



November 6, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Submitted electronically to <http://www.regulations.gov>

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

Dear Administrator Brooks-LaSure:

AARP, which advocates for the more than 100 million Americans age 50 and over, appreciates the opportunity to comment on this important proposed rule that is vital to the health, safety, and well-being of nursing home residents. This proposal is also important to the family caregivers who often assist with their loved ones' care and advocate on their behalf. AARP commends the Centers for Medicare & Medicaid Services (CMS) for undertaking the challenging task of establishing required minimum staffing levels for nursing homes, as staffing impacts quality of care. Any final rule should preserve important provisions in the proposed rule and also include certain improvements to strengthen it to ensure the highest quality care for residents.

AARP strongly supports a federal minimum staffing standard that requires America's nursing homes to have enough staff to provide the hands-on care our most vulnerable seniors need. It is shameful that nursing homes that receive taxpayer dollars, through mainly Medicaid but also Medicare, are not required to ensure quality care through minimum staffing standards. For America's nursing home residents, inadequate staffing in nursing homes can have dangerous—even deadly—consequences. Standards to ensure nursing homes are adequately staffed will help give family caregivers peace of mind, knowing their loved ones are getting the quality of care they deserve. It is long overdue that federal minimum staffing standards be added a condition of participation to operate and continue to operate under the Medicare and Medicaid programs. Such federal standards should be sufficient from an evidence-based perspective to support resident health and safety. Given its importance to health and safety, any exemptions to minimum federal standards should be narrow and limited in scope, designed in a manner to truly be an exception and not simply a loophole that can be abused to avoid staffing requirements. AARP strongly supports the proposed requirement to ensure a registered nurse (RN) is onsite in nursing

homes 24 hours a day, 7 days per week. It is important to clarify, however, that the RN onsite is providing direct resident care. We also support full transparency around Medicaid and Medicare payments and improving facility assessments.

While not part of the proposed rule itself, we appreciate the commitment of \$75 million in new federal funds to support staffing in nursing homes, including scholarships and tuition reimbursement for staff. We encourage the Administration to use its authority across agencies and departments to help support the recruitment and retention of direct care staff in nursing homes, including those in rural and underserved areas. Nursing homes lead with the word “nursing” in their nomenclature because they rely on RNs and direct care nursing teams to provide quality and safe care to their residents. Without an adequate number of qualified nursing staff, including licensed practical nurses/licensed vocational nurses (LPNs/LVNs), and certified nursing assistants (CNAs) led by an onsite RN around the clock, safe care is not possible.

AARP has heard from thousands of our members who have loved ones that have been impacted by inadequate staffing in nursing homes. Joyce in Virginia, whose husband was in a nursing home, noted that she rang for help multiple times due to her husband’s health condition and sometimes no staff responded. She shares, “No facility should be allowed to be so poorly staffed that a patient like my husband was so completely unserved in his hour of need.” We also heard from Laurie in Virginia who cared for her mother who lived in a nursing home. She noted that her mother “would have to lay in her urine-soaked sheets on her bed or her urine-soaked pants” sitting and waiting for assistance. Laurie elaborates “Many times, I had to beg a nurse or med tech to help a CNA so that my mother could be moved or changed. However, a nurse or med tech would tell me that they were busy with other residents and that they did not have time to help my mother. It was a very painful situation day in and day out. I visited my mother daily, and I was always stressed out wondering if there would be enough help for my mother...Lack of staff is the number one issue in nursing homes today. Residents are not getting the level of care they need due [to] poor staffing and are suffering greatly.” These experiences help illustrate the importance of establishing a federal minimum direct care nursing staffing standard.

We also note that over \$80 billion in taxpayer dollars through Medicare and Medicaid are paid to nursing homes annually to provide quality care, including having sufficient staff to provide such care.¹ Taxpayers and consumers paying for this care deserve to know that this money is going to where it is supposed to go.

We offer the following specific comments on the proposed rule. In general, references to nursing homes in this letter apply to skilled nursing facilities in Medicare and nursing facilities in Medicaid, unless otherwise noted.

¹ Medicare Payment Advisory Commission. March 2023 Report to the Congress: Medicare Payment Policy, Chapter 7. Murray, Caitlin, Michelle Eckstein, Debra Lipson, and Andrea Wysocki. “Medicaid Long Term Services and Supports Annual Expenditures Report: Federal Fiscal Year 2020.” Chicago, IL: Mathematica, June 9, 2023.

Setting a Minimum Standard

The COVID-19 pandemic shined a bright light on existing problems and the importance of both an adequately trained staff and a sufficient number of staff in nursing homes. Higher nurse staffing “improves both the process and outcome measures of nursing home quality.”² RNs have a particularly positive impact, but total nursing staff including LPNs/LVNs and CNAs “is also important.”³ Research consistently shows that higher RN staffing levels are associated with better resident care quality across multiple dimensions of care including fewer pressure ulcers; lower restraint use; decreased infections; lower pain; improved activities of daily living (ADLs) independence; less weight loss, dehydration, and insufficient morning care; less improper and overuse of antipsychotics; and lower mortality rates. A strong relationship exists “between higher nurse staffing levels in nursing homes and reduced emergency room use and rehospitalizations from nursing homes. The strongest relationships are found between higher nurse staffing levels and lower deficiencies...for poor quality care issued by state surveyors.”⁴ We also observe that one study found nursing homes with higher RN staffing are strongly associated with fewer COVID-19 related deaths.⁵

Every nursing home resident should be able to receive high quality care that allows them to live with the dignity and quality of life they deserve. Establishing a federal minimum staffing requirement will help ensure there is adequate staff to care for those living in nursing homes. To that end, evidence-based staffing thresholds are needed at the levels determined necessary to ensure adequate care.

Under the proposed rule, nursing homes are required to treat the minimum staffing standard as the floor for required staffing amounts. AARP believes that the actual level of staffing above this minimum should be crafted based on factors including: 1) person-centered service plans designed to meet residents’ assessed needs and identified preferences, 2) the overall characteristics of the nursing home’s population, physical plant, and other unique features, 3) the facility’s assessment under Section 483.71, and 4) the need for readiness to also address unscheduled needs (for residents or the facility) that arise. Staffing above the minimum standards based on such factors is critical so each resident can attain or maintain their highest practicable physical, mental, and psychosocial well-being. We appreciate CMS’s attention in this proposed rule to distinguishing between minimum standards and requirements for nursing homes to staff above such standards to meet resident needs. We urge that such provisions continue to be included in any final rule.

Inclusion of LPNs/LVNs in the Proposal

CMS proposes a minimum standard of 0.55 RN hours per resident day (HPRD) and 2.45 nurse aide (NA) HPRD. We support and appreciate that CMS proposed setting separate specific minimum staffing levels for RNs and nurse aides, though we encourage consideration of the

² Harrington C, Dellefield M, Halifax E, et al., *Appropriate Nurse Staffing Levels for U.S. Nursing Homes*, Health Services Insight. Vol. 13:1-14

³ Ibid.

⁴ Ibid.

⁵ Li Y, Temkin-Greener H, Shan G, Cai X. COVID-19 Infections and Deaths among Connecticut Nursing Home Residents: Facility Correlates. *J Am Geriatr Soc*. 2020 Sep;68(9):1899-1906. doi: 10.1111/jgs.16689. Epub 2020 Jul 21. PMID: 32557542; PMCID: PMC7323378.

term “certified nurse aide” instead of “nurse aide”. We note, however, that CMS does not include LPNs/LVNs in the proposed minimum staffing standards. RN, LPNs/LVNs, and certified nurse aides are all important members of the nursing care team in nursing homes. All members of the team provide different levels of care that residents need. We urge CMS to recognize and include the role of LPNs/LVNs in the final rule establishing minimum nursing home staffing standards. This could be done by establishing a minimum licensed nursing standard (HPRD) that includes a specific RN HPRD minimum with the difference made up of LPN/LVN or RN time as determined by the individual nursing home. This would give a nursing home some staffing flexibility. Another option would be to set separate specific RN and LPN/LVN minimum staffing requirements. Regardless, we believe the final rule should include RNs, LPNs/LVNs, and CNAs in the minimum nursing care staffing standard.

Feedback on a Total Nurse Staffing Standard

CMS requests feedback on 1) whether there should be a minimum total nurse staffing standard and, if so, 2) what the total minimum direct care staffing standard should be. AARP supports the creation of a minimum total direct care nurse staffing standard that includes a minimum RN HPRD, a minimum CNA HPRD, and incorporates LPNs/LVNs whether as part of a minimum licensed nursing standard that includes a minimum RN HPRD or as a separate minimum LPN/LVN HPRD. We note that the 2001 staffing study commissioned by CMS included 4.1 total nursing HPRD comprised of 1.3 total licensed nursing staff HPRD (RNs and LPNs combined), 0.75 RN HPRD, and 2.8 NA HPRD.⁶ Research since and expert opinions have also been supportive.⁷ We encourage CMS to consider an increase more in line with the 2001 staffing study, which included 0.75 RN HPRD and the 2.8 NA HPRD. A 2016 simulation study found that the nurse aide staffing required for activities of daily living care that would result in a rate of care omissions below 10 percent ranged from 2.8 HPRD for nursing homes with a low workload (5th percentile) to 3.6 hours HPRD for nursing homes with a high workload (95th percentile).⁸ AARP also notes that nursing home resident acuity has increased since 2001. Residents can also have unplanned, unscheduled needs.

The Nursing Home Staffing Study recently released finds that “Simulation models indicate the percentage of clinical care either delayed or omitted decreases with greater licensed nurse (RN and LPN) staffing levels, falling below 10 percent at approximately 1.0 hour per resident day (HPRD) and approaching zero at approximately 1.4 HPRD. In combination with previous findings from the literature...this implies that a total nurse (RN, LPN, nurse aide) staffing level

⁶ Centers for Medicare & Medicaid Services (CMS). Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes Phase II Final Report. Baltimore, MD: CMS; 2001.

⁷ Harrington, C., Schnelle, J.F., McGregor, M., Simmons, S.F. The need for minimum staffing standards in nursing homes. *Health Serv Insights*. 2016; 9:13-19. American Nurses Association and Nursing Staffing Requirements to Meet the Demands of Today's Long Term Care Consumer Recommendations from the Coalition of Geriatric Nursing Organizations (CGNO); <https://www.nursingworld.org/globalassets/docs/ana/cgno-nurse-staffing-position-statement-2014--ana-endorsed-11-12-2014-.pdf> and <https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/id/nursing-staffing-requirements-to-meet-the-demands-of-todays-long-term-care-consumer/>. AARP Florida. A Comprehensive Snapshot of Nursing Home Staffing in Florida. <https://aarp-states.brightspotcdn.com/69/46/1219058b42da8dd93b6f933102e5/a-comprehensive-snapshot-of-nursing-home-staffing-in-florida-2023.pdf>

⁸ Schnelle, J.F., Schroyer, L.D., Saraf, A.A., and Simmons, S.F. (2016). Determining nurse aide staffing requirements to provide care based on resident workload: A discrete event simulation model. *J. American Medical Directors Association*. 17:970-977.

between 3.8 HPRD and 4.6 HPRD would be adequate to keep rates of both omitted activities of daily living care and omitted clinical care below 10 percent.”⁹

Importantly, we note that to operationalize minimum direct care nursing staffing standards and possibly other requirements, direct care staffing should be precisely defined to mean RNs, LPN/LVNs, and certified NAs only. No other staff or clinicians should be permitted to be counted in the calculus of whether the total minimum direct care staffing standard has been met. We also believe that the time counted toward the minimum HPRD staffing requirement should be hands-on direct care, as provided by RNs, LPNs/LVNs, and CNAs, not other medical, podiatry, physical or occupational therapy, administrative, activities, meal-prep, janitorial, social worker time, or any other non-hands-on direct resident care. It is not that these other types of services are not important for residents based on their needs and preferences, it is that we think a minimum direct care staffing standard should focus on RNs, LPNs/LVNs, and CNAs. While we recognize important administrative work is part of the jobs of directors of nursing, RNs or advanced practice registered nurses, we believe that CMS should separate administrative work performed by such nurses from hands-on direct care provided by nurses and that this administrative time should not be included in the HPRD total requirements.

Finally, CMS should include easy-to-understand information about whether a nursing home meets the minimum federal nursing care staffing standards on Care Compare for nursing homes. This would provide important information for individuals and their families who are selecting a nursing home. Information for nursing home residents and their families is also essential. Nursing home residents, their representatives, and their families should also be notified if a nursing home is not meeting minimum staffing standards. We will address this further under exemptions.

Disparities in Staffing Levels

From a health equity perspective, we urge CMS to consider the longstanding, systemic disparities in quality of care in nursing homes, including staffing levels. According to a 2021 study, Black/African American individuals are more likely to be admitted to nursing homes with lower nurse staffing ratios.¹⁰ A separate study found that Black residents were .77 times as likely to be in nursing homes with the highest ratio of RNs to all nursing staff, and 1.12 times more likely to be in a nursing home that was greatly understaffed relative to the nursing home’s residents’ needs/acuity.¹¹

In addition, the recently released AARP LTSS State Scorecard found that residents of the nursing facilities with the most Black and Hispanic resident admissions received between 150-200 fewer hours of nursing care compared to residents of nursing facilities with the highest percent of white resident admissions. We note the importance of ensuring minimum standards that not only meet residents’ needs and preferences but are wholly and equitably enforced. They should mitigate and redress longstanding biases in the delivery of nursing home care.

⁹ Abt Associates. Nursing Home Staffing Study. June, 2023. <https://edit.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf>

¹⁰ Gorges RJ, Konetzka RT, (2021) *Factors Associated With Racial Differences in Deaths Among Nursing Home Residents With COVID-19 Infection in the US*

¹¹ Smith DB, Feng Z, Fennell ML, Zinn JS, Mor V, (2007) *Separate and Unequal: Racial Segregation And Disparities In Quality Across U.S. Nursing Home*, Health Affairs

Retaining and Strengthening the 24/7 Onsite RN Requirement

AARP applauds the inclusion of an onsite RN 24 hours/day, 7 days/week requirement for nursing homes. Multiple Institute of Medicine reports have called for around-the-clock RN care.¹² Most recently, the 2022 National Academies of Sciences, Engineering, and Medicine report, *The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Families, and Staff*, also recommended that CMS enhance staffing requirements for every nursing home to include “...On-site direct-care registered nurse (RN) coverage (in addition to the director of nursing) at a minimum of a 24-hour, 7-days-per-week basis with additional RN coverage that reflects resident census, acuity, case mix, and the professional nursing needs for residents as determined by the residents’ assessments and care plans.”¹³ As drafted, however, the proposed rule would only require this RN to be available to provide direct care. It would not require the RN to be onsite for the purpose of providing direct care to residents. This construction would permit an administrator with an RN credential to satisfy this requirement, even if they are not actually providing direct care. We note that it is important for the RN to be both onsite and providing direct care to residents, not through telehealth.

AARP urges CMS to retain the 24/7 onsite RN requirement in the final rule and make clear in the regulatory text that the 24/7 onsite RN must be available at all times for the purpose of providing direct resident care. AARP also notes that the preamble states that meeting the 24/7 onsite RN requirement does not also count as meeting the proposed 0.55 RN HPRD and 2.45 NA HPRD proposed requirement and vice versa. AARP supports this and encourages CMS to also make this clear in the regulatory text.

Facility and Resident Assessments Should Yield Measurable and Enforceable Results

AARP applauds CMS for clearly articulating that the HPRD minimums and 24/7 RN requirement are a floor for direct care staffing in a nursing home. Even once the HPRD minimums are set, it is still imperative that the actual staffing for each given facility (above this required minimum staffing floor) be based on the facility and resident assessments. We appreciate and support CMS’ efforts to improve the current facility assessment provisions in the proposed rule. We are concerned, though, as to how this requirement can be enforceable without uniform methods to review assessments and metrics to track how implementation of data gathered from the assessments are converted into additional time or enhanced type of required direct care staffing. To this end, however, we make the following recommendations:

- 1) Building on proposed language, CMS should include language in the regulatory text noting that actual staffing levels in each facility for licensed nurses (RNs and LPNs/LVNs) and CNAs shall be set to meet or exceed the minimum levels based on the actual needs of each

¹² Institute of Medicine. (2001). *Improving the Quality of Long-Term Care*. Washington, DC National Academy of Medicine. Institute of Medicine 1996, *Nursing staff in hospitals and nursing homes: Is it adequate?* Washington, DC National Academy of Medicine

¹³ 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. <https://doi.org/10.17226/26526>.

resident as outlined in their individualized comprehensive assessments and person-centered services plans, as well as in accordance with the facility assessment.

- 2) The facility assessment should be completed at least quarterly as the nursing home resident population's needs and characteristics change far more often than just annually.
- 3) The facility assessment must be revised as necessary to lead to measurable and sufficient staffing numbers above and in addition to the minimum staffing levels that will be implementable by the nursing home and enforceable by the survey agency.
- 4) The resident assessments must be completed within required timeframes and re-assessments conducted in a timely manner upon all significant changes in condition, as is required in the conditions of participation. This is important to ensure the well-being of residents and consistency in updated resident service plans. It also impacts the level of staff needed to care for residents. If resident assessments for changes in condition are not done in time, resident service plans will not be updated, and staffing cannot be adjusted to meet resident needs accordingly. This can devolve quickly into bad outcomes for residents. CMS oversight and enforcement is important here.
- 5) We suggest that CMS provide guidelines or guidance that nursing homes would use to determine the amount and type of nursing staff needed as resident acuity changes. Such guidelines should draw on work from experts.¹⁴ A standardized formula or methodology is necessary to determine quantifiable hours of direct care required and calculable type of direct care staff required to implement appropriate care for residents, as detailed in their person-centered care plans, which can be readily implemented by nursing homes and that can be monitored for compliance by survey agencies. Nursing homes should be able to demonstrate that they used the guidelines to adjust their staffing to demonstrate ongoing compliance with staffing standards or requirements.
- 6) We also suggest consideration of a tool or system to assist nursing homes in adding and aggregating additional staff time required by the facility assessment and resident assessments and service plans to provide an implementable and enforceable amount of direct care staffing that is required above and beyond the floor set in the final rulemaking.
- 7) Finally, §483.35(a)(1)(v) as proposed reads "Compliance with minimum hours per resident day for RN and NA should not be construed as approval for a facility to staff only to these numerical standards." We urge CMS to modify the text to read "Compliance with minimum hours per resident day for RN and CNA shall not be construed as approval for a facility to staff only to these numerical standards."

We also appreciate CMS' inclusion of input from nursing home staff, including direct care staff, in the facility assessment.

Ensure Strong Guardrails on Exemptions

Nursing home compliance with minimum direct care nursing staffing standards should be the norm. Any exemption from the federal staffing minimum should be narrow in scope and include safeguards against abuse. Staffing below minimum levels can jeopardize the health and safety of residents. Staff providing care in nursing homes with low staffing levels are concerned they are not able to provide the care residents need and that they want to provide. The exemption process

¹⁴ Harrington C, Dellefield M, Halifax E, et al., *Appropriate Nurse Staffing Levels for U.S. Nursing Homes*, Health Services Insight. Vol. 13:1-14.

in §483.35(g) as currently structured is overly broad. Exemptions should be limited based on necessity. Some of our concerns include:

- Nursing homes requesting an exemption or receiving an exemption from minimum staffing standards can continue to accept new residents, putting residents at greater risk due to even lower staffing levels.
- The proposed rule does not detail what level of heightened scrutiny by state survey agencies and CMS will apply when an exemption is in place. Special Focus Facilities are not granted waivers of the requirements they fail to meet, they are instead subject to heightened scrutiny.
- Nursing homes can receive an unlimited number of one-year exemptions and potentially never be in compliance with minimum staffing standards, putting residents at risk.

Recommendations: To help ensure that facilities are delivering appropriate care to residents and not placing them or existing direct care staff at risk of harm, we believe it is critical that:

1) Limitations are Included in the Good Faith Effort Standard for Getting an

Exemption. In revising the proposed rulemaking's criteria for an exemption, CMS should do the following:

- a. Section 483.35(g)(2)(ii) should be strengthened to increase the obligations outlined for facilities to show they are making a good faith effort (focused primarily on wage comparisons, not on broader compensation considerations). Wage to wage comparisons alone -- without considering the impact of other important factors such as available benefits, working conditions, supervision and supports, or turnover -- are not complete. Especially where comparison data is available, we encourage consideration of other factors beyond wages. We suggest that comparison should be made to comparable positions in nursing homes as well as to comparable positions through temporary nurse staffing agencies. If such agencies are able to hire and retain staff to "temporarily" fill the vacant positions in nursing homes, then that suggests that some element(s) of their compensation structure are better at attracting the very workers the nursing homes are not attracting. We urge CMS to include in the final rulemaking who will be reviewing and approving this part of the request, and with what level of quality and financial expertise, as it should be someone with the appropriate expertise to understand the labor and workforce issues and assertions being made.
- b. Section 483.35(g)(3) should require a greater showing around the level of financial resources expended on nurse staffing relative to revenue or perhaps how this comparison is relevant to whether the nursing home should be granted an exemption from the minimum staffing requirements. Simply reporting a percentage without comparison to other comparable facilities or service areas is not meaningful. Additionally, we are concerned about the required level of transparency. As raised in [AARP's comments](#) on the proposed transparency regulations, we are concerned about the complex structuring of financial relationships between nursing homes and parent corporations as well as related parties. CMS should require a heightened level of transparency to satisfy this prong, commit enough staff with appropriate financial expertise for this analysis,

and detail what documentation nursing homes will need to provide to satisfy this inquiry, considering the complex financial relationships noted.

- c. Revise Section 483.35(g)(4)(i) to add that facilities on the Special Focus Facility candidate list should also be disqualified from obtaining an exemption.

2) Exemptions Request Process Should Be Improved. Nursing homes should be required to make a significant showing when requesting an exemption, including:

- a. Submitting a written, standardized application with proof that they meet the standard outlined in Section 483.35(g).
- b. Agreeing to voluntarily self-impose a ban on new admissions as soon as the nursing home realized they are not meeting the standard and demonstrating that to CMS as part of their exemption application process. If a nursing home does not self-impose such a ban on new admissions, we recommend that CMS do so in facilities that do not meet the minimum staffing standards. We note that Florida law prohibits a nursing facility that has failed to comply with state minimum staffing requirements for 48 consecutive hours from accepting new admissions until the facility has achieved the minimum staffing requirements for six consecutive days. For this provision, any person who was a resident of the facility and was absent from the facility for the purpose of receiving medical care at a separate location or was on a leave of absence is not considered a new admission.¹⁵
- c. Committing to the lesser staffing standard it will meet and outlining an actionable plan for achieving compliance with minimum staffing standards with discrete steps the nursing home will take around hiring and retaining workers to improve and meet residents' needs and an anticipated timeline for achieving compliance, as well as regular reporting to CMS on progress throughout the exemption period.

3) Exemptions Process Parameters Should Be Outlined. The final rulemaking should specify more details on the exemptions process. Specifically, the final rule should state that CMS will:

- a. Limit each exemption to a shorter time period.
- b. Prominently display in Care Compare that the nursing home does not meet current federal minimum staffing requirements.
- c. Require a nursing home that does not meet current federal minimum staffing requirements to provide notification to current residents, their representatives, and residents' families.
- d. Affirmatively state what CMS will expect the nursing home to do staffing-wise during the period for which the exemption will be in effect.
- e. Outline the circumstances under which an exemption will be revoked.
- f. Indicate that exemptions cannot be renewed indefinitely, there is a specific limit on the number of renewals, and that renewal will only be granted if the nursing home can demonstrate that it implemented an approved plan for achieving compliance.
- g. Commit to more frequent survey inspections during the exemption period.

¹⁵ [FL Statutes 400.14\(1\)\(n\)\(1\)](#); also related is [FL Statutes 400.967\(3\)\(b\)](#)

- 4) **Sufficient CMS Resources Should Be Available to Implement the Exemptions Process.** CMS should commit adequate resources to facilitate review and approval of exemption requests as well as monitoring and oversight of plans for achieving compliance. Additionally, resources should be sufficient to enable CMS to support all nursing homes with appropriate technical assistance aimed at helping with workforce development, especially for facilities in rural areas.
- 5) **Successful, Innovative Models Should be Considered, as Needed**
Successful, innovative approaches to nursing homes, such as the Green House model, empower highly trained, universal workers to meet residents' needs and preferences. We recognize that any minimum nursing staffing requirements should include some flexibility, as needed, that would consider innovative care models, such as small house nursing homes (Green Houses or others) who may use a universal worker approach.¹⁶ The measures should allow for appropriate flexibility for innovative care in a way that ensures residents get the care they need and that there is a consistent evaluation of such care.

We also note that to minimize risk to residents, CMS could review PBJ data quarterly for nursing homes and issue fines to facilities that are not in compliance with minimum staffing standards and do not have a temporary exemption from such standards.

To this end, we recommend that CMS modify the proposed rule to read as follows (see drafting notes included):

42 CFR 483.35

(g) *Hardship Exemption from the Minimum Hours Per Resident Day Requirements.* A facility may apply for and be granted a limited exemption by the Secretary from the requirements of paragraphs (a)(1)(i) and (ii) of this section if it demonstrates that a verifiable hardship exists that prohibits the facility from achieving or maintaining compliance and commits to a meaningful and specific plan for achieving and maintaining compliance. The facility must meet the four following criteria to qualify for a hardship exemption:

(1) *Location.* The facility is located in an area where:

(i) The supply of applicable healthcare staff (either RN, or NA, or both) is not sufficient to meet area needs as evidenced by at least a medium (20 percent below the national average) or low (40 percent below the national average) provider-population ratio for nursing workforce; or

(ii) The facility is at least 20 miles from another long-term care facility, as determined by CMS; and

(2) *Good Faith Efforts to Hire.* The facility demonstrates that it has been unable, despite diligent efforts, including offering at least prevailing wages and comparable benefits and other compensation, to recruit and retain appropriate personnel. The information is verified through:

¹⁶Green House homes, an alternative to traditional nursing homes, are best known for being smaller structures with just 10 to 12 residents that have the look and feel of a “real home.” But they also fundamentally differ in their workforce model, which is designed to improve the quality of work life for all staff, but particularly for the Shahbazim—the Green House home’s direct care team of certified nursing assistants.

(i) Job listings in commonly used recruitment forums found online at American Job Centers (coordinated by the U.S. Department of Labor's Employment and Training Administration), and other forums as appropriate;

(ii) Documented job vacancies including the number and duration of the vacancies and documentation of offers made, including that they were made at least at prevailing wages;

(iii) Data on applicants, evidence of offers made (including positions, wages and benefits offered) and whether they were accepted or declined and why (to the extent known), exit interview data on why staff are leaving, data on turnover and how that turnover compares to comparable facilities, and worker survey data on the workplace culture demonstrating that the facility is not perpetuating high turnover.

(iv) Data on the average wages in the Metropolitan Statistical Area in which the facility is located and vacancies by industry as reported by the Bureau of Labor Statistics or by the State's Department of Labor; and

(v) The facility's staffing plan in accordance with §483.71(b)(4) of this subpart and a written, CMS-approved plan for achieving compliance that delineates the steps that the facility will take to meet the requirements, the timeframes in which each step will be taken, and its plans to report regularly to CMS with evidence of progress in accomplishing the steps of its plan; and

(3) *Demonstrated Financial Commitment.* The facility demonstrates through documentation the amount of financial resources that the facility expends on nurse staffing relative to revenue and makes a showing that demonstrates that these financial resources are sufficient to attract and pay staff.

(4) *Exclusions.* Facilities must not:

(i) Be a Special Focus Facility, pursuant to the Special Focus Facility Program established under sections 1819(f)(8) and 1919(f)(10) of the Act or a Special Focus Facility Program candidate; or

(ii) Have been cited for having widespread insufficient staffing with resultant resident actual harm or a pattern of insufficient staffing with resultant resident actual harm, or cited at the immediate jeopardy level of severity with respect to insufficient staffing as determined by CMS, within the 12 months preceding the survey during which the facility's non-compliance is identified, or

(iii) Have failed to submit Payroll Based Journal data in accordance with §483.70(p) or have submitted false Payroll Based Journal data.

(iv) An exemption under this paragraph does not constitute a waiver of paragraph (b) of this section. Such a waiver must be granted in accordance with paragraph (e) or (f) of this section.

(5) *Determination of Eligibility.* The Secretary will determine eligibility for an exemption based on the criteria in paragraphs (g)(1) through (4) of this section. The facility must submit a written application on a form approved by the Secretary and provide supporting documentation. The application must include a specific request for a time-limited exemption, a narrative with supporting documentation that demonstrates the facility meets the criteria in 483.35(g)(2) and (3), an affirmation that the facility does not meet the criteria for exclusion, a written staffing plan and plan for achieving compliance within the exemption period, agreement that the facility will self-impose a ban on new admissions during the application and exemption period, and a commitment to submitting milestone reports reflecting progress

in achieving compliance. The Secretary will use staff with expertise in nursing home quality, workforce, and financial operations in analyzing applications and determining whether to grant exemptions.

(6) *Timeframe*. The term for a hardship exemption is less than 1-year (*Note: CMS to fill in specific time period*), unless the facility becomes an SFF facility, SFF candidate facility, or is cited for widespread insufficient staffing with resultant resident actual harm or a pattern of insufficient staffing with resultant resident actual harm. A hardship exemption may be extended no more than X times and for less than 1-year (*Note: CMS to fill in specific time period*), after the initial less than 1-year period (*Note: CMS to fill in specific time period*), if the facility continues to meet the exemption criteria in paragraphs (g)(1) through (4) of this section, has taken all the steps in its staffing plan, and can demonstrate that it still needs an exemption as determined by the Secretary.

(7) *Notice for the Public, Residents, Their Representatives, and Residents' Families*. The Secretary shall prominently display on a facility's Care Compare page that the facility does not meet the minimum staffing requirements, that it has been granted a temporary exemption, and that the facility is operating under a ban on new admissions until it achieves compliance with minimum staffing requirements. A facility that does not meet minimum staffing requirements shall notify facility residents, their representatives, and families of those residing in the facility that the facility does not meet the minimum staffing requirements, whether the facility is applying for or has been granted a temporary exemption, and that the facility is operating under a ban on new admissions until it achieves compliance with minimum staffing requirements.

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Timing of Implementation and Technical Assistance

We appreciate that it will take nursing homes time to plan, prepare, and take action to meet proposed minimum nursing staffing standards and the 24/7 onsite RN requirement. However, adoption of a final rule is essential and long overdue, and the proposed rule provides for staggered implementation of both of these requirements, including longer implementation periods for rural areas. We encourage that the implementation timelines be coupled with CMS provision of robust technical assistance to facilitate full compliance within any timelines in the final rule. Initiatives that support workforce development are already underway at CMS and other agencies and can be bolstered to support more timely implementation. We also encourage that the regulations outline interim milestones that nursing homes will be required to meet as they move towards full compliance. This would help nursing homes gradually ramp up implementation. We also specifically encourage technical assistance to support rural facilities, as well as facilities and areas that have historically struggled to provide adequate staffing, are less likely to have adequate staffing, or have health disparities. We note that helpful technical assistance can be coupled with robust monitoring, oversight, and enforcement, but technical assistance cannot supplant robust monitoring, oversight, and enforcement.

Institutional Transparency Provisions

The proposed rule requires states to report to CMS annually, by delivery system and by facility, the percent of Medicaid payments that is spent on compensation for direct care workers and on

compensation for support staff, according to the specific instructions provided by CMS. We are focusing our comments on these provisions for nursing homes. There is a need for better transparency and accountability to ensure that funds paid to nursing homes are used appropriately, such as for staffing and resident care. AARP supports increased transparency, as well as a federal direct care payment ratio (similar to a federal medical loss ratio), for nursing homes to help ensure that they are devoting sufficient funds directly to resident care, safety, quality, and staff. AARP has also supported provisions in federal legislation that would provide funding for HHS to audit Medicare skilled nursing facility cost reports for more facilities and create a path for HHS to reduce payments to facilities that report inaccurate data. Transparency is important across payers. The need for increased transparency and accountability of finances, operations, and ownership is also included as one of the broad goals and areas with recommendations in the National Academy of Sciences, Engineering, and Medicine's recent consensus study report, [*The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Families, and Staff*](#).

The impetus for stronger oversight and reporting is heightened by complex ownership structures, related-party transactions, changes in ownership, and the rapid growth in private equity firm involvement in nursing home ownership. Private equity (PE) firms often have complex ownership structures with less transparency in how funds are used and the extent to which they are used for resident care and staffing. Private equity ownership of nursing homes has been associated with higher costs and increases in emergency department visits and hospitalizations for ambulatory sensitive conditions.¹⁷ In addition, private equity ownership of nursing homes “has been associated with higher short-term mortality; lower measures of well-being, such as mobility; higher numbers of total deficiencies; lower total nurse staffing ratios (i.e., fewer hours per resident day); and increased costs.”¹⁸

Section 442.43(c) of the proposed rule would require that the states report facility level data on the percent of Medicaid payments spent on compensation to direct care workers and support staff. We encourage CMS to ensure these data are reported as two separate numbers and not an aggregate total by facility. Full transparency would mean that this data collection and reporting be stratified by subtype of direct care worker (as defined in this instance) or support staff person, by subtype of compensation. Transparency is important across fee-for-service and managed care. We appreciate CMS' effort to capture data across both. We also encourage greater financial transparency across Medicare, Medicaid, and all payers.

In AARP's [comments](#) on CMS' proposed rule on nursing home ownership transparency earlier this year, we highlighted the importance of both ownership transparency and financial transparency. Experience also shows that financial transparency is increasingly vital as lawmakers and regulators understand they do not have the information they need to determine how and whether any funds, public or private, are being paid out to related parties, what, if any, expenses or profits are being directed to related parties, and taking this into account, determining

¹⁷Braun, R. T., Jung, H. Y., Casalino, L. P., Myslinski, Z., & Unruh, M. A. (2021). Association of Private Equity Investment in US Nursing Homes With the Quality and Cost of Care for Long-Stay Residents. *JAMA Health Forum*, 2(11), e213817. <https://doi.org/10.1001/jamahealthforum.2021.3817>

¹⁸National 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. <https://doi.org/10.17226/26526>.

whether Medicaid nursing home rates are, in fact, adequate to cover the actual costs of care, not including any concealed profits. Fully audited consolidated financial statements demonstrating how nursing homes direct public and private funds will prove critical to financial transparency. Financial transparency across all payment sources, rather than just Medicaid, is essential when implementing and administering any direct care resident payment ratios that require nursing homes to spend a certain percentage of funds on direct resident care.

We note that the proposed rulemaking defines compensation, but then would have information about Medicaid payment for compensation be reported as high-level aggregates across multiple domains. We urge CMS to modify this requirement to ensure the information is reported out separately by sub-element of the definition of compensation. We encourage that Medicaid payment transparency require stratification across the unique types of compensation identified in the definition. We also encourage the provision of data by subtype of direct care worker (as used in this instance), but that the direct care worker definition focus on those who provide direct care to residents. We also urge CMS to clarify that the direct care worker definition for which the agency proposes additional reporting requirements is broader than that used in the proposed minimum staffing standard and therefore is for the purposes of this section only.

In Section 442.43(b), the proposed rule would require states to report to CMS on data that will need to be gathered from nursing homes. Assuming this provision is in the final rule, we believe this requirement needs to be made a condition of participation (requiring nursing homes to submit to the state all information necessary and in the form required by the state to enable and facilitate the efficient and timely reporting of this information to CMS). We appreciate CMS' efforts to ensure the public availability and accessibility of the information reported by states. We note the importance of providing information in a consumer-friendly manner and encourage CMS to consider the inclusion of nursing home specific information on Care Compare. We encourage implementation of the transparency provisions sooner than four years after the effective date of the final rule.

Avoiding Unintended Consequences

We appreciate CMS' concern about preventing unintended consequences and backsliding in states. We need a strong federal minimum standard because too many nursing homes fail to provide residents with the care they need. We agree that it is critically important that states not undo existing state minimum staffing standards or staffing ratios while waiting for this rule to be finalized. This proposed rule is an important step, and strengthening it will help alleviate CMS concerns.

It is also vital for CMS to reiterate in the final rule that any final minimum staffing standard does not preempt the applicability of any state or local law providing a higher standard. As CMS also notes in the proposed rule, "...this proposed rule is intended to and would preempt the applicability of any State or local law providing for a maximum staffing level, to the extent that such a State or local maximum staffing level would prohibit a Medicare and Medicaid certified LTC facility from meeting the minimum HPRD ratios and RN coverage levels proposed in this rule." We also believe that states that have more robust standards with higher HPRD or greater number of HPRD required of higher trained direct care providers should be encouraged or

incentivized to continue to enforce their state standards. This will continue to improve the overall understanding of how staffing standards impact care outcomes and will encourage states to continue embracing evidence-based efforts to improve nursing homes in their state.

AARP also believes that clearer rules addressing facility and resident assessments could prove critical in preventing the federal minimum staffing standard floor from becoming the actual staffing level. We urge CMS to consider both 1) how to incentivize facilities to maintain their current staffing levels if they are the same or higher than the final rule and sufficient for the residents, and 2) how to require facilities to demonstrate and justify staffing levels lower than their present and pre-effective date PBJ submissions and how to cite them for doing less and/or worse if such levels are not sufficient for the residents.

Monitoring, Oversight, and Enforcement

Rigorous and meaningful monitoring, oversight, and enforcement is essential to achieving better outcomes for residents. State survey agencies should be well-staffed with surveyors who are trained in more than just compliance. They should also be well-trained in quality of care, quality of life, and resident-centered service planning and provision. Survey and certification roles should be adequately funded so that more surveyors can be hired and that all surveyors can be better trained to understand and cite potential risks of harm and actual harm. The Administration has proposed increased funding for CMS Survey & Certification to help provide sufficient resources for state survey agencies. Level funding is not achieving the survey and certification outcomes that residents deserve. Additionally, state survey agencies should be required to cite for risks of harm and actual harm. Mandatory technical assistance or required retraining should co-occur with citation for the underlying violation.

These enforcement requirements need to be part of the conditions of participation and CMS needs to dedicate adequate resources for oversight, management, and enforcement activities.

We appreciate that anticipated positive outcomes that could result from the final rulemaking will not come to fruition without robust monitoring, oversight, and enforcement. We urge CMS to consider the following (some of which are referenced previously above):

- 1) A triaging strategy for enforcement that specifically addresses areas with historic poor staffing and health disparities.
- 2) Automatic meaningful fines for PBJ data demonstrating a failure to comply with the minimum staffing requirements in the final rule.
- 3) Automatic meaningful fines for untimely, incomplete and inaccurate PBJ data submissions.
- 4) Creating a self-imposed ban on new admissions requirement for nursing homes upon non-compliance with the minimum staffing requirements in the final rule with citations possible for failure to self-execute, similar to the moratorium required under Florida law.
- 5) Imposing an automatic ban on new admissions upon any citation for non-compliance until an approved plan of correction is fully implemented and any actual or possible harm experienced by residents was appropriately and timely addressed.

- 6) Increasing auditing staff to train, monitor and evaluate PBJ and financial transparency submissions.

We note that in announcing the proposed rule, CMS also announced expanding audits of the direct care staffing data reported by nursing homes, new analyses of state inspection findings to ensure cited deficiencies receive the appropriate consequence, and new oversight work by the Department of Health and Human Services Office of Inspector General to follow the money on how nursing homes spend the taxpayer funds they receive. These are helpful steps.

AARP appreciates your consideration of our comments and urges you to incorporate them into the final rule, and we urge you to issue that final rule in a timely manner to implement these long-overdue standards. AARP looks forward to continuing to work with CMS to establish and strengthen nursing home staffing standards and to improve nursing home financial transparency and accountability to ensure our nation's nursing home residents receive the quality of care and quality of life they deserve. If you have any questions, please contact me or Rhonda Richards on our Government Affairs staff at rrichards@aarp.org.

Sincerely,

A handwritten signature in black ink, appearing to read "David Certner", with a stylized flourish at the end.

David Certner
Legislative Counsel and Legislative Policy Director
Government Affairs