AAPACN
AMERICAN ASSOCIATION OF POST-ACUTE CARE NURSING

June 10, 2022

Centers for Medicare & Medicaid Services
Washington, DC 20201

Via electronic submission

RE: CMS-1765-P
Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2023

Dear Administrator Brooks-LaSure,

The American Association of Post-Acute Care Nursing (AAPACN) is a professional association representing more than 15,000 long-term and post-acute care nurses across the country. AAPACN is dedicated to supporting nurses and other healthcare professionals by providing education, certification, and resources to foster strong, collaborative communities. AAPACN's programs and initiatives support and drive high-quality care in long-term and post-acute care (LTPAC) settings.

AAPACN respectfully submits these comments in response to the Centers for Medicare & Medicaid Services' (CMS's) **request for information on aspects of staffing in long-term care (LTC) facilities to establish a mandatory minimum staffing level** within the proposed rule for the Fiscal Year 2023 Skilled Nursing Facility Prospective Payment System (SNF PPS). AAPACN's comments offer a close-up perspective on the current state of nurse staffing in post-acute and long-term care facilities while also providing recommendations to help build the necessary nursing workforce. AAPACN strongly urges that, prior to the establishment of any skilled nursing staffing mandate, CMS spearhead new initiatives to recruit, retain, and revitalize nurses in this provider sector.

AAPACN recognizes the need for Medicare beneficiaries to receive individualized, person-centered care in an environment that is safe, compliant with regulations, and meets the expectations of both CMS and the public. We share the goal of ensuring Medicare beneficiaries have quality outcomes. In addition, AAPACN recognizes that nurses should work in an environment that enables them to practice safely and supports their own health and wellness. With these reasons in mind, the initial idea that a mandated staffing level will achieve quality of care and support a healthy work environment in nursing homes seems reasonable. Patient advocates and policymakers have for years attempted to identify ideal staffing ratios and discussed possible staffing mandates. This includes the Staffing Study Phase II report, which recommended 4.1 total nursing hours per patient day (Feuerberg, 2001). However, to achieve and sustain compliance with a mandated minimum staffing level of 4.1 total nursing hours per patient day (PPD), there must be an available workforce to meet the mandated levels.

AAPACN strongly believes that the nursing shortage and loss of 400,000 healthcare workers since the start of the COVID-19 pandemic (AHCA, 2022) renders any staffing mandate unworkable and ill-advised,

at this time or in the near future. In addition, increasing staffing levels would significantly increase labor costs at a time when CMS has proposed to cut reimbursement rather than provide additional funding to meet rising staff costs. These proposals will exacerbate financial solvency issues for skilled nursing facilities, which will disproportionally impact nursing homes providing care in underserved and rural counties. It is fiscally impossible for many nursing homes, especially those caring for higher percentages of Medicaid recipients, to continue operating with the additional cost that meeting an unfunded mandated staffing level would impose.

Discussion: Funding

Cost of a Minimum Staffing Level

Based on 2021 data, the annual estimated cost of wages for the additional nursing home healthcare workers needed to achieve a 4.1 total nursing hours per patient day nationwide is $7.25 billion (Hawk, et al., 2021). Even this estimate may not sufficiently capture the cost since wages have risen significantly in the COVID-19 public health emergency (PHE). The 2021 Hospital and Healthcare Compensation Service survey found that 45.4% of survey respondents reported increasing their merit raise budgets over the last year (Marselas, 2021). Further, 79.4% of responding facilities said they had made pay adjustments for "key employees," most notably using hero or hazard pay (Marselas, 2021). CliftonLarsenAllen (CLA) conducted an analysis and found that wages for nursing department staff increased 28% from 2020 to 2022.

It is not realistic to expect that nursing homes alone can cover the annual cost of $7.25 billion—a number that continues to grow. Additional costs of this magnitude warrant further analysis of the costs versus benefit. Such analysis should involve various stakeholders to determine how such costs would be paid. The Staffing Study Phase II report recommendation for a 4.1 minimum staffing level acknowledges that "the fundamental policy issue [is] how these costs are distributed among providers, public payers (Medicare and Medicaid), and private payers. In addition, policymakers must consider how to strike an appropriate balance among competing objectives: spending sufficient money (both in rates and administrative costs) to achieve staffing objectives; reasonable cost containment; administrative feasibility; accountability; and equity" (Feuerberg, 2001).

Labor costs in the COVID-19 PHE have been exacerbated by anticompetitive pricing practices of staffing agencies that attract nurses to travel and accept temporary assignments. Nursing home providers report paying as much as four times the hourly rate for a staffing agency healthcare worker as compared to permanent staff. Associations representing nursing home providers have called for action from state and federal agencies to address this issue, asserting that not only are staffing agencies engaging in anticompetitive pricing practices, but they are also poaching healthcare workers from facilities with the promise of wages much higher than what nursing homes can pay. LeadingAge noted in a letter to the Federal Trade Commission, "Most long-term care is paid by taxpayers through the Medicare and Medicaid programs; neither program is structured to respond to excessive costs and so monies that should go to caring for residents are diverted to paying private agencies." Legislators have also recognized this problem and called upon the White House to enlist federal agencies that protect competition and consumer interest to investigate and address anticompetitive pricing (Welch, 2022).

Financial Solvency and Healthcare Disparities

Financially solvent facilities are necessary to ensure access to care in local communities, especially for Medicare beneficiaries rural and impoverished areas. In a 2022 analysis, 68% of counties in the United States were found to have facilities at financial risk operating in them. This is a significant increase from 2019 when 37% of counties were noted to have facilities at financial risk (CLA, 2022). In addition, the counties with financial at-risk facilities operating in them were found to have a higher percentage of racial and ethnic minorities, as compared to counties with facilities that were not at financial risk (CLA, 2022).

Rural facilities and those serving larger Medicaid populations will be the most challenged to meet a 4.1 total nursing hours per patient day minimum. An unfunded minimum staffing mandate that places the sole cost of covering additional staff on the facility will severely limit nursing homes' ability to accept admissions. The risk of nursing home closures in underserved areas is a very real threat. Both scenarios will result in health disparities for those Medicare and Medicaid beneficiaries who have the greatest need.

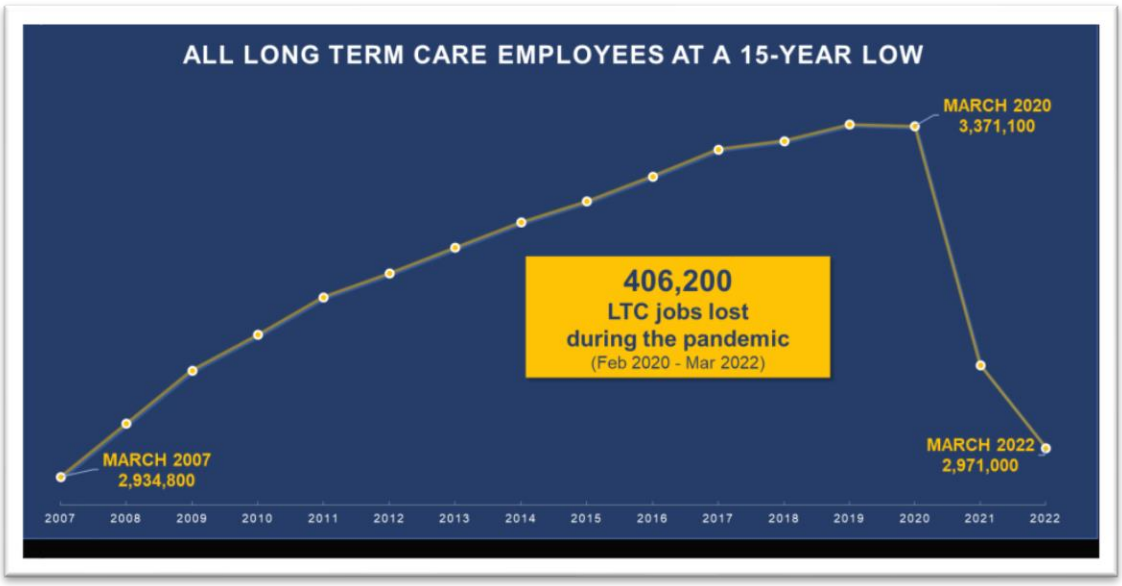
Discussion: Nursing Shortage

Healthcare providers across the U.S. are experiencing a shortage of healthcare workers, especially nurses. CMS and the Department of Health and Human Services (HHS) in 2021 designated the nursing shortage as an "extraordinary circumstance" (HHS, 2021). As a result, nursing homes cannot secure adequate staff to meet current needs with rural facilities citing the most difficulties (CLA,2022). In 2019, only 25% of nursing homes staffed at 4.1 total hours PPD (Hawk et al., 2022). Ensuring the remaining 75% of facilities met a 4.1 hours PPD level would require least an additional 35,803 RN full-time employees (FTEs); 3,508 licensed practical nurse (LPN) FTEs; and 116,929 certified nurse aide (CNA) FTEs. The researchers found that the factors most strongly associated with a facility not meeting the proposed minimum of 4.1 total nursing hours PPD were:

> Higher Medicaid census, larger bed size, for-profit ownership, higher county SNF competition; and, for RNs specifically, higher community poverty and lower Medicare census. Rural SNFs were less likely to meet all categories, and this was explained primarily by county SNF competition. (Hawk et al., 2022)

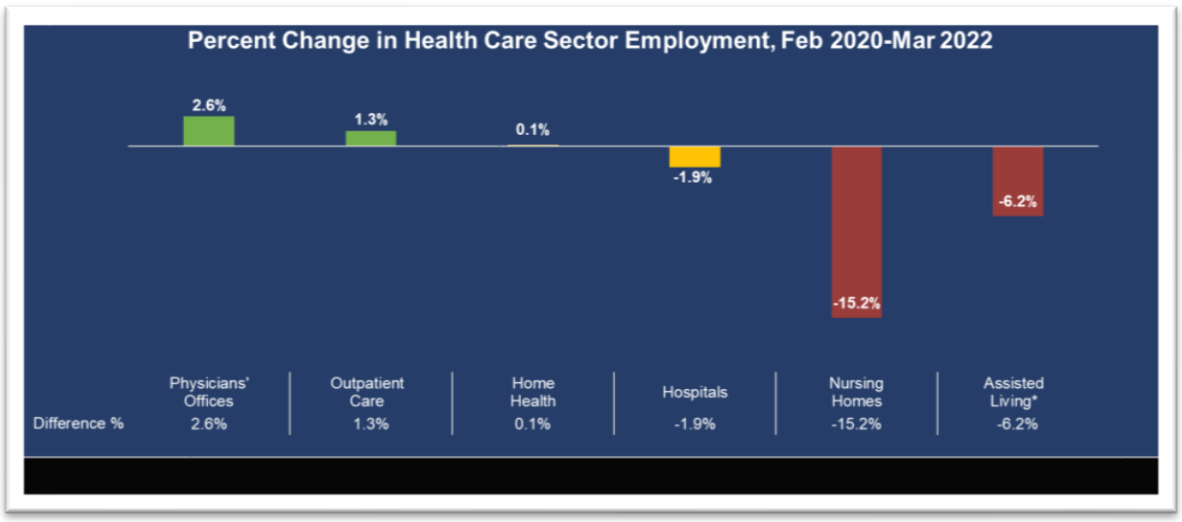
Nurses are not distributed evenly across the United States (Health Resources and Services Administration [HRSA], 2017). This substantial maldistribution results in acute nurse shortages in regions of the United States. HRSA's Health Workforce Simulation Model predicts the supply and demand of nurses based upon assumptions of the current status and the future trends in utilization. The most recent available projections are from prior to COVID-19; they do not reflect the worsened shortage of healthcare workers, including but not limited to nurses, due to the pandemic. COVID-19 dramatically changed healthcare, and one of the most harmful consequences is the "Great Resignation" of healthcare workers. One in five physicians and two in five nurses intend to leave healthcare (Sinskly et al., 2021). AAPACN members have reported losing staff to local grocery stores, fast food chains, and even professional level jobs because the healthcare worker can secure the same or even greater compensation while eliminating the high levels of exhaustion, stress, and burnout they endure alongside stigmas against nursing home employment.

The nursing shortage disproportionally affects nursing homes more than other healthcare settings. According to Bureau of Labor Statistics data, nursing homes lost more than 400,000 employees between March 2020 and March 2022 (American Health Care Association [AHCA], 2022). These losses represent 15.2% of the total nursing home workforce (AHCA, 2022). While the pandemic affected all healthcare settings, nursing homes have lost staff at an even greater rate than other providers. For example, between December 2020 and December 2021, nursing homes lost over 145,000 workers, while hospitals lost 33,000 (Office of the Assistant Secretary for Planning and Evaluation [ASPE], 2022, p. 6).



(AHCA, 2022)

Staffing in nursing homes is not rebounding as it is in other settings. Nursing homes remain at a disadvantage when recruiting due to their inability to offer wages competitive with other provider settings, especially hospitals.



(AHCA, 2022)

Other providers are also experiencing nursing shortages, however. The American Hospital Association [AHA] cites HHS data to report that 23% of hospitals have a critical shortage of workers, with nurses being a key component of that shortage (AHA, 2022). “Nurses, who are critical members of the patient care team, are one of the many health care professions that are currently in shortage. In fact, a study found that the nurse turnover rate was 18.7% in 2020, illustrating the magnitude of the issue facing hospitals and their ability to maintain nursing staff. The same study also found that 35.8% of hospitals reported a nurse vacancy rate of greater than 10%, which is up from 23.7% of hospitals prior to the pandemic. In fact, two-thirds of hospitals currently have a nurse vacancy rate of 7.5% or more” (AHA, 2022).

Nursing Shortage: Burnout and Stigma

The National Academy of Medicine identifies burnout as a significant problem for the nursing profession, which has dire consequences for the healthcare system at large (Kelly et al., 2020). HHS recognizes that nursing burnout can no longer be ignored and has made the issue a priority. U.S. Surgeon General, Dr. Vivek Murthy stated in May 2022 that “The nation’s health depends on the well-being of our health workforce. Confronting the long-standing drivers of burnout among our health workers must be a top national priority” (HHS, 2022). While burnout was a problem before the pandemic, “The COVID-19 pandemic has put extreme stress on the health care workforce in the United States, leading to workforce shortages as well as increased health care worker burnout, exhaustion, and trauma” (ASPE, 2022).

Chronic shortages of healthcare workers in nursing homes have several root causes, including but not limited to lack of funding to pay for human talent, burnout, and stigmas healthcare workers face when they choose to work in a nursing home. Nurses and other nursing home workers are uniquely at risk for burnout as compared to those working in other healthcare settings because COVID-19 has intensified the exhaustion they experience caring for vulnerable elderly who are much more likely to die from COVID-19 than the population at large. When exhaustion continues, healthcare workers experience burnout. The manifestations of burnout fuel and reinforce feelings of incompetence and failure, thereby diminishing the nurse’s sense of competence and self-esteem as a professional and undermining the nurse’s ability to recover (Kelly et al., 2020).

A recent study found that nurses working in nursing homes in four different countries feared contracting COVID-19 but were even more concerned about infecting residents with the virus (Sarabia-Cobo et al., 2020). The feelings of depression and anxiety nurses felt when residents died of COVID-19 was a key factor leading to emotional exhaustion and a sense of hopelessness. A lack of resources, particularly staff to share the workload, left nurses feeling physically and emotionally exhausted as well. Finally, the stigma against nursing homes and geriatric nurses caused them to feel disdain from the public at large, as if the care they were providing was inferior and unimportant when compared to that of the hospital setting (Sarabia-Cobo et al., 2020). When one understands the effects of burnout, it becomes clear why it is associated with job dissatisfaction, compromised performance, and the intention to turnover (Van der Heijden et al., 2019).

Nursing homes are desperate to attract workers but are also confronting a considerable stigma against working in a nursing home. Research (Manchha et al., 2020) identifies three overarching themes influencing the stigma against elder-care healthcare workers:

- Unfavorable characterization of geriatric nurses - Unfounded beliefs posit that geriatric nurses lack the ability to work in other healthcare settings and that unethical behavior is a common trait (e.g., geriatric nurses are lazy or aren't smart enough to work in the hospital).
- Elder care is of lower societal value - Because society does not value care as highly as a cure and does not believe caring for the geriatric population requires a high level of skill, those engaged in providing care are perceived to have lower professional status (i.e., because geriatric nurses don't provide a service that results in a cure or other highly valued outcome, their work is perceived as less important). In addition to the faulty assumption that care doesn't require skill to provide, there is also the belief that the work itself is dirty, with frequent references made to the provision of incontinence care.
- Negative emotional connotations associated with elder care - Society negatively perceives that the care environment for elderly people is sad, depressing, and boring.

The stigma of elder care has been amplified by the pandemic. While hospital healthcare workers were hailed as heroes during the pandemic, nursing home healthcare workers were portrayed as villains who provided poor care, spread COVID-19, and caused suffering and death. Despite numerous studies showing that COVID-19 outbreaks in the community are the biggest risk factor and correlate with outbreaks in nursing homes, falsehoods persist that greedy nursing homes with undesirable employees are to blame for the spread of COVID-19 and even the deaths of those living in nursing homes.

Recommendations: Establishing a Body of Knowledge

Most critically, AAPACN asks that prior to implementing a minimum staffing standard, CMS and other federal agencies work collaboratively and transparently with nursing homes and other stakeholders to address the shortage of healthcare workers. The shortage of nurses and other healthcare workers is a crisis that will not be solved with a mandate for nursing homes to hire people who simply are not available. Similarly, punitive measures will not result in the availability of more staff. Real change is necessary to stabilize staffing levels, recruit new caregivers, and ensure the availability of a competent, diverse, and mentally healthy workforce to provide needed care in all regions of the United States, including rural and underserved areas.

Second, AAPACN asks that CMS and other federal agencies accept the National Academies of Science, Engineering, and Medicine (NASEM) recommendation that "high-quality research is needed to advance the quality of care in nursing homes." (NASEM, 2022). Specifically, AAPACN believes that research is needed to understand the causal relationships and factors between staffing and quality of care and quality of life outcomes for different populations, acuity levels, and other resident-driven factors.

Healthcare has evolved significantly since the 2001 Staffing Study Phase II report. Nursing homes are not a monolith providing the same services and relying upon the same staff mix. Instead, the post-acute and long-term care profession innovates to deliver value, often specializing in the services provided to meet the needs of the communities served. This specialization of services requires flexibility in staffing mix to deliver value-based care. For example, nursing homes offering ventilator care may determine that a respiratory therapist is necessary to meet the needs of residents. In contrast, a nursing home specializing in memory care services may determine that adding music therapists and other life enrichment professionals would best meet the needs of residents. A nursing home specializing in short stay rehabilitation may determine physical trainers and restorative aides are the staff members needed

to provide high quality care and achieve desired outcomes. Research should explore circumstance-specific staffing mixes that include a variety of professionals with different skills and talents collaborating with the most effective mix of RNs, LPNs, and CNAs to produce value for the money spent. Policymakers must have these insights and perspectives to consider minimum staffing proposals. With that information, innovations across the country can be shared and promoted. Without it, arbitrarily determined staffing levels would likely suppress innovation, as facilities would be forced to move away from circumstance-specific staffing mixes.

The Staff Time and Resource Intensity Verification Project (STRIVE) studies contain two weaknesses that present major impediments for use in establishing staffing minimums. First, STRIVE includes nursing homes that did not produce any specific level of quality outcomes. Second, STRIVE measured the time to complete care, but did not study the time in relation to the mix of staff necessary to produce quality outcomes. The Staffing Study Phase II report provides compelling evidence of staffing thresholds in relation to quality-of-care outcomes, but the authors also advise that further analysis is needed to determine a federal level staffing requirement that can be applied to all nursing homes in the country.

Finally, AAPACN asks CMS to determine the cost versus the benefits of additional staffing and include negative outcomes in the analysis. For example, pursuing mandated staffing levels may inadvertently harm other priorities, such as access to care and health equity. Once a cost-benefit analysis is complete, it will be imperative for CMS and other stakeholders to find a reasonable balance of responsibility to cover the cost of the additional staff needed to meet the mandate.

Recommendations for Workforce Stabilization: Recruit, Retain, Revitalize

AAPACN offers the following actions and policy alternatives to a minimum staffing mandate. These actions will address the workforce crisis in nursing homes and help ensure a diverse and inclusive pool of healthcare providers.

Recruit

- Study the influences of stigma against elder care providers. Use the research to develop evidence-based strategies to combat stigmas that CMS, nursing homes, and other stakeholders can deploy.
- Promote wage parity among hospital and other post-acute care settings for nursing home workers, including CNAs, through wage pass throughs, state pay-for-performance programs, and other incentives.
- Emphasize that elder care is a core component of healthcare, not a second-class specialization deserving of stigma by collaborating with educational institutions to promote the inclusion of gerontological course work in nursing curricula, which may be in the form of mentorships, formal course work, clinical experiences, and other learning modalities.
- Offer tuition reimbursement to nurses, especially RNs, who agree to work in nursing homes located in rural and underserved populations.

Retain

- Incentivize facilities to invest in nurses' pursuit of certifications that will increase their level of confidence and competence as clinicians and leaders.

- Invest in the development of educational content that is based on person-centered care principles, gerontological caregiving, and leadership development.
- Continue to share staffing data on Care Compare with the public.

Revitalize

- Invest in research to explore the factors that cause burnout in the nursing home setting and develop evidence-based strategies that CMS, nursing homes, and other stakeholders can deploy to combat those factors.
- Coordinate efforts across CMS and the U.S. Surgeon General's office to tailor interventions addressing healthcare worker burnout for the nursing home workforce.
- Incentivize nursing homes to offer an employee health and wellness program that addresses burnout, supports mental health, and provides support services to help low-income workers.
- Increase reimbursement rates sufficiently to fund additional staff. The Staffing Study Phase II report (Feuerberg, 2001) acknowledged that costs must be distributed among providers and payers yet introducing a mandatory minimum staffing level without simultaneously increasing funding places the entirety of the financial burden on already-strained providers.

These non-punitive alternatives to mandating minimum staffing levels support those nursing homes most affected by the workforce crisis—which are the same nursing homes providing care and services to underserved and rural populations. Instead of penalizing some nursing homes because there are not enough RNs in the country to meet the needs of all healthcare providers, these actions will cultivate a diverse and inclusive workforce capable of meeting the unique needs of the population being cared for.

Recommendations: Align Current Data Collection for Staffing Measures

CMS poses specific questions on the measurement and evaluation of staffing levels. It is difficult to provide detailed responses absent a specified staffing minimum standard. However, AAPACN anticipates considerable problems with measurement of any mandated minimum staffing level.

- *CMS must remove short-term agency staff from inclusion in the turnover calculation.* The very nature of the arrangement of these workers employment is short-term. Therefore, the validity and reliability of the measurement is not accurate.
- *CMS must exclude from the turnover calculation workers who take an extended leave of absence, for example, for maternity or paternity leave.* Treating such temporary absences as staff turnover penalizes nursing homes for supporting their workforce and does not accurately reflect the intent of the measure.
- *CMS should expand the criteria constituting the healthcare professionals that can be captured in the Payroll Based Journal (PBJ) System and included in direct patient care hours.* For example, the system does not allow a nursing home to capture the work provided by professionals they deem necessary to care for residents such as mental health support service workers, music therapists, or respiratory therapists.
- *CMS should align the existing qualitative staffing requirements and any new quantitative staffing requirements.* If a minimum staffing level is mandated, there must be alignment

between the Five-Star Rating System and the SNF Value-Based Purchasing (SNF VBP) program. Currently, Five-Star staffing ratings are based upon the STRIVE study, which does not measure quality outcomes but rather the amount of time. If the intent of the mandatory staffing minimum is to produce quality, the Five-Star and SNF VBP measurement should reflect that as well. Nursing homes could then use this quantitative data to inform the qualitative analysis that occurs through the facility assessment to ascertain if they meet the requirement of "sufficient staffing."

Thank you for the opportunity to respond to this request for information. We are glad to serve as a resource for HHS and CMS. Please contact Amy Stewart, MSN, RN, DNS-MT, QCP-MT, RAC-MT, Vice President of Education and Certification Strategy, astewart@aapacn.org, if you have any questions about these comments or AAPACN's work to support nurses and other nursing home professionals.

Sincerely,

Tracey Moorhead
President and CEO

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