DignityAlliance Massachusetts
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A Proposed Rule by the Centers for Medicare & Medicaid Services (CMS):
CMS Must Establish a Minimum Staffing Standard **File code: CMS-1765-P**

June 10, 2022

Dear Sir/Madam:

Dignity Alliance Massachusetts (Dignity Alliance) submits this testimony in response to "CMS Must Establish a Minimum Staffing Standard. File code: CMS-1765-P". Dignity Alliance is a broad-based group representing a wide range of stakeholders dedicated to transformative change to ensure the dignity of older adults, people with disabilities, and caregivers. We are committed to advancing new ways of providing long-term services, support, living options, and care while respecting choice and self-determination. Dignity Alliance works through education, legislation, regulatory reform, and legal strategies for this mission to become reality throughout the Commonwealth.

Dignity Alliance fully supports a national staffing standard to improve the quality of care, dignity, and quality of life of nursing home residents across the country. The implementation of a minimum staffing standard will be the most important and significant increase in protections for nursing home residents in decades. We applaud the Secretary for taking this necessary step.

Nursing home residents, their families, and advocates already know what research confirms - there is a direct relationship between sufficient staffing and quality care for residents. It is well known that a 2001 CMS study[1] found that 4.1 hours per resident per day (HPRD) are required just to prevent harm. However, we submit that even higher standards are now necessary, since 20+ years later, residents have more complex needs[2] and the 2001 rate does not consider quality of life and dignity issues that are rightful expectations. In order to fill these positions, better wages, and benefits, including additional training opportunities, are necessary to expand and stabilize the workforce.

Such critical standards must be required across the country and not left to the whim of 50 state legislatures, 50 state departments of public health, and pressures by the nursing home industry. A national minimum staffing standard will create a staffing baseline below which a nursing home cannot go, no matter where the facility is located. This will improve residents' quality of care and better protect their health safety and well-being in each and every state. It will also motivate nursing homes to improve the quality of jobs, which will help keep the staff they have and hire new employees. Staff, especially certified nursing assistants, need better wages and benefits, more training, better working conditions, more respect and better treatment from employers, less

discrimination against women of color and immigrants, and more. Some of these staffing issues will require additional federal regulations. Other issues require actions by parties other than CMS.

Establishing a national staffing standard for nursing home residents and stabilizing the caregiver workforce have great potential to better the lives of all, and we thank you for considering our views.

Sincerely,

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This submission has been endorsed by twenty-five members of Dignity Alliance Massachusetts including the following:

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Please note there are 2 attachments:

Dignity Alliance Massachusetts Response
Based on Massachusetts Experiences
Questions 4, 5, 6, 10, 11, and 12

Please note that current MA pending legislation, H.4780 *An Act to improve quality and oversight of one-term care*, addresses a wide range of long-term care issues seeking many improvements to nursing home resident care and has been included (grey highlight) in response to related questions.

Question 4: Is there evidence that resources that could be spent on staffing are instead being used on expenses that are not necessary to quality patient care?

The following 3/27/16 Boston Globe article by Kay Lazar provides evidence that there are financial resources that could be spent on staffing, but are instead being used for self-dealing transactions or for other purposes unrelated to quality resident care:

A pattern of profit and subpar care at Mass. nursing homes
http://www.bostonglobe.com/metro/2016/03/26/profit-and-care-massachusetts-nursing-homes/JfpOM6rwcFAObDi2JLcAnN/story.html.

Excerpts from the article:

The Boston Globe scrutinized 2014 financial reports [latest available at the time research was conducted] from 396 Massachusetts nursing homes and examined the money spent on nursing care, patient food, management, rent, and fees for therapy, office support, and other services. Also examined were health and safety violations for each nursing home.
Here are several quotes:

- On forms they submit to the state, nursing homes frequently report they are losing money. But that's only part of the story. A review of records from companies affiliated with the homes shows they are directing cash to subsidiaries and to help pay executives' six-figure salaries.
- The financial reports show that 80 Massachusetts nursing homes each paid more than $1 million in rental fees, with the money often directed to property companies they also own.
  - Among these nursing homes, the health and safety problems found by state inspectors were 42 percent higher than for the facilities that spent less than $1 million. All but one of those that spent more than $1 million in rental fees was for-profit.
- Precise numbers are hard to pinpoint because many nursing home companies failed to report executive salaries or include required information about their affiliated companies in financial reports filed with state regulators.
- Massachusetts nursing homes are asked to provide salary and benefit information about their three highest paid employees, in addition to top executives, in annual financial reports. The Globe found many companies failed to provide complete information, particularly about executive pay and benefits.
- No nursing homes have been penalized for incomplete or even falsified information on their annual financial reports, according to the state Medicaid office.
- Massachusetts Senior Care Association, nursing home trade association, reports about half of nursing homes are operating in the red because of paltry Medicaid reimbursements. The association has not tracked whether nursing homes reporting financial losses are, at the same time, paying hefty executive salaries or large amounts to related companies, according to Gregorio, the association's senior vice president. "It sounds as if it is something we should look at," Gregorio said. Continued

Question 4: (continued)

Boston Globe Chart:
As of 2014, there were 420 MA nursing homes: 20 of the 420 did not receive government funding and were not required to file financials; 4 others were excluded because of incomplete information or because they were government run.

	Nursing Homes		Pd rental fees To affiliate	Pd >$1M rental fees to affiliate
For-profit	: 293	[74%]	163 [56% of ForPr]	45
Not-for-profit	: 103	[26%]	11 [11% of NonPr]	1
	396		174 [44% of All nh]	

While the above financial situations cause concern, H4780 includes audit and financial reporting guidance in an effort to bring financial transparency and accountability: We recommend similar in-depth audits for Medicare funding of nursing homes.

- The Center for Health Information and Analysis (CHIA https://www.chiamass.gov/), in consultation with MassHealth (MA Medicaid), DPH, and the health policy commission, shall annually conduct an examination of cost trends and financial performance of nursing homes. The information shall be analyzed on an institution-specific and industry wide-basis. The examination shall also aggregate financial information by ownership and look at affiliations with other health care providers. Financial data shall be by long-term vs short-term residents when possible.

Question 5: What factors impact a facility's capability to successfully recruit and retain nursing staff? What strategies could facilities employ to increase nurse staffing levels, including successful strategies for recruiting and retaining staff? What risks are associated with these strategies, and how could nursing homes mitigate these risks?

Dignity Alliance supports the many recommendations included in the Addendum to recruit and retain staff. In addition to those efforts, provide hazard pay at necessary times and give CNAs respect and a voice in resident care, including care plan meetings as required by current federal regulations. And respect and a voice as supported by the "Culture Change Movement" initiated in 1997 by the Pioneer Network[3]-- lauded and participated in by the nursing home industry for over two decades[4]. The industry must be held accountable and follow through with the care concepts it claims to support.

Massachusetts is one of only 19 states[5] that still requires 75 hours of training to become a CNA, and we strongly recommend increasing this basic requirement to 120 hours (per National Academy of Medicine) [also recommended in the Addendum].

"Nurse aides in-training" is a newly created crisis-only position. MassHealth Bulletins (155, 163, 166)[6] require separate reporting of nurse aides in-training, thereby helping to determine the percentage of staff hours. Only licensed positions (RNs, LPNs, and CNAs,) should be used to calculate HPRDs. However, as of April 2021, "nurse aides in-training" are in the calculation of the 3.58 HPRD, thereby weakening care.

In the MassHealth Bulletins footnotes dealing with nurse aides in-training, it states that **"resident care assistants"[7]** may be included in the nurse aides in training category until the latter of the end of the federal state of emergency. We also have concerns that these positions could be erroneously included in HPRD calculations and should be monitored.

Question 6: What should CMS do if there are facilities that are unable to obtain adequate staffing despite good faith efforts to recruit workers? …"

When facilities are unable to obtain adequate staff, CMS must require the facility to cease new admissions until the facility is able to meet the staffing requirement. Inadequate staffing is a threat to the health and well-being of residents. We support admission freezes, but urge CMS to review the criteria for and implementation of admission freezes. For instance, admissions freezes are publicly reported on this Mass.gov site: https://www.mass.gov/info-details/long-term-care-covid-19-family-information-center#additional-resources-. Select or scroll down to "Temporary Admissions Freeze." There is a link in this section to the current facilities that have freezes and the reason. As of the submission date of these comments, only 4 facilities are listed as having temporary admission freezes and for reasons other than inadequate staffing levels. Since there is a widespread staffing shortage and known understaffing, why don't more MA nursing homes have an admissions freeze? We are aware of a couple of facilities where one CNA is charged with taking care of 40-50 residents on the 11:00PM-7:00AM shift and continue to accept residents. Further, CMS should ensure that residents and representatives can voice complaints about staffing shortages to state health departments and require responsive action. Yet, to ensure an immediate response, some residents contact the police, not DPH, to report inadequate staffing and lack of care.

Question 10: What should a minimum staffing requirement look like, that is, how should it be measured? Should there be some combination of options? For example, options could include establishing minimum 1 nurse HPRD, establishing minimum nurse to resident ratios, requiring that an RN be present in every facility either 24 hours a day or 16 hours a day, and requiring that an RN be on-call whenever an RN was not present in the facility. Should it include any non-nursing requirements? Is there data that supports a specific option?

We recommend using both minimum nursing hprd and nurse to resident ratios. "HPRD" clarifies the direct care hours residents require to meet their basic needs and prevent negative outcomes. However, solely relying on hprd is confusing for staff, residents, and families in determining whether a facility has adequate staffing. RN/LPN/CNA to resident ratios is a clearer way to identify staffing capacity. For instance, adding RN/LPN/CNA to resident ratios would be particularly helpful to residents and families for the daily staff reporting mandated to be posted for each shift on every unit[8]. It's much easier to understand that there is one CNA on duty to help a specified number of residents than just posting total hours and total number of residents, CNAs, LPNs, and RNs. Furthermore, it's our understanding that this reporting requirement for statistics by shift is not being consistently done and when reported, is not accurate. Confirmation of these reports should be done as part of the DPH survey process.

Question 11: How should any new quantitative direct care staffing requirement interact with existing qualitative staffing requirements? We currently require that facilities have ''sufficient nursing staff'' based on a facility assessment and patient needs, including but not limited to the number of residents, resident acuity, range of diagnoses, and the content of care plans…"

We support the position stated in the Addendum that CMS should utilize facility assessments to determine the number of residents with specialized needs requiring higher staffing standards, such as 5.6 – 6.8 total hprd. (continued)

Question 11: (continued)

The MDS report captures the residents' health and functional status, and CMS most definitely should require facilities to use MDS data to help determine resident acuity for purposes of staffing requirements.

To support these statements, the following Q1 '22 Minimum Data Set (MDS)[9] sample of MA nursing home resident statistics show the clear need for a staffing standard higher than the current MA 3.58 HPRD or 2001 federal 4.1 HPRD.

Q1 '22 MDS --- % of MA nursing home residents:

- 50% require pain management last 5 days (J0100A);
- 58% diagnosed with Alzheimer's (I4200) or dementia (I4800);
- 67% wheelchair assists (G0600C);
- 85% incontinent assists(H0300);
- 95% risk of pressure ulcers (M0150);
- 96% shower/bath physical assists (G0120B); etc.

Additional staffing is also necessary to implement non-pharmacological approaches (unless contraindicated) in order to reduce the overuse or misuse of antipsychotics or other psychotropic drugs. MA nursing homes have had one of the highest antipsychotic usage rates in the country for many years. As of 2/1/22, MA is ranked as having the 6th highest antipsychotic usage rate at 18.8%[10]. In early 2016, MA implemented informed written consent before the administration of psychotropic drugs to nursing home and rest home residents to protect these vulnerable populations. Inexplicably, informed written consent has been ineffective.

Furthermore, misdiagnosing nursing home residents with schizophrenia, an ailment of young people and for which antipsychotics are allowed, means antipsychotics are dispensed with impunity. Nearly 10% of MA nursing home residents are diagnosed with schizophrenia, even though it occurs in less than 1% of the US population[11].

Question 12. Have minimum staffing requirements been effective at the State level? What were facilities' experiences transitioning to these requirements? We note that States have implemented a variety of these options, discussed in section VIII.A. of this proposed rule, and would welcome comment on experiences with State minimum staffing requirements.

We provide the following history of Massachusetts staffing requirements to underscore the importance of a mandated federal staffing standard to achieve quality nursing home care across all states. As our history shows, despite Massachusetts' efforts, low staffing standards were implemented, continuing to put residents in jeopardy. Based on our experience, we strongly recommend that a national staffing standard is necessary to prevent a patchwork of inadequate, and dangerous, staffing levels across the country.

- In 1994[12], seven years prior to the 2001 CMS study that determined that a 4.1 HPRD was necessary just to prevent harm, MA implemented a 2.6 HPRD (2.0 HPRD CNA and 0.6 HPRD combined RN/LPN care). MA did not heed the 2001 CMS study results, and the inadequate and harmful 2.6 HPRD staffing standard was in place for nearly 25 years until March '18.

Continued

Question 12 (continued)

Not only was the MA staffing standard set too low, a large percentage of MA nursing homes never achieved the standard. As of Q1 '18, the last quarter the standard was in place, 31%[13] of MA nursing homes were still staffed below the MA subpar CNA goal of 2.0 HPRD.

a. The March, 2018 elimination of the 2.6 HPRD was the outcome from the review of all MA regulations, a review required by Gubernatorial Executive Order No. 562: To Reduce Unnecessary Regulatory Burden | Mass.gov. As justification for eliminating the 2.6 HPRD staffing standard, the MA Department of Public Health stated, "There is no data to support setting staffing ratios in long-term care facilities."[14] This reasoning not only ignored the 2001 CMS study, but also ignored 87 research articles and reports from 1975-2003 that found nursing homes with higher staffing levels had residents with better health outcomes[15].

b. The following new 2018 staffing standard replaced the 1994 2.6 HPRD with a "sufficient" staffing requirement (no specific staffing benchmark) similar to, but weaker than, current federal staffing regulations[16]. The MA 2018 staffing standard[17] omitted the following critical requirements included in the federal staffing standard:
   - "…appropriate competencies and skills sets to provide nursing and related services…"
   - "…to assure resident safety and to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident…"
   - "…considering the … diagnoses of the facility's resident population in accordance with the facility assessment…." The MA requirement was more vague: "…other relevant factors as determined by the facility…"

c. In April '21, MA initiated a care standard of 3.58 HPRD (.75 RN HPRD). However, MA did not "raise the bar" with this rate --- a 3.58 HPRD represents the 2017 MA statewide average[18], and was compared to the "lower bound" HPRD level in the mediocre 3-star range in Care Compare[19]. Furthermore, the 3.58 HPRD is beneath the 2001 federal 4.1 HPRD standard necessary just to prevent harm.
   - It also should be noted that as of Q3, '21[20], the most recent available staffing statistics, the vast majority of MA nursing homes fail to meet the new state standard and fail to meet the basic federal standard necessary to prevent harm:
     - ✓ 264, or 73%, of MA nursing homes do not meet the current 3.58 HPRD.
     - ✓ 320, or 89%, of MA nursing homes do not meet the 2001 federal 4.1 HPRD standard.

d. **H.4780** mandates an "analysis and issue a report on nursing personnel in long-term care facilities" to determine "hours of care per resident per day required to prevent a substandard quality of care… including cost impact on long-term care facilities, satisfaction of the workforce and quality of care for residents…" This is a laudable effort to achieve a meaningful staffing standard. However, we submit that MA (or any other state) does not have the resources or manpower that CMS has to achieve a thorough staffing study.

[1] Abt Associates for U.S. Centers for Medicare and Medicaid Services, "Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes." December 2001.
[2] Op.Cit., page 11: "…Although the Phase II analysis did not identify different staffing levels that maximized quality for different case mix groupings, it did find that adverse outcomes were significantly higher at the same staffing levels for facilities of higher case mix. The investigators concluded that higher staffing levels are warranted for facilities with residents of higher acuity and functional limitations…"
[3] https://www.pioneernetwork.net/culture-change/what-is-culture-change/.
[4] Nearly two decades ago, the "Massachusetts Culture Change Coalition" was initiated and primarily run by Mass Senior Care (MA for-profit nursing home industry) and LeadingAge-MA. While dormant through the COVID-19 pandemic, a link to the Coalition is currently still provided on Mass Senior Care Foundation's website: https://www.maseniorcare.org/culture-change.
[5] http://phinational.org/advocacy/nurse-aide-training-requirements-state-2016/ On the Table tab, Texas is listed as 100 training hours which is correct, but on the interactive map Texas is noted at the old 75 training hours. Consequently, the total number of states at the 75 training hours is 19, not 20.
[6] Ibid. [Bulletin 166, Aug. 2021],page 2 Footnote: "Notwithstanding the time-limitations described in the Electronic Staffing Data Submission Payroll-Based Journal Long-term Care Facility Policy Manual, Version 2.5, nurse aides in training, including resident care assistants, may be reported and counted towards total staffing levels through the nurse aides in training category without time limitations through the end of the federal state of emergency, declared due to the novel coronavirus disease 2019 (COVID-19) outbreak. At the end of the of the federal emergency, nurse aides in training, including resident care assistants, may only be counted for the first four months of their employment, provided they are enrolled in a state-approved nurse aide training program. After the first four months of employment, the individual who was a nurse aide in training may only be counted towards staffing levels if they obtain certification or other licensure credentials that may be reported through another staffing category…"
[7] Ibid. [Bulletin 166, Aug. 2021],page 2 Footnote:
[8] §483.35 Nursing services. 42 CFR 483.35 Nursing Services (g) Nurse Staffing Information (1)Data Requirements https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-B#p-483.35(g)(1).
[9] https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Minimum-Data-Set-3-0-Public-Reports/Minimum-Data-Set-3-0-Frequency-Report.
[10] CMS Care Compare 2/1/22 - State Averages:
In file: Statistics/NH Compare Statistics/ NH Compare_2022 2.1/ _StateUSAverages_Feb2022.xls
'Percentage of long stay residents who received an antipsychotic medication, excludes residents diagnosed with schizophrenia, Huntington's, and Tourettes.

ME	20.73721
MS	19.94716
MO	19.88055
ND	19.65522
AL	19.52332
MA	18.80175

[11] As of the last available federal statistics (Q2 '21) Minimum Date Set https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Minimum-Data-Set-3-0-Public-Reports/Minimum-Data-Set-3-0-Frequency-Report.
US schizophrenia https://www.nimh.nih.gov/health/statistics/schizophrenia
[12] *NURSING HOME STAFFING STANDARDS IN STATE STATUTES AND REGULATIONS*, Charlene Harrington. Ph.D., 2008, page 19, https://www.justice.gov/sites/default/files/nursing_home_staffing_standards_in_state_statutes_and_regulations.pdf.

[13] Long-term Care Community Coalition staffing data for Q1, 2018: https://nursinghome411.org/nursing-home-staffing-2018-q1/ This schedule was based on CMS data submitted through the Payroll Based Journal system.
[14] *Request for Approval for Promulgation of Amendments to 105 CMR 150.000: Licensing of Long-Term Care Facilities*, 3/16/18 Memo to Commissioner Monica Bharel, MD and Members of the Public Health Council from Elizabeth Chen, Interim Bureau Director, Bureau of Health Care Safety and Quality, page 3.
[15] Bostick, J.E., Rantz, M.J., Flesner, M.K. and Riggs, C.J. (2006). Systemic review of studies of staffing and quality in nursing homes. J. Am. Med Dir Assoc. 7:366-376.
[16] **Federal staffing requirement effective October 2016 --- §483.35 Nursing services:**
The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).
[17] **MA staffing requirement effective March 2018 --- 150.007: Nursing Services B(2)(d):**
Sufficient nursing personnel to meet resident nursing care needs, based on acuity, resident assessments, care plans, census and other relevant factors as determined by the facility.
[18] 10/18/19 Nursing Facility Taskforce Workforce Presentation, Massachusetts Senior Care Association, presented by Tara Gregorio, President, 10/18/19 Nursing Facility Taskforce Workforce Presentation, slide 18 https://www.mass.gov/doc/october-18-2019-presentation-msca/download.
[19] Nursing Facility Accountability and Supports Package 2.0, September 10, 2020, page 2 (including footnote 1), https://www.mass.gov/doc/covid-19-nursing-facility-accountability-and-supports-package-20/download.
[20] Long-term Care Community Coalition staffing data for Q3, 2021 https://nursinghome411.org/data/staffing/staffing-q3-2021/. Total Direct Care Staff combines hours from RNs, LPNs, and nurse aides (CNAs, Med Aide/Tech, and NA in Training) that are directly involved in resident care while excluding Admin & DON. Total RN Care Staff excludes RN Admin & RN DON. The data for the schedule is taken from the PBJ Daily Nurse Staffing Data for Q3 2021.