

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

November 6, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Center for Medicare & Medicaid Services
U.S. Department of Health & Human Services
200 Independence Avenue S.W.
Washington, DC 20201
Submitted electronically via regulations.gov

Re: Medicare and Medicaid Programs: Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting [CMS-3442-P; RIN 0938-AV25], 88 Fed. Reg. 61,352 (September 6, 2023)

Dear Administrator Brooks-LaSure:

Justice in Aging appreciates the opportunity to comment on the Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting proposed rule issued by the Centers for Medicare & Medicaid Services (CMS).

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable healthcare, economic security, and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on populations who have been marginalized and excluded from justice such as older adults of color, older women, LGBTQ+ older adults, older adults with disabilities, and older adults who are immigrants or have limited English proficiency.

Washington, DC



Los Angeles, CA



Oakland, CA

Introduction

Justice in Aging strongly supports the proposed requirement that a nursing facility have at least one registered nurse (RN) on-site 24 hours per day, seven days per week. The current requirement of eight hours per day is inadequate and places residents at risk of harm.

Regarding the overall staffing standards, we thank this Administration and CMS for proposing mandatory minimum staffing levels. The current “sufficient staffing” regulatory language has proven to be ineffective. Minimum staffing standards have been long overdue, and we very much appreciate this proposal to address the problem.

That being said, the proposed staffing levels of 3.0 hours-per-resident-day (HPRD) are too low, despite CMS’s assumption that facilities would employ additional nurses outside the mandated categories of certified nurse aides (CNAs) and registered nurses (RNs). Also, the phase-in period is unduly long, and the proposed regulations would exempt an excessive number of facilities from compliance.

We recommend a minimum standard of 4.2 HPRD, comprised of:

- At least 2.8 HPRD for CNAs;
- At least .75 HPRD for RNs; and
- At least .65 HPRD of additional nursing hours, either RNs or licensed practical nurses (LPNs).

In addition, we urge CMS to adopt a more stringent enforcement system. Without enforcement rules specific to the staffing minimums, too many facilities will be able to short-staff indefinitely, without CMS or the states having adequate leverage to obtain compliance.

We support increased Medicaid transparency regarding direct care wages and thank CMS for those proposals. We also believe, however, that more can and should be done in this area. The current proposals do not go far enough and, as a practical matter, transparency around finances is not usable unless it is comprehensive. With only partial transparency, CMS and the states would be unable to set appropriate Medicaid reimbursement rates or, in general, to truly understand the economics of nursing facilities, Medicare and Medicaid.

Minimum Staffing Standards for Certified Nurse Aides

Countless studies and reports highlight the importance of having well-staffed nursing facilities to protect residents' health and safety. In understaffed facilities, residents experience horrifying pressure ulcers, wounds that became gangrenous, bladder and bowel incontinence due to limited assistance with toileting, falls resulting in multiple fractures, and even death.¹ Even before the COVID-19 pandemic, nursing facility staff experienced high burnout and poor wages, leading to high rates of turnover later exacerbated by the pandemic. The impact of low staffing levels has been particularly felt by residents of color where majority Black or Latino facilities face significantly lower staffing levels than majority white facilities.²

For decades, CMS's requirement for facilities has been that they have "sufficient staff to meet residents' needs."³ But during those decades many thousands of residents have endured substandard care linked to short-staffing, due to the "sufficient" standards being too vague for effective enforcement.

CNAs provide the vast majority of direct care each day to nursing facility residents.⁴ Among many other tasks, CNAs assist residents with activities of daily living such as bathing, eating, dressing, and transferring.⁵ When facilities 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. For all these reasons, adequate CNA staffing is critical to residents' health and well-being.

¹ Christopher Rowland, *Decades of Neglect in Nursing Homes Spur Biden Plan for Staff Mandates*, Wash. Post (Nov. 15, 2022) <https://www.washingtonpost.com/business/2022/11/15/nursing-home-staff-neglect/>; Jayme Fraser et. al., *Dying for Care Many Nursing Homes are Poorly Staffed, How do they Get Away with It?*, USA Today (Dec. 1, 2022) <https://www.usatoday.com/in-depth/news/investigations/2022/12/01/skilled-nursing-facilities-staffing-problems-biden-reforms/8318780001/>.

² Jeff Lowenstein, Center for Public Integrity, *Nursing Homes Serving Minorities Offering Less Care Than Those Housing Whites* (Nov. 17, 2014), <https://publicintegrity.org/health/nursing-homes-serving-minorities-offering-less-care-than-thosehousing-whites/>.

³ 42 C.F.R. § 483.35.

⁴ Stephen Campbell et. al., *Caring for the future: The power and potential of America's direct care workforce*, PHI, (Jan. 12, 2021).

⁵ *Id.*

CMS has proposed a CNA HPRD staffing minimum that would place all residents at risk of harm. CMS relies heavily on the CMS-commissioned 2023 Abt Study in its proposal to establish a 2.45 CNA HPRD.⁶ This reliance is unfortunate because, in selecting the 2.45 HPRD, CMS ignores significant evidence that these staffing levels will result in significant levels of omitted care. The staffing recommendations from the 2023 study notably are *not* based on the foundational federal requirement that all nursing facilities provide “nursing services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident.”⁷ And CMS has justified its proposed staffing level by comparing it to state minimum HPRD requirements, but that is not the proper metric.⁸

Importantly, the 2023 Abt Study cited research that nursing facility residents need at least 2.8 HPRD of CNA care each day to keep omitted care below 10 percent.⁹ Also, the 2023 Abt Study continued to find statistically significant differences in resident safety at CNA staffing levels beyond 2.45 HPRD.¹⁰

Regardless, the 2023 Abt Study offered only four CNA staffing levels to CMS to consider: 2.15 HPRD (Low), 2.25 HPRD (Medium), 2.35 HPRD (Higher), and 2.45 HPRD (Highest). The 2023 Abt Study offered these levels despite finding that three of these levels had no impact on the likelihood of better quality and health outcomes.¹¹ This is too limiting, given other material in the study. Specifically, the 2023 Abt Study could and should have used the 2.45 HPRD as the “Low” recommendation, while the “Medium” should have been 2.62 HPRD and the highest 2.93 HPRD, since these were the only three CNA levels that had documented positive impacts on quality and safety.

Notably, the 2023 Abt Study relied on “The Schnelle Study” from 2016 to measure omitted care. The Schnelle Study found that, based on resident acuity, each nursing facility resident needed 2.8 to 3.6 CNA HPRD to keep omitted care

⁶ 88 Fed. Reg. at 61352.

⁷ 42 U.S.C. § 1395i-3(b)(4)(A)(i).

⁸ 88 Fed. Reg. at 61352, 61363.

⁹ Abt Associates, *Nursing Home Staffing Study: Comprehensive Report* (June 2023) at 76, <https://www.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf> (hereafter “2023 Abt Study”).

¹⁰ *Id.* at 51, 54.

¹¹ *Id.* at xiv, 51 & 54; See also John F. Schnelle et al., *Determining nurse aide staffing requirements to provide care based on resident workload: A discrete event simulation model*, 17 J. Am. Medical Directors Association 970, 970–977 (2016).

below 10 percent.¹² The 2.8 HPRD corresponded to the lowest acuity facilities, or the 5th percentile, while 3.6 HPRD corresponded to highest acuity facilities, or 95th percentile.¹³

Importantly, the Schnelle Study provides an evaluation of 2.45 CNA HPRD, the level proposed by CMS. For lowest acuity homes (5th percentile), omitted care would be at or near 15 percent. As a resident's acuity rises, so does the omitted care. The nursing facilities with average acuity, according to the Schnelle Study, would experience between 20-25 percent omitted care daily at the proposed 2.45 CNA HPRD level.¹⁴

As noted previously, the 2023 Abt Study continues to show a positive relationship between higher CNA staffing levels and safety outcomes beyond the 2.45 HPRD. For instance, there is an increase in the likelihood of positive safety outcomes of 8.4 percent between the 2.45 HPRD and 2.62 HPRD levels. However, the greatest increase in the likelihood of better safety outcomes is from 2.62 HPRD to 2.93 HPRD, with an increase of 16.9 percent.¹⁵

Another CMS-commissioned Abt study dates from 2001. The 2001 Abt Study found that, at a minimum, nursing facility residents require 2.8 CNA HPRD to avoid compromised care.¹⁶ Importantly, the 2.8 CNA HPRD was later confirmed in another study, which showed that nursing facilities that staff over 2.8 CNA HPRD performed better on 13 out of 16 care processes, when compared with lower-staffed nursing facilities.¹⁷ And as CMS notes in the NPRM, this was the level of staffing deemed necessary to meet the “optimal standards” in the federal law.¹⁸

¹² Schnelle, *supra* note 11, at 9.

¹³ 2023 Abt Study at 76.

¹⁴ Schnelle, *supra* note 11.

¹⁵ 2023 Abt Study at 55.

¹⁶ Centers for Medicare & Medicaid Services, Abt Associates Inc. *Appropriateness of Minimum Nurse Staffing Ratios in Nursing facilities. Report to Congress: Phase II Final*. Volumes I–III. Baltimore, MD: CMS, 2001 (hereafter “2001 Abt Study”).

¹⁷ John F. Schnelle et al., *Relationship of Nursing Facility Staffing to Quality of Care*, 39 Health Serv. Res., 225, 225-250 (2004).

¹⁸ 88 Fed. Reg. at 61,359.

This level of staffing was again confirmed in the Schnelle Study in 2016. As discussed above, the Schnelle Study found that, for the lowest acuity homes, 2.8 CNA HPRD was necessary to keep omitted care below 10 percent.¹⁹

We recommend, based on the 2001 Abt Study, the Schnelle Study, and the 2023 Abt Study, a minimum CNA HPRD of 2.8 HPRD. This standard would keep the level of omitted care below 10 percent for the lowest acuity homes, contribute to the reduction of compromised care, and result in the increased likelihood of better quality and safety outcomes.

Staffing by Registered Nurses Around the Clock

Many studies have found a strong relationship between nursing staffing levels and improved quality of care, based both on process and outcome measures.²⁰ In particular, studies have found strong relationships between RN staffing levels and positive quality measures.²¹ Studies have shown that higher nurse staffing levels are associated with improved resident outcomes in each of the following areas:

- reduced incontinence;²²
- reduced urinary tract infections and catheterizations;²³
- reduced incidence of pressure ulcers;²⁴ and
- less incidence of weight loss and/or dehydration.

In addition, higher staffing levels are strongly associated with fewer quality of care deficiencies.²⁵

¹⁹ Schnelle, *supra* note 11.

²⁰ The relationship between registered nurses and nursing home quality: An integrative review (2008-2014). *Nursing Economic\$*, 33 (2):95-108 and 116; Castle, N.G. & Anderson, R.A. (2011).

²¹ Mary Ellen Dellefield et al., *The relationship between registered nurses and nursing home quality: An integrative review (2008-2014)*, 33 *Nursing Economic\$* 95, 95-108, 116 (2015).

²² David A. Dorr et al., *Cost analysis of nursing home registered nurse staffing times*, 53 *J. of Am. Geriatrics Soc'y* 840, 840-845 (2005).

²³ Susan D. Horn et al., *RN staffing time and outcomes of long-stay nursing home residents: pressure ulcers and other adverse outcomes are less likely as RNs spend more time on direct patient care*, 105 *Am. J. Nursing* 58, 58-70 (2005).

²⁴ Dorr, *supra* note 22; Susan D. Horn et al., *supra* note 23; Haizhen Lin, *Revisiting the relationship between nurse staffing and quality of care in nursing homes: An instrumental variables approach*, 37 *J. of Health Economics* 13, 13-24 (2014).

²⁵ Hongsoo Kim et al., *Registered nurse staffing mix and quality of care in nursing homes: A longitudinal analysis*, 49 *Gerontologist* 81, 81-90 (2009).

In a report last year, the National Academy of Sciences, Engineering, and Medicine (NASEM) recommended, at the least, the on-site presence of an RN 24-hours per day, 7 days per week.²⁶ Additionally, NASEM recommended that the number of RNs present be adjusted for acuity and case-mix. This need for an around-the-clock RN presence has also been endorsed by nursing facility providers.²⁷

The NASEM report emphasized that around-the-clock RN coverage should be “direct care” and in addition to the work of the director of nursing (DON).²⁸ We urge CMS to incorporate this requirement into the regulations. The current proposal only requires an RN to be “on site” and “available to provide direct care.”²⁹ The currently proposed language will result in RNs whose only duties are administrative (DONs or Assistant DONs) being counted towards the requirement, but it is not the mere presence of an RN in a facility that results in better outcomes for residents, but the actual provision of direct care by the RN.

Accordingly, we recommend that CMS revise the regulatory language as follows:

Except when waived under paragraph (e) or (f) of this section, the facility must have at least one registered nurse on site providing direct care, 24 hours per day, 7 days a week.

Overall Staffing Minimums

In the proposed regulations, CMS has set standards for CNAs (2.45 HPRD) and RNs (.55 HPRD) totaling to 3.0 HPRD, but with the expectation that facilities hire LPNs and/or additional CNAs and RNs in order to reach sufficient staffing levels. We believe that this reliance on facility discretion shortsighted, since it is the inadequacy of a “sufficiency” standard that has necessitated staffing minimums.

We recommend a minimum standard of 4.2 HPRD, comprised of:

- At least 2.8 HPRD for CNAs;

²⁶ National Academies of Sciences, Engineering, and Medicine, *The National Imperative to Improve Nursing Facility Quality: Honoring Our Commitment to Residents, Families, and Staff*, at 510 (2022).

²⁷ American Health Care Association & Leading Age, *Care for Our Seniors Act Clinical: Enhance the Quality of Care, 24-Hour Registered Nurse*,

<https://www.ahcancal.org/Advocacy/Documents/24-Hour-RN.pdf>

²⁸ NASEM, *supra* note 26.

²⁹ 88 Fed. Reg. at 61,428.

- At least .75 HPRD for RNs; and
- At least .65 HPRD of additional nursing hours, either RNs or licensed practical nurses (LPNs).

This is a minimum requirement necessary to prevent illness or injury to residents. This level of staffing was first supported by the 2001 Abt Study, based on findings that residents' health and safety were compromised below that level.³⁰ Subsequent studies have confirmed those recommendations.³¹

The studies cited above support the need for greater staffing of both nurse aides and nurses, and CMS, by stating its assumption that facilities will provide such “extra” staffing, is implicitly in accord. We urge CMS to convert its assumption into a requirement. The inadequacy of a “sufficient” standard is the reason for a minimum staffing standard and now, over 30 years into the federal nursing facility standards, CMS should not miss this opportunity to set a meaningful overall standard.

Notably, the current CMS numerical proposal ignores LPN staffing. This can be best addressed by adopting a total standard that includes CNAs, RNs and LPNs, and that grants facilities limited discretion to determine how the “extra” HPRD of nursing hours are provided, whether through RNs or LPNs.

Hardship Exemptions

We oppose the hardship exemptions at proposed section 483.35(g) and, if CMS nonetheless implements such exemptions, recommends that they be more limited than in the current proposal. Any exemption should last for no more than one year. During that time, facilities should be required to create a specific staffing plan to move into compliance. Also, the facility should be subject to surveying six months after the exemption is granted.

We question the 20-mile test set forth in subsection (g)(1). The exemption should be based on whether the facility has justification for not being able to meet the staffing standards, and is unclear how the distance from another nursing facility is relevant to that determination.

³⁰ 2001 Abt Study.

³¹ Ann Kolanowski et. al., *A Call to the CMS: Mandate Adequate Professional Nurse Staffing in Nursing Homes*, 121 Am. J. Nurs. 24, 24-27 (2021); Harrington et al., *The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes*, 9 Health Serv. Insights 13, 13-19 (2016).

Regarding good faith efforts to hire, we recommend that facilities be required to offer higher wages. The “prevailing wage” may reflect the historical lack of respect given to nursing facility work. Reversal of that attitude could be an important step to staffing at appropriate levels. Given the opaqueness of nursing facility finances, we recommend that wage rates be based on what is necessary to attract workers, rather than wading at this time into an administrative hornet’s nest of weighing wages against what the facility claims it is able to spend relative to financial resources. We support the requirement that the facility demonstrate its financial commitment, but facilities must be required to offer attractive wages without having those wages dragged down by purported financial limitations.³²

We support the requirement of a facility staffing plan. Since retention is at least as important as recruiting, we support CMS’s intention to require retention plans as well.

In proposed subsection (g)(4), CMS proposes several “exclusions” from the exemptions. We propose that the Special Focus Facility (SFF) exclusion be expanded to include facilities who are SFF candidates, since there is no difference in quality between the 88 SFF facilities and the others who are candidates. The 88-facility limit is an arbitrary distinction between SFF facilities and candidates.

Enforcement

Difficulties in the survey process include flat funding, workforce shortages, and backlogs. This past year, the Senate Aging Committee released a report, “Uninspected and Neglected,” that found state survey agencies to be stretched to the brink. According to the report, 31 state survey agencies have surveyor vacancy rates at 20 percent or higher. One in nine nursing facilities had not undergone an annual inspection in over two years. These shortages are, in part, attributable to flat funding from Congress for survey and enforcement for the past ten years.³³

Staffing violations, however, are not necessarily dependent upon surveying. CMS requires facilities to report staffing levels through the Payment-Based Journal (PBJ) system. As a result, violations of staffing minimums can be determined

³² See 88 Fed. Reg. at 61,381.

³³ Senate Aging Committee, Uninspected and Neglected (2023), <https://www.aging.senate.gov/imo/media/doc/UNINSPECTED%20&%20NEGLECTED%20-%20FINAL%20REPORT.pdf>.

through facility-submitted reports, without the need for surveyors to enter the facility. CMS should take a lead in enforcing the staffing minimums, consistent with its acknowledgment that it has “been moving towards more data-driven enforcement.”³⁴

CMS notes that in 2022 over 1,000 facilities were cited for insufficient staffing.³⁵ According to CMS’s qcor.cms.gov, in fiscal year 2022 there were 1,644 citations for inadequate staffing, but 1,068 (92%) of these violations were found to be “no harm.” CMS should treat violations of the mandatory minimums as prima facie documentation of harm, consistent with the studies that show that short staffing at certain levels harms residents.

Facility Assessments

We support and thank CMS for the updated facility assessment standards, but note that their success depends significantly on enforcement. Since CMS first introduced the facility assessment requirement in 2017, there has been little evidence that facilities are complying with the regulation or that it has had any impact on resident care. 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.

We support inclusion of direct care staff in development of and updates to the facility assessment provisions. These staff could provide valuable input on the day-to-day needs and activities of residents as well as detailed and realistic information about the staff needed to address those needs.

Proposed section 483.71(a)(1)(ii) would require the facility assessment to be consistent with and informed by resident assessments on functional needs, types of diseases, conditions, physical and behavioral health issues, cognitive disabilities, overall acuity, and other pertinent factors. While we support this consistency of information as a good step toward identifying clinical needs and the resources to meet those needs, we note that the requirement is framed completely around resident needs and deficits. The facility assessment should also include a staffing plan that allows for consideration of residents as whole persons, consistent with the philosophy of resident-centered care..

³⁴ 88 Fed. Reg. at 61,367.

³⁵ 88 Fed. Reg. at 61,368.

We support the requirement that the facility assessment be completed at least annually, or more often as needed to address significant changes in resident acuity and needs and the staff capabilities needed to address those needs. We also support the requirement that a facility assessment address behavioral health needs. In addition, we recommend that the requirements be revised to ensure that these requirements will be honored, by enabling enforcement.

In addition, we support the focus on addressing staff shortages on nights and weekends in proposed section 483.71(b)(1). In accord, we recommend that CMS revise the PBJ system to capture night and weekend staffing trends and to better reveal the true 24-hour staffing levels at homes.

We support proposed section 483.71(b)(2), (3), which 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 needs upon significant changes in the resident population. We again emphasize that enforcement will be necessary to ensure that facilities comply with these requirements.

Also, we support proposed section 483.71(b)(4), (5), which links staffing recruitment and retention strategies as well as staffing contingency planning, below the level of emergency planning, to the Facility Assessment. We encourage CMS to consider not only the requirement but how it would be enforced.

Finally, we recommend that the facility assessment be coordinated with Medicaid transparency reporting on categories and levels of staffing. 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 are able to 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.

Transparency and Reporting

We support the proposed regulations' efforts to improve payment transparency. We are concerned, however, that the proposal may fall short, by failing to address private equity ownership and related party transactions. CMS states that it will not comment on private equity and the resulting corporate organizational

structures and related party transactions, and instead will focus on data collection and transparency related to compensation of nursing home staff.

Unfortunately, nursing facilities' ownership structures have become an essential element in nursing facility finances. Private equity firms create complicated ownership structures to avoid transparency and accountability. It is common for private equity firms to report minimal revenue on cost reports, all while funneling millions of taxpayer dollars back to facility owners and operators through related party transactions.³⁶ These funds are being diverted away from resident care and nursing staff compensation.

In its March 2023 report, the Medicaid and CHIP Payment and Access Commission (MACPAC) noted that “states should consider the costs of staffing facilities at appropriate levels to meet residents’ care needs and the potential for transactions with related parties in the same nursing facility chain to inflate costs reported on state cost reports.”³⁷ MACPAC’s recommendations thus included the need for comprehensive data on nursing facility financing and ownership to compare Medicaid payments to the costs of related party transactions and real estate ownership. We recommend that CMS incorporate private equity ownership and related party transactions into the final regulations to accurately determine nursing facility expenditures that could be spent on staffing.

Another concern is that the proposed reporting requirements only apply to Medicaid spending. We strongly recommend that CMS extend these requirements to Medicare expenditures as well. Medicare is the second largest payor for nursing facility residents, spending about \$28.5 billion on nursing facility

³⁶ The National Consumer Voice for Quality Long-Term Care, *Where Do the Billions of Dollars Go? A Look at Nursing Home Related Party Transactions* (2023), <https://theconsumervoice.org/uploads/files/issues/2023-Related-Party-Report.pdf>; Jordan Rau, *Care Suffers as More Nursing Homes Feed Money into Corporate Webs*, KFF Health News (Dec. 31, 2017), <https://kffhealthnews.org/news/care-suffers-as-more-nursing-homes-feed-money-into-corporate-webs/>; Bill Hammond, Empire Center, *Following the Money An Analysis of ‘Related Company’ Transactions in New York’s Nursing Home Industry* (July 5, 2022), <https://www.empirecenter.org/publications/following-the-money-2/>.

³⁷ Medicaid and CHIP Payment and Access Commission, *Chapter 2: Principles for Assessing Medicaid Nursing Facility Payment Policies*, (March 2023), <https://www.macpac.gov/wp-content/uploads/2023/03/Chapter-2-Principles-for-Assessing-Medicaid-Nursing-Facility-Payment-Policies.pdf>.

care in 2021.³⁸ Yet reliable information on facilities' Medicare spending is difficult to access under current cost reports. These cost reports may be incomplete or inaccurate, since the report is not tied to reimbursement rates, thus giving facilities little incentive to complete them comprehensively.³⁹ Additionally, facilities can easily manipulate cost reports to conceal profits, shielding even more funds from direct resident care.⁴⁰ Standardized reporting requirements for both Medicaid and Medicare would be crucial to establishing true transparency, and CMS has such authority to require reporting on Medicare expenditures for staff compensation under Section 6104 of the Affordable Care Act.⁴¹ Thus, we recommend CMS implement the disclosure and reporting requirement of Section 6104 to both Medicaid and Medicare expenditures.

We offer the following detailed comments on specific provisions related to transparency:

Proposed Section 442.43(a)(1): Definition of compensation

We support requirements for states to report on compensation for direct care workers and support staff. Poor compensation is one of the most cited reasons for high turnover among nursing facility staff, and in particular workers providing direct care.⁴² We support the definition of compensation at proposed section 442.43(a)(1) to include salaries, wages, benefits like health insurance and sick leave, and the share of the employer's payroll taxes for direct care workers and support staff.

Proposed Section 442.43(a)(2): Definition of Direct Care Worker

We are concerned with the broad scope of workers that would be captured in the transparency and reporting requirements under proposed section

³⁸ Medicare Payment Advisory Commission, *Skilled Nursing Facility Services Payment System*, (Oct. 2023) https://www.medpac.gov/wp-content/uploads/2022/10/MedPAC_Payment_Basics_23_SNF_FINAL_SEC.pdf.

³⁹ Government Accountability Office, Report to Congress, *Skilled Nursing Facilities CMS should Improve Accessibility and Reliability of Expenditure Data*, (Sept. 2016), <https://www.gao.gov/assets/gao-16-700.pdf>.

⁴⁰ Charlene Harrington *et al.*, *Hidden owners, hidden profits and poor nursing home care: A case study*, 45 *Int. J. Health Serv.*, 779, 779-800 (2015).

⁴¹ Patient Protection and Affordable Care Act (ACA) (Pub. L. 11-148).

⁴² Hari Sharma & Lili Xu, *Association Between Wages and Nursing Staff Turnover in Iowa Nursing Homes*, 6 *Innovation in Aging* 1, 1-9 (2022).

442.43(a)(2). Accordingly, we recommend limiting the definition of direct care workers to an RN, LPN, CNA, Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS). These categories of workers provide a significant amount of direct care to residents and are the primary subject for establishing minimum staffing levels in this proposed rule. All other staff members listed in proposed section 442.43(a)(2) should be reported as ancillary service staff to maintain consistency with Medicare cost reports.

In addition to differentiating direct care workers from ancillary service staff, we strongly recommend that wages reported for these direct care workers are assessed distinctly based on the job duties. There is a significant wage disparity even among our proposed narrower definition of direct care workers. For example, as noted in the NPRM, RNs in nursing facilities an average \$37.11 per hourly wage while CNAs average \$16.90.⁴³ Aggregating these amounts would not provide much transparency since it could over-inflate the percentage of Medicaid expenditures spent on lower-paid direct care workers like CNAs, who incidentally face particularly high turnover rates mostly due to poor compensation.⁴⁴ Disaggregating the reported data by specific job duties would provide meaningful transparency for nursing facility staff across socioeconomic statuses.

We support the inclusion of third-party contracted staff in mandatory reporting requirements in order to achieve better transparency. However, nursing facility ownership structures have gotten extremely complicated. As noted in comments earlier on nursing facility ownership, organizations can engage with facilities in a variety of ways including complicated related-party transactions.⁴⁵ Thus, we recommend expanded this definition to include:

⁴³ United States Bureau of Labor Statistics, *May 2022 National Industry-Specific Occupational Employment and Wage Estimates, NAICS 623100-Nursing Care Facilities (Skilled Nursing Facilities)*, available at https://www.bls.gov/oes/current/naics4_623100.htm#29-0000.

⁴⁴ The National Consumer Voice for Quality Long-Term Care, *High Staff Turnover: A Job Quality Crisis in Nursing Homes*, (Sept 8, 2022) https://theconsumervoice.org/uploads/files/issues/High_Staff_Turnover-A_Job_Quality_Crisis_in_Nursing_Homes.pdf.

⁴⁵ Justice in Aging, *Comment Letter on Disclosures of Ownership and Additional Disclosable Parties Information for Skilled Nursing Facilities and Nursing Facilities* (April 14, 2023) <https://justiceinaging.org/wp-content/uploads/2023/04/Justice-in-Aging-Comments-on-Disclosures-of-Ownership-for-Nursing-Facilities-.pdf>; The National Consumer Voice for Quality Long-Term Care, *Comment Letter on Disclosures of Ownership and Additional Disclosable*

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 includes direct care workers, ancillary services staff, and support staff providing goods or services to the facility under a contract, subcontract, or other related agreement, in-whole or in-part, and regardless if the individual receives a W2 from either the contracted organization or the facility.

We recommend keeping the terminology “direct care workers” for the categories of nurses, nurse practitioners, and certified nurse aides identified above. We also recommend including workers who support a resident’s ability to transition from the facility into the reporting requirements only if they are in a separate category from direct care workers. These workers are providing important services to improve the residents’ health, safety, and autonomy, but the job duties vary much more broadly than in the case of the direct care workers identified above.

Proposed Section 442.43(a)(3): Definition of Support Staff

We support the broad definition of support staff stated in the proposed rule. However, reporting for support staff compensation should not be included with direct care workers like RNs, LPNs, NPs, and CNAs, or ancillary service staff. All reporting requirements for these groups of workers should be distinct and disaggregated based on job duty. Further, we support fewer exceptions since that will make it the easier to assess total compensation for staff. For this reason, including security guards as support staff would be beneficial to maintain uniformity.

Finally, we recommend inclusion of Medicare data. As previously stated, by limiting the reporting requirements just to Medicaid expenditures, facilities are able to obscure Medicare dollars from any meaningful direct care spending requirements. We strongly urge CMS to expand this rule, not just to include more categories of workers, but to also include Medicare, to accurately assess

Parties Information for Skilled Nursing Facilities and Nursing Facilities (April 14, 2023)
<https://theconsumervoive.org/uploads/files/issues/6101-Comments-CV.pdf>.

the percentage of facilities' spending directed to workers providing crucial care to residents.

Proposed Section 442.43(b): Reporting Requirements for Base and Supplemental Payments

We strongly recommend that reporting requirements apply both to base and supplemental payments as one report. This would provide the most accurate assessment of how much facilities are spending on nursing facility staff. Payment rates do not fluctuate drastically year-to-year without changes to the state plan. Therefore, including both payments would not be burdensome and would provide greater clarity on nursing facilities' expenditures. We also support requiring reporting at least annually for both Fee-For-Service (FFS) and managed care delivery systems to better observe trends in worker compensation across facilities.

Proposed Section 442.43(b)(1) Exempting Swing Bed Hospitals from Reporting Requirements

We support the exemption for swing bed hospitals from the reporting in this proposed rule. Swing bed hospitals utilize different accounting systems for their expenditures and thus should not be included in nursing facility reporting.

Proposed Section 442.43(b)(2): Exclusions from Medicaid Payment Reporting

As stated above, facility finances are not solely dependent upon Medicaid. Unless reporting requirements extend to other payors, there is no transparency as to whether Medicare dollars are being spent on workers providing direct care to residents.

We also recommend including beneficiary expenses, like Medicaid cost sharing, in the reporting requirements. These are Medicaid-affiliated expenses that go towards the resident's care and should be counted.

We also support no exclusion for providers with low Medicaid revenues as this could disincentivize providers from taking Medicaid beneficiaries. This could be especially problematic for facilities with distinct part certification, where they could limit the number of beds in the facility to below a particular threshold to avoid these reporting requirements.

Proposed Section 442.43(c)(1): Reporting at Facility Level and Staff Median Hourly Wages

We strongly support facility level reporting of compensation for direct care workers, ancillary service staff, and support staff. Staffing levels and compensation vary significantly across facilities, even within the same geographic location, and thus require individual reporting to assess adequate compensation across facilities. We also support additional median hourly compensation data in addition to the percentage of Medicaid spending going to direct care workers, ancillary service staff, and support staff. The percentage provides useful information for accountability purposes to ensure a significant portion of Medicaid funds are going towards nursing facility staff. However, it does not provide any insight as to whether staff are receiving appropriate and competitive pay for their work. Hourly earnings, coupled with the reported percentages, provides significant better context on staff compensation. Hourly wage reporting would also help determine if a particular facility's staffing difficulties are related to poor compensation. Similar to the discussion above, median hourly wages should be disaggregated by job duty and not just the categories identified in the NPRM, to better differentiate between higher and lower paid workers within each category.

Proposed Section 442.43(c)(2): Proposed Methodology for Reporting Payments

We recommend that at a minimum, the data reported is disaggregated so it can be analyzed more accurately based on each specific job duty. Furthermore, we also recommend reporting both median wages and the range of wages that is offered for new staff. This would provide greater clarity into whether facilities are underpaying new hires, which suggests an insincere effort to add or recruit staff. Any proposed methodology should ensure that reporting is provided in a standardized format across states, as recommended by MACPAC.⁴⁶

We support making per diem rates for FFS delivery systems public. The reported per diem rates should be based on a statewide average, and include both base and supplemental payments to increase transparency and provide a complete picture of Medicaid spending. Relatedly, we strongly recommend requiring managed care delivery systems to report contracted rates for facilities. Limiting reporting requirements just to FFS does not provide accurate transparency, particularly as the prevalence of managed care systems continues to increase.

⁴⁶ MACPAC, *supra* note 37.

We support requiring a minimum percentage of all Medicaid and Medicare expenditures to be spent on direct care workers, ancillary service staff, and support staff. Several reports, including the recent MACPAC report, show that facilities are adept at maximizing profits by cutting essential resident services like quality staff and engaging in complex corporate structures, including related party transactions.⁴⁷ In order to be proper stewards of funds, CMS should ensure expenditures are going directly towards resident care. Therefore, a minimum percentage threshold, coupled with other transparency mechanisms available under Section 6101 of the Affordable Care Act is an appropriate starting point to guarantee proper use of public funds.⁴⁸

Proposed Section 442.43(d): Website Reporting

We support the accessibility requirements in proposed section 442.43(d). In addition to the requirements in 42 CFR § 435.905(b), we also propose that the website include the contact information for a designated individual within the state Medicaid agency responsible for nursing facility oversight who is available to address any accessibility concerns.

We also recommend that the state operate one website with all the data and information related to reporting requirements. This would make accessing data much easier and more accurate than having external links to various managed care websites. We strongly support at least a quarterly review with an added requirement that missing or inaccurate information is remedied within two weeks of the review. Delayed reviews can lead to publication of misrepresented data which contradicts these efforts for increased transparency. Further, if the period for review is too long, it increases the likelihood that more facilities and managed care plans will have inaccurate information which will take longer to correct.

We also support proposed section 442.43(d)(4) requiring prominent language that additional assistance is available at no cost, with clear instructions for requesting assistance or additional accommodations. We suggest the website also

⁴⁷ *Id.*

⁴⁸ See Justice in Aging, *Comment Letter on Disclosures of Ownership and Additional Disclosable Parties Information for Skilled Nursing Facilities and Nursing Facilities* (April 14, 2023) <https://justiceinaging.org/wp-content/uploads/2023/04/Justice-in-Aging-Comments-on-Disclosures-of-Ownership-for-Nursing-Facilities-.pdf>.

include the contact information for the state Medicaid agency responsible for nursing facility oversight.

Proposed Section 442.43(f): Timeline for Implementation and Interested Parties Advisory Group

We recommend three years to implement the reporting requirements for FFS and managed care delivery systems. Most of the data for these reporting requirements like hourly compensation and base or supplemental Medicaid payments are easily available to facilities and state Medicaid agencies. Given the importance of these transparency reporting requirements, an expeditious implementation period is necessary to prevent further harm due to insufficient staffing and misapplication of public funds. We also support the establishment of an interested parties' advisory group to consult on nursing facility and ICF rates to better gain stakeholder perspectives in rate setting.

Conclusion

We appreciate the opportunity to comment. We again thank the Administration and CMS for adopting minimum staffing standards and addressing the ongoing quality of care problems in nursing facilities.

Sincerely,

A handwritten signature in black ink, appearing to read 'Eric M. Carlson', written in a cursive style.

Eric M. Carlson

Attorney and Director of Advocacy for Long-Term Services and Supports