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Medicare and Medicaid Programs: Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting

CMS–3442–P

Comments submitted by Dignity Alliance Massachusetts

CMS-2023-0144-0001

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Dignity Alliance Massachusetts (Dignity Alliance) submits this testimony in response to "Medicare and Medicaid Programs: Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting. File code: CMS-3442-P". Dignity Alliance, a grass-roots coalition of aging and disability service and advocacy organizations and supporters, works to secure fundamental changes in the provision of long-term services, support, and care. Dignity Alliance is a coalition of more than 30 organizations committed to a new vision of dignity and care for older and disabled people in Massachusetts.

Dignity Alliance's overarching position regarding CMS-3442-P is that the proposed rule does not go far enough to protect nursing home residents and nursing home staff. Furthermore, even a stronger rule will not be effective without meaningful oversight and enforcement by federal and state agencies.[1]

[1] Since 2020, two Office of Inspector General reports on DPH operations in 50 states:

- U.S. Health and Human Services Office of Inspector General, January 2022, OEI-06-19-00460: https://oig.hhs.gov/oei/reports/OEI-06-19-00460.asp. 2015-18: MA DPH failed by large margins to meet 95% threshold to initiate surveys of high-priority complaints within 10 days.
- Office of the Inspector General (OIG), States continued to fall short in meeting required timeframes for investigating nursing home complaints: 2016-2018, September 2020, OIG OEI-01-19-00421, Data Brief, Results page 6, https://oig.hhs.gov/oei/reports/OEI-01-19-00421.pdf
  2011-18: MA DPH one of only 10 states that failed to perform timely investigations of high priority complaints for 8 consecutive years.

Our history lays the foundation for this position. In the fearful, early days of the COVID-19 Pandemic, as the abject failure of nursing homes serving some of our most vulnerable residents became more apparent, several Massachusetts leaders in the fields of aging, disabilities, and caregiving came together to advocate for a better system of care. Our founding group included a former MA Secretary of Elder Affairs, a co-founder and long-time Executive Director of the Massachusetts Advocates for Nursing Home Reform, the Executive Director of the Boston Center for Independent Living, and the former MA Senate Chair of the Joint Legislative Committee on Health Care Financing, collectively representing nearly a century of experience developing public policies serving the needs of older adults, people with disabilities and their caregivers. Over the past three years, this core group of experts has expanded exponentially, providing greater depths in the observations of the shortcomings of the long-term care industry as "caregivers", too often placing corporate profits before the needs of vulnerable people. We have also, sadly, witnessed a substantial failure of federal and state government oversight and enforcement to protect those in the twilight of their lives. Dignity Alliance has developed as a non-profit, all volunteer coalition of individuals and organizations experiencing increasing success in advocating for our most vulnerable citizens. Our combined knowledge and experience served as the basis for our detailed presentation in support of our testimony.

INFORMATION IN SUPPORT OF OUR POSITION: In order to protect nursing home residents and staff from harm, to ensure high quality of life for residents and a safe workplace for nursing home staff, the following steps are essential to the establishment of a meaningful minimum staffing standard rule:

1. **Require nursing homes to meet a total staffing standard of at least 4.1 hours per resident day (HPRD) within two years.**

   The total should be comprised of at least:
   - **1.3 HPRD of licensed nursing care composed of not less than .75 HPRD registered nurse (RN) care, (*Dignity Alliance strongly supports this requirement*) and**
   - **2.80 HPRD of not less than certified nurse aide care (CNA).**

   RNs, LPNs, LVNs, and CNAs each have important roles in the provision of quality care to residents. The staffing standard should address total direct care for residents. These staffing levels are supported by decades of research and by the Staffing Study commissioned by CMS last year.
   The standards should not be a "one-size-fits-all" approach to staffing. By this Dignity Alliance means that the 24/7 RN rule should apply for every 40 residents so that in larger nursing homes there would need to be more than one RN on duty and this should apply to evening and weekend shifts as well.

Phase in period: There also needs to be a phase in period before the targeted implementation, rather than permitting nursing homes to wait until the implementation date to comply.

Financially viable: These additional staffing requirements are financially feasible, since the costs would be less than five percent of the more than $100 billion that nursing homes receive from Medicare and Medicaid annually.

In order to comply with the new staffing minimum, the nursing home industry claims that they don't receive enough government (spelled "taxpayer) funding to cover costs.[2] This tired trope has been raised since Medicare and Medicaid began covering long-term care in nursing homes. Nursing homes have never made their financial situation public, transparent, or easily understandable to justify this demand. They often raise the specter of insufficient payments, resulting in their inability to serve older adults and people with disabilities.[3]

Strengthen home and community-based services: As the new staffing regulations are being "phased in", the federal government should also focus on strengthening home and community-based supports and services that promote dignity and independence, and that is sought by at least 88% of Americans over age 65.[4] Such resources are critical to successfully support transitioning nursing home residents to the community. For instance, when mental health institutions, which had a poor record of treatment, were closed in the nineteen seventies, at least in Massachusetts, there was insufficient housing and services to accommodate the displaced residents.

Support small house model: Furthermore, the federal government and the states need to prepare for implementation of the minimum staffing requirement by supporting construction of small house model (similar to those recommended by the Veteran's Administration). These improvements are needed so that those nursing home residents who may be unable to return to a level of independent living, especially those with dementia, have more appropriate 24/7 care settings.[5]

Impact from the COVID-19 Pandemic: More than 200,000 – residents and staff of skilled nursing facilities across the United States[6], over 6,000 in the Commonwealth of Massachusetts alone, died during the COVID – 19 Pandemic. This

[2] Medicaid and Nursing Homes: Don't Believe Owners and Operators That All Medicaid Rates Are Too Low - Center for Medicare Advocacy

[3] Nursing Home Owners Drained Cash During Pandemic While Residents Deteriorated - KFF Health NewsKFF Health News

[4] LTC_Report_AgingatHome_final.pdf (apnorc.org)

[5] https://www.cfm.va.gov/til/space/spChapter106.pdf#:~:text=Small%20House%20%28SH%29%20Model%3A%20A%20VA%20facility%20or,House%2C%20the%20Neighborhood%20Center%2C%20and%20the%20Community%20Center.

[6] https://www.kff.org/policy-watch/over-200000-residents-and-staff-in-long-term-care-facilities-have-died-from-covid-19/.

number, arguably, understates the real total loss of lives since it fails to include those who died of depression, loneliness, and neglect.

Staffing shortages in nursing homes were a factor in long-term care before COVID. However, staffing shortages became more serious during the Pandemic and continue to adversely impact residents and staff in the post-COVID era. When staff are expected to care for too many residents, especially an increasing number with complex mental and physical health issues, care suffers and residents are left in unsafe conditions.

Working Conditions: Experience has demonstrated that the overwhelming majority of nursing homes are unwilling to invest in providing "sufficient staffing", let alone needed capital improvements, claiming that the level of reimbursement is inadequate to provide care. The nursing home industry asserts that during a workforce shortage across the economy, workers cannot be found even if the funding is available. However, the major problem is not that workers cannot be found, but that pay and benefits, plus unhealthy working conditions, are insufficient to retain staff.[7] In most instances, the problem is less one of not enough people to hire, but failure to provide a living wage[8] and requiring staff to care for too many residents that has produced high turnover rates.

Federal staffing reports: The federal government (CMS) has long recommended "sufficient nursing home staffing" to meet care needs, but did not previously mandate a specific minimum ratio. On September 1, 2023, at the direction of President Joseph R. Biden, CMS proposed minimum staffing standards that nursing homes must meet, based in part, on evidence from a new research study[9] that focus on the level and type of staffing needed to ensure safe and quality care.

As the HHS Office of Inspector General reported in August 2020 (081-04-18-00450)[10] **"CMS has identified nurse staffing as a vital component of a nursing home's ability to provide quality care**. Nursing staff are responsible for delivering care, ensuring residents' care plans are followed, and providing most of the day-to-day care for residents. This OIG review, initiated before the COVID-19 pandemic emerged, focuses on staffing data from 2018. However, the 2020 pandemic reinforces the importance of sufficient staffing for nursing homes, as inadequate staffing can make it more difficult for nursing homes to respond to infectious disease outbreaks like COVID-19. Our analysis raises concerns about the reported daily staffing levels for some nursing homes and about how well the Staffing Star Ratings on the Nursing Home Compare website, which uses quarterly averages only, convey enough information to consumers about nursing home staffing."[11]

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[7] Poor Management Skills: "A Contributing Factor to High Turnover Rate in Nursing Homes" (fortuneonline.org)

[8] ~~Living Wage Calculator (mit.edu)~~

[9] Find link.

[10] https://oig.hhs.gov/oei/reports/OEI-04-18-00450.pdf.

[11] Some Nursing Homes' Reported Staffing Levels in 2018Raise Concerns; Consumer Transparency Could Be Increased, OEI-04-18-00450 (hhs.gov)

The Nursing Home industry argues that the regulations are meaningless since they cannot find staff to fill vacancies. However, at least 25%[12] of Massachusetts nursing homes exceed state staffing requirements, demonstrating that it's possible, by treating staff with respect, keeping caseloads reasonable, and paying a living wage, staff can be found.

2. Waivers should not be granted to facilities that cannot provide a level of care that ensures resident safety and avoids staff burnout and turnover.

Nursing home residents all have similar needs. Consequently, we strongly recommend that there should be NO exemptions to the staffing rule. To ensure equity, staffing rules should also be standardized and not vary from one nursing home to the next.

- However, if exemptions are provided, the exemption should be limited to one-year, with a cap on the number of times such an exemption is allowed.

There should be NO exemption from the requirement to have RN coverage on a 24/7 basis. There needs to be enough RNs depending on the size of the facility. Supervisory RNs such as the Director of Nursing or the Infection Preventionist should not be counted to meet the minimum staffing rule.

Registered Nurse Time Studies have shown a relationship between greater RN presence in facilities and higher quality of care. Higher RN staffing levels are associated with fewer pressure ulcers; lower restraint use; decreased infections; lower pain; improved activities of daily living (ADLs); less weight loss, dehydration, and insufficient morning care; less improper and overuse of antipsychotics; and lower mortality rates.[13]

State Nursing Home Staffing Standards Summary Report: "Increased RN presence is essential for a number of reasons. Over the last several decades, the acuity level of nursing home residents has increased dramatically. This requires expert nursing skills and a high level of knowledge for oversight of care and to anticipate, identify and respond to changes in condition. The higher acuity level of residents requires the presence in the facility at all times of someone who is capable of assessing and responding when residents' medical conditions suddenly change or deteriorate. RNs by training and licensure are the only nursing staff with the skills that are essential for timely assessment, intervention, and treatment."

Dignity Alliance recommends that if any exemption application is submitted, the application should be considered *prima facie evidence* that the facility or group of facilities are not in compliance with minimum staffing and, are therefore, not

[12] Based on Q1, 2023 staffing statistics, most recent available at this time.

[13] Harrington C, Dellefield ME, Halifax E, Fleming ML, Bakerjian, D. Appropriate Nurse Staffing Levels for U.S. Nursing Homes. Health Services Insights. 2020; vol. 13.

providing quality and safe care. In addition, any nursing home seeking an exemption, should:

- Be required to include on their web site a list of any deficiencies cited in the past five years and corrective action taken in each case.
- Be required to assume the cost of the preliminary survey in order not to frivolously apply for exemptions. States are under -staffed with surveyors and an unusually high number of exemption applications could easily overwhelm state survey agencies from conducting their inspections of all nursing homes, including those claiming to meet the regulation requirements.
- Not have exemption approved for any facility that relies on temporary staffing when the staffing provider is a related third party to the facility or when temporary staffing receives a higher rate of pay than the facility's regular staff.[14]
- File the request for extension from compliance with CMS staffing minimum as a public record and available on a searchable database for public comment to ensure that eligibility requirements are met.[15]
- Have new admissions frozen or, at least monitored, to promote safe care.[16]/[17]
- Be required to submit independently audited cost reports, including finances of related third parties to demonstrate true transparency.[18]/[19]
- Evaluate and justify the use of antipsychotic, antianxiety, and anti-depressive drugs. Too often, understaffed facilities improperly employ medication to sedate residents in order to reduce demands on care staff.[20]

Greenhouse or VA small home models focus on person-centered care and may have different staffing needs. Should they be governed by a different set of rules?

If waivers are granted, the criteria for waivers should be location (proximity of next closest nursing home with capacity for additional residents), demonstration of a good faith effort to hire and retain staff. Said "good faith" effort must include a recruitment and retention plan in accordance with 42 C.F.R. S 483.71 (b)(5).

Demonstrated financial commitment such as compliance with requirements in states such as New York, Massachusetts, and New Jersey that 75% or more of revenues be expended on staff, with a means to independently confirm that commitment.

Exclude certain nursing homes from eligibility for waivers, such as nursing homes on CMS special focus facility listing and special focus facility candidates, one star nursing

[14] AG Campbell Issues Advisory on Maximum Rates for Temporary Staffing in Nursing Homes | Mass.gov
[15] https://www.faegredrinker.com/-/media/files/linked-articles/the-need-for-data-transparency-in-skilled-nursing-facilities.pdf
[16] Most US nursing homes are understaffed, potentially compromising health care for more than a million elderly residents (theconversation.com)
[17] Nursing Home Staffing at All-Time Low; Which Solutions Will Help? - Center for Medicare Advocacy
[18] 2023-Related-Party-Report.pdf (theconsumervoice.org)
[19] Nursing Home Quality and Financial Performance: Is There a Business Case for Quality? - PMC (nih.gov)
[20] Long-Term Trends of Psychotropic Drug Use in Nursing Homes, OEI-07-20-00500 (hhs.gov)

homes, nursing homes with an abuse icon, a pattern of serious regulatory violations, etc.

Demonstration that the provider-population ratio is at least 20%, per statistics provided by the Bureau of Labor Statistics, or are above the national average.

A history of failure to meet minimum staffing standards should not be a criteria for initial exemptions or waivers, since nursing home oversight agencies have frequently not cited nursing homes for insufficient staffing, and since the federal standard of "sufficient to meet the needs of resident acuity," has not been objectively defined.[21]

3. **Restrict new admissions when minimum staffing levels are not met.**[22]

   Requiring nursing homes to freeze admissions when they fail to meet minimum staffing regulations is a common method used in nursing homes across the country.[23] This should be one method of enforcement. Another method for handling new admissions when there has been a determination that staffing level regulations are not met, those new admissions should not be eligible for reimbursement until staffing levels have been in compliance for at least the previous six months.

4. **Reduce the time frames for implementation, particularly in rural areas and require phased in compliance for all nursing homes, but no longer than two years.** Federal studies have demonstrated no significant difference between rural and non-rural facilities.

   The National Academy of Medicine (formerly the Institute of Medicine) called for minimum staffing standards in 1986, and the 1987 Nursing Home Reform Act gave the U.S. government authority to create staffing standards. In 2001, a Centers for Medicare and Medicaid Services (CMS) study said each nursing home resident needed at least 4.1 hours of direct care a day to avoid being at risk of harm.[24]

   Nursing home eligible older adults have waited for over twenty years for sufficient staffing to be specifically defined but they need to be at a level that ensures quality and safety.

5. **Require oversight agencies to enforce minimum staffing rules, and establish meaningful penalties, or risk loss of federal funding.**
   According to CMS, this proposed rule would establish minimum staffing standards to address ongoing safety and quality concerns for the 1.4 million residents receiving care in Medicare and Medicaid certified Long-Term Care (LTC) facilities.

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[21] Failure to Meet Nurse Staffing Standards: A Litigation Case Study of a Large US Nursing Home Chain - PMC (nih.gov)

[22] What Can and Must Be Done About the Staffing Shortage in Nursing Homes (medicareadvocacy.org)

[23] https://www.news5cleveland.com/news/local-news/staffing-shortages-causing-nursing-homes-to-freeze-admissions

[24] https://www.cms.gov/blog/centers-medicare-medicaid-services-staffing-study-inform-minimum-staffing-requirements-nursing-homes

CMS states that a major purpose in proposing the update to nursing facility regulations is that the new rule would be used to survey facilities for compliance and enforced as part of CMS's existing survey, certification, and enforcement process for LTC facilities.

Inadequate staffing has existed in nursing homes for decades. As stated above, nearly 30% of MA nursing homes do not meet the Commonwealth's minimum staffing regulation of 3.58 HPRD - .58 higher than the proposed national standard. Fifty percent do not meet the new minimum of 3.0 HPRD.[25]

Sadly, it's not surprising that so many nursing home residents and staff died from COVID-19, since most nursing homes were not adequately staffed or prepared for such a highly contagious virus – it's worth repeating these tragic figures also stated above: nationally, over 200,000 nursing home residents and staff died, and over 6,000 died in Massachusetts. Homes with better staffing experienced fewer deaths.[26] Nursing home residents and staff account for nearly 30% of all COVID deaths in the state. Massachusetts has not effectively provided oversight of nurse staffing regulations. Without meaningful federal staffing oversight and significant sanctions, the new federal minimum staffing will not improve care.

6. **Minimum staffing compliance must be monitored beyond a survey of those seeking exemptions. Funding for compliance should be sufficient to enforce the regulations through annual and surprise survey inspections.** States should be required to certify that they have sufficient staff and that staff are actively enforcing minimum staffing regulations, as well as all other federal or state requirements, or face a reduction in Medicare and/or Medicaid reimbursements. If any exemptions or waivers are granted beyond the initial waiver, an updated survey should be conducted for each extension.

   Strong federal oversight and penalties are critical to ensure the safety and well-being of residents, especially since penalties imposed for abuse of state regulations can vary widely between states. For instance, even though MA has specific financial penalties built into its current staffing standard requirement, the state's overall penalty for infractions against MA nursing home regulations is a mere $50/day! And if the fine is not paid on a timely basis, the $50 late penalty accumulates daily until paid, but only to a maximum $5,000![27] Hardly a deterrent.

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[25] HPRD statistics as of 3/31/23, most recent available data on following website: https://nursinghome411.org/data/staffing/staffing-q1-2023/

[26] Study of US nursing homes with one or more COVID-19 cases found that high nursing aide and total nursing hours were associated with a lower probability of a COVID-19 outbreak and with fewer deaths. Georges RJ, Konetzka RT (2020) Staffing Levels and COVID-19 Cases and Outbreaks in U.S. Nursing Homes. JAGS 68: 2462-2466 https://agsjournals.onlinelibrary.wiley.com/doi/full/10.1111/jgs.16787

[27] 10/13/21 MA Department of Public Health Memorandum, Fines for Violations of, or Continued Non-Compliance with, State Long-Term Care Facility Regulations, https://www.mass.gov/memorandum/fines-for-violations-of-or-continued-non-compliance-with-state-long-term-care-facility-regulations?_gl=1*zqbjsy*_ga*MTgzMDM0ODkxNy4xNjk0ODE1NDE0*_ga_MCLPEGW7WM*MTY5ODU2MjUzMy42LjAuMTY5ODU2MjUzMy4wLjAuMA.

As U.S. Senator Robert Casey of Pennsylvania, Chair of the Senate Committee on Aging, has stated. "However, in order to make sure the proposed rule has this intended effect, we must also address the severe staffing shortages my investigation uncovered at state nursing home survey agencies across our Nation." Per this May 2023 US Senate Committee on Aging report, Uninspected and Neglected[28], it is clear that states, like Massachusetts, need help to improve nursing home surveillance:

- MA ranks 30th in US along with Puerto Rico for the # nursing homes a surveyor handles – 30 nursing homes per surveyor.
- MA ranks even lower, 39th in US along with Puerto Rico, for the # residents that a surveyor is responsible for --- 504 residents per surveyor.

7. **Dignity Alliance recommends that the phase-in period be much more limited than at present. The phase-in for RN staffing for two years in urban settings and 3 years in rural settings, and the phase-in for care staff of 3 years in urban and 5 years in rural settings are inappropriate**. There appears to be no evidence for the differential between rural and urban settings, and no validity to the length, especially when facilities can, by seeking an exemption(s), drag their feet even longer. Residents in rural facilities have the same level of needs as those in urban facilities, every resident deserves quality care today.

   Data compiled by the Administration on Aging places the average length of stay at a nursing home at about one year[29]. Assuming that a facility does not seek one or more one-year exemptions, an older adult entering the nursing home after the regulations are final, assuming no subsequent litigation and assuming effective enforcement of the minimum staffing standards, is unlikely to benefit from the new requirements.

   Residents and staff have waited more than twenty years since the initial 2001 staffing study recommending 4.1 HPRD. While it is reasonable, given workforce issues in nearly every field, to allow a limited time for implementation, nursing homes have been under a "sufficient staffing" requirement for years. Implementation must occur within one year from the date of final publication of the rule!

8. **Temporary staffing should not be countable toward achievement of minimum staffing requirements**. Only permanent staff should be countable in determination of compliance. Temp nurses, temp CNAs, and their pay differentials lead to unhappiness with regular staff and create low morale and more turnover. Temp nurses and CNAs add to increased cost, without an increase in care quality, since they are unfamiliar with residents and coworkers. Residents, especially those with dementia, are more comfortable receiving care from familiar staff, who also know resident needs.

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[28] *Uninspected and Neglected*, US Senate Committee on Aging, Table 1. Nursing Homes, Certified Beds, and Surveyor Positions, by State, FY22, pages 74-75.
Report: https://www.aging.senate.gov/imo/media/doc/UNINSPECTED%20&%20NEGLECTED%20-%20FINAL%20REPORT.pdf
Announcement: https://www.casey.senate.gov/news/releases/casey-unveils-new-report-detailing-nursing-home-oversight-crisis
Further Background: https://www.axios.com/2023/09/07/nursing-home-enforcement-staffing

[29] https://acl.gov/ltc/basic-needs/how-much-care-will-you-need.

9. **Many states have nursing home staffing requirements higher than the level selected by CMS. Massachusetts, for example, requires direct care staff to be at a level of 3.58 HPRD. There needs to be a requirement that any state that reduces or eliminates a nursing home staffing level that is higher than the federal minimum will have their Medicaid reimbursement cut by the same ratio as the staffing minimums.** In the alternative, states that maintain a higher ratio than the national standard should be rewarded. As President John F. Kennedy stated, "A rising tide lifts all boats." In a similar way, encouraging states to maintain or increase minimum staffing ratios will be better for residents and staff, by providing an incentive not to default to a national minimum.

10. **Use of "prevailing wages" should not be the basis for determining "good faith" effort in hiring care staff,[30] since the prevailing wage of care staff is already too low. Dignity Alliance suggests that the "prevailing wage rates" for care staff in most regions are insufficient to attract and retain qualified nursing and nurse assistant care, unless the calculation of prevailing wage includes acute care hospitals.** If the rates fail to include all nurses and nurse assistants, not just those employed in long-term care, nursing homes will continue to lose the best candidates to acute care hospitals. Another alternative in determining wages, if only long-term care rates are used, might be to set a percentage above that prevailing rate. Prevailing wage requirements are often used in construction trades (Davis-Bacon Act) to require contractors to pay a rate comparable to the collectively bargained union rate since contractors in non-government construction projects often pay below the union rate which is based on the training and apprenticeship requirements among union workers. While some nursing home staff hold membership in a union, the practice is not universal. Caregivers need to earn a "living wage" in order to be attracted and retained in long-term care.[31]

    Nursing Home ownership issues need to be addressed for all nursing homes.[32] While regulations have been improved, it is still difficult for government agencies, advocates, and researchers to understand who are the true owners of nursing homes. Data must be transparent and searchable and should include anyone who has any financial interest in a nursing home or related third parties in a searchable database. Many states, including MA, have an ownership interest reported of at least 5%. However, as the New York Attorney General has found, even a 1% interest can still be involved in fraudulent activities. Kansas requires any amount of interest to be subject to disclosure.

11. **Cost reports submitted by nursing homes to CMS and to state agencies, such as the Massachusetts Center for Health Information and Analysis CHIA), must include consolidated financial information including finances from related-third parties** that are able to charge whatever the owners (who are often similar to the owners of the nursing home) want to charge. These charges are not competitive and do not fairly represent what a willing buyer would reasonably pay a willing seller in the open market.

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[30] https://www.americanprogress.org/article/prevailing-wages-frequently-asked-questions/

[31] Livable Wage by State [Updated June 2023] (worldpopulationreview.com)

[32] CMS Posts More Nursing Home Ownership Data | CMS Compliance Group

Too often the data, if it is submitted at all, is incomplete, a year or two old, and in a pdf format. For proper oversight and research, the data must be public, as current as possible, and in an Excel or similar format that is searchable. Here is a link to the latest data available on the CHIA website --- 2020 cost reports: https://www.chiamass.gov/long-term-care-facility-cost-reports/#nursing-homes.

To further support our plea for a user-friendly searchable database for financial and statistical nursing home cost reports and other related data, it should be noted that the CHIA reports currently available online are in pdf form and over 60 pages each. The downloadable searchable Excel file provided to us was more than two thousand lines of data covering over 350 nursing homes. All data had to be manually reorganized into financial statements and various reports, creating a monumental project just to locate and reorganize the data into a usable format.

Dignity Alliance is currently analyzing 2019 and 2020 cost reports, and here are several 2020 MA findings that support the fact that nursing homes already have the financial means to provide a quality-staffing standard --- without additional funding. In 2020:

- 359 MA nursing homes had a combined net profit of $73.6M, meaning that 56% of all MA nursing homes were profitable: 59, or 60%, of non-profit nursing homes and 142, or 55%, of for-profit nursing homes.
- The $134.4M of depreciation provides some flexibility to funding staff on an emergency, or possibly ongoing basis, by managing capital expenditures. Technically cash retained due to depreciation could be used currently for staffing as needed, as long as capital expenditures are managed safely.
- Furthermore, "administrator" and "key people" expenditures are very high, again utilizing 2020 data and again showing that nursing homes can find funding when needed: 50% of nursing homes paid Administrator salary and benefits of $150,000 or more, with some salary packages exceeding $300,000. Furthermore, reporting the three highest paid positions for "key people" (no titles were given) is also required, separate from the Administrator data. The top highest paid position was paid an average of about $180,000 per year.

12. **Minimum staffing compliance must be monitored beyond a survey of those seeking exemptions. Penalties for compliance should be sufficient to enforce the regulations through both annual and surprise survey inspections.** States should be required to certify that they have sufficient staff and that staff are actively enforcing minimum staffing regulations, as well as all other federal or state requirements, or face a reduction in Medicare or Medicaid reimbursements.[33]

Financial penalties appear to be insufficient to cause meaningful corrective action, and are often viewed as simply the cost of doing business. Penalties for failure to comply

[33] The danger of nursing homes defying federal staffing guidelines (usatoday.com)

with minimum staffing regulations need to be significant.[34/35] Please refer back to issue 6. for discussion of the extremely low $50/day penalty rate for infractions against the majority of MA nursing home regulations.
Documentation of how much facilities spend on nurse staffing is critical to the success of these regulations. Massachusetts law and regulations for nursing homes require calculation of what's called the Direct Care Cost Quotient (DCC-Q). Massachusetts requires that at least 75% of nursing home revenues be utilized for DCC-Q expenses, including: direct care staffing salaries and benefits; plus other defined resident costs, such as food, dietary, laundry, and housekeeping supplies. For every 1% below the 75% DCC-Q threshold, a 0.5% downward adjustment is imposed[36]. Of course to ensure compliance, this needs to be independently audited with the outcomes publicly reported.

The DCC-Q could serve as a possible model for CMS to monitor ongoing compliance with staffing. Setting a minimum ratio of revenue to be applied to staffing should be accompanied by efforts to provide incentives to reduce turnover of staff and to retain qualified employees. Some nursing homes have added a day care facility to attract and retain staff with children.

13. **Missing from the provisions of the new staffing rule is a provision to hold state survey agencies accountable for active oversight and enforcement.[37]**
A USA TODAY investigation has documented, for the first time, how rarely the federal government enforces decades-old staffing guidelines and rules for nursing homes. Citations and penalties remained sparse even as regulators developed three ways to measure staffing. [38] Using a record of citations for "insufficient staffing is not a meaningful statistic on which to base exemptions from the new staffing rules, since there was no specific federal standard, only the vague term, "sufficient," on which to base citations for a deficiency.

14. **The proposed staffing rule, should recognize the need to require a full-time social worker for every forty residents.[39] It is the social worker who interacts with:**
Residents/Families who do not understand why a service has changed.

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[36] Administrative Bulletin 21-02 2/20/21: https://www.mass.gov/doc/administrative-bulletin-21-02-101-cmr-20600-standard-payments-to-nursing-facilities-nursing-0/download. Eligible direct care workforce expenses attributable to the following workforce categories: RNs, LPNs, CNAs; non-certified or resident care aides; director of nurses; in-house clerical staff regularly interacting with residents and caregivers (e.g., receptionists, business office staff working onsite), for resident care only: food and dietary supplies; laundry and housekeeping supplies. Also, expenses attributable to recreational therapy and social service worker workforce categories multiplied by 1.5 before being added to the overall direct care workforce expense amount.

[37] Tougher Federal Penalties to Come for Failing Nursing Homes (usnews.com)

[38] The danger of nursing homes defying federal staffing guidelines (usatoday.com)

[39] Despite Their Importance, Many Nursing Homes Lack Social Workers (forbes.com)

Residents who are upset about a roommate and their choices about sleep time, TV on/off, etc.
Staff who find it a challenge to work with families who advocate for residents.
Families who refuse to speak or work with a staff member of a color different than the family member or who uses a different language.
Staff who find it difficult to work with residents who do not cooperate with them.
All staff as social workers train them about dementia, behavior issues, impacts by families, etc.

15. **Staffing regulations should recognize the need for a full-time infection preventionist[40] in every nursing home as recommended by the Association for Professionals in Infection Control and Epidemiology (position should not be counted to satisfy the RN staffing regulations).[41/42]**

[40] *APIC Calls for Properly Trained Infection Prevention Expertise in All New York State Nursing Homes*, 2/11/21, https://apic.org/apic-calls-for-properly-trained-infection-prevention-expertise-in-all-new-york-state-nursing-homes/.
[41] Relias Media
[42] Nursing Homes Need Fulltime Infection Preventionists (infectioncontroltoday.com)