PHI QUALITY CARE THROUGH QUALITY JOBS

February 2, 2026

Re: Medicare and Medicaid Programs: Repeal of Minimum Staffing Standards for Long-Term Care Facilities (CMS-3442-IFC)

Thank you for the opportunity to respond to the interim final rule with comment period (IFC) *Medicare and Medicaid Programs: Repeal of Minimum Staffing Standards for Long-Term Care Facilities*. We strongly urge CMS to withdraw this IFC. Long-term care (LTC) facility residents and staff cannot wait for progress in the context of a nationwide LTC facility staffing crisis. Public Law 119-21 has delayed implementation of the 2024 Final Rule's staffing standards until 2034. CMS has an opportunity to use this delay to robustly address nursing home staffing by: investing in technical assistance to providers to address recruitment and retention challenges; supporting states in expanding the pipeline of LTC facility workers; and driving improvements in LTC facility workers' job quality. Minimum staffing standards for LTC facilities—along with significant investments from CMS to support job quality for nursing assistants and other nursing home workers—are critical to ensuring workers and residents are safe in our nation's LTC facilities.

About Us. PHI is a national organization committed to strengthening the direct care workforce by producing robust research and analysis, leading federal and state advocacy initiatives, and designing groundbreaking workforce interventions and models. For more than 35 years, we have brought a 360-degree perspective on the long-term care sector to our evidence-informed strategies. **As the nation's leading authority on the direct care workforce, PHI promotes quality direct care jobs as the foundation for quality care.**

PHI strongly opposes this IFC and urges CMS to withdraw it. This rule abandons standards that were carefully and thoughtfully crafted over decades, ignores overwhelming evidence linking adequate staffing to quality care, and fails to provide any viable alternative for ensuring the safety and well-being of this country's LTC facility workforce and residents.

In November 2023, PHI submitted detailed comments strongly supporting CMS' proposed minimum staffing standards for LTC facilities. The arguments we made in support of those standards remain valid and have only been reinforced by subsequent research. We have attached our 2023 comments as an appendix, as well as reiterating the key points here.

Notably, this repeal of nursing home staffing standards comes at a time when the direct care workforce faces multiple compounding threats. As PHI has documented, federal Medicaid cuts and increasingly harsh immigration policies are destabilizing this workforce and driving further declines in direct care job quality at a moment when the need for investment in this essential workforce could not be more urgent.[1] Repealing the one federal policy that would have established minimum nursing home staffing levels compounds these harms and removes a critical lever for workforce improvement.

The critical role of nursing assistants—in challenging conditions.
Nursing assistants (NAs) provide the vast majority of direct, hands-on care to LTC facility residents.[2] There are approximately 492,000 nursing assistants employed in LTC facilities across the U.S. and they are overwhelmingly women (91 percent) and people of color (61 percent), while 21 percent are immigrants.[3] They assist with activities of daily living, monitor changes in resident condition, and are often the first to identify and report emerging health concerns. They also provide invaluable social engagement and emotional support to nursing home residents.

In the absence of clearly defined and enforced staffing standards, these essential workers face workloads that compromise the safety of both workers and the residents they serve. NAs in nursing homes typically care for 11 or more residents per shift—a ratio that makes it impossible to provide adequate attention to each resident's needs or maintain their own and their residents' safety.[4]

Untenable workloads are a driver of extraordinarily high turnover among NAs in nursing homes. Estimates of annual turnover range from more than 40 percent to nearly 100 percent, depending on the data source—meaning typical LTC facilities are replacing half to their full NA workforce each year.[5]

Beyond high workloads and unsafe working conditions, NAs also experience inadequate wages, limited training and advancement opportunities, and a general lack of support and recognition. Median hourly wages for NAs are just $18.83—

approximately $30,600 annually—and 36 percent live in or near poverty, while 49 percent rely on public assistance programs to make ends meet.[6] Not only do low wages undervalue the critical role of NAs, but the industry is failing to keep up with wages in other entry-level occupations with similar barriers to entry and, as a result, are losing workers to retail, fast food, and other industries.[7]

The 2024 Final Rule's requirement of 2.45 NA hours per resident day would have begun to address untenable workloads and incentivize investments in workforce recruitment and retention.[8] Without these minimum standards, the cycle of understaffing, burnout, attrition, and further understaffing will continue—harming staff, residents, and families.

The evidence supporting staffing standards remains overwhelming. The 2024 Final Rule's staffing standards were based on decades of research and advocacy from experts across the LTC field. This includes PHI, which has long advocated for minimum staffing standards that foster reasonable workloads and promote safety while ensuring the delivery of quality care to nursing home residents.[9] The need for strong staffing standards has grown only greater over time, given the ever-increasing acuity of residents and growing NA workloads.[10] The less prescriptive federal staffing requirement to which this IFC returns is not stringent enough to protect LTC facility residents or the staff that care for them. Thus, the 2024 Final Rule's staffing standards, which create a floor rather than a ceiling, are critical for lessening NAs' untenable workloads, safeguarding their health and well-being, improving their job satisfaction, and strengthening care continuity and quality for LTC facility residents.

As PHI has long emphasized, quality jobs are the foundation for quality care. The 2024 Final Rule's staffing standards represent a critical step toward ensuring both. The 2024 Final Rule was designed to create accountability for reasonable workloads, providing leverage for the workforce investments that research shows improve recruitment, retention, and care quality. In addition, the 2024 Final Rule also recognized both the connection between NAs' job quality and access to LTC services and quality care and the need to reform LTC financing in order to improve NA compensation and stabilize the workforce. In other words, staffing standards are not a panacea, but are a necessary policy lever that must be coupled with sufficient federal and state investment and accountability.

While PHI's comments are largely focused on NAs, we also want to highlight the importance of staffing standards for Registered Nurses (RNs). Today's population of LTC facility residents are living with complex conditions, including dementia, cardiovascular disease, and diabetes, among many others.[11] These individuals deserve sufficient support, including consistent RN oversight, since RN staffing is so closely tied to positive resident outcomes.[12] Given the on-the-job challenges NAs face, consistent, accessible, and supportive supervision is also a key component to ensuring their success. When RNs have sufficient training and capacity to establish and maintain a strong culture of supervision in the LTC facility, research shows the positive impacts on NA job stress and satisfaction, intention to leave and turnover, decision-making, and effectiveness.[13] By removing the requirement that LTC facilities staff an RN at all times, this IFC ensures that many NAs will *not* have the supervision they need to be safe and successful at work.

Finally, the evidence linking LTC facility staffing to resident health outcomes has only strengthened since PHI submitted comments for the 2023 NPRM on staffing standards. A 2024 systematic review of 13 prior reviews, synthesizing 187 primary studies, confirmed that staffing has a positive relationship with resident safety outcomes, with pressure ulcers and urinary tract infections among the most consistently studied endpoints.[14] This new research further supports the decades of evidence CMS already has, including the research showing that the 2024 Final Rule's staffing standards that this IFC repeals would save approximately 13,000 lives per year.[15] This estimate was based on peer-reviewed methodologies and reflects the enormous human cost of inadequate staffing. By repealing these standards without any replacement, CMS is accepting the preventable deaths of thousands of nursing home residents annually.

Repealing the 2024 Staffing Standards is an improper use of interim final rulemaking. PHI objects to CMS's decision to repeal the minimum staffing standards through an interim final rule without prior notice and comment. The Administrative Procedure Act permits agencies to bypass notice-and-comment rulemaking only when they "for good cause find" that ordinary rulemaking procedures would be "impracticable, unnecessary, or contrary to the public interest."[16] CMS's stated rationale—that maintaining unenforceable regulations in the Code of Federal Regulations would cause "confusion"—utterly fails to meet this high standard. Rather than eliminating potential confusion about the implementation timeline for the final rule, this IFC communicates that

the federal government is turning away from meaningful staffing accountability and nursing home safety and instead allowing understaffing and the devaluation of staff to go unchecked.

CMS engaged in a rigorous public comment process on its proposed staffing standards in 2023, receiving nearly 47,000 submissions which were overwhelmingly in support of the proposed rule.[17] To now reverse course without affording the public the same opportunity to comment is procedurally improper, undermines public confidence in the rulemaking process, and will lead to bad policy and worse outcomes for the American public. The IFC itself mentions that the staffing standards serve an important public health interest, a fact that clearly indicates the necessity of public participation.

In addition, CMS's claim that the moratorium imposed by Congress necessitates repeal is totally unfounded. Congress chose to suspend enforcement until September 30, 2034, rather than repealing or changing the final rule in any other way.[18] CMS can and should comply with the moratorium by preserving the standards for their future implementation. The clear path to avoiding confusion on the part of LTC facilities is to retain the staffing standards in regulation and guidance while noting the new implementation date. Permanently repealing these standards is a policy choice, not a legal requirement, and should be subject to full notice-and-comment procedures under federal law.[19]

CMS also fails to consider significant and important reliance interests created by the 2024 Final Rule that call for proper public notice and comment. Even though the staffing standards have not been implemented by the federal government, states, facilities, residents, and advocates may have relied on the future existence of these staffing standards to shape policy, strategy, and planning. CMS's use of an interim final rule incorrectly ignores the extensive reliance interest of numerous stakeholders who should all have a right to inform CMS's decision prior to the issuance of a final rule.

Finally, CMS uses inadequate cost savings calculations to improperly justify this IFC and minimize its real costs. CMS's cost savings calculations fail to recognize the broader costs of *not* having adequate staffing, such as staff burnout and turnover, increased recruitment and temporary staffing expenses, legal challenges, and impacts on the broader health system (e.g., expenses from additional preventable hospitalizations and emergency room use). They also

completely ignore the staggering human toll—13,000 lives per year—that will also bring immense financial costs to the healthcare system and American families.[20]

CMS's workforce shortage rationale misdiagnoses the problem and the solution. CMS justifies the repeal of the 2024 Final Rule primarily on the basis of workforce shortages, arguing that facilities cannot meet staffing standards due to labor supply constraints. This rationale fails to acknowledge the primary drivers of the workforce crisis in long-term care, which are inadequate wages, unsustainable workloads, and other job quality concerns, along with workforce pipeline development challenges and immigration barriers. Addressing these modifiable factors will improve recruitment and retention in the industry and thereby facilities' abilities to meet staffing standards.

For example, the American Health Care Association's 2024 State of the Sector survey found that 95 percent of nursing homes are actively hiring NAs, with 94 percent reporting it is somewhat or very difficult to recruit new staff.[21] These statistics reflect high turnover and limited incentives to join this workforce, not necessarily an absence of willing workers. When NAs experience median annual turnover approaching 100 percent, facilities must constantly recruit and use expensive staffing agencies simply to maintain existing staffing levels.[22]

As CMS acknowledges, many LTC facilities currently find it difficult to attract and retain workers, especially NAs, in jobs that are difficult, dangerous, and emotionally draining, yet at the same time often poorly compensated and with limited employment benefits. Yet, CMS has a responsibility to use its authority and resources to address this workforce crisis so that facilities across the country can meet safe staffing levels. Allowing LTC facilities to staff at unsafe levels will not address the workforce crisis. Instead, a proactive and coordinated effort is needed across the federal, state, and employer levels to improve job quality and thereby strengthen recruitment and retention in order to achieve safe staffing levels and quality care delivery.

In asserting that the staffing standards would impose a one-size-fits-all set of requirements, CMS completely misrepresents the standards. In reality, the standards are designed to provide a baseline paired with a facility assessment process to evaluate resident acuity, operational needs, and other distinct qualities of each facility. These facility assessments would require the participation of NAs with their on-the-ground insight into staffing levels and resident needs. The

minimum staffing standard and facility-specific assessment are designed to be complementary: preventing extreme understaffing everywhere, while ensuring higher staffing where it is most needed.

Furthermore, the IFC's assertion that the staffing standards would increase LTC access issues, particularly in rural and tribal areas, also misunderstands the cause of the staffing crisis. Facility closures and staffing instability are driven by the same underlying issues that minimum standards are meant to confront (e.g., low wages, overwork, lack of quality support and supervision). Rural nursing home closures have been occurring *without* minimum staffing standards—driven by pandemic workforce losses, low Medicaid reimbursement, and competition from other sectors. The solution is addressing these root causes through adequate reimbursement and improved job quality, not eliminating baseline protections that rural residents deserve equally.

In short, by establishing minimum staffing requirements, CMS would have created accountability and incentives for LTC facilities to invest in their workforces. Repealing these standards removes any federal floor and allows the current crisis to continue unabated because the repeal will:

- Worsen NA workloads and safety, exacerbating the workforce crisis;
- Return to a federal staffing requirement that is not stringent enough to protect LTC facility residents or the staff that care for them;
- Devalue both LTC facility workers and residents; and
- Turn the back the clock on progress towards better nursing home quality, with potentially dire impacts.

Instead of repealing this rule, CMS should be investing in NA job quality. The solution to high turnover is improving job quality, not abandoning staffing standards. Research consistently demonstrates that higher wages reduce turnover. An older national study found that each $1 increase in hourly wages extended CNA tenure by 2.1 months, while another from last year showed the same increase had significant positive effects on the overall quality of the facilities and the care they provide.[23] Another recent study in Iowa found that wages combined with staff empowerment significantly improved retention, with each retained CNA saving facilities $3,000–$6,000 in replacement costs, making wage investments cost-effective.[24]

While ensuring the staffing standards are reinstated is a vital step, the federal government must do more to address the LTC facility staffing crisis. Years of underinvestment in job quality and workforce development in the LTC sector have created this crisis. Systemic investments, coupled with payment transparency and accountability, must be made to strengthen our LTC infrastructure. In particular, to address LTC access issues, the federal government must first understand that low compensation is the leading cause of the workforce issues that limit access to LTC facilities and reduce the quality of care that residents receive and that compensation levels are vital to creating a stable workforce with well-qualified staff, lower turnover, and safe, high-quality care.

By repealing staffing standards, CMS removes the regulatory pressure that could drive facilities to make critically needed workforce investments. Instead of taking this step backward, CMS should be:

- Working to increase investments in reimbursements to LTC facilities while ensuring those funds are passed on to NAs and other staff through better pay and benefits;
- Providing clear guidance to facilities on staffing plans that reflect nationally recognized NA job quality standards;[25]
- Disseminating best practices for recruiting and retaining DCWs;
- Developing a national compensation strategy;
- Providing technical assistance to states trying to address benefits cliffs that can adversely impact NAs and other low wage workers;[26]
- Developing, along with experts, a national direct care workforce strategy;
- Incentivizing states to build minimum standards for direct care jobs, including NAs.

Conclusion. PHI strongly urges CMS to withdraw this IFC and maintain the minimum staffing standards established in the 2024 Final Rule. These standards were decades in the making, grounded in extensive research, and refined through robust public comment—and are predicted to save 13,000 lives annually. The rationales offered for repeal—workforce shortages, rural facility concerns, and the legislative moratorium—do not withstand scrutiny and do not justify abandoning evidence-based protections for nursing home residents.

If CMS proceeds with this repeal, the agency must commit to developing an alternative regulatory framework that addresses the documented harms of inadequate staffing. This framework should include requirements for transparent staffing data, accountability mechanisms for workforce investment, and meaningful protections for nursing home residents. To eliminate minimum staffing standards without a viable alternative is to accept an unacceptable status quo that harms both residents and workers.

PHI appreciates the opportunity to provide these comments and stands ready to support efforts to strengthen the direct care workforce and improve care quality for nursing home residents.

Notes.

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Appendix

CMS Proposed Rule [CMS 3442-P]

PHI Comments

November 6, 2023

Re: Proposed Rule – Medicare and Medicaid Programs; *Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting*

Thank you for the opportunity to respond to the proposed rule from the Centers for Medicare & Medicaid Services (CMS) regarding staffing standards in long-term care facilities.

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Overall Comments

General. PHI is pleased to provide comments on the proposed rule "Medicare and Medicaid Programs: Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting (CMS 3442-P)."

Most of our comments are focused on the provisions of the proposed rule that are particularly relevant to enhancing job quality for and recruitment and retention

of nursing assistants (NAs) in long-term care (LTC) facilities. The text and intent of this proposed rule is an important step towards recognizing the essential role the direct care workforce, including NAs, plays in delivering LTC services, improving health outcomes and quality of life for older adults and people with disabilities, and strengthening the economy overall. We are gratified to see CMS acknowledge the critical links among job quality, workforce recruitment, retention, and care quality reflected throughout the proposed rule.

We support CMS' proposal to create a staffing standard for LTC facilities, including by requiring facilities to employ a registered nurse (RN) across all shifts and to maintain minimum levels of RN and NA staffing on every shift. The proposal is in line with decades of research and advocacy and is a crucial step towards ensuring NAs have appropriate workloads, LTC facility staff are safe and have better job satisfaction, and residents experience better care and outcomes. In addition, we urge CMS to consider a total direct care hours requirement that not only includes but exceeds the individual minimums for RNs and NAs.

We also support the goals of this proposed rule to strengthen transparency about how Medicaid dollars are used to compensate workers and to move incrementally toward addressing the longstanding issues of low wages and difficult working conditions that have contributed to workforce shortages in the LTC industry. Our comments below focus on sections of the rule that provide opportunities to advance policies that will better support, train, and compensate NAs who provide daily care to residents. We believe improving job quality for these workers is foundational to stabilizing the LTC workforce and ensuring access to high-quality care.

This proposed rule continues the Biden-Harris Administration's historic momentum toward recognizing the value of direct care work. Repeatedly, the Administration has acknowledged the vital role direct care workers (such as home health aides, nursing assistants, and personal care aides) play in our LTC system and larger economy while recognizing the tremendous challenges facing that workforce. Key examples of the Administration's commitment to this workforce include: 2020's Build Back Better legislation; 2022's State of the Union and nursing home initiative announcement; and 2023's Executive Order on Increasing Access to High-Quality Care and Supporting Caregivers, CMS's proposed rule on Ensuring Access to Medicaid Services, CMS' Request for Information related to Medicare Home Health Services; and this proposed rule.

Job Quality. The Administration's work, including this proposed rule, highlights the connection between job quality for direct care workers (in this rule: nursing assistants or NAs) and access to LTC services. One throughline across the Administration's initiatives outlined above is the recognition that by improving job quality for direct care workers, we can meaningfully improve access to the LTC services a growing number of Americans need. In particular, we applaud CMS' recognition in this proposed rule that:

- NAs are poorly compensated, and low compensation is a leading cause of the workforce issues that limit access to LTC facilities and reduce the quality of care that residents receive; and
- Compensation levels are vital to creating a stable workforce with well-qualified staff, lower turnover, and safe, high-quality care.

We agree with CMS that the poor quality of direct care jobs—limited training and advancement opportunities, a general lack of support and recognition, and, especially, inadequate compensation—prevents many LTC providers from delivering optimal care and meeting demand. According to PHI's most recent workforce estimates, the 2022 median hourly wage for NAs in nursing homes was $17.06, which represents only a modest increase over the last 10 years (when adjusted for inflation).[1] Median annual earnings for NAs were just $25,748 in 2021 (the most recent year available), 39 percent lived in or near poverty (defined as less than 200 percent of the federal poverty line), and 40 percent relied on public assistance programs to meet their basic needs.[2]

Poverty-level jobs harm the economic security of NAs and push many of them out of this sector. As CMS notes, because industries such as fast food and retail pay higher wages than direct care—and can offer better schedules and less dangerous work—LTC employers cannot compete with these other industries.[3] As a result, retention (and recruitment) in this sector are in crisis: the median annual turnover for NAs in nursing homes was nearly 100 percent in 2017-2018, according to the most recent research available.[4]

This evidence substantiates the importance of sound and decisive measures that improve compensation and stabilize this workforce. However, they also underscore the profound necessity to reform LTC financing (which relies heavily on Medicaid) as part of these efforts. Medicaid funding levels must be

strengthened, and reimbursement rates under this program (and other public payment programs) must be examined to ensure that employers can afford to offer competitive wages and invest in direct care job quality. In addition, aligning with key elements of this proposed rule, data reporting measures and clear transparency requirements are needed to ensure this funding is spent properly.

Section-Specific Comments

Minimum Staffing Standards. We strongly support CMS' proposal to create and enforce minimum staffing requirements for LTC facilities, which sends a strong message that all LTC facilities must be adequately staffed to protect both staff and residents from harm. For decades, PHI has advocated for minimum staffing standards that would foster reasonable workloads and promote safety while ensuring the delivery of quality care to nursing home residents.[5] The need for strong staffing standards is even more clear today, given the ever-increasing acuity of residents and the evidence that NAs support, on average, 13 residents per shift (and more, in many cases).[6] The current, less prescriptive federal staffing requirement is not stringent enough to protect LTC facility residents or the staff that care for them. Thus, the proposed standards, which create a floor rather than a ceiling, are a critical step towards lessening NAs' untenable workloads, safeguarding their health and well-being, improving their job satisfaction, and strengthening care continuity and quality for LTC facility residents.

We support the requirement in the proposed rule for facilities to maintain at least 0.55 hours per resident day (HPRD) for RNs and 2.45 HPRD for NAs. However, we also strongly encourage CMS to add a total direct care HPRD requirement (which includes but exceeds the RN and NA minimums). Although the proposed rule names 3.48 HPRD as a minimum total staffing standard, we urge CMS to raise this minimum level to at least 4.1 HPRD, and to consider increasing the RN and NA minimums, in line with decades of research and evidence on the impact of higher staffing for staff and resident outcomes. We do not take a position on whether the standard should be three-part or four-part but do acknowledge the importance of both the care provided by LPNs and LTC facilities' need for flexibility in determining the staffing mix to meet the standards.

We are also in support of the proposed requirement that nursing homes must ensure an RN is on-site 24 hours a day, seven days a week. Today's population of nursing home residents, as with other LTC beneficiaries, are living with higher acuity levels than in previous years,[7] as evidenced by high rates of dementia, cardiovascular disease, and diabetes, among other conditions, which are also among the leading causes of death in this country.[8] These individuals deserve sufficient support, which requires consistent RN oversight, since RN staffing is so closely tied to positive resident outcomes.[9]

Moreover, RNs are vital to the supervision of NAs, which is key for supporting NAs' job quality (and, therefore, retention) and promoting positive resident outcomes. Given the on-the-job challenges NAs can face, consistent, accessible, and supportive supervision is a key component to ensuring their success. When RNs have sufficient training and capacity to establish and maintain a strong culture of supervision in the LTC facility, research shows the positive impacts on NA job stress and satisfaction, intention to leave and turnover, decision-making, and effectiveness.[10] By requiring LTC facilities to staff an RN at all times, CMS is taking an important step towards ensuring NAs have the supervision they need to be safe and successful at work.

As CMS acknowledges, many LTC facilities currently find staffing a challenge as it remains difficult to attract and retain workers, especially NAs, to do difficult, dangerous, and emotionally draining work for low pay, particularly when that is paired with poor job quality and access to benefits. Yet, as we will detail below, there are solutions to this workforce crisis within the authority of CMS and individual providers. Allowing LTC facilities to staff at unsafe levels will not address the workforce crisis and, in fact, negatively impacts quality of care and while driving dissatisfaction and turnover in facilities where NAs lack access to quality support and supervision due to inadequate staffing (in addition to significant impacts on quality of care).

Facility Assessments. We strongly support the proposed requirements at § 483.70 for LTC facilities to solicit input from frontline staff, including direct care workers, when conducting facility assessments. Facility assessments, which are already a requirement, are designed to ensure that staffing levels at any given

nursing home meet the needs of residents in that facility. Proactively engaging direct care staff in this effort is essential.

We fully endorse CMS' arguments here (bolding added):

> *…direct care employee representation in the facility assessment is critically important to securing an accurate analysis of staffing needs required to ensure resident health and safety. Direct care employees and their representatives are uniquely positioned to assess and communicate what staffing competencies and levels, as well as equipment and other resources are needed to provide appropriate care.* ***These individuals have a unique understanding of the resident population's health needs because of their on-the-ground knowledge of residents' care needs and facility operations.*** *As examples, direct care employees have distinct perspectives into what additional training is needed to manage increased acuity in resident needs; what ethnic, cultural, and religious factors are critical to the provision of culturally competent resident care; and how health information technology may be better leveraged to deliver consistent, quality care according to resident preferences.*

While all staff have a role to play in a comprehensive facility assessment, here we highlight the importance of NA input. These staff spend the most time with residents and know their needs and the amount of time and personnel it takes to meet those needs better than anyone else—yet they are often excluded from interdisciplinary care team planning and assessment efforts.[11] Including NA input will lead to more comprehensive and accurate assessments which will benefit resident care and improve NA inclusion and job satisfaction.

We share CMS' concerns that language barriers and fear of retaliation could limit the collection of information from NAs for facility assessments. Thus, the process through which facilities gain information from their staff needs to be carefully structured. We support the recommendation from CMS to allow facilities to engage direct care representatives such as a union representative or third-party worker advocacy groups to help facilitate this. Such an approach has a role to play in obtaining feedback while protecting workers. To further ensure that workers have sufficient opportunities to contribute, we also urge CMS to support employers in developing additional engagement strategies for NAs—including those that account for language and cultural differences, address schedule and

shift limitations, and promote a workplace culture free from fear of retribution—to engage a broader depth of workers.

We recommend CMS provide guidance and best practices for how facilities effectively solicit and incorporate input from direct care staff, both individually and through their representatives. For example, facilities could be encouraged to use anonymous surveys, focus groups, or individual interviews to collect feedback, protecting time for NAs to join real-time discussions.

Furthermore, facilities should be required to document how they obtain input from direct care staff and how that input informs their final assessments. This will increase accountability for meaningfully engaging with direct care staff.

A broader engagement strategy is necessary, especially where union representation or other third-party groups are not available, to fully realize CMS' objective of ensuring employees contribute to improved resident care and facility operations.

Staffing Plans. We strongly support § 483.70, which requires LTC facilities to use their facility assessments to develop staffing plans aimed at maximizing recruitment and retention of employees. Thoughtful, proactive workforce planning is essential to stabilize the LTC industry's depleted workforce after years of underinvestment in job quality and workforce development. However, while we agree facilities should have some flexibility in developing their staffing plans, we think it is important for CMS to require facilities to consider those aspects of job quality that have been proven to affect recruitment and retention.

With regards to the NA workforce specifically, we recommend CMS provide clear guidance to facilities about how to reflect nationally recognized NA job quality standards in their staffing plans. One example is PHI's *5 Pillars of Direct Care Job Quality* framework, summarized below.[12]

1. **Quality Training.** The research shows that sufficient and quality training for NAs and other direct care workers improves job satisfaction, workforce outcomes, and care quality.[13] LTC providers should identify ongoing training opportunities to upskill NAs and other staff to provide person-centered, condition-specific, high-quality care for all residents. To be

effective, NA training programs should be competency-based, adult-learner-centered, and culturally and linguistically appropriate.

2. **Fair Compensation.** Research shows that raising wages would not only improve recruitment and retention but also care outcomes.[14] One analysis using CMS quality data found that higher wages for NAs were associated with increased income and retention, fewer inspection violations, and lower rates of preventable health outcomes and mortality among residents.[15] Many LTC providers need to increase real compensation to ensure that NAs receive a living and competitive wage commensurate with their challenging and essential role, along with critical employment benefits such as health insurance, paid sick leave, family and medical leave, and retirement savings.
3. **Quality Supervision and Support.** Evidence from across occupations shows that effective supervisory relationships help mediate job stress and improve job satisfaction,[16] and supervision in LTC has been identified as a primary driver of job satisfaction, intent to leave, turnover, and more.[17] For example, the coaching supervision model implemented by PHI and partners across 17 nursing homes and home care agencies showed statistically significant improvements in job satisfaction and satisfaction with supervision among nearly 1,500 direct care staff and garnered an estimated $6,000 in cost savings per supervisor among those reporting efficiencies due to the supervision training.[18] LTC providers should aim to develop or strengthen existing supervisory training programs for nurse managers, with a focus on communication, coaching, problem-solving, and empowerment to better prepare them to support NAs, develop their skills, recognize their achievements, and effectively align them with the expectations of their roles.
4. **Respect and Recognition.** Research has clearly shown the benefits of empowering NAs and integrating them into interdisciplinary care teams and in organizational decision-making. For example, the nursing home "culture change" movement has produced several team-based models that elevate nursing assistants' status.[19] The Green House® nursing homes model, as one example, aims to empower nursing assistants in their direct care role and in relation to clinical partners and has been shown to create opportunities for more appropriate and timely resident care.[20] In addition to integrating NAs into interdisciplinary care teams, LTC providers should create organizational structures and workflows that promote NA respect

and recognition, including: creating opportunities for NAs to engage in relevant organizational decisions; providing clear communication about changes impacting NAs, with opportunities for feedback; and training other members of the interdisciplinary care team to value NAs' input and skills.

5. **Real Opportunity.** LTC providers should strengthen career pathways for NAs to retain talented and committed workers, leverage their unique skills and expertise, and maximize their contributions to resident care quality and outcomes. Examples of advanced NA roles include condition-specific specialist roles, such as diabetes and dementia care specialists, care integration or care transition aides that bridge the gaps between settings and services, and peer mentors and assistant trainers. These career advancement opportunities must be complemented by accessible career pathways from direct care to other health care occupations.[21] One of the most widely noted pathways is from direct care to licensed practical/vocational nurse (LPN/LVN) and registered nurse (RN), but this option may not be viable for many NAs and other direct care workers due to the significant educational prerequisites, training time, and costs involved.[22] Work-based learning, up-front tuition assistance, micro-credentialing, wraparound supports (to address childcare, transportation, and other needs), and other strategies and approaches are needed to expand access to this career pathway.

While CMS need not require facilities to adopt every best practice related to NA job quality, it should require all facilities to consider these best practices when developing their staffing plans. This research and reflection is critically necessary for facilities to create effective staffing plans that enable them to recruit and retain a sufficient, qualified workforce. For example, all facilities' staffing plans should include an analysis of compensation and benefits offered relative to local market wages and identify adjustments needed to become a competitive employer. Facilities should also assess their organizational culture and workplace policies through staff surveys and other mechanisms to identify areas for improvement. Plans should outline measurable steps aligned with the 5 *Pillars of Direct Care Job Quality*, or similarly recognized job quality models, to correct any deficiencies identified.

To provide oversight, CMS should require facilities seeking a hardship exemption to demonstrate their consideration of best practices in their staffing plans. This is

partly how CMS should define "diligent efforts… to recruit and retain appropriate nursing staff including NAs." In other words, it should be an explicit criterion of the "good faith effort to recruit and retain" in this proposed rule's hardship exemption.

Requiring comprehensive staffing plans focused on recruitment and retention would push LTC facilities to make investments in job quality for direct care workers that are long overdue. Thoughtfully developed plans have the potential to significantly move the needle on stabilizing the LTC workforce.

Facility Hardship Exemption. We support the criteria CMS has proposed at new § 483.35(g)(2) for facilities to demonstrate a good faith effort to recruit and retain nursing staff if seeking an exemption from the proposed minimum staffing requirements. Requiring facilities to document their use of a prevailing wage, recruitment activities, job offers, duration of vacancies, and resources expended on staffing relative to revenue will increase transparency and accountability regarding facilities' hiring and employment practices. This evidence can shed light on whether facilities are making serious attempts to proactively address the staffing crisis while encouraging all facilities to follow best practices.

To ensure exemptions are granted only when truly warranted, we recommend CMS also require facilities seeking a hardship exemption to:

- Demonstrate in their staffing plans a consideration of nationally recognized best practices, such as PHI's *5 Pillars of Direct Care Job Quality*[23] (as mentioned in the above section)
- When providing evidence they have implemented their staffing plans, include evidence related to best practices beyond offering prevailing wages. For example, implementation steps could include: enhancing benefits, expanding training programs, conducting worker surveys to inform workplace improvements, improving scheduling policies, participating in job fairs and partnerships with schools, or any other activities outlined in their plans. Requiring execution of workforce strategies in addition to recruitment documentation sets a higher bar for facilities to demonstrate they have made every effort to hire and retain staff.

With these additions, the exemption criteria will ensure that facilities cannot take advantage of blanket exemptions without making meaningful attempts to improve job quality and address known staffing challenges. We support granting hardship exemptions only to facilities that thoroughly demonstrate recruitment challenges despite investing in wages and strategies to support their workforce.

Additional Steps CMS Can Take to Address Staffing Shortages in Nursing Homes. CMS, in collaboration with other federal agencies, has enormous power to address staffing shortages for NAs and the direct care workforce crisis in general. Many of these opportunities are addressed in PHI's report, *Federal Policy Priorities for the Direct Care Workforce.*[24] In summary, CMS should:

- Disseminate, along with the Department of Labor (DOL) and through the National Direct Care Workforce Strategies Center (funded by the Administration for Community Living (ACL)), best practices for recruiting and retaining direct care workers, including NAs. These should be based on nationally recognized, evidence-based best practices like those found in PHI's *5 Pillars of Direct Care Job Quality* framework, which focuses on quality training, fair compensation, quality supervision and support, respect and recognition, and real opportunity.[25] Together, CMS, DOL, and ACL (through the National Direct Care Workforce Strategies) could greatly expand the use of best practices by serving as a trusted hub for recruitment and retention strategies, educating providers, and connecting providers to technical assistance. For example, these agencies could hold regular convenings, hearings, and briefings on topics, such as staffing challenges, training and advancement, data collection and research, and equity and inclusion.
- Develop a national compensation strategy for the direct care workforce, including specific recommendations on how states should set their Medicaid rates to ensure competitive wages and benefits for direct care workers. The recommendations should then be translated into regulations for rate-setting and enforcement processes at the state level.
- Develop, along with DOL, a strategy with analyses, rules, regulations, and guidance to help states address benefit cliffs and benefit plateaus among

direct care and other low-wage workers.[26] This strategy should build on existing research and guidance from the field and explore approaches such as adjusting the design of public benefit eligibility limits and requirements and assisting workers to reduce the impact of losing benefits, among other strategies.

- Fund a research-based framing strategy—like the "Reframing Aging" initiative—to help develop effective, strength-based frames and messages on the value and needs of direct care workers.[27]
- Develop a national direct care workforce strategy, convening an advisory council to identify actions that government, providers, public and private sector organizations, philanthropy, and others can take to completely transform direct care jobs. This council should include direct care workers themselves, and its strategy should include identifying funding for the council's recommendations, producing regular progress reports, and developing new recommendations as needed. This council could take on some of the important issues facing NAs and the rest of the direct care workforce, including: a national compensation strategy, competency-based training standards, and updated workforce definitions.
- Incentivize (and provide guidance to) states to build minimum standards for direct care jobs, including NAs, into their value-based payment contracts with providers and managed care organizations (MCOs). Effectively leveraging the role of direct care workers in value-based payment arrangements helps improve health care quality while reducing unnecessary costs.[28]

Medicaid Institutional Payment Transparency. We strongly support the proposed requirement at § 442.43(b) for state Medicaid agencies to report annually the percentage of payments for Medicaid-covered services in nursing facilities and intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs) that are spent on compensation for direct care workers and support staff. This reporting will provide critically needed transparency on the allocation of taxpayer dollars for LTC. In particular, it is incumbent upon CMS to increase oversight of whether Medicaid, as the largest payor of LTC, is adequately supporting and compensating NAs and other staff who bear the responsibility for delivering that care.

We agree that states contracting with MCOs or Prepaid Inpatient Health Plan (PIHPs) should report on the percentage of MCO or PIHP payments to nursing facilities and ICF/IIDs that is spent for compensation, and that states delivering services through both fee-for-service (FFS) and managed care arrangements should report separately for each delivery system. All reported data should be housed on one website, following a standardized format and reviewed quarterly (per § 442.43(d)(1)).

We underscore the importance of defining "compensation" (per § 442.43(a)(1)) to include annual wages or salary and employment benefits, such as medical, dental and vision benefits, paid leave, and a retirement plan. We also agree with including the employer share of payroll taxes in the compensation formula, as this is also an important component of the full compensation cost.

We do not recommend that states have the option to exclude payments to providers that have low Medicaid revenues or that serve a small number of Medicaid beneficiaries, because a complete picture of Medicaid spending on compensation in *all* nursing homes and ICF/IIDs is critically needed. In order to accurately report expenditure on compensation as a proportion of total Medicaid payments to providers, states should include (as relevant) all state, federal, and beneficiary payments in the denominator, including base payments, supplemental payments, managed care-directed payments, and beneficiary contributions.

We also urge CMS to add two measures to these requirements. First, we agree that the compensation data should be disaggregated according to the staff categories specified at § 442.43(a)(2) and (3). This disaggregation is necessary for assessing how investments in different segments of the workforce vary across states and over time. Second, we urge CMS to add a requirement for states to report median hourly compensation rates in addition to reporting the percentage of Medicaid payments going to overall compensation (per § 442.43(c)(1)). This reporting should also cover total compensation (inclusive of benefits and employer payroll contributions) and be disaggregated by staff categories and by base versus supplemental payments. CMS should also encourage states to explore ways to track and report racial and gender disparities. All of this data is critically needed to examine the adequacy of wages in these facilities and their competitiveness relative to competing industries and occupations; identify

variation in wage levels between staff groups; assess whether supplemental payments are being appropriately allocated to worker compensation; and study variation across states and over time. In turn, these assessments can inform interventions to increase workers' access to livable and competitive wages and sufficient benefits, address inequities in this sector, and stabilize the workforce for the benefit of nursing home and ICD/IID residents.

With regards to the categorization of staff at § 442.43(a)(2), we agree with the job categories included, but strongly urge CMS to use different terminology to describe the "direct care worker" group. This term should be reserved for certified nursing assistants (NAs) and, where relevant, home health aides and personal care aides—consistent with the way that the term has otherwise been used by CMS and by other federal agencies like the Administration on Community Living—rather than broadened to include licensed clinical and therapy roles as well. Defining registered nurses, licensed practical nurses, therapists, and others as "direct care workers," risks confusion and obscures the unique contributions and challenges of each role. For example, poverty-level wages and a disproportionate reliance on low-income women of color and immigrants create unique barriers for the NA workforce compared to other nursing home staff—and these realities must be addressed. We suggest "licensed staff" and "support staff" as the two primary category labels.

Finally, we propose that states be given three years to implement these reporting requirements across both FFS and managed care delivery systems (versus the four years proposed at § 442.43(f)). With sufficient guidance, technical assistance, and practical tools and templates from CMS, this timeframe should be sufficient for states to develop or amend the regulations, policies, procedures, and infrastructure needed to meet the requirements. This basic level of transparency is long overdue and is critically needed to achieve changes in nursing home staffing and employment practices that will improve job quality, stabilize the workforce, and improve resident care.

Requiring a Minimum Percentage of Medicaid Payments Go Towards Staff Compensation. In future rulemaking, CMS should consider requiring that a minimum percentage of the payments for Medicaid-covered nursing home and ICF/IID services be spent on compensation for NAs and other nursing,

therapy, and support staff. The data reported through the current proposed rule provisions will help assess how Medicaid dollars are spent and determine where improvements can be made. However, transparency alone will not guarantee better wage investments. Minimum spending thresholds may be needed to ensure that taxpayer funds adequately support the workforce and delivery of high-quality care. The specific minimum percentage of payments that should be allocated to compensation should be determined through robust evaluation of current spending patterns and related workforce, care, and cost outcomes.

Interested Parties' Advisory Groups. We support CMS' proposed requirement at § 447.203(a)(6) that state Medicaid programs establish advisory groups focused on evaluating the sufficiency of payment rates for LTC facility services, similar to what is proposed for home and community-based services (HCBS) in the Medicaid Access Rule.

Nursing facility and ICF/IDD rates have long been recognized as inadequate and as driving workforce shortages. An advisory body is needed to conduct structured reviews of rate adequacy and provide recommendations to each state Medicaid agency and legislature. At a minimum, the advisory group should examine whether base payment rates cover the full costs associated with employing a stable, well-compensated workforce, including livable and competitive wages, essential employment benefits, other compensation-related expenses (such as employer payroll contributions), sufficient training and ongoing supervision, and other labor-related considerations.

The group should include a balanced representation of residents and family members; nursing home workers and/or third-party representatives, including labor unions and other worker organizations; operators representing non-profit and for-profit facilities; researchers; and state Medicaid officials. Diverse perspectives are critical to assess current rates and identify the changes needed to support quality jobs and quality care. The group should meet at least annually and issue detailed reports on their reviews and recommendations.

Creating a transparent, data-driven process to regularly evaluate Medicaid payment adequacy for nursing home and ICF/IDD services and worker compensation will be instrumental to advancing solutions. We urge CMS to

finalize provisions requiring interested parties' advisory groups in the next iteration of this rule.

Conclusion. We appreciate the opportunity to provide comments on the proposed LTC staffing requirements that will support needed investments in the workforce and quality care. Establishing a staffing standard is an important starting point. To achieve its intent, further investment in cultivating a robust NA workforce is necessary. We stand ready to support these efforts going forward. Investing in direct care workers will benefit residents, workers, providers, and the entire LTC system. We look forward to continued partnership to stabilize this essential workforce.

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