffing in some areas of the country is relatively high, but no state or region is immune. Facilities in North Dakota, for example, staff on average at 4.45 HPRD, yet one-third of facilities in the state staff under the 4.1 HPRD standard. California averages 4.1 HPRD, but less than half of facilities staff at or above the 4.1 HPRD level.[23]

Inadequate staffing is a national problem, but it disproportionately affects for-profit facilities. According to CMS data, the average nonprofit staffs at a level that is 19.8% higher than the average for-profit facility; the average government facility staffs at a level that is 17% higher than the average for-profit facility. Nonprofits and for-profits are treated similarly by Medicaid Medicare, yet nonprofits staff at higher levels than for-profits in 49 out of 50 states.[24] As the 2023 Abt study points out, nonprofit facilities offer an average of 4.28 HPRD – far above what

[18] Medicare and Medicaid Programs, 88 Fed. Reg. 61355 (Sept. 6, 2023) (amending 42 C.F.R. § 483).
[19] See §§1819(b)(4)(C)(i) and 1919(b)(4)(C)(i) of the Social Security Act for skilled nursing facilities and nursing facilities respectively.
[20] Burns, A., Chidambaram, P. Neuman, T., and Rudowitz, R., *What Share of Nursing Facilities Might Meet Proposed New Requirements for Nursing Staff Hours?* Issue Brief, Kaiser Family Foundation, September 18, 2023. Available at https://www.kff.org/medicaid/issue-brief/what-share-of-nursing-facilities-might-meet-proposed-new-requirements-for-nursing-staff-hours/#:~:text=KFF%20estimates%20that%2019%25%20of,meet%20the%20nurse%20aide%20requirement.
[21] Harrington, *supra* note 6.
[22] Medicare and Medicaid Programs, supra note 18 at 61367. More than 70% of nursing homes in the country do not staff at the level needed to avoid harm to residents, according to the latest data from the Long-Term Care Community Coalition, *LTCCC Alert: Most U.S. Nursing Homes Understaffed, Federal Data Finds*, July 2023. Available at https://nursinghome411.org/alert-staffing-q4-2022/.
[23] LTCCC Alert, *supra* note 22.
[24] *Better Staffing is Achievable: A Look at For-Profit versus Non-Profit Nursing Homes*, National Consumer Voice for Quality Long-Term Care, September 2023. Available at https://theconsumervoice.org/uploads/files/issues/Better_Staffing_Is_Achievable.pdf.

CMS proposes and above what we recommend in these comments.[25] This difference in staffing is crucial since approximately 70% of nursing homes are for-profit.[26] The performance of these high-performing nonprofit facilities shows that higher staffing levels, even those recommended in these comments, are feasible even in a labor market where hiring is difficult.

The difference in staffing between these two models may be related to the tendency of for-profit entities, particularly those with private equity investors, to divert significant funds through related party transactions. These for-profit firms typically have multiple corporate layers and separate property, management, and staffing entities that allow them to reduce their tax liability and boost profits through related-party transactions. Recent reporting indicates that nearly 75% of nursing homes in the US had related-party transactions – about the same percentage of nursing homes that are for-profit providers – totaling $11 billion in 2015, according to Medicare cost reports.[27] Such practices raise serious concerns about the long-running concealment of profits and diversion of funds intended for staffing.

The relationship between related-party transactions and poor staffing is evident in a series of nursing homes in North Carolina that are all owned by the same company, according to the National Consumer Voice for Quality Long-Term Care.[28] For the three years starting in 2020, the company operated eight facilities and made $27.2 million in total profits. The individual facilities paid $53.6 million to related parties, including $11 million to the indecipherable category of "home office costs."[29]

This data is a reminder of how corporate financial practices impact staffing. During this period, staffing at the eight facilities was grossly inadequate – averaging 3.32 HPRD – almost an hour below the levels documented in these comments to keep residents safe and provide a safe working environment. At the same time, the company also paid significantly lower than average wages. From 2020-2022, CNAs were paid $14.27 per hour, licensed practical nurses (LPNs) were paid $23.59 an hour, and RNs were paid $28.40 per hour. While tens of millions of dollars in profits were flowing to owners of these facilities, an RN in one of their nursing home was

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[25] 2023 Abt study, *supra* note 5.

[26] Harrington, C., Montgomery, A., King, T., Grabowski, D. C., Masserman, M., *These Administrative Actions Would Improve Nursing Home Ownership and Financial Transparency In The Post COVID-19 Period*, Health Affairs Forefront, February 11, 2021. Available at https://www.healthaffairs.org/content/forefront/these-administrative-actions-would-improve-nursing-home-ownership-and-financial#:~:text=About%2070%20percent%20of%20nursing,led%20to%20complex%20organizational%20structures.

[27] *Where Do the Billions of Dollars Go: A Look at Nursing Home Related Party Transactions*, Report from the National Consumer Voice for Long-Term Care, 2023. Available at https://theconsumervoice.org/uploads/files/issues/2023-Related-Party-Report.pdf. See also Gupta, A., Howell, S. T., Yannelis, C., Gupta, A., *Owner Incentives and Performance In Healthcare: Private Equity Investment In Nursing Homes* NBER Working Paper 28474 http://www.nber.org/papers/w28474. Rau, J. *Care Suffers As More Nursing Homes Feed Money Into Corporate Webs*, KFF News, December 31, 2017. Available at https://kffhealthnews.org/news/care-suffers-as-more-nursing-homes-feed-money-into-corporate-webs/.

[28] The individual companies are Carolina Rivers Nursing & Rehab, Harmony Hall Nursing, Riverpoint Crest Nursing & Rehab, River Trace Nursing, Premier Nursing and Rehab, Grantsbrook Nursing, Cherry Point Bay Nursing, and Croatan Ridge Nursing.

[29] Data available at https://www.cms.gov/data-research/statistics-trends-and-reports/cost-reports/cost-reports-fiscal-year. Calculations by the National Consumer Voice for Long-Term Care, October 2023.

making 65% of the national RN average wage, according to the CMS cost reports.[30] At a time when some claim that higher staffing is unaffordable given current reimbursement rates, it is worth remembering how common corporate financial practices divert resources at the expense of residents and workers.

Recommendations

24/7 RN Staffing
We strongly support a final rule that requires the presence of an RN in facilities 24 hours a day, seven days a week, as proposed in the NPRM. However, only RNs providing direct care to residents should be counted towards this staffing requirement. RNs performing administrative duties should not be included. In addition, a Director of Nursing in facilities with more than 30 residents should not count towards this requirement. After all, it is the actual direct care provided by RNs that improves health outcomes for residents, not their mere presence in the building.

Minimum Staffing Levels
We strongly support a final rule that would strengthen the staffing requirements by requiring:

- The care provided by a licensed nurse should be set at 1.4 hours per resident day (HPRD), with at least 0.75 of that provided by an RN. CMS should determine a LPN-specific standard to meet part or all of the remainder of the licensed nurse requirement.
- The care provided by a CNA should be 2.8 HPRD.

Registered Nurses
Each type of direct care worker in a nursing home contributes to a facility's ability to provide quality care. RNs are responsible for the coordination and care delivery, including problem-solving, assessing, planning, implementing, and evaluating residents' care plans. RNs are responsible for the management and supervision of LPNs and CNAs and collaborate with other interdisciplinary team members, such as physicians, social workers, and rehabilitation staff, regarding care goals and interventions. RNs are also responsible for implementing new or modified regulatory requirements. Ultimately, any effective chain-wide implementation of policies and procedures needs to be tailored to the unique physical layout of a facility and the collective competencies of its nursing staff.[31]

CMS proposed a requirement for licensed nurses that includes a minimum of 0.55 HPRD of care from RNs. While this proposal is better than no standard, the 2023 Abt study supports a significantly higher staffing standard that would be far more protective of both residents and workers. The 2023 Abt study examined the impact of different staffing levels on the probability that a nursing home would surpass the 25th and the 50th percentile for various quality and safety measures. The study's results were unambiguous: as staffing levels increased, there was a steady increase in the predicted probability that a facility would exceed the minimum acceptable quality thresholds.[32]

[30] CMS Cost Reports by Fiscal Year available at https://www.cms.gov/data-research/statistics-trends-and-reports/cost-reports/cost-reports-fiscal-year.
[31] Harrington, *supra*, note 6.
[32] 2023 Abt study, *supra* note 5, page 50.

CMS chose a staffing level between 0.52 and 0.60 HPRD, but we strongly recommend the study other options discussed by the study that are more protective of residents and workers. We believe a better choice for a minimum RN staffing standard would be to require staffing at the 7th decile – between 0.70 and 0.82 HPRD – which significantly improved quality and safety outcomes.[33] A minimum staffing standard is designed to identify a level below which care is likely to be compromised. If that is the case, then a staffing standard should provide residents and their families with a better-than-even chance at getting at least middle-of-the-road quality care.[34]

We recognize that having a minimum staffing standard based on a range of HPRD is not helpful and therefore recommend a minimum RN staffing standard of 0.75 HPRD. This is close to the midpoint of the range discussed; it is also a level of staffing recommended in the 2001 Abt study and endorsed by respected health researchers.[35] For what it is worth, it is also higher than every state's minimum RN staffing requirement.

We are quite concerned that an RN staffing standard lower than the current average level of RN staffing could have the unintended but foreseeable effect of reducing RN staffing in facilities across the country. If the goal of this rulemaking is to align RN staffing to the level supported by the research, then 0.75 HPRD is a far better policy choice. If RN staffing time has the most significant impact on the quality of care, then a minimum staffing standard that could reduce the average RN staffing nationally would be a significant policy mistake.

Licensed Practical Nurses[36]

LPNs provide practical care and a variety of essential tasks, such as administering medications and treatments. While the LPN designation is not an equivalent substitute for the RN, these workers are an essential part of the nursing home workforce. The industry routinely employs them because they can perform care duties that CNAs are not trained or allowed to do under state scope of practice laws, but at a lower wage than RNs.

The Administration proposes a minimum staffing level for RNs and CNAs but not for LPNs – because Abt study did not find consistent positive relationship between LPN staffing and

[33] Id. See diagram on page 52.

[34] The RN staffing standard suggested by CMS would primarily increase staffing at the worst-performing facilities. Improving care in those facilities is an important goal, but urge the Administration to adopt a final rule that improves staffing for a broader continuum of facilities. We are also troubled by a minimum staffing standard that aims to ensure that more residents are in. facilities that reach the 50th percentile for quality measures and safety measures. We think the 2001 Abt study had it right when it sought to analyze a level of staffing above which additional amounts of direct care did not improve health outcomes; we also reject any standard that aims for the 25th percentile, which we believe would fall woefully short of the agency's own stated goal of ensuring that "all residents across all LTC facilities" are at a significantly lower risk.

[35] Harrington, *supra*, note 6. *See also* Harrington, C., Dellefield, M. E., Halifax, E., Fleming, M. L., and Bakerjian, D., *Appropriate Nurse Staffing Levels for U.S. Nursing Homes*, Health Serv Insights, June 2020. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7328494/. See also Schnelle J. F., Simmons S. F., Harrington C., Cadogan M., Garcia E., Bates-Jensen B. (2004). *Relationship Of Nursing Home Staffing To Quality Of Care?* Health Services Research, 39 (2), 225–250. Available at https://pubmed.ncbi.nlm.nih.gov/15032952/.

[36] In some states, these workers are called licensed vocational nurses (LVNs). We refer to the collective pool of LPNs and LVNs as LPNs.

improved care.[37] The study seems to dismiss the fact that these finding may have more to do with staffing patterns, than the potential impact that LPNs have on care. As the 2023 Abt study noted, facilities with higher LPN staffing tend to have lower RN staffing.[38]

Not including LPNs within a national minimum staffing standard creates an unnecessary ambiguity about the proper mix of direct care staffing. It also fails to utilize a significant pool of direct care workers who are ready and able to contribute.[39] At a time when many are concerned with adequate staffing in rural and isolated communities, it is critical to utilize all of the licensed nurse staff available. A staffing standard that leaves out LPNs would undercut the efficiency and reach of the combined licensed nurse staff.

A specific minimum staffing requirement for LPNs is also important from a workforce perspective. Providing CNAs and other direct care workers with opportunities for career advancement is an important strategy for retaining and ultimately growing the LTC workforce.[40] For many CNAs, becoming an LPN is a more achievable jump in the career ladder than becoming an RN. For a CNA with ambitions, the opportunity to become an LPN may be the difference between continued employment in a nursing home and getting a job at Amazon or in the fast-food industry. A minimum staffing standard that doesn't include LPNs sends a message that LPNs are not valued. This is exactly the wrong message to send about a workforce that we need to grow.

A minimum standard for LPNs would reinforce a minimum standard of 1.4 HPRD for licensed nurses. This standard of 1.4 HPRD is consistent with the 2001 Abt study (recommending 1.3 HPRD but with average acuity lower than it is now in most facilities) and with simulation modeling in the 2023 Abt study (noting that licensed nurse staffing between 1.4 and 1.7 HPRD kept delayed or omitted care below 10% for facilities at the 50th percentile). A lower level of licensed nurse staffing would allow delayed or omitted care to balloon to 19%, which we find a poor policy choice.[41] Allowing one in five residents to experience delayed or omitted care would make poor-quality care commonplace.

Certified Nurse Assistants

CNAs provide the vast majority of direct care to nursing home residents. CNAs help residents with aspects of daily living, such as bathing, eating, dressing, and transferring. When facilities

[37] 2023 Abt study, *supra* note 5, page 13.
[38] Id.
[39] Nursing homes and extended care settings in the United States employ 30% of LPNs, compared to 4.4% of RNs. See the 2022 National Nursing Workforce Study, National Council of State Boards of Nursing. Available at https://www.ncsbn.org/research/recent-research/workforce.page.
[40] NASEM report, note 3, *supra*. See also Fishman, M. E., Glosser, A., Gardiner, K., *Recruiting and Retaining a Quality Paraprofessional Long-Term Care Workforce: Building Collaboratives with the Nation's Workforce Investment System*, ASPE/HHS, May 21, 2004. Available at https://aspe.hhs.gov/reports/recruiting-retaining-quality-paraprofessional-long-term-care-workforce-building-collaboratives-0. Mulloy, P., *The Key to Retention in Long-Term Care? Create Career Paths*, McKnight's, March 9, 2023. Available at https://www.mcknights.com/marketplace/marketplace-experts/the-key-to-retention-in-long-term-care-create-career-paths/. Sick, *supra* note 11. Scales, K. *Growing a Strong Direct Care Workforce: A Recruitment and Retention Guide for Employers*, PHI-National, May 2018. Available at https://www.phinational.org/resource/growing-strong-direct-care-workforce-recruitment-retention-guide-employers/.
[41] 2023 Abt study, *supra* note 5, page 74.

have inadequate CNA staff, the quality of life for residents is degraded, resulting in residents waiting hours to be fed, dressed, have adult diapers changed, or have their call bell answered. [42] CNAs are critical to the health and well-being of nursing home residents.

The proposed rule would establish a minimum staffing level of 2.45 HPRD for CNAs based on the finding that staffing below that level did not improve safety or quality. CMS is suggesting 2.45 HPRD because it was the first staffing level in which the 2023 Abt study saw quality improvements for residents.

The level suggested by the NPRM is an improvement over the *status quo* in which the average facility provides 2.22 HPRD of CNA staffing.[43] However, the 2023 Abt study presents evidence that supports a higher CNA staffing level that we strongly believe would be a significantly better policy choice for meeting the agency's stated goals. The 2023 Abt study cites the 2016 study by Schnelle study showing that staffing of 2.45 HPRD would lead to omitted or delayed care for 15% of residents, even for the lowest level of acuity. For facilities with average acuity, omitted or delayed care would increase to between 20-25% of residents.[44] Under either scenario, residents would routinely experience significant gaps in care. As a country, we need to do better. As stewards of the Medicare and Medicaid programs, the federal government needs to do better.

We strongly support a final rule that would require a minimum CNA staffing requirement of at least 2.8 hours per resident day (HPRD). The support for this level of staffing is consistent over time and across studies, starting with the 2001 Abt study and continuing with the two independent studies by two of the most highly regarded national experts. In both cases, these are the staffing levels needed to keep delayed or omitted care below 10% for facilities with the lowest acuity level.[45] We also believe that 2.8 HPRD of CNA care is a staffing level that best meets the statutory obligation that nursing homes provide "nursing services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident." [46] For what it is worth, 2.8 HPRD of CNA care is also a level of staffing that is higher than all state minimum requirements for HPRD of care.

Conclusion on Minimum HPRD Requirement

CMS seeks comments on several related staffing issues. CMS notes that an alternative staffing minimum is a combined level of 3.48 HPRD, based on 0.55 HPRD for RNs, 0.48 HPRD for

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[42] Hsu, A., *Nursing Home Residents Suffer From Staffing Shortages, But The Jobs Are Hard To Fill*, NPR, April 6, 2022. Available at https://www.npr.org/2022/04/06/1088660155/nursing-home-minimum-staffing-labor-shortage-medicare-medicaid-nurses.

[43] Nursing Home Staffing Q3 2022, Long Term Care Community Coalition. Available at https://nursinghome411.org/data/staffing/staffing-q3-2022/map/.

[44] Schnelle, J. F., Schroyer, L. D., Saraf, A. A., Simmons S. F., *Determining Nurse Aide Staffing Requirements to Provide Care Based on Resident Workload: A Discrete Event Simulation Model*. J. Am. Med Dir Assoc., 2017 Nov. 1:17(11): 970-977.Available at https://pubmed.ncbi.nlm.nih.gov/27780572/.

[45] Schnelle, J. F., Simmons, S. F., Harrington, C., Cadogan, M., Garcia, E, Bates-Jensen, B., *Relationship Of Nursing Home Staffing To Quality Of Care?* Health Serv Res, 2004; 39 (2):225-250. Available at https://pubmed.ncbi.nlm.nih.gov/15032952/#:~:text=The%20highest%2Dstaffed%20homes%20performed,care%20than%20all%20other%20homes. Harrington, C., Dellefield, M., Halifax, E., Fleming, M., and Bakerjian, D. *Appropriate Nurse Staffing Levels for US Nursing Homes*, Health Services Insights. 2020: 13:1-14. Jun 29. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7328494/.

[46] 42 USC 1395i-3(b)(4)(A)(i) of the Social Security Act.

LPNs, and 2.45 HPRD for CNAs. We support the four-part structure of this policy, but believe the science supports a higher numerical threshold for all job categories, as discussed above.

Direct care workers in nursing homes face daunting and complex jobs that require a combination of manual labor and intellectual effort. Each type of worker contributes a particular set of skills based on their training and experience. Optimal care is provided by a skill mix that includes all three job classifications.

It is essential for minimum staffing standards to avoid aggregating HPRD across job classifications. Most studies have separate HPRD recommendations for RNs, LPNs, and CNAs. In states where minimum staffing laws did not disaggregate HPRD among different job classifications, suboptimal staffing patterns were pursued as nursing homes used the least expensive worker to fulfill the statutory obligation.[47]

If CMS adopts a three-part staffing standard (RN, CNA, and aggregate) in a final rule, we believe there should be safeguards to ensure an appropriate mix of direct care workers. One option could be a "maintenance of effort" requirement that facilities continue to employ at least the number of LPNs or the ratio of LPNs/residents employed on September 6, 2023.

Role of Acuity

As CMS has noted, these proposed staffing standards are minimums. Facilities must staff at higher levels when called for by resident acuity and complexity of care required. To that end, CMS should clarify that minimum staffing standards are calculated based on residents with the lowest acuity needs. This is suggested when CMS says minimum staffing standards apply to all facilities, even those with below-average acuity populations. Still, there is some ambiguity since the NPRM also says that "most facilities have either an average acuity or higher."[48] The risk of linking minimum staffing standards to average acuity is that some facilities may conclude that a population of low-acuity residents justifies a lower level of staffing. This re-creates the same discretionary staffing regime that is failing us now. A minimum staffing requirement should make it clear that facilities cannot staff below the prescribed level.

Hardship Exemptions

The NPRM would establish a one-year "hardship exemption" from the minimum HPRD requirement if the facility meets the following criteria:

(1) It must be in a geographic area where

(a) the supply of healthcare staff is either medium (*i.e.* where the provider-to-population ratio is 20 percent below the national average) or low (*i.e.* 40 percent below the national average) or

(b) the facility is at least 20 miles from another long-term care facility; and

[47] Chen M. M. and Grabowski, D. C., *Intended and Unintended Consequences of Minimum Staffing Standards for Nursing Homes*. Health Econ. 24: 822-839 (2015). Available at https://pubmed.ncbi.nlm.nih.gov/24850410/. Hyer, K., Temple, A., and Johnson, C. D. (2009) *Florida's Efforts to Improve Quality of Nursing Home Care Through Nurse Staffing Standards, Regulation, and Medicaid Reimbursement*. J. of Aging Social Policy. 21 (4):318-37. Available at https://pubmed.ncbi.nlm.nih.gov/20092125/.

[48] Outside of Lake Wobegon, this seems mathematically impossible.

(2) The facility must demonstrate a good-faith effort to hire and retain staff by developing and implementing a recruitment plan that includes an offer of prevailing wages; and
(3) The facility must demonstrate a financial commitment to expend a certain amount of revenue on wages.

Facilities that have not submitted payroll-based journal data or are part of the Special Focus Facility program are not eligible for an exemption, according to the NPRM.

The AFL-CIO opposes a hardship exemption for the minimum HPRD requirement. The minimum staffing requirement is intended to fulfill the statutory obligation that facilities care for its residents "in such a manner and in such an environment as will promote maintenance or enhancement of the safety and quality of life of each resident." [49] CMS received comments as part of the earlier RFI that included graphic descriptions of the poor health outcomes and resident abuse resulting from inadequate staffing.[50] The qualitative portion of the 2023 Abt study also recounted medical errors and medically unsafe conditions caused by inadequate staffing.[51] Allowing a hardship exemption from safe staffing standards would allow these conditions to continue. The recent pandemic showed how inadequate staffing can adversely affect the mortality of residents and staff during an unpredictable and unexpected public health emergency. The staffing standards are intended to ensure safe and equitable quality care.[52] Exempting facilities from minimum staffing standards endangers residents and allows dangerous working conditions to continue. For residents in a nursing home that has been granted an exemption, those statutory and regulatory goals would have been forfeited.

Should the minimum staffing proposal be finalized, a non-compliant facility presents regulators with two options: (1) grant an exemption or (2) require the facility to adjust its in line with staffing minimums. The first option ignores the impact of inadequate staffing on both residents and workers. It allows a facility to continue operating in violation of its statutory obligation to assure resident safety and to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The second option is not optimal, but it recognizes that facilities have choices in achieving staffing minimums. Hiring additional staff is one option. Achieving compliance by adjusting the number of residents is another. Facilities that cannot meet the "hours" requirements can always reduce the "resident days" part of the metric.

Though some may see the options facing regulators as granting an exemption or closing down the facility, that is a false dichotomy. A corporate decision to close a facility that lacks adequate staffing is likely based on a complex set of financial calculations, including the cost of agency staff, alternative investment opportunities, and other factors. The decision to close a facility is one that is entirely in the hands of the providers and often occurs for reasons that have nothing to do with staffing. Facility owners threatening to cut off access to skilled nursing care cannot hold a community hostage and pretend it is the fault of CMS.

[49] § §1819(b)(4)(C)(i) and 1919(b)(4)(C)(i) of the Social Security Act.
[50] Medicare and Medicaid Programs, *supra* note 18 at p. 61356
[51] Medicare and Medicaid Programs, *supra* note 18 at pp 61302 and 61356.
[52] Medicare and Medicaid Programs, *supra* note 18 at p. 61357.

We recognize that reducing a facility's census will cause some financial pain for the facility. Frankly, that is a feature, not a bug. Nursing homes that fail to meet minimum staffing standards should be treated like any other regulated entity engaged in dangerous behavior; there should be policy incentives to bring it into compliance.[53]

To the extent that CMS allows for exemptions, we strongly encourage the agency to limit their frequency and number. Moreover, any exemption process should require a corrective plan of action with specific milestones for the facility to meet in order to be in compliance with the staffing requirements. The granting of a second exemption should require a revised plan of action with more aggressive milestones for compliance. Without escalating demands on the facility for violations of staffing standards, staffing levels are unlikely to change facility staffing patterns.

While CMS may be the administrative entity granting the exemption, the "hardship" is ultimately borne by the residents and workers. Any exemption granted should be clearly communicated to the workers and residents in languages they understand, making it clear that the facility has chosen to continue current operations in violation of a federal staffing standard designed to protect both groups. Any newly hired workers and newly admitted residents should be told about the facility's continued non-compliance. Notice of the exemption and non-compliance (and past exemptions if this is not the first) should also be posted prominently on the Nursing Home Compare website to warn community members considering the facility.

With respect to the exemption process, we object to CMS' goal of developing a process that ensures "as little administrative burden on LTC facilities as possible."[54] These facilities are in violation of an important federal law protecting consumers and workers from the risk of physical and mental harm. Reducing the administrative burden on the regulated entity that has violated the law will only reduce the incentive for future compliance with federal staffing requirements. CMS should consider additional administrative burdens such as quarterly reports documenting interim efforts of the facility to hire additional staff.

To the extent that there is an exemption process, we urge CMS to deny payment for new admissions to a facility that is out of compliance. CMS payment for new admissions to a noncompliant facility implicitly condones inadequate staffing. It would also create an overwhelming incentive to ignore minimum staffing requirements. A ban on payment for new admissions should not be lifted until the facility has documented that it has met the minimum

[53] We are deeply troubled by the fact that a reduction in the size of the resident population will cause inconvenience to families and may have a negative impact on the health of residents. We believe these adverse impacts should be considered in light of the needs of the remaining residents. We also believe states and CMS should take every reasonable action to minimize these adverse consequences of the facility's conduct. For example, nursing homes must not be allowed to discharge residents without state oversight and approval. Moreover, CMS should issue guidance on involuntary discharges. All facilities cited under staffing requirements must be ordered to produce and follow a directed plan of corrections with specific milestone to comply with staffing requirements and return residents. Notice of the nursing home's decision to reduce its resident population through involuntarily discharges should be prominently displayed on the Nursing Home Compare website so that prospective residents understand the risks of entering this facility at a later date. Facilities should work with residents and families to find a new facility; residents that are required to leave should be given plenty of time to find an acceptable facility; extensions of time should be granted at the resident's request.

[54] Medicare and Medicaid Programs, *supra* note 18 at p. 61378

standard for several shifts. CMS should also initiate enforcement actions, including citations for understaffing at the resident harm level and require a directed plan of correction for facilities that are not meeting the staffing requirements.

Regarding the exemption criteria, we also urge CMS to require the facility to be in an area with a low provider-to-population ratio. We also urge CMS to drop the requirement that a facility be at least 20 miles from another facility to qualify for an exemption. It is unclear from the NPRM how the 20-mile increment "best addresses" some unspecified concerns over the combination of provider-to-population ratios and travel time. CMS claims the 20-mile criteria best addresses the concerns of families, but it is not at all clear that family members as a demographic group have a homogenous view about this criterion or exemptions more broadly. For families in rural areas with cold and snowy winters, road conditions on major highways leading to the nursing home may be the determining factor in their ability to visit a resident; the distance may be longer but shorter roads may not be passable. For families in the rural outskirts of more temperate climates with significant traffic congestion spilling over from suburban areas, the time it takes to drive to a nursing home may be a more critical factor than the distance to the facility.

Moreover, it is not clear that a mileage criterion does much to help facilitate the supply of direct care workers, particularly for CNAs who, because of their relatively low wages, may be more dependent on public transport than RNs or resident families. For that reason alone, time and opportunities for public transport may be more significant factors than distance.[55]

More troubling from a policy perspective, this criterion is the equivalent of the federal government requiring there to be a nursing home every 20 miles. Such a policy statement seems wrong in an era when the number of facilities has shrunk as more people prefer home and community-based services. We believe that any exemption should be based on the availability of workers, compensation offered, and working conditions, not facility distance or location.

We also believe facilities seeking to demonstrate a good-faith effort need to show they are offering more than "prevailing wage." Offering the same wage as other employers in an industry may be a valid measure of employer efforts in a sector where labor supply is abundant. Offering the prevailing wage in a sector with an imbalance between supply and demand is the opposite of good-faith. A nursing home that offers what is considered a living wage for that particular community would be a better example of what constitutes a good faith effort.

We are also concerned that the vagueness of the "demonstrated financial commitment" criteria makes it difficult to evaluate. A facility that can document that it spends at least 80% of its total revenue on nurse staffing would be one example of a demonstrated financial commitment.[56] Regardless, CMS needs to offer guidance to clarify this criteria. To the extent that CMS fleshes out this criteria, we recommend that it focus on direct care staff (RNs, LPNs, and CNAs); other

[55] The 20-mileage criterion does not make sense given that the average commuting distance in the U.S. may be as long as 41 miles to and from work, according to Zippia.com. The average adult spends 55 minutes a day behind the wheel and drives 29 miles a day, according to the Department of Transportation's Bureau of Transportation Statistics. For information, see https://www.bts.gov/statistical-products/surveys/national-household-travel-survey-daily-travel-quick-facts.

[56] The NASEM report, *supra* note 3, recommended that the federal government should require that nursing homes spend a specific percentage of revenues on direct care staff, including wages and benefits.

workers should be included in a separate category. In all such cases, it would be important for the amount spent to be disaggregated by job classification since RNs make significantly more than CNAs and physical therapists and significantly more than janitorial staff.

Surprisingly, the current exemption criteria do not include any metrics that address staff retention, which is an important indicator of working conditions and facility labor practices. A nursing home that cannot retain staff will need frequent exemptions, even at fairly low levels of HPRD. The average nursing home loses half of its direct care staff every year[57]; churn is far greater, if one takes into account the hours of care provided by departing staff.[58] CMS should add a fifth criteria that requires a nursing home seeking an exemption to have an above-average retention rate over each of the last four quarters.

It is fair to assume that most nursing homes seeking an exemption will be for-profit since they make the largest share of the industry and staff at far lower levels than nonprofit providers (3.57 HPRD v. 4.28 HPRD). These facts justify the development of a sixth criterion related to the diversion of funds through related party transactions. Providers that use related party transactions to drain resources for corporate enrichment should not be granted an exemption.

We do not support a hardship exemption based on the financial condition of the provider. We do not allow car manufacturers in financial distress to produce vehicles without seatbelts or with less effective crumple zones in front-end bumpers; we do not allow airlines in financial distress to fly without stewards or qualified pilots. Adequate staffing should be a core element of any nursing home's financial plans; it should not be an extra for those facilities that can afford it.

Rural Communities

Industry advocates claim that rural facilities will be hard-pressed to meet minimum staffing requirements and will have to close.[59] Yet recent data show that rural facilities staff at comparable levels to urban facilities.[60] The relatively small difference in staffing – 0.14 HPRD – is not surprising. Rural communities have smaller labor pools to choose from, but workers in rural areas also have fewer job options. It is not unusual for a nursing home or hospital to be the largest employer in town. Nursing homes also employ many older workers without college

[57] *LTCCC Alert: Nursing Home Staff Turnover Above 50%*, Long Term Care Community Coalition, August 24, 2022. Available at https://nursinghome411.org/alert-staffing-q1-2022/.

[58] Gandhi, A., Huizi, Y., and Grabowski, D. C., *High Nursing Staff Turnover In Nursing Homes Offers Important Quality Information*, Health Affairs Vol. 40, No. 3, March 2021. Available at https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00957.

[59] See January 20, 2023 letter from Sens. John Brasso (R-WY) and Jon Tester (D-MT) et al. Available at https://www.tester.senate.gov/wp-content/uploads/1-20-23-Nursing-Home-Staffing-Mandate-Letter-FINAL.pdf. See also October 23, 2023 letter from Sens. John Boozman (R-AR), James Lankford (R-OK) and Jon Tester (D-MT) et al. Available at https://www.boozman.senate.gov/public/index.cfm/2023/10/boozman-lankford-tester-urge-biden-administration-to-halt-unworkable-nursing-home-staffing-rule.

[60] As the 2023 Abt study notes, rural nursing homes provide 3.66 hours per day on average versus 3.80 hours per day for urban nursing homes. Rural nursing homes also perform well on other metrics. Rural facilities also perform well on other criteria. A higher percentage of facilities in the most isolated communities (so-called non-core counties) have four and five stars in staffing and survey ratings than metropolitan providers. *Nursing Homes In Rural America: A Chartbook Key Facts About Nursing Home Availability In Rural America*, Rural Policy Research Institute, July 2022. Available at https://rupri.public-health.uiowa.edu/publications/other/Nursing%20Home%20Chartbook.pdf.

degrees – a good match for a rural workforce that skews toward older non-college workers, according to the comments submitted by the Economic Policy Institute.

Indeed, these critics of the NPRM may be conflating rural nursing homes with rural hospitals, which have struggled due to the lack of insurance coverage in many such communities. States like Wyoming, the state with the largest percentage of hospitals experiencing financial losses, is also one of few states that have chosen not to expand Medicaid under the Affordable Care Act.[61] With nursing homes, however, it is rare for there to be concerns with coverage since most residents are covered by Medicare or Medicaid or pay out-of-pocket until they qualify for Medicaid. Hospital closures are just not a good proxy for the impact of this proposed regulation on nursing homes, particularly since the closure of some rural hospitals could make it easier for rural nursing homes to hire RNs and other healthcare workers.[62]

This is not to say that rural access to nursing homes will not change over time. Indeed, nursing homes close every year at a fairly regular pace in both rural and urban markets. A review of data on nursing home closures between 2011- 2021 indicates a small but steady stream of such transactions – between 100 and 200 a year.[63] Since 2019, 17% of the nursing homes in Montana have closed; Maine lost 8% of its facilities during that same period.[64]

Nursing homes close for a variety of reasons. Rural nursing home have been closing for years for financial reasons that have nothing to do with staffing: a fiscal conservativism by makes it unwilling to increase Medicaid reimbursement rates and a preference for home and community based services.[65] Other nursing homes close nursing home companies simply become overextended or because of better investment opportunities in other communities.[66] The influx of private equity has contributed to the closures and consolidation of chain facilities, with firms

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[61] *Confronting Rural America's Health Crisis*, Bipartisan Policy Center, April 2020. Available at https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2020/04/WEB_BPC_Rural-Health-Care-Report.pdf.

[62] Id. The Bipartisan Policy Center report also suggested that the expansion of telehealth used to address some of the gaps in outpatient care in rural areas could free up RNs to work in nursing homes.

[63] Hughes, K., Zhanlian, F., Qinghua, L., Segelman, M., Oliveiera, L., Goldberg Dey, J., *Rates Of Nursing Home Closures Were Relatively Stable Over The Past Decade, But Warrant Continuous Monitoring*. Health Affairs Scholar, Vol.1, Issue 2, August 2023. Available at https://academic.oup.com/healthaffairsscholar/article/1/2/qxad025/7227995.

[64] Author's own calculations based on data from Long Term Care Community Coalition.

[65] Healy, J. *Nursing Homes Are Closing Across Rural America, Scattering Residents*, New York Times, March 4, 2019. Available at https://www.nytimes.com/2019/03/04/us/rural-nursing-homes-closure.html.

[66] Strickler, L. Gosk, S., Hanssen, S., *A Nursing Home Chain Grows Too Fast And Collapses, And Elderly And Disabled Residents Pay The Price*, NBC News. July 19, 2019. Available at https://www.nbcnews.com/health/aging/nursing-home-chain-grows-too-fast-collapses-elderly-disabled-residents-n1025381; *What's Causing Nursing Home Closures?*, Center for Medicare Advocacy, April 4, 2019. Available at https://medicareadvocacy.org/whats-causing-nursing-home-closures/. *See also* Zinn, J., Mor, V., Feng, Z., Intrator, O., *Determinants of Performance Failure in the Nursing Home Industry*, Social Science & Medicine, Vol. 68, Issue 5 Mar 2009. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3692277/ and Spanko, A., *As Genesis Restructures and Leaves NYSE, the Regionalization of Nursing Homes Hits New Milestone*, Skilled Nursing News. March 21, 2021. Available at https://skillednursingnews.com/2021/03/as-genesis-restructures-and-leaves-nyse-the-regionalization-of-nursing-homes-hits-new-milestone/.

typically wanting to exit the sector in three to five years after doubling or quadrupling their investment through staff cutbacks and closures of unprofitable operations.[67]

In many ways, nursing homes in urban areas are more vulnerable to closure than rural facilities. One study of closures between 2011 and 2021 showed that nursing homes in urban locations were more likely to close for reasons that have nothing to do with labor supply: they face competition from other facilities, have a higher percentage of residents of color, and are more likely to be situated in communities with higher poverty rate. These factors made them almost 30% more vulnerable than non-urban facilities.[68] While there are far fewer nursing homes in rural areas, they may be less vulnerable to market pressures that lead to closure.[69]

Some nursing home closures have been the result of state efforts to close poor performing facilities in favor of home and community based care.[70] The facilities that are targeted are often have one or two-star ratings on health inspections and far more deficiencies than average, including multiple deficiencies for actual harm.[71] Other states are simply trying to address overcapacity. Data shows that rural states have more beds per thousand residents than metropolitan areas. A recent article in *Skilled News* that focused on Iowa, is illustrative. The article noted that "25 facilities have closed in the past 18 months." A closer look at the data shows that Iowa had 415 homes for a population of 3.2 million or 7,710 residents per facility. This ratio compares to one facility per 31,519 residents in Florida and 24,583 residents per facility in Texas. It is not surprising that among the 25 facilities that closed in Iowa, occupancy averaged only two-thirds full.[72]

There are nursing home deserts – areas without access to nursing home services – but it is important to see them in context. In 2018, approximately 7% of the 3,142 counties in the US lacked a nursing home. Of those 243 counties, however, only 40 were rural counties that saw a closure during the previous 10 years.[73] Nursing home desserts are significant, but it is a problem

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[67] *How Long Does A Private Equity Group Wait Before Selling Your Company Again?* https://clearridgecapital.com/articles/how-long-does-a-private-equity-group-wait-before-selling-your-company-again/. *Private Equity Industry Overview*, https://www.streetofwalls.com/finance-training-courses/private-equity-training/private-equity-industry-overview/. Rafiei, Y., *When Private Equity Takes Over a Nursing* Home, New Yorker, August 25, 2022. Available at https://www.newyorker.com/news/dispatch/when-private-equity-takes-over-a-nursing-home. *Private Equity Ownership of Nursing Homes Linked to Lower Quality of Care, Higher Medicare Costs*, November, 19, 2021. Available at https://news.weill.cornell.edu/news/2021/11/private-equity-ownership-of-nursing-homes-linked-to-lower-quality-of-care-higher.

[68] Hughes, *supra*, note 63.

[69] It is worth noting that industry complaints of lack of staff may also contribute to the lack of public confidence in nursing homes and the low occupancy rates that cause financial peril for many facilities.

[70] Center for Medicare Advocacy, *supra*, note 66.

[71] Id.

[72] Analysis by The National Consumer Voice for Quality Long Term Care. It is also worth noting that almost all the nursing homes that closed were in towns that had other nursing homes. None of them were in so-called nursing home deserts where residents had no other option. The furthest drive to an existing facility was approximately 20 minutes. Interestingly, of the 25 that closed, eight were part of hospitals, so the closure was likely part of a larger corporate strategy to rationalize its operations. Perhaps most relevant, the 25 closed facilities that closed averaged staffing of almost 4.0 HPRD.

[73] Sharma, H., Batten, R., Ullrich, F., MacKinney, C., Mueller, K., *Trends in Nursing Home Closures in Nonmetropolitan and Metropolitan Counties in the United States*, 2008-2018, Rural Policy Research Institute, February 2021. Available at https://rupri.public-

for a relatively small number of "non-core" communities that have a population of less than 10,000 people. It is important to distinguish these from "micropolitan counties" in non-metropolitan areas.[74] Even then, the impact on the overall Medicaid and Medicare beneficiary pool is even more negligible when one considers that these nursing homes were more likely to have a smaller number of beds and lower occupancy rates – characteristics that made them financially vulnerable to closures in the first place.

Workforce Challenge

As EPI noted in its comments, there is confusion about the potential impact of these staffing standards on the labor market. The proposed rule contains concerns about the feasibility of any staffing requirements, ignoring the fact that a more robust staffing standard and a regime of very limited exemptions will help the Administration achieve its stated policy goal of ensuring that the long-term care workforce is "supported, valued and well-paid." A staffing standard is an opportunity to shape the labor market, not simply be shaped by it.

Agency concerns about feasibility overlook the current state of the labor market. Nursing home employment plummeted during the pandemic as more than 400,000 direct care workers left the sector. While some of those people have returned to work in nursing homes, many have not. As the NPRM notes, employment of direct care staff is approximately 235,000 less than at its peak before the pandemic.[75]

These workers did not vanish. A relatively small share may have died from COVID-19, and some may have retired (the median age of nursing home nursing staff is only 38). But the vast majority of those 235,000 workers are doing other paid work, or they are performing unpaid work at home. They are trained and ready to provide care if compensation and working conditions are more attractive. This NPRM only calls for an additional 89,000 nursing home workers.[76] Even if CMS were to heed our recommendations for a higher staffing standard, the pool of former nursing home workers who left the sector is more than sufficient to cover the demand for new workers.

Any shortage of nursing home staff is by definition a temporary, since most positions require very little training and the barriers to entry are fairly low. According to the NPRM, approximately 85% of the new nursing home jobs created by staffing standards will be for CNAs – workers needing only 75 hours of training. People seeking to be LPNs do not need a college diploma and could join the workforce within a year. New people could be quickly trained to fill these positions if they were seen as desirable jobs.

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health.uiowa.edu/publications/policybriefs/2021/Rural%20NH%20Closure.pdf. See also *Nursing Homes In Rural America: A Chartbook*, *supra*, note 60.

[74] Research & Training Center On Disability In Rural Communities: Defining Rural. See https://www.umt.edu/rural-disability-research/focus-areas/rural_disability/defining-rural.php#:~:text=Noncore%20counties%3A%20Noncore%20counties%20are,most%20rural%20of%20this%20designation.

[75] Paulin, E., *Inside the 'Staffing Apocalypse' Devastating U.S. Nursing Homes*, AARP. June 9, 2022 Available at https://www.aarp.org/caregiving/health/info-2022/labor-shortage-nursing-homes.html.

[76] Medicare and Medicaid Programs, *supra* note 18 at p. 61412 (Tables 23 and 24).

As we have said in earlier comments, there is no worker shortage, just a shortage of well-compensated jobs. A nursing home worker not only attends to the health needs of residents but does so in a way that ensures residents' dignity and sense of self; it is essential and important work that, as the NPRM notes, takes technical and interpersonal skills. But the compensation fails to provide a livable wage for most direct care worker and real wage increases have been modest.

Real Wages for Nursing Occupations in Nursing Homes					
	2019	2020	2021	2022	2023Q1
RN.	$37.14	$34.62	$34.09	$34.37	$38.35
LPN	$27.42	$27.56	$26.99	$24.31	$24.73
NA	$16.56	$17.28	$17.11	$17.77	$18.59

Source: EPI analysis of CPS ORG microdata.

This is why a robust staffing standard is critical to any policy effort to grow the long term care workforce. A minimum staffing standard that reflects where the Administration wants the labor market to be, rather than where it is right now, will force employers to increase wages and improve working conditions – making the work more attractive to people considering a job in the care economy.

Transparency

We applaud CMS for seeking to increase the transparency of Medicaid reimbursement but believe the provisions need to be broadened to provide a fuller and more accurate view of expenditures on staff. Specifically, we recommend that the reporting requirement include staff expenditures as a percentage of all revenues, not just Medicaid payments. Almost all facilities care for Medicare beneficiaries and private-pay residents in an integrated way without distinguishing by payment source. Examining just one revenue stream would allow facilities to manipulate the allocation of expenses in a manner that distorts their actual percentage of spending on staff and the actual deployment of resources. The NPRM, as currently written, would fail to cover initial revenues from the 13% of Medicaid beneficiaries in nursing homes that are dually eligible[77]; it would also exempt a profitable revenue stream and a highly desirable market niche.

Reporting requirements should include the percentage of revenue spent on direct care workers and support staff and median hourly wages for each category of employees. Further, the data should be disaggregated by job duty since wages for different types of direct care workers and support staff are wide-ranging. Just posting broad categorical percentages or median hourly wages for a range of job classifications does not provide transparency regarding how the facility is staffed and how each type of worker is compensated.

[77] Pena, M.T., Mohamed, M., Burns, A., Fuglesten Biniek, J., Ochieng, N. and Chidambaram, P., *A Profile of Medicare-Medicaid Enrollees (Dual Eligibles)*, Kaiser Family Foundation Issue Brief, January 31, 2023. Available at https://www.kff.org/medicare/issue-brief/a-profile-of-medicare-medicaid-enrollees-dual-eligibles/.

We are concerned with the broad scope of workers that would be included in the transparency and reporting requirements. We recommend limiting the term direct care workers to RNs, LPNs, and CNAs providing direct care to residents. These categories of workers provide the most significant amount of direct care to residents and are the primary subject of this NPRM. The definition of "direct care worker" in this section should also mirror the types of workers covered by the HPRD minimum staffing requirement. To have a broader definition here is to invite confusion among the public.

This recommendation to narrow the term direct care worker does not mean spending on other categories of workers listed in § 442.43(a)(2) should not be reported. They should be under a new category of workers called ancillary staff. This category of worker should also include physicians, nurse practitioners, speech and occupational therapists, therapy aides, and pharmacists, who provide direct service to residents but are not counted as direct care staff.

In addition to differentiating direct care workers from other workers listed under § 442.43(a)(2), we strongly recommend that wages reported for these direct care workers should be assessed distinctly based on the job duties. There is a significant wage disparity even among our proposed narrower definition of direct care workers, as noted in the previous chart. Aggregating these would give little insight into the adequacy of wages for each category of direct care workers and may hide a readily apparent reason for staff turnover. Prospective residents should also see how a facility compensates each type of direct care staff at a particular facility.

Nursing homes should be required to detail other expenses, including any payments to related parties. A more robust nurse staffing standard and greater financial transparency are prerequisites for discussing greater nursing home reimbursement.

We agree with National Consumer Voice for Quality Long-Term Care that third-party contracted staff should be included in mandatory reporting requirements. As noted in our comments to the NPRM on nursing home transparency, the ownership structures of these corporate entities have become exceedingly complex to hide interested parties and financial flows. We recommend expanding § 483.71(a)(2)(v) to include "all individuals or entities, providing services under contract, subcontract, or other related agreement, in whole or in part, with an organization or provider that provides goods or services to the facility through contract, subcontract, or other related agreement, in whole or in part. This applies regardless of whether the individual receives a W2 from either the contracted organization or the facility." We understand that this proposed rule does not comment on corporate organizational structures and related party transactions broadly. However, we think this provision should encompass transactions with any party that fits into one of three categories of staff (RN, LPN, and CNA) or is under contract to provide staff in those categories. We hope and expect the NPRM regarding transparency to shed light on the role of private equity and similar entities in the corporate structure of nursing homes, but suggest this language because we realize it may not shed light on the deployment of direct care workers.

Facility Assessments

The AFL-CIO supports the updated facility assessment guidelines in the hopes that this provision becomes a more powerful tool for shaping the quality of care and working conditions in nursing homes.

As other commenters have noted, the success of the facility assessment tool depends currently on state survey agency enforcement. There has been little evidence of compliance or impact on resident care since CMS introduced the facility assessment requirement in 2017. Enforcement data shows that from fiscal year 2021 to fiscal year 2023, there were only 592 violations issued regarding the facility assessment process. Only ten of these were cited at a level where a financial penalty is likely to be imposed.[78]

As the NPRM notes in several places, a minimum staffing standard is not meant to discharge a facility's obligation to staff at higher levels when acuity calls for it. CMS should issue guidance on how facilities should assess acuity and staffing; the guidance should provide an acuity scale for staffing that is easily understood and will enable staff and management at the facility to meet the needs of each resident.

The AFL-CIO commends CMS for including direct care staff and their representatives in the development of and updates to the Facility Assessment provisions. These parties can provide valuable input on the daily needs and activities of residents as well as detailed and realistic information about resident acuity the facility needs to provide quality care. Hospital staffing committees may provide a model for how to structure this input.

It is unclear, however, how CMS will enforce these provisions if there is no organization representing staff. CMS needs to publish guidance on how staff or its bargaining representative can say whether they have been included in this process and whether management has shared sufficient information from resident assessment documents or care plan information for staff to be well-informed.

The draft rule requires that the Facility Assessment be completed at least annually -- more often as needed to address significant changes in resident acuity. We suggest that facility assessments be carried out more often than that – both because nursing home acuity levels change but because it is less likely to always coincide with a visit from surveyors. We also suggest that the assessment include, among other things, a discussion of whether the facility has met the minimum staffing requirement and, if not, a discussion of the reasons. The AFL-CIO suggests that the discussion makes staff shortages on nights and weekends a priority with updated data from the Payroll-Based Journal (PBJ) system to capture night and weekend staffing trends and to better reveal the actual 24-hour staffing levels at homes.

We support a suggestion that the Facility Assessment be required to address behavioral health needs, noting the importance of staff competencies and skill sets in this domain.

The NPRM requires facilities to account for staffing in specific residential units within the building and by specific work shifts and to document and then adjust that assessment of staffing

[78] See comments from the Consumer Voice for Quality Long Term Care.

needs upon significant changes in the resident population. We support this idea but question how and by whom the use and updating of the Facility Assessment will be monitored and enforced. If this and other Facility Assessment provisions are to be overseen by the state survey teams, those survey agencies will need additional funding and training to monitor facilities' actions properly.

Finally, the Facility Assessment should be coordinated with Medicaid Transparency regarding staff categories. The assessment and the reporting on spending must reflect matching identified needs for types and numbers of staff so that once a transparency report is submitted, states can identify needs that were known and reflected in the Facility Assessment and whether the actual spending on staffing addressed those needs for any given year.

Timelines

We understand the need for a reasonable phase-in period to complete the policy process. In addition to the federal guidance that will be needed, there may need to be adjustments in both state and federal Medicaid budgets. The completion of the Administration's nursing home transparency proposal may have an impact on the availability of additional Medicaid resources. A phase-in period may also be useful if representatives of the nursing home industry want to work with representatives of workers to adapt worker training programs that have been developed at the state level for homecare programs and bring them to scale.

This NPRM, however, sets new requirements for a workforce with a relatively short training pipeline. None of the nursing home workers need more than two years of training, and the overwhelming majority take one year or less. Given the existing pool of former nursing home workers, there is no need for a three-year delay unless delay is the goal.

Also, a lengthy phase-in is unnecessary if the staffing standards are finalized with an exemption process. The two parts of the rule are related. The looser the exemption process, the shorter the phase-in should be; the more difficult the exemption process is to navigate successfully, the greater justification there is for a longer phase-in.

Regardless of the length of the phase-in, there is no justification for a distinction between rural and urban facilities, given the similar staffing and performance patterns. To the extent that there are communities (rural or urban) that find it difficult to attract workers, the problem is an economic one that needs to be addressed through policy and community collaboration. It is unlikely to be a problem involving physical infrastructure that needs to be built over many years. In fact, a lengthy phase-in only creates uncertainty that makes corporate planning and the political commitment of resources difficult.

It is important to remember that any phase-in, regardless of length, entails a cost in terms of continued poor care and poor quality jobs. Even a three-year phase-in means that virtually no resident currently in a facility will enjoy improved care from improved staffing. A whole "generation" of residents will be deprived of what we know to be better care at perhaps the most vulnerable time of their lives. A longer phase-in also means the continued flow of disgruntled and burned-out workers leaving the sector – making the implementation of a meaningful staffing requirement that much more difficult.

Conclusion

We commend the Administration for these minimum staffing standards and the broader Presidential initiative to improve nursing home care. These are politically and substantively difficult issues, and the Administration has shown remarkable political courage in seeking to tackle these difficult, decades-old problems.

The staffing standards and the proposed transparency regulations issued earlier this year have the potential to be landmark policy achievements that would help this country handle the demographic realities of an aging population. These rules have the potential to vastly improve the quality of care for a vulnerable population and the working conditions of the people who are responsible for providing so much of that needed care.

At the same time, we strongly believe these regulations need to be significantly strengthened and we hope our suggestions are useful in that regard. We stand ready to work with this Administration and with the industry to quickly finalize and implement a set of staffing standards that will make a difference in the lives of residents and workers. We stand ready to collaborate with all stakeholders to ensure these facilities are fully staffed and fully funded with a well-trained and dedicated workforce.

Thank you for the opportunity to comment on these proposed rules. The staff of the AFL-CIO is available to provide additional input that may be needed.

Sincerely,

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