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June 10, 2022

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9911-P, P.O. Box 8016
Baltimore, MD 21244

RE: Medicare Program: Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Quality Reporting Program and Value-Based Purchasing Program; Long-Term Care Facilities to Establish Mandatory Minimum Staffing Levels (CMS-1765-P)

Dear Administrator Brooks-LaSure,

As the union representing the largest number of nursing home workers in the United States, the Service Employees International Union (SEIU) appreciates this opportunity to comment on the proposed rule and related Requests for Information referenced above.

SEIU represents more than one million healthcare workers across the country, including 150,000 nursing home workers. Our members work in hospitals, nursing homes, home care, ambulatory care, mental health services, and other healthcare settings. While a majority of our members who work in nursing homes are certified nursing assistants, we also represent dietary workers, housekeeping workers, registered nurses, and licensed practical nurses in nursing homes. SEIU members are also themselves consumers of healthcare and public sector workers who help monitor the quality of healthcare providers. Given the instrumental roles that our members play in the delivery of care in nursing homes, rulemaking to improve the quality of care and the quality of employment opportunities in nursing homes is deeply important to us.

SEIU is proud of the diversity that exists among our members who work in nursing homes. We represent groups of people who have been

marginalized and whose work is too often undervalued, including women, people of color, LGBTQ people, and immigrants. 92 percent of nursing assistants working in nursing homes are women and 59 percent of direct care workers are people of color. Therefore, it is important for us to couch our recommendations on reforms that impact the nursing home workforce through an equity lens. Improving workforce conditions in nursing homes and thereby improving the quality of care for residents in nursing homes advances equity. Acknowledging this underscores the urgency and importance of implementing meaningful nursing home sector reforms.

It is well-documented that nursing home residents and workers have borne the brunt of the COVID-19 pandemic. More than 200,000 residents and workers in nursing homes have died from COVID-19. Nursing homes also continue to feel the impact of COVID-19 as new variants of the virus emerge. To cite just one example, as of the reporting period ending on May 10, 2022, nursing homes in Connecticut have experienced a six-fold increase in coronavirus infections from the previous month. While the disproportionate impact of COVID-19 on nursing homes is in part due to the relative vulnerability of the nursing home resident population, it is also largely a result of a longstanding failure of our leaders to enact policies that keep nursing home residents and workers safe. SEIU commends the Biden administration for deciding to take action on many of the problems that have plagued nursing homes for decades, including short staffing and high turnover rates.

Our comments begin by responding to the questions raised in the Request for Information (RFI) on the establishment of minimum staffing levels for long-term care facilities. In this first section, we offer feedback on the structure, financing, attainment, and implementation of a national staffing standard for nursing homes. Next, we propose creation of a new requirement that a specific percentage of nursing home revenue be dedicated to resident care as well as creation of a process to ensure that Medicaid rates for nursing homes are adequate to support improved staffing and workforce standards. Finally, we address the changes to the SNF Quality Reporting Program (QRP) and SNF Value Based Purchasing (VBP) program proposed in the rule, and respond to your requests for input regarding potential future changes to those two programs.

Among other suggestions, we recommend that the structure of the upcoming minimum staffing standard explicitly reflects the critical value of work performed by certified nursing assistants (CNAs). Our recommendation on the creation of a minimum spending on resident care ratio reflects the need to ensure that nursing homes allocate appropriate resources to direct care, which includes worker wages. With regard to the SNF QRP, we recommend adding a measure of workforce equity in addition to a measure of equity for residents. Although we believe the SNF

VBP program could benefit from substantial changes in program design, we support the addition of staffing ratio and staffing turnover metrics to the program.

Request for Information on Regulatory Changes to Establish Mandatory Minimum Staffing Levels

SEIU applauds CMS for committing to issue a national staffing standard for nursing homes within one year. Our members have been fighting for safe staffing levels and a minimum national staffing standard for nursing homes for decades. Research shows that adequate staffing levels are associated with better resident health outcomes and fewer infection control violations. Although the COVID-19 pandemic has brought the issue of short staffing in nursing homes to the national stage, this problem along with other serious quality of care issues existed well before the pandemic.

SNFs are reporting a loss of 15 percent of their total workforce two years into the pandemic. Data from the Bureau of Labor Statistics suggests that long-term care facilities lost more than 400,000 workers between February 2020 and March 2022. While this reduction in workforce has been accompanied by a parallel decline in census that occurred during the past two years, more than a quarter of nursing home operators are self-reporting staffing shortages to CMS. Moreover, the census is likely to increase as admissions for post-acute care that temporarily fell during the pandemic return to previous levels. According to Zimmet Healthcare Services Group, nursing homes experienced the largest decline in Census in December 2020 when 67.5 percent of their occupancy was lost. As of December 2021, only 39 percent of that loss had been recovered. As the census recovers and more residents are admitted to nursing homes, more direct care workers will be needed to meet minimum staffing requirements.

Our members have expressed that much of the burnout nursing home workers feel is a result of short staffing, low wages, inadequate benefits, unsafe working conditions, and employers who do not treat them with the dignity and respect they deserve. We believe that adopting a robust staffing standard is an important first step towards addressing these issues and strengthening the workforce. Below, we offer our input in response to the questions raised in the RFI on a minimum staffing standard for nursing homes contained in this rule.

A. Design of a staffing standard that includes a staff-to-resident ratio.

CMS raises a number of questions that speak to the design of new national minimum staffing standards. Question one asks about research that provides evidence concerning an

appropriate threshold for the standard; question two seeks input on how resident acuity may impact a standard; question eight asks if different job classifications should have different standards; question nine touches on whether administrative staff should be covered under a staffing standards; question eleven asks how a new quantitative standard might interact with the current qualitative standard; and question fourteen poses the question of whether to require a Registered Nurse (RN) at all times in nursing homes. We address these questions and program design issues in this section.

We recommend establishing a minimum staffing standard that can be expressed in both hours per resident day (hprd) and as a staff-to-resident ratio. This approach is possible because an hprd ratio can be easily converted to a staff-to-resident ratio. We also recommend that staff-to-resident ratios be reported through the Payroll-Based Journal (PBJ) reporting process to increase transparency and public accountability. Regarding the numerical value of the ratio, we await new evidence from the study CMS is commissioning on optimal minimum staffing levels in nursing homes. However, given that 4.1 hprd was determined to be the minimum safe staffing level for nursing homes in 2001 and the overall nursing home population has since increased in acuity, we fully expect the new staffing standard to be greater or equal to 4.1 hprd.

Staff-to-resident standards that spell out exactly how many residents a given classification of nursing home worker should be responsible for during a particular shift can provide more clarity than an single hprd standard for residents, family members, and direct care workers. For example, a staff-to-resident standard that mandates that one certified nursing assistant (CNA) cares for no more than seven residents during the day shift would make violations immediately apparent to workers as workers know when they are assigned to care for more than seven workers during one day shift. A staff-to-resident ratio also allows for different ratios to be applied to different shifts depending on the time of day, recognizing that more staff may be needed during the day than are needed in the evening or on the overnight shift.

An hprd standard on the other hand states the amount of time nursing staff should spend caring for each resident on average each day. For example, an hprd standard of 4.1 hprd means that each resident on average should receive four hours and six minutes of nursing care each day. Because the hprd measure is a more abstract measure and is often expressed in fractions, it can be difficult to understand how it works on a practical level and to keep track of the amount of care time a particular resident received in one day. In

contrast, the introduction of an explicit staff-to-resident ratio can shed more light on whether a staffing standard is being met. However, some utility exists in continuing to report staffing levels in the hprd format. For instance, hprd has long been the prominent method for calculating nursing home staffing levels and stakeholders have grown accustomed to using the hprd measure. Thus, we recommend that an hprd-based standard be issued in conjunction with a new staff-to-resident ratio standard.

This approach is not novel, with experts often recommending using a combination of a minimum hours per resident day standard with an accompanying staff-to-resident ratio conversion. In 2000, for example, experts recommended minimum staffing levels for direct care workers (CNA,LPN,RN) that included a ratio of one direct care worker for every five residents during the daytime, one direct care worker for every ten residents during the evening, and one direct care worker for every fifteen residents overnight. Standards were also presented for licensed nurse ratios: one licensed nurse for every fifteen residents during the day, twenty residents in the evening, and thirty residents overnight. The total recommended time was 4.18 hours per resident day for direct nursing care and 4.55 hours per resident day of direct and indirect care and administration time.

More recently, a 2019 bill (HR 5216), proposed a 4.1 total hours per resident day minimum standard with 2.81 hours provided by a nurse aide, 0.75 provided by a RN, and 0.54 by a licensed practical nurse in conjunction with the following minimum staff-to-resident ratios in Chart 1:

Chart 1: Minimum Staff-to-Resident Ratios Under a 4.1 minimum hprd

Shift	1 Nurse Aide per	1 LPN per	1 RN per
Day shift	7 residents (1.14 hprd)	40 residents (0.2 hprd)	28 residents (0.29 hprd)
Evening shift	7 residents (1.14 hprd)	40 residents (0.2 hprd)	30 residents (0.26 hprd)
Night shift	15 residents (0.53 hprd)	56 residents (0.16 hprd)	40 residents (0.2 hprd)

In order to calculate the accompanying minimum staff-to-resident ratios, the legislation distributes the 2.81 nurse aide hprd by allocating 1.14 hours to the day shift, 1.14 hours to the evening shift, and 0.53 hours to the night shift. Then, to figure out the appropriate staff-to-resident ratio, the 8 hours in the shift is divided by the hprd assigned for the shift. For example, the day shift of 8 hours is divided by 1.14 nurse aide hprd, which equals 7.02, thus a ratio of 1 nurse aide to 7 residents on the day shift. If CMS adopts a minimum total hours per resident day staffing standard, it should also be similarly allocated across the various shifts and among the nursing staffing classifications. Moreover we strongly recommend that the minimum certified nurse aide hprd standard be set at a significantly higher level than licensed nurses, since nurse aides typically provide the most direct resident care, as discussed below.

In terms of applying the minimum staff-to-resident ratios, the facility's daily resident census will determine the necessary number of direct care staff for each shift, and the ratios are typically rounded up. The HR 5216 proposed minimum staff-to-resident ratio standard for a facility with 100 residents equates to 15 nurse aides (100/7= 14.28 = 15), 3 LPNs (100/40=2.5=3), and 4 RNs (100/28=3.57 = 4) on the day shift; 15 nurse aides (100/7= 14.28 = 15), 3 LPNs (100/40=2.5=3), and 4 RNs (100/30=3.33 = 4) on the evening shift; and 15 nurse aides (100/15= 6.67 = 7), 3 LPNs (100/56=1.78=2), and 4 RNs (100/40=2.5 = 3) on the night shift to comply with the minimum staffing standard. This level of staffing results in 4.48 hprd. For some facilities a higher level of staffing is necessary since they have higher acuity residents and need this level of staffing to provide high quality care. Because the number of staff required is rounded up when converting hprd to a staff-to-resident ratio, some facilities may be in compliance with the standard even though staff-to-resident ratio levels are slightly below the standard. To address this concern CMS could consider providing some limited flexibility on the staff-to-resident ratios based on the facility's daily census. For example, CMS could provide a guide to facilities listing exactly how many nursing staff are necessary per shift based on the facility's resident daily census to comply with both the staff-to-resident ratio and hprd minimums.

In addition, we recommend that different classifications of direct care staff should be assigned different ratios. Because registered nurses, licensed practical nurses, and certified nursing assistants provide different types of care, each nursing job classification should have a unique staffing standard. CNAs provide the majority of direct care to residents and their primary role is to assist with resident activities of daily living (ADLs) such as bathing, getting

out of bed, and eating meals. Assisting with these ADLs requires spending substantial amounts of time directly caring for residents. Massachusetts' new 3.58 hprd enacted in October 2021 recognized the distinction in CNA care versus licensed nurse care in establishing an additional standard that at least 0.508 of those hprd must be care provided by a registered nurse. We recommend that the staffing standard include a separate and specially targeted staff-to-resident ratio for CNAs.

In 2014 the State of Oregon converted its existing 2.46 hours per resident day minimum staffing requirement for CNAs to a CNA-to-resident ratio of 1:7 during the day shift, 1:9.5 during the evening shift, and 1:17 during the night shift. The state also provides a guide to facilities with details on the number of CNAs required per shift depending on the facility's resident census. In 2021, the State of New Jersey implemented a minimum staff-to-resident ratio for CNAs of 1:8 for the day shift, 1:10 for the evening shift, and 1:14 for the night shift. The New Jersey standard provides some flexibility allowing licensed staff members to count towards fulfilling the ratio requirement provided they are performing certified nurse aide duties during the shift.

In this proposed rule, CMS refers to several studies on minimum staffing levels in nursing homes, including a study by Schnelle that included 13,500 nursing homes and concluded that CNAs should be staffed at levels between 2.8 hprd and 3.6 hprd to adequately assist residents with the activities of daily living. SEIU believes this study is particularly useful in the crafting of a national minimum staffing standard for nursing homes because it separates out different classifications of direct care workers, closely studies the role of CNAs, includes a large sample size, and recognizes that minimum safe staffing levels may vary depending on the amount of assistance residents need with performing activities of daily living. Note that this study does not include feeding assistants in the minimum ratio for CNAs and SEIU does not support the inclusion of feeding assistants in a national minimum staffing standard. Social workers, mental health workers, and physical, occupational, and speech therapists should also not be counted when calculating minimums for direct care staff. Providers using "universal care workers" should also be required to strictly account for time spent working as a nursing assistant rather than providing ancillary services.

CMS should weigh the time of temporary agency staff less heavily than directly employed staff time when calculating compliance with a new staffing standard. The average stay for nursing home residents is 28 months. Over this amount of time, directly employed full-time

staff have an opportunity to get to know residents and their individual needs. Agency staff, on the other hand, are temporary and therefore unable to spend as much time learning the particular needs of each resident. Additionally, the use of staffing agencies is not as cost effective as direct employment of staff because agencies charge administrative fees on top of the cost of worker wages that are often directed at least in part to corporate profit. Because reliance on agency staff can cause nursing home labor costs to rise to unsustainable levels and result in inefficient use of Medicare and Medicaid funds, a staffing standard should include elements that discourage overreliance on agency staff.

While the national staffing standard will provide universal criteria for minimum staffing ratios, this standard may not be sufficient when applied to nursing homes where residents have greater levels of need. The Medicare Conditions of Participation for Long-Term Care facilities require that nursing staffing levels must be sufficient to "attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident" and "facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies", which is inclusive of employee resources and competencies.

We believe that input from workers is invaluable in identifying where residents have greater needs or higher levels of acuity. In addition to a specific minimum staffing standard, nursing homes should also be required to establish facility level staffing committees composed of both workers and managers to periodically determine whether the federal staffing standard is sufficient based on the acuity of residents in a particular facility. To aid facility staffing committees in determining an appropriate staffing plan, CMS should provide a guide to facility staffing committees of expected staffing minutes based on resident clinical conditions, similar to standards now used to determine the Five-Star staffing star ratings. However, it is imperative that the expected staffing minutes by nursing job classification are not based on the outdated STRIVE study from 2006 since it under counts the nursing needs of residents by only measuring the usual nursing time provided to residents in the sampled homes (which included understaffed facilities with quality of care issues). These committees should also be used to address other resident and worker concerns. This model is being used in Oregon and New York hospitals, where the staffing committees consist of both management-level nursing staff and direct-care nursing staff to create a staffing plan for each unit in the hospital. Since 2016, Oregon hospital staffing committees must include a direct care staff member that is not an RN, so CNAs and LPNs also have a voice on these committees. We recommended that facility level staffing

committees in nursing homes be composed of various classifications of nursing staff with required representation from CNAs.

A. State Experience and Lessons on Implementation of a Staffing Standard

Questions twelve and thirteen ask about state experiences with staffing standards. We address those questions here. While Washington, DC is the only locality that has a minimum staffing ratio of 4.1 hprd or higher, as recommended by the landmark 2001 study commissioned by CMS, there are other states with approaches that should be studied when designing a national minimum staffing standard for nursing homes. As CMS notes in this proposed rule, the care needs of the nursing home population have increased dramatically in recent decades, suggesting that the 4.1 hprd standard recommended by the 2001 study may now be too low. The fact that only one state has a standard of 4.1 hprd or higher in 2022 despite the previous recommendations underscores the importance of establishing a national minimum staffing standard for nursing homes.

In response to the long overdue call to action on nursing home quality, and reacting to the COVID-19 pandemic that has swept the nation, many states have recently made improvements to their nursing home staffing standards. Connecticut, Rhode Island, Arkansas, Massachusetts and New York have all increased required minimum staffing levels in nursing homes since March of 2020. New Jersey has established staff-to-resident ratios to make it easier for staff, residents and family members to determine when staffing standards are being met. In New Jersey, nursing homes are required to staff one CNA for every eight residents during the day shift, one CNA for every ten residents in the evening shift, and one CNA for every fourteen residents during the overnight shift. As stated previously, our recommendation for the national minimum staffing standard is creation of a hybrid standard that is expressed in both hprd and a staff-to-resident ratio.

A. Costs and Financing of a Staffing Standard

Question three of the RFI asks about potential costs of implementing a staffing threshold as well as potential savings due to reduced hospitalizations and other adverse events, and question four asks about the potential for a shift in resources away from expenses that do not support quality patient care to support staffing. These key questions–what is the net cost of an increase in staffing, what resources are already available, and (by extension) what new resources will be needed–in turn raise additional issues concerning the financing of

nursing home care, particularly the role of Medicaid, which pays for the majority of nursing home beds. Chapter seven of the recent report on nursing home issues released by the National Academies of Science, Engineering and Medicine (NASEM) points to the complexity of the current payment system and the perverse incentives it creates, as well as the inequities that result, such as a higher likelihood of closure for nursing homes that are financed predominantly by Medicaid. We believe that this complexity needs to be taken into account when addressing the question of how to pay for a staffing standard. For instance, while question three seems to assume that some portion of an increase in new costs for staffing could be offset by a reduction in increased hospitalizations, the fact is that any savings from the latter are much more likely to accrue on the Medicare side, while higher costs for staffing are more likely to be incurred by Medicaid, so while from a broad budget perspective the cost might be offset, that would not be the experience of individual facilities or state Medicaid programs. Depending on payer mix, facilities may also vary widely in resources they can tap to pay for increased staff, and it is very important to ensure that funding increases actually support higher staffing levels, both by paying for new positions but also by ensuring that wages and benefits for nursing home staff are sufficient to attract and retain the workforce needed to meet a future staffing standard. We believe it is crucial to address the question of how to ensure that there is adequate funding in order to ensure meaningful implementation of a future staffing standard. In the remainder of this section we provide some context to these issues, address the questions you raise, and suggest some actions (more fully described in subsequent comments) that would support rulemaking to create a national staffing standard.

Any discussion of costs and financing of a staffing standard must consider the current nursing home financing landscape. As the NASEM report confirms, the vast majority of nursing home care is funded by Medicaid and Medicare, which pay for 62 and 12 percent, respectively, of nursing home residents, with the balance funded through private payers, as a Veterans Administration benefit, and through other public sources. However, Medicare and Medicaid pay for somewhat different sets of services and the relationship between the cost of care and reimbursement levels differs. Medicare margins are generally positive, while Medicaid payments often do not fully cover the cost of care. The result, as both the NASEM report and previous MedPAC reports have found, is that Medicare accounts for a disproportionately high share of nursing home revenue in relation to the number of Medicare patient days. This disparity has consequences, as facilities with higher levels of Medicare beds are more likely to have the resources to support higher staffing levels while, conversely, homes that rely primarily on Medicaid are less likely to be able to do so. Indeed,

a recent MACPAC report that looked at state policy levers to address nursing home staffing showed a direct relationship between reliance on Medicaid funding and staffing levels, with the proportion of homes receiving only a one- or two-star staffing rating on the CMS Nursing Home Compare website rising as as the proportion of beds paid by Medicaid increased. The disparity may lead to discrimination against Medicaid beneficiaries in nursing home admission practices. It has implications for the quality of care in nursing homes and exacerbates racial inequities, since as the MACPAC report shows, residents in facilities that depend highly on Medicaid are disproportionately people of color. Notably, the same report also points to data that suggests that *increases* in Medicaid payment rates are associated with higher staffing levels.

Another important aspect of the current landscape is the role of for-profit corporations that own the majority of nursing homes, and the related role of private equity investors. For-profit nursing home companies have developed increasingly complex corporate ownership structures that make it difficult to track the extent to which revenue is going to support the delivery of care rather than simply increasing the profits of operators. There is evidence that corporate operators use related party transactions to divert revenue to profits, and that homes that use such transactions have lower staffing levels and poorer quality of care. Another recent report that examined the impact of the COVID-19 pandemic on the financial status of several for-profit chains and real estate investment trusts found that they remained profitable during this period. Finally, we note the increasing use of staffing agencies, and the associated costs with some operators reporting that staffing agencies are charging as much as $70 per hour to provide nursing assistants. While these agencies may have a necessary role in addressing temporary staffing needs, the huge expansion we have seen in the last few years, and the high costs they charge (not all of which goes to pay workers) suggest there may be opportunities to shift some of these payments to support higher staff levels directly employed by nursing homes.

In response to CMS's specific question concerning estimates of the potential costs of a higher staffing level, we note that two recent studies have attempted to produce such estimates. One of these compared current staffing levels with the standard recommended by CMS in 2001 (4.1 HPRD) and found that 95 percent of nursing homes would need to increase staffing levels, with an estimated cost of $7.25 billion; a second recent study by John Bowblis that compared current staffing against a benchmark based on acuity levels and data from 1995/97 Staff Time Measurement studies, found that 60 percent of homes would

need to increase staffing levels, with average costs per home of $500,000 per year and a total cost of $4.9 billion annually.

However, while these studies may provide a useful initial indication of total cost, they have their limits. On the cost side, these estimates by design focus on the incremental cost of new positions and appear to assume current wage levels when calculating new costs, and do not reflect the very real need to raise wages for CNAs and other frontline staff, both in order to attract new staff and to retain current workers, and thus they run the risk of underestimating new costs. At the same time, Bowblis and other recent estimates do not take into account the current diversion of some revenue into profits that could be shifted to supporting new staffing costs, thus potentially overestimating the real, net cost. As noted above, there is good evidence that such profits exist, but as we also note the use of multiple layers of ownership and related party transactions makes it difficult to estimate the extent to which these resources can be used to offset new costs. A complaint filed to block a recent New York law that capped nursing home profits at 5 percent and required homes to use at least 70 percent of revenue on resident care estimated that profits above the profit cap level amounted to $144 million.

Yet while aggregate and average per facility cost estimates are helpful in understanding cost to the entire long-term care system, they are not very useful in assessing how imposition of a standard will affect specific facilities, given the wide variation in current staffing levels and payment sources. As we suggested above–and as the Bowblis study appears to confirm–nursing homes that are more dependent on Medicaid as a source of revenue are much more likely to have difficulties in paying for the costs of meeting a new staffing standard. And while it is clear that some portion of current profits can, and should be, used to pay for higher staffing levels, the actual amount and the feasibility of an immediate shift is less clear. In other words, we assume that there will be some new cost to implementing a staffing standard and raising wages for current workers, and that part of that cost can be borne by operators (ie, by ensuring that funds are used for care and not corporate profits), but that new public dollars will likely be necessary to support higher levels of staffing. While an estimate of the net aggregate public and private cost would be useful, and we hope that CMS will undertake to produce one, given the substantial variation among nursing homes when it comes to current staffing levels, payment sources, and ability to shift resources, we believe that it is most important to ensure that public financing of nursing homes is structured in a way that ensures ensures that current revenue is used for patient care, that

directs new resources to the nursing facilities that need them most, and that addresses the issue of Medicaid rate adequacy.

We suggest a multi-pronged approach:

- Creation of a federal minimum spending ratio-type requirement that would ensure that nursing homes use the majority of service revenue on care for residents, supplemented by transparency requirements to ensure that spending requirements can be calculated accurately and fully enforced. One model for such transparency can be found in recent California legislation that requires nursing facilities to provide a consolidated financial report with data that will allow scrutiny of the value of related party transactions. We provide further details on a proposal to cap profits below.
- Stronger requirements to ensure that Medicaid rates are adequate to support staffing and other workforce standards that support access to quality care for the Medicaid beneficiaries who make up the bulk of the nursing home residents. We expect this would be accomplished through more robust enforcement of section 1902(a)(30)(A) of the Social Security Act that includes a process for scrutiny of nursing home financing structures, data on corporate profits, estimates of the wage levels necessary to maintain a stable workforce and the Medicaid rate levels needed to support these costs, coupled with requirements to pass rate increases on to workers. See separate section below for a more detailed description.
- Potential creation of quality metrics within the Medicare Value Based Purchasing Program that reflect the performance of facilities in providing enhanced wages and benefits for direct care and support staff, and the percentage of total revenue spent on direct care and support services. For example, facility wages could be compared to living wages for the area, or to 150 percent above the minimum wage for the area, with the facility earning more points the closer they are to meeting the benchmark. Additionally, facilities could earn more points with a higher percentage of total revenue spent on direct care and support services above a threshold of at least 60 percent.

A. Recruitment and Retention

Question five in the RFI asks about ways to improve nursing home worker recruitment and retention efforts. Our members have expressed that the single best way to recruit and retain workers is to provide adequate compensation in the form of wages and benefits. We recommend that CMS require reporting of wages through the Payroll-Based Journal system so that average wages paid in a facility are transparent and can be viewed alongside

reported staffing levels. According to PHI, the median annual income for CNAs is $24,400 per year, 34 percent rely on at least one social safety net program, and 41 percent live in low-income households. A recent report by Leading Age found that increasing nursing home worker wages would decrease staff turnover and the costs of doing so could be offset by increases in productivity.

Benefits are also an important part of a compensation package for nursing home workers. Retirement plans, affordable comprehensive health insurance coverage, paid sick leave, and life insurance policies are important tools in the recruitment and retention of nursing home workers. When workers have the opportunity to join together in a union they are able to collectively bargain with their employers to secure enhanced benefits packages. Labor unions also provide benefits to members, including health insurance and enhanced training opportunities, in many instances. CMS should encourage employers to work together with labor unions to provide competitive benefit packages to nursing home workers.

Wages and benefits are not the only factors driving nursing home staff recruitment and retention. Workers also benefit from enhanced training opportunities, defined career ladders, and empowerment of their voices through participation in a union. Ongoing training programs have been found to increase job satisfaction and reduce turnover. Workers with more training and higher skill levels have the tools necessary to perform their duties in a way that improves the quality of resident care. High-quality training opportunities are also associated with higher levels of job satisfaction. SEIU recommends that CMS incorporate enhanced training opportunities beyond the minimum necessary for certification and available at no cost to workers in efforts to improve nursing home worker retention rates.

To recruit more workers, CMS should direct operators to work together with unions in labor-management partnerships on training initiatives that connect workers to training and apprenticeship programs and that provide the support necessary for workers to complete such programs. CMS can also coordinate with the Department of Labor to identify funds that can support such initiatives. Union training funds are uniquely positioned to connect workers to high-quality training opportunities because their missions involve advancing workers in their professions from a worker-centered perspective. SEIU training and education funds operate programs focused on nursing home worker recruitment and

retention in several states. We encourage partnerships with union training funds in nursing home worker recruitment efforts wherever available.

Workplace safety is also a major factor in nursing home worker recruitment and retention. For many years nursing assistants have had one of the highest rates of workplace injuries compared to other occupations, and nursing assistants are more than three times more likely to be injured on the job compared to a typical US worker. At the onset of the COVID-19 pandemic, there were reports around the country about nursing home workers who were not being provided with basic personal protective equipment (PPE). Staffing shortages also contributed to unsafe working conditions as workers rushed to care for more residents that one worker can safely provide care for. At the height of the pandemic, nursing home workers had the most dangerous job in America when comparing the work-related death rate among nursing home workers with death rates in the nation's deadliest occupations. To recruit and retain workers, CMS should take steps to ensure that nursing home workers are provided with adequate PPE, safe staffing levels, and other measures to ensure workplace safety.

A. Enforcement and Compliance

Question six in the RFI requests feedback on how CMS should deal with facilities that make a good faith effort to meet the staffing standard yet fail to do so. Because safe staffing levels are essential to providing quality resident care and a healthy work environment, SEIU does not support the issuance of waivers or the use of other methods that permit nursing homes to operate at substandard staffing levels without penalty. Current federal regulations allow for nursing homes to waive the requirement for full-time RN staffing in certain circumstances. However, given recent research that highlights the importance of RNs to quality of care, waivers given to nursing homes to excuse the RN requirement may contribute to lower quality of care. We recommend against incorporating such waivers into the new minimum staffing standard for nursing assistants.

Section 1919 of the Social Security Act gives CMS the statutory authority to impose civil monetary penalties (CMPs) on nursing homes that are found to have deficiencies. This statute also provides the Secretary with some discretion concerning the dollar amount of the CMPs based on the severity of the deficiency. We believe that a system of progressive enforcement that applies the harshest penalties to the worst violators would incentivize

better performance in meeting the new minimum staffing requirements. SEIU also recognizes that while all violators should face consequences, there may be extenuating factors that may be used to mitigate the severity of consequences in very limited circumstances.

Because meeting minimum staffing levels is a basic requirement for staff and resident safety, we recommend that CMS institute serious penalties for violating minimum staffing requirements, including penalties for understaffing certain shifts. Currently, it is rare that deficiencies or civil monetary penalties are issued for non-compliance with the federal "sufficient staffing" requirement. We suggest that CMS consider developing an administrative penalty program that is specifically focused on staffing compliance, and with the helpful tool of the Payroll-Based Journal data which provides daily staffing information each quarter, it will not be burdensome for CMS to determine if a facility was not compliant with minimum staffing standard and is subject to a penalty.

The state of California offers a good model of staffing standard enforcement. California conducts audits of nursing facilities and administrative penalties for noncompliance have been successful in ensuring compliance with the minimum staffing requirements. During the 2017-2018 year, more than 94 percent of facilities were compliant with the staffing standard for the audited days. Initially, when the program began, administrative penalties were $15,000 if a facility failed to meet the minimum staffing requirements for five percent to 49 percent of the audited days and $30,000 for failure to meet minimum staffing requirements for more than 49 percent of the audited days. In 2021, the penalty amounts increased to $25,000 if a facility failed to meet the minimum staffing requirements for five percent to 49 percent of the audited days and $50,000 for failure to meet minimum staffing requirements for over 49 percent of the audited days. Additionally, if facilities are not compliant with the minimum staffing standard, they are not eligible for performance-based Medi-Cal Quality and Accountability Supplemental Payments. New York State's new minimum staffing standard includes penalties up to $2,000 per day based on a quarterly review of PBJ data. Providers can petition for a lower penalty if the state declares a regional labor shortage, and providers have made concrete efforts to recruit more staff including by increasing starting wages.

To be eligible for a reduced but firm penalty for not meeting CMS staffing standards, facilities should be required to thoroughly document that they have taken various steps to attempt to hire the appropriate staff to meet the minimum staffing requirement and that

the facility does not have a pattern of understaffing or significant quality of care concerns. First, facilities would need to demonstrate their starting wage rates for direct care staff are above the 75th percentile hourly wage for that job classification in their local area and their facility retention rates for employees at their facility are higher than other nursing facilities in their area. They would also need to show that they have properly advertised the vacant positions and made attempts to recruit new employees and provide a recruitment and hiring report for the preceding twelve months detailing the number of interviews conducted, experience of the candidates and salary and benefits offered, and whether the candidate accepted or rejected the position. Information on local CNA training programs as well as data on the workforce would be collected to determine if the facility could reasonably hire enough staff. If there are local hospitals or other types of healthcare facilities in the area that employ CNAs, those hiring wages and turnover rates should be observed in order to evaluate the options that a CNA has in obtaining employment. Additionally, facilities that are special focus facilities, have a CMS five-star overall rating of two stars or less, or have received substantiated complaints of insufficient staffing, neglect or abuse within the past twelve months, or received a deficiency, citation, or civil monetary penalty for insufficient staffing or a harm-level or substandard quality of care issue within the past three years, should not be eligible for the penalty reduction. For facilities that are part of a large chain that has ample resources, penalty reductions should be restricted. Lastly, there should be a limit on the number of penalty reductions a facility can receive during a defined period of time, and the facility should demonstrate it is making positive progress in filling vacant direct care positions in order for a subsequent penalty reduction to be approved.

Ensuring that Nursing Home Payments Go to Care

In light of the anticipated changes to the Medicare Conditions of Participation, including the national staffing standard, SEIU recommends that CMS create a requirement for a minimum spending ratio in the annual Medicare payment rule, which would require that a minimum percentage of nursing home revenues are spent on direct care costs. A minimum spending ratio would ensure that a significant portion of Medicare dollars paid to nursing homes were directed to resident direct care and support services, including worker wages, as appropriate. The April 2022 NASEM report on improving conditions in nursing homes includes a recommendation for HHS to require nursing homes to spend a minimum percentage of Medicare and Medicaid funds on direct care. NASEM suggests that a minimum spending requirement on direct care could help to reverse the recent trend of more and more spending on acquisition costs related to private equity ownership. Consumer groups, including the Center for Medicare Advocacy and the

Long-Term Care Community Coalition have also advocated for a designated percentage of nursing home expenditures to be spent on direct care in order to free up resources for staffing and other resident care needs.

A minimum spending ratio would be an important tool in preventing nursing home owners and operators from misappropriating funds through related party transactions. Related party transactions essentially allow owners and operators to funnel more money into their own pockets by contracting out services with companies they own or paying rent in a building in which they themselves have an ownership stake. As we discussed in the financing overview above, the use of related party transactions is associated with low staffing and quality levels. According to Kaiser Health News, nearly three quarters of nursing homes engage in related party transactions. Nursing homes that contracted with related parties were found to employ eight percent fewer nursing staff. Requiring nursing homes to spend a minimum percentage of their revenue on direct care costs would reduce the ability of nursing homes owners to increase their own profits by contracting with related parties.

Three states have recently passed a law or established new state regulations requiring a minimum percentage of nursing home revenues to be spent on resident care. Massachusetts established state regulations requiring nursing facilities to have a Direct Care Cost Quotient (DCC-Q) of at least 75 percent beginning October 1, 2020. This DCC-Q standard mandates that 75 percent or more of total ordinary operating revenues be spent on direct care workforce expenses that may include nursing, dietary, restorative therapy and social worker staff expenses. Beginning in October 2022, Massachusetts facilities will receive a downward adjustment in their Medicaid reimbursement rate if the facility was not compliant with the requirement. The New York law was passed in April of 2021 and requires nursing homes to spend at least 70 percent of revenue on direct care costs and at least 40 percent of revenue on resident-facing staffing, which is a component of direct care. The law applies to all revenue that a long-term care facility receives, including payments from Medicare, Medicaid, and private insurers and individuals. The New York law also requires nursing homes to return excess revenue exceeding five percent of expenditures to the state. We recommend for CMS to structure a minimum spending ratio on direct care within the Medicare payment rule in a similar manner where nursing home revenue from all sources is subject to the requirement.

Ensuring Medicaid Rate Adequacy

As we proposed above in our discussion of financing a staffing standard, we believe that CMS should expand current regulations implementing the Medicaid equal access requirement–which

currently do not address payment adequacy for any long-term services and supports except home health–to require creation of state level processes to assess the Medicaid rate levels that are necessary to ensure a stable workforce and to comply with a future staffing standard. While this proposal is somewhat beyond the scope of the staffing RFI included in the proposed rule, as we noted in our response to the RFI, we believe that meaningful implementation of a staffing standard requires attention to Medicaid rate adequacy. We also note that CMS has already undertaken an initiative to address Medicaid access issues, starting with an RFI earlier this year to which we responded with a proposal similar to what we suggest here.

As we noted in those comments, given the central role of CNAs and other direct care workers in providing services, maintaining a stable workforce is a crucial part of ensuring access to long term services and supports. We recommend that CMS use its authority under Sections 1902(a)(30)(A), 1903(m)(1)(A)(i), and 1932 of the Social Security Act to set minimum standards for sufficient access to care for Medicaid enrollees utilizing institutional LTSS in nursing homes, under both FFS and managed care. These minimum standards would be developed by state advisory boards on nursing home access and payment rates. We note that some states have recently proposed or actually created advisory boards for nursing homes that are a first step towards the process we propose. Boards would:

- Gather data on nursing home costs and revenue sources, including examining corporate structure and profitably of homes and parent companies.
- Gather information on local economic and labor market factors regarding prevailing wages and benefits for health care workers and develop recommendations on the wage levels needed to attract and retain the number of workers needed to meet optimal staffing levels (as defined in future regulations to implement a staffing standard). This process would include input from worker organizations, as well as examination of collective bargaining agreements that cover nursing homes in the state.
- The board would develop and publish recommendations concerning the rate levels and rate structures that will support staffing levels and sufficient wages, taking into account factors such as payer mix and availability of resources currently not used for care.
- When proposing rate changes for nursing homes, the state would need to document whether and to what extent rate increases align with the board’s recommendations and explain any discrepancy between the recommended and actual rates. States would also need to have a process for ensuring that the adopted rates are passed through to workers in the form of increased wages and benefits.

Changes to the Quality Reporting Program (QRP)

The SNF Quality Reporting Program (QRP) is a pay for reporting program that reduces Medicare payments by 2 percent to nursing homes that do not meet the reporting requirements of the program (which include reporting on measures such as falls and changes in mobility). QRP data is used to inform the Five Star Rating System featured on the Medicare Care Compare website. The proposed rule proposes adoption of a new measure looking at the flu vaccination rates among nursing home staff, and it also contains an RFI on whether a measure of health equity should be added to the QRP in future years, and if so, how it should be structured.

Inclusion of staff influenza rates in the QRP

In regard to the proposal to include reporting of staff influenza vaccination rates as part of the SNF QRP, we are supportive. CDC guidelines recommend that long-term care workers receive flu vaccines annually and the CDC provides a toolkit to long-term care facilities with recommendations on how to increase flu vaccine uptake among nursing home workers. This proposed rule takes the next step in requiring that flu vaccination rates among workers are reported to CMS and made available to the public. We also submitted public comments in support of the COVID-19 vaccine mandate for healthcare workers that went into effect earlier this year. SEIU locals played an instrumental role in increasing COVID-19 vaccination rates among nursing home workers through peer and community-led vaccine education initiatives.

Future Inclusion of a health equity measure in the QRP

We are also pleased that CMS is considering inclusion of a health equity measure in the QRP in future years and offer some initial thoughts in response to your request for information. In 2020, under a previous administration, we wrote to CMS about the importance of collecting demographic data on COVID-19 cases. Collecting demographic data allows the government and interested parties to identify and then address disparities. Previously, we have recommended that CMS require reporting on key health outcomes on the basis of race, ethnicity, sex, age, disability, primary language, sexual orientation, gender identity, socio-economic status, and urban or rural locale. In addition to reporting demographic information on health outcomes, we agree with the addition of a measure of resident health equity to the SNF QRP. We believe CMS should take into account the following considerations when designing such a measure:

- **Healthcare workforce equity should be considered when measuring health equity.**

In addition to a measure of health equity that measures resident outcomes, SEIU also recommends the addition of a measure that considers workforce equity to the SNF QRP. The nursing home workforce is composed of large numbers of groups of people whose labor is commonly undervalued. As stated above, the vast majority of direct care workers are women, and a sizable number are people of color. Black women direct care workers earn 70 cents per hour less than their white male counterparts and are more likely to live in poverty. An equitable nursing home workforce is one in which direct care workers are compensated appropriately for their labor and treated with respect by their employers.

We believe that promoting healthcare workforce equity can have a positive impact on resident health outcomes. For example, workers who are underpaid may be more likely to work in more than one nursing home in an effort to make ends meet. During the pandemic, an analysis of anonymous cell phone data showed that this trend was linked to increased rates of COVID-19 transmission. By paying workers a living wage, employers can reduce the need for workers to work in multiple nursing homes. A recent study found that increasing nursing assistant wages by ten percent may have been able to prevent between 14,600 and 15,300 resident deaths in one year. Workforce improvements, including higher wages, are integral to improving resident health outcomes and reducing healthcare disparities.

Health equity also includes ensuring that healthcare workers have access to high quality affordable healthcare benefits through their employer. Some 34 percent of nursing home workers rely on Medicaid, indicating that employers are relying on public assistance programs to provide their employees with healthcare rather than providing it themselves. A workforce health equity measure should consider whether employers provide adequate health benefits to their employees or leave their employees to depend on social safety net programs for healthcare.

When measuring workforce equity, CMS should not simply compare wages in one SNF to wages in other SNF because occupational segregation has contributed to wage suppression throughout the nursing home landscape. Instead, CMS should define a gold standard of what makes a high-quality job for nursing assistants working in nursing homes. Nursing home workers, particularly women of color, should be engaged in defining this new standard as they have firsthand knowledge of the factors that improve the quality of their own jobs. Examples of workforce equity metrics include measuring a

facility's wages against a geographical cost-of-living factor or against wages in other industries with comparable entry-level educational requirements, staff turnover rates, existence of defined career ladders, and worker-reported data on labor rights violations.

Value Based Purchasing Program (VBP)

The VBP currently provides SNFs with incentive payments based on a single measure of hospital readmissions. The incentive payments are sourced from a withholding of 2 percent of Medicare per diem payments to SNFs. Of the amount withheld, 60 percent is returned to SNFs in the form of incentive payments under the VBP and the remaining 40 percent is retained for VBP program operations. The Consolidated Appropriations Act of 2021 authorized CMS to add up to nine additional measures to the program, and the proposed rule would add three new measures to the program: healthcare associated infections requiring hospitalization, staffing levels, and successful discharges to the community. The proposed rule also contains an RFI on potential addition of a measure of staff turnover to the VBP.

Before addressing the proposed change to include a staffing measure in the VPB and responding to the RFI on a potential turnover metric, we first address the current form of the program. In particular, we believe that in order to increase the incentive power of the VBP, CMS should consider making changes to the program that will increase the incentive value of payments issued to SNFs. According to a June 2021 MedPAC report, the VBP program has fundamental design flaws that prevent it from being effective. First, the incentive payments are too low to motivate nursing homes to make substantial changes. MedPAC recommends either increasing the percentage of Medicare payments withheld or redistributing the entire amount of program withholdings to nursing homes in the form of incentive payments. MedPAC also recommends adding a risk adjustment factor to the hospital readmissions measure so that it does not unfairly disadvantage nursing homes that serve underserved populations. SEIU agrees that incentive payment amounts should be increased, and a risk factor adjustment should be added to the hospital readmissions measure so as to not punish homes whose hospital readmission rates may be influenced by factors outside of their control

Addition of New Metrics to the VBP

SEIU supports the addition of staffing level, healthcare associated infection, and community discharge measures to the VBP. We recommend that a VBP staffing level metric separates out different classifications of direct care staff so that CNA, LPN, and RN staffing levels are evaluated independently. We also recommend that the staffing metric apply less weight to agency staff time, in order to disincentivize over-use of these agencies. Adding the number of healthcare

associated infections requiring hospitalization is useful in promoting a safe work environment for our members. The addition of a measure of community discharges also supports our belief that individuals should be able to live in their own homes and communities whenever possible. SEIU represents more than 500,000 home care workers and supports measures that facilitate the ability of people to remain in the community, while at the same time ensuring that people who do need an institutional level of care receive quality services.

Potential Future Addition of a Staff Turnover Metric
SEIU generally supports the addition of a measure of staff turnover to the SNF VBP. We applaud CMS for recently beginning to report staff turnover rates on Care Compare based on Payroll-Based Journal data. However, to best capture the ability of nursing homes to retain staff, this measure should focus more on retention than turnover. A staff turnover rate measures the percentage of employees who left (voluntarily or involuntarily) during the measurement period, whereas a staff retention rate measures the percentage of employees who have worked in the nursing facility at the beginning and end of the measurement period. Staff retention has been linked to better quality outcomes for nursing home residents since staff who have been working for a longer period of time at a nursing facility are more familiar with the residents and can easily assess when changes in health status or behavior occur or anticipate the care needs of the residents, resulting in improved quality of care, and residents are generally more comfortable with staff members they know which results in better quality of life. Additionally, staff that have been employed longer at the facility are more familiar with the policies and procedures within the facility compared to newer or temporary staff.

The state of California uses a staff retention measure in the CMS approved Medi-Cal Skilled Nursing Facility Quality and Accountability Supplemental Payment System. The staff retention measure is calculated with a numerator of “Number of Continuously Employed Direct Nursing Staff During the Report Period” and denominator of “Number of Direct Nursing Staff at the Beginning of the Report Period,” with a higher retention rate scoring more points. A staff retention measure can be easily calculated using the existing CMS Payroll-Based Journal data, to determine whether an employee has been employed for the duration of the measurement period. It may be useful to have an overall direct care staff retention measure and staff retention measures by nursing job categories, especially for certified nursing assistants that provide the most direct care for residents in the SNF VBP. In the future it will be helpful to have an overall staff retention measure since support staff, management, and other non-nursing staff have vital roles in the resident experience and workforce stability should be encouraged.

Again, SEIU applauds CMS for taking bold steps to improve conditions in our nation's nursing homes. We appreciate the opportunity to share our thoughts on upcoming regulations and we hope that CMS finds the aforementioned recommendations helpful. We hope to continue to communicate with CMS as the administration's nursing home reform efforts take shape in the coming months and years. If you have any questions or feedback about this letter, please contact Ahimsa Luthuli, Senior Policy Analyst, at Ahimsa.Luthuli@seiu.org.

Sincerely,

Leslie Frane
Executive Vice President