



ADDRESSING THE NATION'S CHRONIC NURSING HOME UNDERSTAFFING CRISIS

A White Paper for Policymakers & Stakeholders



Long Term Care Community Coalition

www.nursinghome411.org

© 2023 The Long Term Care Community Coalition

Contents

Introduction and Background	3
State Staffing Policies.....	6
Federal Minimum Staffing Regulatory Activity.....	8
Enforcement	9
Training	11
Changes to Staff Training Requirements Post-COVID	12
Industry-Supported Policies Designed to Address Staffing Shortages	14
Weakening Minimum Training & Competency Requirements.....	14
Permitting Training of CNAs by Deficient Nursing Homes.....	16
Reining in Temporary Nursing Staffing Agencies.....	16
Perpetuating Poor Quality Jobs and Other Factors That Reduce Retention Rates	18
Low Wages and Inadequate Benefits	19
CNA Empowerment Practices	19
Reducing Staffing to Generate Profit for Private Equity Investors	20
State Policies to Address Nursing Home Understaffing	20
General Medicaid Payment Rate Increases	20
Cost-Based Payment Methodologies and Wage Pass-Through Policies	21
Value-Based Payment Programs.....	22
Minimum Wage Strategies	23
Recent Approaches to Address Understaffing.....	24
Multi-Pronged Rate Reform Legislation	24
Direct Care Minimum Spending Ratios	25
Conclusion and Recommendations	26

Introduction and Background

Decades of extensive research shows that nursing homes with more nursing staff have better quality, on-site survey scores, and resident outcome measures.¹

Conversely, residents in understaffed nursing homes are more likely to suffer harm, live in degrading conditions, and experience negative outcomes.²

The COVID-19 pandemic has further demonstrated the need for adequate staffing in nursing homes, with numerous studies and reports linking higher direct care staffing levels to fewer COVID-19 outbreaks and resident deaths.^{3 4}

Research indicates that the imposition of minimum staffing requirements resulted in larger increases in staffing levels, including RN staffing, for facilities serving a higher share of residents with Medicaid as their primary payor. This resulted in larger gains in other measures of quality of care.

For several decades, minimum staffing requirements have been the subject of extensive debate at both the federal and state levels. In 1987, in response to media and government reports shining light on the deplorable state of nursing home care, Congress passed the Nursing Home Reform Act, also referred to as the Omnibus Budget Reconciliation Act of 1987.⁵

The extensive reforms in the Reform Law included basic requirements for nurse staffing that remain in place today. Those standards, however, are extremely limited, and in some instances, vague and subjective. They require nursing homes to have a licensed nurse 24 hours a day (at least eight provided by a RN) seven days a week. [Note: Nursing homes, regardless of size, are not currently required to have a RN on site 24 hours a day. However, in CMS's proposed regulations on nursing home staffing, nursing facilities would be required to have a RN on site around-the-clock.]^{6 7}

¹ Bostick JE, Rantz MJ, Flesner MK, Riggs CJ, JAMDA, "Systematic review of studies of staffing and quality in nursing homes," (April 26, 2006). Available at [https://www.jamda.com/article/S1525-8610\(06\)00051-X/fulltext](https://www.jamda.com/article/S1525-8610(06)00051-X/fulltext).

² Harrington C, Kovner C, Mezey M, Kayser-Jones J, Burger S, Mohler M, Burke R, Zimmerman D, The Gerontologist, "Experts Recommend Minimum Nurse Staffing Standards for Nursing Facilities in the United States," (February 2000). Available at <https://pubmed.ncbi.nlm.nih.gov/10750309/>.

³ Harrington C, Ross L, Chapman S, Halifax E, Spurlock B, Bakerjian D, Policy, Politics, & Nursing Practice, "Nurse Staffing and Coronavirus Infections in California Nursing Homes," (July 7, 2020). Available at <https://journals.sagepub.com/doi/10.1177/1527154420938707>.

⁴ Li Y, Temkin-Greener H, Shan G, and Cai X, Journal of the American Geriatrics Society, "COVID-19 Infections and Deaths among Connecticut Nursing Home Residents: Facility Correlates," (June 18, 2020). Available at <https://agsjournals.onlinelibrary.wiley.com/doi/epdf/10.1111/jgs.16689>.

⁵ The Nursing Home Reform Act passed into law as part of H.R.3545 - Omnibus Budget Reconciliation Act of 1987. On 12/22/1987 it became Public Law No: 100-203. Available at <https://www.congress.gov/bill/100th-congress/house-bill/3545/text>. Henceforth, "Nursing Home Reform Law" or "Reform Law."

⁶ Several Institute of Medicine studies have recommended that at least one RN be on duty at all times.

⁷ See LTCCC's dedicated nursing home staffing and standards page, www.nursinghome411.org/staffing, for more information and updates on the proposed federal standard.

Though nursing homes must provide nursing services that are “sufficient” to meet resident needs, federal law and regulation fail to provide specific guidance on what constitutes “sufficient” staffing. [Legislators excluded specific staffing ratios from the Reform Law as a concession to the industry, which feared the increased costs.^{8]}

A landmark 2001 federal study found that **nursing homes need a minimum of 4.10 total nurse staff hours per resident day (HPRD)** to prevent resident harm.

In 2001, a landmark study⁹ prepared for CMS identified specific levels of nursing care needed to prevent harm to residents: 4.1 nursing hours per resident day (HPRD), including 0.75 registered nurse (RN) HPRD, 0.55 licensed nurse/licensed practical nurse (LVN/LPN) HPRD, and 2.8 (to 3.0) certified nursing assistant (CNA) HPRD.¹⁰ These minimum thresholds were reconfirmed in subsequent studies in 2004 and 2011. Still, despite rising resident acuity,¹¹ the 2001 CMS recommendations have never been adopted due to strong industry opposition.

Understaffing, unfortunately, is a common practice among nursing homes striving to reduce operating costs and maximize profits, since personnel expenditures can constitute more than half of operating costs. According to a U.S. Government Accountability Office (GAO) report,¹² only about one-third of nursing homes (5,200 total) “frequently”¹³ reached the 4.1-hour threshold while one-fifth of nursing homes (3,000 total) met that standard less than 20 percent of the time. For-profit nursing homes tend to have lower nurse-to-resident staffing ratios than their non-profit counterparts so that they can increase profits to distribute to corporate owners and shareholders.¹⁴ Understaffing is particularly common in facilities taken over by private

⁸ Kaiser Family Foundation, “Nursing Home Quality: Twenty Years After the Omnibus Budget Reconciliation Act of 1987, (November 29, 2007). Available at <https://www.kff.org/medicaid/report/nursing-home-care-quality-twenty-years-after/>.

⁹ Centers for Medicare & Medicaid Services, “Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes Phase II Final Report,” (2001). Available at <https://www.phinational.org/wp-content/uploads/legacy/clearinghouse/PhaseIIVolumelofIII.pdf>. (See Chapter 2: The relationship between nurse staffing levels and the quality of nursing home care, by Kramer AM and Fish R and Chapter 3: Minimum nurse aide staffing required to implement best practice care in nursing facilities, by Schnelle JF, Simmons SF, and Cretin S.)

¹⁰ This recommended minimum threshold level was later confirmed in a 2004 observational study of nursing home staffing (available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361005/>) and in a reanalysis by Abt Associates in 2011.

¹¹ Mor, V, Caswell, C., Littlehale, S., Niemi, J., Fogel, B. (2009). Changes in the quality of nursing homes in the U.S.: A review and data update

¹² GAO, “Additional Reporting on Key Staffing Information and Stronger Payment Incentives Needed for Skilled Nursing,” (July 2021). Available at <https://www.gao.gov/assets/gao-21-408.pdf>.

¹³ “Frequently” is defined as at least 80 percent of the days in a year.

¹⁴ GAO, “Additional Reporting on Key Staffing Information and Stronger Payment Incentives Needed for Skilled Nursing,” (July 2021). Available at <https://www.gao.gov/assets/gao-21-408.pdf>.

equity firms that aim to rapidly maximize profits.¹⁵ Understaffing is a vicious circle. CNAs are forced to take on unreasonably heavy workloads and become burnt out, leading to high CNA turnover rates (frequently exceeding 100 percent).¹⁶ Conversely, recent research has linked higher levels of CNA HPRD to greater CNA retention.¹⁷

The nursing home industry has opposed setting minimum staffing standards since they were first proposed. In support of their argument, industry leaders claim that government funding is insufficient to hire more staff. However, there are no independent data to support these claims. The fact is that nursing homes are seen as an attractive investment by knowledgeable investors, including real estate investment trusts, private equity firms, and other sophisticated enterprises.

The problem is not the amount of funds that nursing homes are paid but, rather, how these funds are being used. Studies have found that, rather than spending on resident care, too many nursing homes are devoting resources for items such as exorbitant administrative costs, unchecked related-party transactions, and excess profits.¹⁸ Several states are addressing this by imposing direct care

NURSING HOME STAFFING STANDARDS	
INDUSTRY CLAIM	vs REALITY
Nursing homes can not afford to provide sufficient staffing because of a labor crisis caused by a lack of workers.	The industry has opposed minimum staffing standards since the Reform Law, even during periods of high unemployment.
Minimum requirements are one-size fits all and do not permit customized care.	Minimum standards merely establish a threshold and facilities have enormous flexibility to configure staffing levels and patterns.
A minimum staffing requirement will reduce access to care for seniors by forcing nursing homes to close their doors.	Nursing homes closures are nothing new; closures are primarily amongst homes that provide extremely poor care.
More research is needed to determine the correct need for additional research to determine appropriate minimum levels.	The 2001 landmark CMS study staffing level findings have been confirmed by numerous additional studies.

Figure 1: Staffing standards: Industry claims vs. reality.

¹⁵ Braun RT, Jung H, Casalino LP, Myslinski Z, and Unruh MA, JAMA Health Forum, “Association of Private Equity Investment in US Nursing Homes With the Quality and Cost of Care for Long-Stay Residents,” (November 19, 2021). Available at <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2786442>. Gupta A, Howell ST, Yannelis C, and Gupta A, National Bureau of Economic Research, “Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes,” (February 2021). Available at <https://www.nber.org/papers/w28474>.

¹⁶ PHI, “Direct Care Workers in the United States,” (2022). Available at <https://www.phinational.org/wp-content/uploads/2022/08/DCW-in-the-United-States-2022-PHI.pdf>

¹⁷ Berridge C, Lima J, Schwartz M, Bishop C, and Miller SC, JAMDA, “Leadership, Staff Empowerment, and the Retention of Nursing Assistants: Findings from a Survey of U.S. Nursing Homes,” (September 2020). Available at [https://www.jamda.com/article/S1525-8610\(20\)30147-X/fulltext](https://www.jamda.com/article/S1525-8610(20)30147-X/fulltext).

¹⁸ Harrington C, Montgomery A, King T, Grabowski DC, and Wasserman M, Health Affairs, “These Administrative Actions Would Improve Nursing Home Ownership and Financial Transparency In The Post COVID-19 Period,” (February 11, 2021). Available at <https://www.healthaffairs.org/doi/10.1377/forefront.20210208.597573/>.

minimum spending requirements for nursing homes.¹⁹

Note: Nursing home industry leaders regularly make debunked claims for opposing minimum staffing standards, as shown in Figure 1.^{20 21}

State Staffing Policies

Many states have established their own staffing requirements to “put meat on the bones” to the federal “sufficient staff” standard. All but 18 states have some type of legislation or regulation that define “minimum direct care.” However, only one jurisdiction (the District of Columbia) meets the 4.1 HPRD minimum levels recommended in 2001 and six states approach that threshold (total HPRD 3.50-4.09). No state meets the recommended staffing standard of .75 HPRD for RNs.²²

Total hprd Recommended Staffing Standard: 4.1	No. of States	States
4.10+	1	DC
3.50 – 4.09	6	CA, FL, IL, MA, NY, RI
3.00 – 3.49	6	AR, CT, DE, MD, VT, WA
2.50 – 2.99	8	ME, MS, NJ, NM, OH, OK, PA, WI
2.00 – 2.49	13	CO, GA, IA, ID, KS, LA, MI, MN, OR, SC, TN, WV, WY
1.50 – 1.99	1	MT
1.00 – 1.49	0	
< 1.00	1	AZ

For 18 states, the Total Nursing Staff time cannot be calculated because they do not have a Direct Care hprd or Certified Nurse Aide/Nurse Aide hprd, which are necessary to find the Total. These states are not included in Table 1.

Figure 2: “State Nursing Home Staffing Standards,” via Consumer Voice, theconsumervoice.org/uploads/files/issues/CV_StaffingReport.pdf.

The evidence suggests that staffing standards work! Researchers have found that specific minimum staffing standards are associated with improvements in staffing, particularly for CNAs. In California and Ohio, the implementation of minimum staffing requirements coincided with a five percent increase in HPRD overall. Though the regulations unintentionally resulted in a reduction in skill mix (i.e., the ratio of RNs to all direct care staff), the staffing requirements led to a decrease in severe deficiency citations and improvement in specific health conditions requiring intensive nursing care.²³ In another study, facilities that served a higher share of Medicaid residents reported larger increases in staffing levels, including RN staffing, as a result of the imposition of minimum staffing requirements. This resulted in larger gains in other measures of quality of care.²⁴

¹⁹ See discussion below and LTCCC Policy Brief, “Direct Care Minimum Spending Laws” (2022). Available at <https://nursinghome411.org/minimum-spending-laws/>.

²⁰ See <https://saveourseniors.org/>.

²¹ Edelman T, Center for Medicare Advocacy, “Nursing Home Closures: Causes and Solutions,” (July 2022). Available at <https://medicareadvocacy.org/wp-content/uploads/2022/07/Special-Report-Nursing-Home-Closures.pdf>.

²² The National Consumer Voice for Quality Long-Term Care, “State Nursing Home Staffing Standards,” (November 2021). Available at https://theconsumervoice.org/uploads/files/issues/CV_StaffingReport.pdf.

²³ Chen MM, Grabowski DC, Health Economics, “Intended and Unintended Consequences of Minimum Staffing Standards for Nursing Homes, (May 22, 2014). Available at <https://onlinelibrary.wiley.com/doi/10.1002/hec.3063>

²⁴ Bowblis JR, Health Serv Res., “Staffing ratios and quality: an analysis of minimum direct care staffing requirements for nursing homes,” 2011 Oct; 46(5):1495-516. doi: 10.1111/j.1475-6773.2011.01274.x. Epub 2011 May 24. PMID: 21609329; PMCID: PMC3207189.

The pandemic has led many states to reconsider the issue of staffing requirements, though results have been mixed. While a few states (CT, MA, NY, RI) have taken steps toward meaningful, permanent improvements to their existing requirements (i.e., establishing specific ratios per shift, raising the total amount of direct care HPRD), other states' efforts to address staffing are illusory at best. In Arkansas, a permanent HPRD "increase" was accompanied by the elimination of long-required specific per-shift ratios and an inflated definition of direct care that included physical therapy assistants and medication assistants.²⁵ Florida retained its total HPRD, but authorized nursing homes to hire personal care attendants whose work would count towards the minimum HPRD.

Legislation aimed at permanently increasing minimum staffing requirements post-COVID was proposed but not passed in at least two states: Arizona and Kentucky. Virginia's governor approved a staffing bill in March 2023. However, it does not go into effect until July 2025, and it includes numerous provisions for nursing homes to avoid sanctions for failing to meet the minimum standard.²⁶ Georgia, on the other hand, has adopted a permanent *decrease* to its previous HPRD standards, from 2.30 to 2.06 HPRD.²⁷

Unfortunately, staffing laws can face significant hurdles even after they are passed. Industry opposition frequently intensifies post-enactment to delay or prevent implementation, or to water down standards. In 2021, New York passed a law requiring every facility to maintain daily staffing hours of 3.5 HPRD and requiring facilities to spend at least 70 percent of their operating revenue on direct resident care and at least 40 percent of revenue on resident-facing staffing.²⁸ ²⁹ In December 2021, over 200 nursing homes filed suit against the state seeking to overturn the minimum spending law. They claim in their lawsuit that, had the law been in effect in 2019, they each would have had an average of over two million dollars in excess income which they would have to return to the state nursing home quality improvement fund.³⁰

Even longstanding state requirements are in constant jeopardy of being repealed due to lobbying by influential industry trade associations. In certain instances, the lack of specific federal staffing standards (as of September 2023) can serve as a rationale for states to eliminate their own more detailed, stronger standards. For example, in 2021, Arkansas repealed existing per-shift staffing ratios, diluted the definition of direct care, and removed penalties for violating staffing rules that had been on the books since 2001. Supporters of the

²⁵ Both New York and Rhode Island established a direct care minimum, while Connecticut increased its direct care minimum requirement. See "State Nursing Home Staffing Standards." Available at https://theconsumervoice.org/uploads/files/issues/CV_StaffingReport.pdf.

²⁶ See <https://lis.virginia.gov/cgi-bin/legp604.exe?231+sum+HB1446>.

²⁷ Georgia House Bill 987. Available at <https://www.legis.ga.gov/api/legislation/document/20192020/194812>.

²⁸ Section 2895-b of the New York Public Health Law. Available at <https://regs.health.ny.gov/sites/default/files/proposed-regulations/Minimum%20Staffing%20Requirements%20for%20Nursing%20Homes.pdf>

²⁹ Section 2828 of the New York Public Health Law. Available at <https://regs.health.ny.gov/sites/default/files/proposed-regulations/Nursing%20Home%20Minimum%20Direct%20Resident%20Care%20Spending.pdf>.

³⁰ See "LTCCC Alert: NY Nursing Homes Admit Excess Profits," available at <https://nursinghome411.org/nys-provider-lawsuit/>.

bill said it would “remove redundancies” by eliminating state laws that duplicate federal staffing laws.³¹

Federal Minimum Staffing Regulatory Activity

Despite strong recommendations from numerous nursing home experts and consumer advocates, the Obama Administration’s 2016 revision of federal nursing home standards did not incorporate staffing ratios. As an alternative to staffing ratios, CMS essentially beefed up its requirements for facilities to self-assess the provision of care and services in the facility, including staffing needs. Unfortunately, since that time, nurse staffing levels have decreased by 9.4%, according to an investigative report from *USA Today*.³² Clearly, relying on nursing homes to provide meaningful “quality assurance and performance improvement (QAPI)” is not a winning plan for residents, their families, or American taxpayers.

Clearly, relying on nursing homes to provide meaningful “quality assurance and performance improvement (QAPI)” is not a winning plan for residents, their families, or American taxpayers.

In February 2022, the Biden Administration announced it would propose new regulations establishing more specific, detailed, and quantitative minimum staffing requirements by Spring 2023. President Biden’s announcement cited adequate staffing levels as the “measure most closely linked to the quality of care residents receive.”³³ To inform the rulemaking, CMS issued a Request for Information that received thousands of comments. CMS also conducted a qualitative and quantitative staffing study,³⁴ building on previous studies, to help identify a minimum staffing level, or “threshold below which residents would be at substantially increased risk of not receiving the safe and quality care they deserve.”³⁵

However, CMS did not conduct an evidence-based analysis of how much time it actually takes to provide care to nursing home residents in accordance with the requirements laid out in the 1987 Nursing Home Reform Law. As a result, the study which CMS conducted to support development of a rule was significantly flawed. While the study begins by pointing out the

³¹ Besson E., “State Panel Oks Bill to Overhaul Nursing Homes’ Staffing Rules,” *Arkansas Democrat Gazette* (April 8, 2021). Available at <https://www.arkansasonline.com/news/2021/apr/08/panel-favors-bill-on-nursing-homes/>.

³² Fraser J and Penzenstadler N, “Many Nursing Homes are Poorly Staffed. How Do They Get Away with It?,” *USA Today* (December 1, 2022). Available at <https://www.usatoday.com/in-depth/news/investigations/2022/12/01/skilled-nursing-facilities-staffing-problems-biden-reforms/8318780001/>.

³³ The White House, “FACT SHEET: Protecting Seniors by Improving Safety and Quality of Care in the Nation’s Nursing Homes,” (February 28, 2022). Available at <https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/28/fact-sheet-protecting-seniors-and-people-with-disabilities-by-improving-safety-and-quality-of-care-in-the-nations-nursing-homes/>.

³⁴ <https://www.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf>.

³⁵ Centers for Medicare & Medicaid Services, “Centers for Medicare & Medicaid Services Staffing Study to Inform Minimum Staffing Requirements for Nursing Homes,” (August 22, 2022). Available at <https://www.cms.gov/blog/centers-medicare-medicaid-services-staffing-study-inform-minimum-staffing-requirements-nursing-homes>.

seminal 2001 CMS report to Congress on the appropriateness of minimum staffing standards,³⁶ it omits a crucial point that total nurse staffing for nursing home residents of below 4.1 HPRD, with .55 (for short stay and .75 RN staffing (for long stay residents), .55 LPN staffing, and 2.4 to 2.8 CNA HPRD led to a likelihood of harm or jeopardy to residents. Because those findings are over 20 years old, CMS should have focused on whether the extent to which they are still valid and might need to be updated to reflect (among other factors) the extent to which resident acuity has increased over the last 22 years.

On September 1, 2023, CMS released the long-awaited proposed rule to implement a national minimum staffing standard for nursing homes.³⁷ The proposed per-day levels of 3.0 hours per resident day (HPRD) are much below the 4.1 HPRD identified in the CMS report over 20 years ago. Specifically, the new rule requires: 1) minimum nurse staffing standards of 0.55 HPRD for RNs and 2.45 HPRD for CNAs, and 2) an RN onsite 24 hours per day. This is far below the minimum identified in CMS's own 2001 report and decades of subsequent research on the minimum staffing necessary to provide a safe and humane environment for both residents and staff.

For more information and updates on the proposed federal staffing requirement, visit www.nursinghome411.org/staffing.

Enforcement

Enforcement of staffing standards at both the federal and state levels is generally inadequate. Though short staffing is pervasive, few, if any, facilities are subjected to meaningful penalties for understaffing. During the Trump administration, CMS directed state survey agencies to favor per instance rather than per day fines for facilities failing to comply with minimum standards for an extended period.³⁸ This policy change has resulted in a significant reduction in (already low and infrequent) penalties for substandard care, abuse, or neglect. This policy was rescinded in 2021 by the Biden administration.³⁹ However, as of September 2023, CMS has not officially reinstated the

The failure to penalize facilities for inadequate staffing practices, even when they lead to unnecessary suffering or death, sends a perverse message to the nursing home industry: substandard care can be provided to vulnerable individuals with impunity.

³⁶ "Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes," available at www.nursinghome411.org/staffing.

³⁷ <https://www.federalregister.gov/documents/2023/09/06/2023-18781/medicare-and-medicaid-programs-minimum-staffing-standards-for-long-term-care-facilities-and-medicaid> Public comments are due November 6, 2023.

³⁸ Centers for Medicare & Medicaid Services, "Revision of Civil Money Penalty (CMP) Policies and CMP Analytic Tool," S&C: 17-37-NH (July 7, 2017). This guidance document was rescinded July 19, 2021.

³⁹ Abelson R, The New York Times, "Trump-era Limit on Nursing Homes Safety Fines is Lifted," (July 28, 2021). Available at <https://www.nytimes.com/2021/07/28/health/biden-nursing-homes-safety-fines.html>.

“per instance per day” guidance, resulting in what is essentially a non-policy that allows too many nursing homes with egregious violations to avoid accountability.

Even when strong staffing standards and appropriate regulatory authority exist, regulators tend to understate the seriousness of violations. Our studies of national citation data persistently indicate that approximately 95% of nursing home health deficiencies are classified as “not causing harm.”⁴⁰ And in the rare cases that CMS determines staffing deficiencies pose an “immediate jeopardy” to residents, nursing homes are often not penalized. Few staffing deficiencies were identified in 2019 and even fewer in 2020.⁴¹

When staffing deficiencies are appropriately cited, nursing homes are generally provided with an opportunity to correct them, without incurring fines or other penalties. Meanwhile, enforcement action is taken only in about half of the cases of the more serious deficiencies (those CMS identifies as causing “actual harm” or posing “immediate jeopardy”).⁴² The failure to penalize facilities for inadequate staffing practices – even when they lead to unnecessary suffering or death – sends a perverse message to the nursing home industry: substandard care can be provided to vulnerable individuals with impunity.

Research shows that staffing and quality of care improvements occur when state regulatory agencies adopt stronger enforcement programs.⁴³ Nevertheless, enforcement of staffing violations at the state level is generally wanting, with low level fines imposed only rarely and generally only after multiple and recurrent instances of understaffing have been cited. For example, in 2020, before New York passed a new staffing law, a nursing home received the maximum fine of \$7,000 after “multiple insufficient staffing deficiencies cited by the department during three unannounced inspections.”⁴⁴

In Florida, the enforcement of staffing requirements was initially delegated to the nursing homes themselves. A provision in the state’s recently passed staffing legislation requires nursing homes to place a self-imposed moratorium on admissions of new residents if they fail to comply with minimum staffing requirements for two consecutive days. The moratorium must

⁴⁰ LTCCC, “Broken Promises: An Assessment of Nursing Home Oversight,” (November 2021). Available at <https://nursinghome411.org/reports/survey-enforcement/survey-data-report/>.

⁴¹ Center for Medicare Advocacy, “Staffing Deficiencies in Nursing Facilities: Rarely Cited, Seldom Sanctioned,” (March 7, 2014). Available at <https://medicareadvocacy.org/staffing-deficiencies-in-nursing-facilities-rarely-cited-seldom-sanctioned/>. Edelman T, Center for Medicare Advocacy, “Report: Nursing Staffing Deficiencies,” (January 10, 2019). Available at <https://medicareadvocacy.org/report-nurse-staffing-deficiencies/>.

⁴² Edelman T, Center for Medicare Advocacy, “Report: Nursing Staffing Deficiencies,” (January 10, 2019). Available at <https://medicareadvocacy.org/report-nurse-staffing-deficiencies/>.

⁴³ Mukamel DB, Weimer DL, Harrington C, Spector WD, Ladd H, and Li Y, Health Services Research, “The Effect of State Regulatory Stringency on Nursing Home Quality,” (October 2012). Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3513606/>.

⁴⁴ Med-Net, “New York Nursing Home Gets Maximum \$7,000 Fine for Repeated Understaffing Deficiencies,” (February 6, 2020). Available at <https://www.mednetcompliance.com/fined-insufficient-staffing-deficiencies/>.

continue until the facility complies with the minimum staffing requirements for six consecutive days. Facilities that fail to impose such a moratorium upon themselves could be fined \$1,000.⁴⁵

In Illinois, at the height of the pandemic, the state contracted with Manatt Health Strategies to review the state's nursing home regulatory agency's operations and recommend improvements to its oversight of nursing homes. According to the Manatt report, the state's regulatory agency (Office of Health Care Regulation, OHCR) "has not made effective use of its authority to impose penalties," and its "fines and penalties may not be sufficient to deter poor behavior, even though facilities view OHCR as highly punitive."⁴⁶ As a follow-up to the Manatt report, the OHCR created two new divisions in its Bureau of Long-Term Care dedicated to certification and licensure as well as compliance, including a new unit to implement staffing ratio rules.⁴⁷

Training

Closely tied to the issue of appropriate nurse staffing levels is the issue of CNA training requirements.⁴⁸ CNAs perform the bulk of care received by nursing home residents. The Nursing Home Reform Law prohibits facilities from using individuals as aides for more than four months unless they take state-required training, consisting of a minimum of 75 hours, including at least 16 hours of supervised practical (clinical hours). They must also pass the state's competency evaluation test.

At least as far back as 2002, as documented in a report by the Office of the Inspector General (OIG), there were concerns about these limited federal training requirements, particularly the number of clinical hours (16) being insufficient to prepare CNAs for their responsibilities.⁴⁹

Barriers to Enforcement of Staffing Regulations:

- The lack of clear, workable standards.
- Poorly staffed and insufficiently funded regulatory agencies leading to slower responses to complaints and less thorough surveys.
- Surveyors subjected to pressure from their supervisors, facilities, and elected officials to downgrade or remove deficiencies.
- Nursing home staff reluctant to relay information about understaffing to surveyors due to fear of retribution by employers.

⁴⁵ Section 400.141(1)(n)1., F.S. Available at http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0400-0499/0400/Sections/0400.141.html.

⁴⁶ The Manatt report was made public only after the *Chicago Tribune* obtained it by means of a FOIA request.

⁴⁷ Meisel H, NPR Illinois, "As Pritzker Administration Pushes for Nursing Home Reform, Unpublished Report Details Weaknesses in State's Long-Term Care Oversight," (October 18, 2021). Available at <https://www.nprillinois.org/statehouse/2021-10-18/as-pritzker-administration-pushes-for-nursing-home-reform-unpublished-report-details-weaknesses-in-states-long-term-care-oversight>.

⁴⁸ See LTCCC's report, "A Guide to State CNA Certification and Training Requirements," (March 2023). Available at <https://nursinghome411.org/cna-reqs/>. Hereinafter, LTCCC Guide to State CNA Training Requirements.

⁴⁹ OIG, "Nurse Aide Training," (November 2002). Available at <https://oig.hhs.gov/oei/reports/oei-05-01-00030.pdf>.

Furthermore, the OIG report identified the high turnover rate amongst graduates of CNA training as “a potential consequence of insufficient clinical training experience...”⁵⁰ CNAs indicated that they felt ill-prepared and would prefer additional hours of clinical training.⁵¹

In response to those concerns, prior to the pandemic, over half of the states required CNAs to undergo more than the federally required 75 hours of training to meet the increasingly complex care needs of residents. Thirty states and the District of Columbia extended their minimum training hours beyond 75 to as many as 180 hours. Thirteen states and DC require 120 hours or more as recommended by the National Academies in 2008,⁵² and again in 2022.⁵³ Thirty-two states and the District of Columbia require more than the minimum 16 hours of clinical training, with required clinical hours ranging up to 100 hours.⁵⁴

Certified Nurse Aide (CNA) training and certification requirements vary considerably across the U.S. To view state specific training requirements, visit nursinghome411.org/cna-reqs.

Researchers studying training length for CNAs have found that CNAs who reported having received high quality training were more likely to work in states requiring additional training hours and were more satisfied with their jobs. Researchers in this study recommended requiring additional hours for CNA training to improve job satisfaction and ultimately reduce staff turnover.⁵⁵

Nursing homes in states with CNA training and in-service hours above federal minimums have also been shown to have better resident outcomes, such as fewer falls and lower average medication use. Nursing homes in states requiring additional clinical training hours above the federal minimum (i.e., >16hr) had significantly lower odds of adverse resident outcomes, particularly pain, falls with injury, and depression.

Changes to Staff Training Requirements Post-COVID

Many states temporarily reduced state training requirements for nursing assistants to increase the pool of individuals available to work in nursing homes during the pandemic. A few states,

⁵⁰ Id.

⁵¹ Sengupta M, Harris-Kojetin LD, Ejaz FK, Gerontology & Geriatrics Education, “A National Overview of the Training Received by Certified Nursing Assistants Working in U.S. Nursing Homes,” (2010). Available at <https://pubmed.ncbi.nlm.nih.gov/20730649/>.

⁵² National Academies of Sciences, Engineering, and Medicine, “Retooling for an Aging America,” (2008). Available at <https://nap.nationalacademies.org/catalog/12089/retooling-for-an-aging-america-building-the-health-care-workforce>.

⁵³ National Academies of Sciences, Engineering, and Medicine, “The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Families, and Staff,” (2022). Available at <https://nap.nationalacademies.org/catalog/26526/the-national-imperative-to-improve-nursing-home-quality-honoring-our>.

⁵⁴ LTCCC Guide to State CNA Training Requirements.

⁵⁵ Han K, Trinkoff AM, Storr CL, Lerner N, Johantgen M, Gartrell K, International Journal of Nursing Studies, “Associations Between State Regulations, Training Length, Perceived Quality and Job Satisfaction Among Certified Nursing Assistants: Cross-Sectional Secondary Data Analysis,” (2014). Available at <https://www.sciencedirect.com/science/article/abs/pii/S0020748913003866>.

however, used the pandemic to adopt permanent changes that had long been sought by the nursing home industry. One of these states, Wisconsin,⁵⁶ permanently reduced training hours for nurse aides from 120 hours to the federal minimum of 75 hours and set forth in its code a prohibition against any future requirements for any mandatory training hours that exceed the federal minimums.

Many states also adopted changes that allow temporary nursing assistants (TNAs) who were hired during the pandemic to become CNAs without having to complete the minimum federally required 75-hour training. For example, in New York, TNAs who worked in a facility for at least 30 days or 150 hours received an automatic credit for 35 of their required 75 hours of training. Then, the temporary nurse aide was given at least three attempts to pass the required certification test. Virginia waived the majority of its required training hours and allowed TNAs who had worked in a facility and had been deemed competent by that facility to take the certification exam.⁵⁷

In March 2020, in response to the COVID pandemic, CMS waived the federal prohibition against employing uncertified aides for longer than four months. In response, many states declared that individuals who had completed an eight hour on-line training program which has been developed by industry lobbyists were qualified to work as nursing assistants during the pandemic.⁵⁸

In April 2021, CMS advised that when it lifted the waiver of nurse aide training requirements, aides would have four months to complete their state's required training. States and nurse aides were urged to ensure that all training and certification requirements were completed as soon as possible.⁵⁹

About one year later, on April 7, 2022, CMS lifted the blanket nurse aide training waiver, requiring aides hired after that date to complete training and testing by October 6, 2022. In its memo to state agency survey directors, CMS expressed concern that while the waivers may have provided flexibility in how nursing homes may operate, they also removed the minimum standards for quality that help ensure residents' health and safety are protected. Findings from onsite surveys have revealed significant concerns with resident care that are unrelated to infection control (e.g., abuse, weight-loss, depression, pressure ulcers, etc.). We are concerned that the waiver of certain regulatory requirements has contributed to these outcomes and raises the risk of other issues. For example, by waiving requirements for training, nurse aides

⁵⁶ Wisconsin Miscellaneous Health Provisions, § 146.40(3). Available at <https://docs.legis.wisconsin.gov/statutes/statutes/146/40/3>.

⁵⁷ See Virginia Department of Health Professions Board of Nursing Announcement, "Temporary Nurse Aides to Certified Nurse Aides ('TNA2CNA')", (June 28, 2022). Available at <https://www.dhp.virginia.gov/Boards/Nursing/AbouttheBoard/News/Announcements/Content-473068-en.html>.

⁵⁸ Though CMS stated that they were still requiring that everyone providing resident care must have the requisite skills and competencies, the agency did not track the extent to which so-called TNAs (nurse-aides in training) were utilized in nursing homes or monitor for any changes in quality of care or outcomes. In fact, CMS significantly curtailed its requirements for state monitoring, inspections, and responses to complaints during the first phase of the pandemic.

⁵⁹ CMS also suggested states consider allowing some of the time worked in a nursing facility to count towards the state's required training hours.

and paid feeding assistants may not have received the necessary training to help identify and prevent weight-loss.⁶⁰

In August 2022, bowing to concerns from the industry and states about barriers to training and testing backlogs, CMS once again permitted waivers of training requirements, but this time, on a facility, state, or county basis for the duration of the PHE.^{61 62}

Industry supported legislation, the Building America's Health Care Workforce Act, introduced in May 2022, would give TNAs an additional 24 months following the end of the PHE to achieve certification. It would also allow them to apply all hours worked as TNAs during the pandemic towards the 75-hour training requirement. In addition, it would allow the nursing home that employs the aide to conduct its own competency evaluation if the state does not offer certification exams at least weekly.⁶³ Due to concerns that this bill, if enacted, would extend the exposure of too many nursing home residents to substandard care, neglect, and potential abuse, LTCCC strongly opposes it.

Industry-Supported Policies Designed to Address Staffing Shortages

Staffing challenges, while exacerbated during the pandemic, have long plagued the nursing home industry. The reasons for nursing homes' inability to recruit and retain a sufficient workforce are numerous, multidimensional, and interrelated. They include poor pay and benefits, unrealistic workloads, dangerous working conditions, limited advancement opportunities, and lack of respect. For the most part, the industry has failed to address these persistent problems, instead advocating almost exclusively, for many decades, for funding increases with little to no accountability for that funding.

In addition to a long history of opposing minimum staffing ratios that could address the workload issues and rejecting robust minimum training requirements that could improve worker safety, as discussed above, the industry continues to advance failed, band-aid policies that have been proven to exacerbate the staffing problem.

The industry continues to advance failed, band-aid policies that have been proven to exacerbate the staffing problem.

Weakening Minimum Training & Competency Requirements

For decades, despite the Reform Law's 75-hour training requirement for those performing nursing and care duties, industry lobbyists pushed to allow a new class of worker, called "single

⁶⁰ CMS, "Memorandum: Update to COVID-19 Emergency Declaration Blanket Waivers for Specific Providers," (April 7, 2022). Available at <https://www.cms.gov/files/document/qso-22-15-nh-nltc-lsc-revised.pdf>.

⁶¹ Id.

⁶² As of November 2022, CMS had granted waivers to 17 states: Rhode Island, Massachusetts, Washington, Indiana, Louisiana, Maryland, Minnesota, Oklahoma, Pennsylvania, Texas, Vermont, New York, Georgia, New Jersey, Tennessee, South Carolina, and Mississippi. Approximately 746 individual facilities have submitted waiver requests, with 439 already covered under state waivers. Employment under these approved waivers lasted for the duration of the public health emergency, which expired on May 11, 2023.

⁶³ This bill was reintroduced in the 118th Congress. "H.R.468 - 118th Congress (2023-2024): Building America's Health Care Workforce Act." February 3, 2023. <https://www.congress.gov/bill/118th-congress/house-bill/468>.

task workers,” to provide direct care for nursing home residents. Chief among these workers were paid feeding assistants (PFAs) to help nursing home residents with nutritional and hydration needs. Until 2003, those who provided feeding assistance required at least 75 hours of training. That changed when the industry achieved new regulations that permitted individuals with as little as eight hours of training to serve as feeding assistants.⁶⁴

The approval of PFA use was driven by the acceptance of industry claims of shortages of CNAs and that they were finding it “increasingly difficult to train and retain sufficient numbers of qualified nursing staff, especially certified nurse aides.”⁶⁵ As noted elsewhere in this brief, these claims, which industry lobbyists have been making for decades, are belied by the industry’s long record of extremely high turnover rates.

From a consumer and caregiver perspective, permitting PFA use is a dangerous practice and precedent. Dining assistance is a complex task. Many residents have difficulty swallowing and residents with dementia may need special help, such as cuing to chew and swallow. Further, single-task workers like PFAs further diminish the role of the CNA. From a regulatory perspective, the approval of PFA use undermines the requirements that residents be treated with dignity in dining and other activities.

While the use of PFAs appears to increase the numbers of staff present during mealtimes and may free up nursing staff to attend to other duties, there is no evidence that it results in an increase of overall facility nursing staff levels or nursing hours per resident per day. In fact, most PFAs are existing facility staff who do not normally perform nursing functions (such as administrative or clerical staff) and who are asked to, or volunteer to, assist residents in addition to their regular jobs.

In Florida,⁶⁶ as of March 2022, PFAs (who do not perform nursing duties) can now be included in the required minimum nurse staffing ratio, thus diluting the actual minutes of nursing care residents receive.

PFAs who are not existing staff are generally paid by the hour at rates lower than those of CNAs, for mealtimes only, with few, if any, benefits. Neither PFAs recruited from existing staff or from external sources are systematically provided opportunities to become CNAs or otherwise encouraged to pursue a nursing career, even though these workers would be likely candidates for CNA training.⁶⁷

⁶⁴ CMS, “Final Rule: Requirements for Paid Feeding Assistants in Long Term Care Facilities,” (September 26, 2003). Available at <https://www.federalregister.gov/documents/2003/09/26/03-24362/medicare-and-medicaid-programs-requirements-for-paid-feeding-assistants-in-long-term-care-facilities>.

⁶⁵ See CMS Proposed Rule, “Requirements for Paid Feeding Assistants in Long Term Care Facilities (March 29, 2002). Available at <https://www.federalregister.gov/documents/2002/03/29/02-7344/medicare-and-medicaid-programs-requirements-for-paid-feeding-assistants-in-long-term-care-facilities>.

⁶⁶ FL House of Representatives Staff Final Bill Analysis, (April 8, 2022). Available at <https://www.flsenate.gov/Session/Bill/2022/1239/Analyses/h1239z1.FFS.PDF>.

⁶⁷ We have been unable to find any research documenting the extent to which feeding assistants become CNAs.

Permitting Training of CNAs by Deficient Nursing Homes

Given that CNAs provide the bulk of hands-on care to nursing home residents, the quality of the training they receive should be of the highest caliber. CNA training is offered by several different institutions such as community colleges, adult learning centers, vocational schools, and unions.

Federal law also permits nursing homes to run their own in-house CNA training programs, except under certain circumstances. Facilities without the required numbers of licensed nursing staff may not legally offer CNA training, as these nurses should not be diverted from resident care for training duties. In addition, facilities that have had serious quality of care deficiencies resulting in the imposition of civil money penalties (CMPs) of (at present) at least \$11,160 are prohibited from offering in house training for two years.⁶⁸ These prohibitions are intended to ensure facilities are in compliance with basic requirements before they can train staff.

States may waive the prohibition of a facility-conducted nurse aide training program if it determines that “there is no other such program offered within a reasonable distance of the facility” and if the facility assures that it provides “an adequate environment” for a program conducted by a third party. Federal law also allows the Secretary of Health and Human Services (“the Secretary”) to waive the ban on an in-house training program if the civil money penalty was not related to quality of care provided to residents.

For many years, the nursing home industry has advocated for federal legislation⁶⁹ to eliminate or shorten the mandatory two-year waiting period, arguing that this “training ban” can make it more difficult for facilities to retain staff. Similar legislation was most recently introduced in June 2022 in both houses of Congress and appears to be a priority for national and state nursing home trade associations throughout the country.⁷⁰

It is important to note that such bans are rarely imposed and generally only on those facilities that have been found to provide extremely poor care. The two-year ban is a recognition by CMS that these homes should not be in the business of training new employees when they are not providing an acceptable level of care.⁷¹

Reining in Temporary Nursing Staffing Agencies

Even prior to the pandemic, nursing homes’ use of contract staff from nursing staffing agencies was common. Many nursing homes use contract staff to contain costs, increase scheduling flexibility, reduce overtime for regular employees, and reduce the need for additional

⁶⁸ The ban on in-house CNA training continues for 2 years until which time a facility can demonstrate it can sustain its ability to meet quality standards.

⁶⁹ Ensuring Seniors’ Access to Quality Care Act, S. 4381 and H.R. 8805.

⁷⁰ See, <https://leadingage.org/leadingage-statement-on-the-ensuring-seniors-access-to-quality-care-act/>.

⁷¹ See, “Protect Nursing Home Nurse Aide Training Requirements; Protect Residents’ Right to High Quality Care,” (January 6, 2020). Available at <https://medicareadvocacy.org/protect-nursing-home-nurse-aide-training-requirements>.

permanent staff positions. Unfortunately, the heavy reliance on agency contract staff may exacerbate staffing woes by obviating the need for facilities to invest in their own employees through better job quality, increased salaries, and benefits. This in turn leads to higher turnover rates and lower morale.⁷²

High reliance on contract staff has been associated with poorer quality measures.⁷³ Lower-quality (1-star) nursing homes had the highest levels of contract nurse staffing prior to the pandemic, and they increased their contract nurse staffing levels the most in 2020.⁷⁴

Many nursing homes see contract staff as an effective way of containing costs... Unfortunately, the heavy reliance on agency contract staff may exacerbate staffing woes, by obviating the need for facilities to invest in their own employees through better job quality, increased salaries, and benefits.

During the pandemic, the use of temporary staff and the costs associated with it increased significantly.⁷⁵ As agencies raised rates, the use of contract employees became less cost effective, cutting into nursing home profits. Instead of offering competitive pay, benefits, workplace flexibilities, or other incentives to recruit and retain staff, the industry has lobbied for federal and state legislation that would impose significant regulatory barriers on staffing agencies – capping how much agencies can charge or targeting their profit margins. Regulation of nurse staffing agencies appears to have been a top industry priority. In Iowa, the state association head declared it to be “definitely the most important and of most consequence to our members.”⁷⁶

At the federal level, legislation introduced in 2022, the Travel Nursing Agency Transparency Study Act,⁷⁷ would require the Government Accountability Office to report to Congress on the business practices and effects of hiring agencies across the healthcare industry during the COVID-19 pandemic. In January 2022, the industry succeeded in enlisting more than 200

⁷² See, “LTCCC Alert: Nursing Home Staff Turnover Above 50%”, (August 24, 2022). Available at <https://nursinghome411.org/alert-staffing-q1-2022/>.

⁷³ ASPE, “Issue Brief: COVID-19 Pandemic Increased Nursing Homes’ Reliance on Contract Staff to Address Staffing Shortages in 2020,” (September 12, 2022). Available at <https://aspe.hhs.gov/sites/default/files/documents/f7c0751d7b3ae7337a3b5d5e3dcc2ae7/nh-reliance-contract-staff-brief.pdf>.

⁷⁴ ASPE, “Issue Brief: COVID-19 Pandemic Increased Nursing Homes’ Reliance on Contract Staff to Address Staffing Shortages in 2020,” (September 12, 2022). Available at <https://aspe.hhs.gov/sites/default/files/documents/f7c0751d7b3ae7337a3b5d5e3dcc2ae7/nh-reliance-contract-staff-brief.pdf>.

⁷⁵ According to PHI, “More than three in five nursing homes relied on nursing assistants from staffing agencies to fill staffing vacancies in 2021. Nursing homes that brought in contract nursing assistants used these temporary workers for a median of 166 days during the year. These figures indicate a large increase in reliance on contract staffing in 2021 as compared to 2020, when 41 percent of nursing homes used contract nursing assistants for a median of 89 days during the year.” PHI, “Direct Care Workers in the United States,” (September 6, 2022). Available at <https://www.phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-3/>.

⁷⁶ Stulick A, Skilled Nursing News, “Nursing Homes See Movement on Staffing Agency Reform,” (May 30, 2022). Available at <https://skillednursingnews.com/2022/05/nursing-homes-see-movement-on-staffing-agency-reform/>.

⁷⁷ S.4352 – 117th Congress (2021-2022): Travel Nursing Agency Transparency Study Act. Available at <https://www.congress.gov/bill/117th-congress/senate-bill/4352>.

legislators to sign onto a letter⁷⁸ to the Federal Trade Commission and the White House COVID-19 Response Team to investigate potential price gouging and anti-competitive activity by nurse staffing agencies.

At the state level, during the 2021-2022 biennium, lawmakers in at least six states enacted legislation to regulate staffing agencies,⁷⁹ to study their practices and rates or to establish a process for setting their rates,⁸⁰ or to require agencies to pay agency nurses the full hourly rate that the agency charges the facility.⁸¹

Note that none of these bills require or even incentivize nursing homes to utilize the “savings” accrued from capped agency rates on improving salaries or benefits for their own direct care staff. Given the strong association between lower agency use and higher nursing home quality, and the lack of any requirement to redirect these reduced expenditures towards compensation for permanent staffing, the industry’s heavy emphasis on regulating nurse agencies appears to be, at best, a short-sighted fix for nursing home staffing woes, intended solely to protect the industry’s bottom line.

Perpetuating Poor Quality Jobs and Other Factors That Reduce Retention Rates

According to CMS, over half of this nation’s nursing home direct care nursing staff leave their positions each year. While turnover in nursing home staff is a highly complex issue, it is well documented that high staff turnover is harmful to nursing home residents.⁸² The costs of turnover are popularly thought to be detrimental to nursing homes’ bottom lines. However, some researchers suggest that staff turnover results in net savings to nursing homes.⁸³ It can be a strategy to reduce costs, such as by avoiding pay raises associated with longer tenure in a job.

⁷⁸ Zorn A, Skilled Nursing News, “Members of Congress Urge White House to Investigate Price Gouging From Staffing Agencies,” (January 26, 2022). Available at <https://skillednursingnews.com/2022/01/members-of-congress-urge-white-house-to-investigate-price-gouging-from-staffing-agencies/>.

⁷⁹ Iowa HB 2521 – An Act Relating to Health Care Employment Agencies, And Providing Penalties. Available at <https://www.legis.iowa.gov/legislation/BillBook?ga=89&ba=hf2521>. Louisiana HB 958 – Provides for licensure and regulation of nurse staffing agencies by the Louisiana Department of Health. Available at <https://www.legis.la.gov/Legis/BillInfo.aspx?i=243051>.

⁸⁰ Connecticut HB 5313 – An Act Concerning Temporary Nursing Services Agencies, Reporting of Involuntary Transfers and Discharges from Nursing Homes and Residential Care Homes, Elder Abuse Training, Legal Rights of Long-Term Care Applicants and a Study of Managed Resident Community Issues. Available at https://www.cga.ct.gov/asp/CGABillStatus/cgabillstatus.asp?selBillType=Bill&bill_num=HB05313&which_year=2022. Oregon SB 1549 – Relating to health care temporary staffing agencies; and declaring an emergency. Available at <https://olis.oregonlegislature.gov/liz/2022R1/Measures/Overview/SB1549>. Tennessee SB 2463 – Relative to temporary healthcare staffing. Available at <https://wapp.capitol.tn.gov/apps/BillInfo/default.aspx?BillNumber=SB2463&GA=112>.

⁸¹ Illinois HB 4666 – Amends the Nurse Agency Licensing Act. Available at <https://www.ilga.gov/legislation/fulltext.asp?DocName=&SessionId=110&GA=102&DocTypeId=HB&DocNum=4666&GAID=16&LegID=138827&SpecSess=&Session=>

⁸² Consumer Voice, “High Staff Turnover: A Job Quality Crisis in Nursing Homes,” (September 8, 2022). Available at https://theconsumervoic.org/uploads/files/issues/High_Staff_Turnover-A_Job_Quality_Crisis_in_Nursing_Homes.pdf.

⁸³ Mukamel D, Spector WD, Limcangco R, Wang Y, Feng Z, and Mor V, Medical Care, “The Costs of Turnover in Nursing Homes,” (2009). Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2761533/>.

Fundamentally, high turnover is the product of many factors – including unreasonable workloads and insufficient training – perpetuated by an industry opposed to known policy solutions.

Low Wages and Inadequate Benefits

Most CNAs are paid close to the minimum wage, and approximately 40 percent of them rely on public assistance.⁸⁴ Because many CNA positions are advertised as part-time, CNAs often work in multiple facilities to make ends meet.⁸⁵ Typically, these part-time positions do not provide health insurance or other benefits, compelling workers to rely on public health coverage, most commonly Medicaid.⁸⁶ Most nursing homes do not provide their staff with paid sick leave, even though paid sick leave is associated with better CNA staffing rates (CNA hours per resident day increased by 2.3 percent) and improved quality and safety measures for residents (including reduced mortality rates).⁸⁷

While the costs of turnover are popularly thought to be detrimental to nursing homes' bottom lines... researchers in at least one study suggest that staff turnover results in net savings to nursing homes, and therefore may be an intentional part of most nursing homes' cost minimizing strategies.

Over the years, the industry has lobbied successfully for increased reimbursement rates. During the pandemic, it received millions of dollars through temporary federal COVID-19 relief and state funding. Yet only in a few states, as discussed below, have nursing homes been required to pass any of these funds on to direct care workers in the form of better wages and benefits. Moreover, they have often lobbied against such requirements when they have been proposed.

According to the US Department of Labor's Wage and Hour Division, long-term care operators are among the health providers which have been found to have willfully violated federal wage and hour laws. A number of operators have been fined for such practices, including incorrectly classifying employees to avoid paying appropriate wages and failing to pay or incorrectly calculating overtime.⁸⁸

CNA Empowerment Practices

Recent research shows that a combination of higher hourly wages and the use of CNA empowerment practices (such as involving CNAs in scheduling, hiring or quality improvement

⁸⁴ PHI, "U.S. Nursing Assistants Employed in Nursing Homes," (September 3, 2019). Available at <https://www.phinational.org/resource/u-s-nursing-assistants-employed-in-nursing-homes-key-facts-2019/>.

⁸⁵ During the pandemic, staff working across nursing homes was found to contribute to the cross-facility spread of the virus. See Chen MK, Chevalier JA, and Long EF, PNAS, "Nursing Home Staff Networks and COVID-19," (December 28, 2020). Available at <https://www.pnas.org/doi/10.1073/pnas.2015455118>.

⁸⁶ Nursing homes can avoid offering coverage under the Affordable Care Act by restricting hours of part time workers to fewer than 30 per week.

⁸⁷ Datta P, "The Impact of Mandated Paid Sick Leave Laws on the Long-Term Care Industry," (November 19, 2021). Available at https://priyankardatta.net/uploads/Datta_JMP.pdf.

⁸⁸ Department of Labor, "News Release: Department of Labor Initiative Finds Violations in 80% of Care Industry Investigations; Recovers \$28.6M for Nearly 25k Workers, Mostly Women," (November 16, 2022). Available at <https://www.dol.gov/newsroom/releases/whd/whd20221116>.

activities, or implementing career ladders) results in greater CNA retention.⁸⁹ Such practices were also recommended by the 2022 National Academies of Sciences, Engineering and Medicine report, referred to above.

The industry adoption of empowerment practices has been mixed and often unsustainable. To date, public policies requiring implementation of such practices have been extremely limited. CMS has, since 2016, required nursing homes to include CNAs as part of their interdisciplinary teams and involve them in care planning. However, the extent to which this is occurring is unknown.

Reimbursement policies that promote and reward the adoption of evidence-based empowerment processes, combined with effective oversight to ensure financial incentives are used and having the intended impact (such as the recently enacted Illinois legislation discussed below) are a promising development.

Reducing Staffing to Generate Profit for Private Equity Investors

Recent increases in private equity investment in nursing homes have been shown to lead to intentional reductions in staffing and poorer care for residents. Given that staffing accounts for more than half of nursing facility operating costs (GAO 2021), it is not surprising that private equity-owned nursing homes tend to cut staffing costs to generate cash for their investors. Research has shown that while overall staffing declines by 1.4 percent, private equity investment leads to much more significant cuts in CNA and LPN staffing levels.⁹⁰

Recent state and federal legislation focused on greater transparency and scrutiny of nursing home ownership & operations,⁹¹ if passed and enforced, have the potential to curb the dangerous understaffing practices of these actors.⁹²

State Policies to Address Nursing Home Understaffing

General Medicaid Payment Rate Increases

Medicaid is the primary payer for nursing facility care in the country, covering approximately 62 percent of nursing home residents.⁹³ It is not surprising then that, over the years, states have turned to Medicaid payment rates to address nursing home staffing sufficiency.

⁸⁹ Kennedy KA, Abbott KM, and Bowblis JR, *Journal of Applied Gerontology*, “The One-Two Punch of High Wages and Empowerment on CNA Retention,” (August 2, 2021). Available at <https://doi.org/10.1177/07334648211035659>.

⁹⁰ Gupta A, Howell ST, Yannelis C, and Gupta A, National Bureau of Economic Research, “Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes,” (February 2021). Available at <https://www.nber.org/papers/w28474>.

⁹¹ See, for example proposed federal legislation, Linking Investors and Nursing Home Quality Act, or the LINHQ Act. Available at <https://www.congress.gov/bill/117th-congress/house-bill/8624/all-info>.

⁹² Recently, CMS has started to publish new public information about nursing home ownership and federal lawmakers have introduced legislation requiring more transparency. See <https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/skilled-nursing-facility-change-of-ownership>.

⁹³ Jaffe S, Kaiser Health News, “Medicaid Weighs Attaching Strings to Nursing Home Payments to Improve Patient Care,” (June 10, 2022). Available at <https://khn.org/news/article/medicaid-nursing-home-payments-care-mandate/>.

The putative goal of these increases is to enable nursing homes to hire more direct care staff and increase their wages. However, in the absence of any federal requirement to maintain a specific minimum staffing level, meaningful enforcement of existing staffing standards, or mandate to spend a set portion of Medicaid dollars on staffing, there is no assurance that additional Medicaid funding will be spent on staffing.⁹⁴

Despite the frequency and size of Medicaid rate increases, nursing homes commonly point to the insufficiency of Medicaid payment rates as the reason for which they are unable to pay rates sufficient to attract workers. While this policy brief does not address the adequacy of Medicaid payment rates, facilities have no requirement or effective incentive to allocate general rate increases to direct care staffing.⁹⁵ Furthermore, there is no independent evidence to support the industry's contention that Medicaid rates are insufficient.

Cost-Based Payment Methodologies and Wage Pass-Through Policies

Certain state Medicaid reimbursement policies are more targeted, using Medicaid payment methods to help direct greater spending on staffing. At least 30 states and the District of Columbia have cost-based payment systems that pay nursing facilities based on their actual reported spending for direct care.⁹⁶ Under such a system, facilities that spend more on staffing are reimbursed for their spending.

Fourteen states have wage pass-through policies for nursing homes that tie Medicaid payments to wage costs. In at least two of these states, Kansas and Texas, participation in the wage pass-through is voluntary. According to MACPAC, it is unknown how many facilities participate.^{97 98}

The existing research – though limited and from more than 10 years ago – suggests that cost-based payment systems and wage-pass through payments *may* be associated with higher staffing rates.⁹⁹ One multivariate study using 2002 data found that cost-based payment methods were associated with both higher RN staffing and higher total staffing.¹⁰⁰

⁹⁴ MACPAC, “State Policy Levers to Address Nursing Facility Staffing Issues,” (March 2022). Available at <https://www.macpac.gov/wp-content/uploads/2022/03/State-Policy-Levers-to-Address-Nursing-Facility-Staffing-Issues.pdf>.

⁹⁵ See “LTCCC Policy Brief: Direct Care Minimum Spending Laws,” (2022). Available at <https://nursinghome411.org/minimum-spending-laws/>.

⁹⁶ MACPAC, “Nursing Facility Fee-for-Service Payment Policy,” (December 2019). Available at <https://www.macpac.gov/wp-content/uploads/2019/12/Nursing-Facility-Fee-for-Service-Payment-Policy.pdf>.

⁹⁷ MACPAC, “State Policy Levers to Address Nursing Facility Staffing Issues,” (March 2022). Available at <https://www.macpac.gov/wp-content/uploads/2022/03/State-Policy-Levers-to-Address-Nursing-Facility-Staffing-Issues.pdf>.

⁹⁸ The Institute for Healing Justice & Equity, “Direct Care Worker Wage Pass-Through Law Final Report,” (September 2020). Available at https://ihje.org/wp-content/uploads/2020/12/Direct-Care-Worker-Wage-Pass-Through-Law-Final-Report_September-2020_Institute-of-Healing-Justice-and-Equity.pdf.

⁹⁹ MACPAC, “State Policy Levers to Address Nursing Facility Staffing Issues,” (March 2022). Available at <https://www.macpac.gov/wp-content/uploads/2022/03/State-Policy-Levers-to-Address-Nursing-Facility-Staffing-Issues.pdf>.

¹⁰⁰ Harrington C, Swan J.H., Carrillo H, Health Services Research, “Nurse Staffing Levels and Medicaid Reimbursement Rates in Nursing Facilities,” (2007). Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955251/>.

Little is known about the effectiveness of wage pass-throughs in improving nursing home staffing levels and reducing turnover rates, as states' oversight of these policies varies tremendously.¹⁰¹ A review of wage pass-through policies implemented between 1996 and 2004 found that CNA staffing rates increased in the initial years after implementation, but there was no statistically significant effect on RN or LPN staffing.¹⁰²

Value-Based Payment Programs

Another approach, Medicaid value-based payment (VBP) policies, such as pay-for-performance (P4P) programs, provide facilities with Medicaid incentive payments based on certain quality metrics, which may or may not include staffing. In use in about 16 states, these incentive payments increase the Medicaid base payment rate or are paid as a supplement to facilities. The VBP payments are typically funded through the state's Medicaid general fund, nursing home bed taxes or civil monetary penalties. Recently, a few VBP programs have been funded with federal COVID relief dollars.¹⁰³

The existing literature on the impact of nursing facility P4P incentives is limited, and "it is unclear whether VBP achieve their goals because most programs have not been formally evaluated."¹⁰⁴ One early review of eight Medicaid P4P programs compared to a nationwide control group found that P4P did not result in consistent improvements in nursing home quality and found a statistically significant effect on staffing measures in only one state.¹⁰⁵ A federal evaluation of the CMS Nursing Home Value-Based Purchasing Demonstration, which studied P4P models in three states, also found it to have a minimal direct effect on quality.¹⁰⁶

Pay for performance and other value-based payments, suggested by industry players and supported by generally well-meaning policymakers, typically lack well-defined staffing and workforce measures. In addition, they may not offer a financial reward sufficient to garner provider interest or offset the costs of meeting specified metrics. Fundamentally, the lack of oversight of value-based purchasing programs and the absence of penalties for failing to meet promised metrics contribute to the failure of these programs in the nursing home sector.

¹⁰¹ Abbasi E, LeadingAge, "States Legislatures Taking Steps to Address Direct Care Wages," (October 12, 2022). Available at <https://leadingage.org/states-legislatures-taking-steps-to-address-direct-care-wages/>.

¹⁰² Feng Z, Lee YS, Kuo S, Intrator O, Foster A, Mor V, Health Services Research, "Do Medicaid Wage Pass-through Payments Increase Nursing Home Staffing?" (June 2010). Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2875757/>.

¹⁰³ Pennsylvania Pressroom, "Department of Health to Invest Nearly \$12 Million to Enhance Long-Term Care Facilities," (November 15, 2022). Available at <https://www.media.pa.gov/pages/Health-details.aspx?newsid=1799>.

¹⁰⁴ Tyler DA, Porter KA, Mulmule N, Oliveira I, Squillante M, Dey J, Office of the Assistant Secretary for Planning and Evaluation, "State Use of Value-Based Payment in Nursing Facilities Issue Brief," (August 18, 2022). Available at <https://aspe.hhs.gov/reports/state-use-vbp-nursing-facilities>.

¹⁰⁵ Werner RM, Konetzka RT, and Polsky D, Health Services Research, "The Effect of Pay-for-Performance in Nursing Homes: Evidence from State Medicaid Programs," (February 10, 2013). Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3657568/>.

¹⁰⁶ L&M Policy Research, LLC, "Evaluation of the Nursing Home Value-Based Purchasing Demonstration," (August 26, 2013). Available at https://innovation.cms.gov/files/reports/nursinghomevbp_evalreport.pdf.

Minimum Wage Strategies¹⁰⁷

Some states are addressing nursing home understaffing by establishing minimum wages for direct care workers (at levels exceeding the states' general minimum wage). These wage hikes are often accompanied by increased provider rates.

Recently, Florida increased its provider rates and required facilities receiving the increased rate to pay a minimum wage of \$15 per hour for direct care workers. Employers must attest under penalty of perjury that they are paying at least that rate and employees may bring a civil action and recover damages from employers who fail to pay that rate. Colorado and Louisiana also raised provider rates and required facilities to pay minimum hourly wages of \$15 and \$9, respectively. New Jersey lawmakers also approved a phased-in minimum wage increase. By 2024, the minimum facility wage must be three dollars more than the prevailing minimum wage at that time.

It is too early to determine the extent to which these recent minimum wage increases for nursing home direct care workers will meet their intended recruitment and retention goals. One recent study found this type of targeted minimum wage hikes to have a positive impact on staffing, increasing hours worked per resident day by nursing assistants as well as the number of days per month that facilities were able to meet at least 75% of the minimum recommended levels of staffing for nursing assistants.¹⁰⁸

States implementing such policies differ greatly as to their reporting requirements. Some have no reporting requirements, others require employers to attest to their compliance under penalty of perjury, while still others require submissions of documentation. State auditing and enforcement mechanisms differ greatly as well, with some states performing no active auditing or enforcement activities, while others implementing regular audits and strong enforcement measures that include recoupment of funds, assessment of monetary penalties, and provisions for civil action by workers who have not been paid the increased wage.¹⁰⁹

Fundamentally, the lack of oversight of value-based purchasing programs and the absence of penalties for failing to meet promised metrics contribute to the failure of these programs in the nursing home sector.

¹⁰⁷ This policy brief does not address temporary wage increases implemented during the pandemic.

¹⁰⁸ McHenry P, Mellor JM, Journal of Labor Research, "The Impact of Recent State and Local Minimum Wage Increases on Nursing Facility Employment," (November 18, 2022). Available at <https://doi.org/10.1007/s12122-022-09338-x>.

¹⁰⁹ National Governors Association, "Addressing Wages Of The Direct Care Workforce Through Medicaid Policies," (November 1, 2022). Available at <https://www.nga.org/publications/addressing-wages-of-the-direct-care-workforce-through-medicaid-policies/>.

Recent Approaches to Address Understaffing

Multi-Pronged Rate Reform Legislation

In May 2022, Illinois House Bill 246, a long awaited and heavily negotiated rate reform bill, was signed into law. Supported by the state regulatory agency, trade associations representing the industry, the union representing direct care workers, and consumer advocates, the compromise legislation provides a \$700 million increase for nursing home funding, linking that funding to meeting specific staffing levels. The legislation also includes significant transparency, accountability, quality of care, and equity measures.¹¹⁰

The legislation overhauls the state's nursing home reimbursement methodology by transitioning to a Patient Driven Payment Model (based on the federal methodology of the same name for Medicare reimbursement) and increasing the base per diem rate by \$7 to a total of \$92.25.¹¹¹ Nursing homes serving an above-average percentage of Medicaid residents would receive \$4 more per day.

Most of the funding (\$515 million) is generated by increasing the nursing home bed tax and drawing down matching federal Medicaid funds. That funding is earmarked as follows:

- \$360 million for incentive payments for nursing homes to increase their staffing levels up to or greater than certain target levels. Those targets are tied to the CMS Staff Time and Resource Intensity Verification, or STRIVE study.^{112 113} Incentive payments are made once the facility reaches 75 percent of its STRIVE target and they increase as the facility improves its target percentage.¹¹⁴
- \$85 million for hourly raise increases for CNAs based on their years of experience as CNAs working in the state. CNAs with one year of state experience would receive a \$1.50 per-hour raise. Hourly raises max out at \$6.50 per hour for those with at least six years of experience.
- \$70 million for add-on payments to facilities that show improvement on certain quality measures.

The legislation also makes additional funding available for facilities that incentivize the retention and promotion of those CNAs who have additional training, roles, or specialties, such as CNA trainers, CNA scheduling "captains," and CNA specialists for resident conditions like dementia or memory care or behavioral health.

¹¹⁰ Illinois Public Act 102-1035. Available at <https://ilga.gov/legislation/publicacts/102/PDF/102-1035.pdf>.

¹¹¹ PDPM moves away from the current RUG-IV reimbursement system.

¹¹² CMS, Time Study (STRIVE). Available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPSS/TimeStudy>.

¹¹³ Some experts question the use of STRIVE targets for this purpose due to concerns about the merits of its methodology. This issue is beyond the scope of this issue brief.

¹¹⁴ The Illinois nursing home industry successfully lobbied to include in the legislation an 18-month phase-in period during which all facilities would be reimbursed as if they were at 85 percent of their STRIVE target.

Additionally, to facilitate transparency and oversight, the legislation includes enhanced ownership reporting requirements which are intended to aid regulators in determining nursing ownership interest, profitability, and compliance with the law.

Direct Care Minimum Spending Ratios

During the pandemic, nursing homes benefited not only from permanent Medicaid increases but also from a vast influx of COVID-related funds through several federal programs. Two of these programs were the Provider Relief Fund (PRF) and the Paycheck Protection Program (PPP). Approximately \$9.5 billion from the PRF were distributed directly to nursing homes to compensate for lost revenue and expenses and to improve infection control practices and infection rates.¹¹⁵ The PPP provided loans to nursing homes to enable them to retain staff during the pandemic. Loans could be forgiven if they were used for approved expenses and if employment and compensation levels were maintained.

As of March 2021, a total of \$5.7 billion was loaned to an estimated 10,000-plus nursing homes (\$551,000 average). The Center for Medicare Advocacy calculated that a total of more than \$1 billion in PPP loans was received by 389 nursing facilities and organizations as of March 1, 2021.¹¹⁶

According to MedPAC,¹¹⁷ the new federal assistance made available to skilled nursing facilities helped to offset much of their financial losses and costs incurred due to COVID-19, with total margins increasing in 2020 based on preliminary data.¹¹⁸ A study on the profitability of nursing homes in California before and during the pandemic found that some (but not all) nursing homes substantially increased profit margins from 2019 to 2020.¹¹⁹

The poor performances of many nursing homes during the pandemic and the vast amount of federal and other monies distributed to nursing homes with little transparency or accountability, prompted lawmakers in a few states to pass direct care minimum spending legislation.¹²⁰ These laws mandate how much nursing homes must spend on resident care and

¹¹⁵ OIG, “COVID-19 Pandemic Relief Funding and Its Effects on Nursing Homes in Select Locations: Pandemic Response Accountability Committee Impact Study,” (Expected Issue Date: 2024). Available at <https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000634.asp>.

¹¹⁶ Edelman T and Edelman M, “Special Report | Nursing Facilities Have Received Billions of Dollars in Direct Financial and Non-Financial Support During Coronavirus Pandemic,” (March 17, 2021). Available at <https://medicareadvocacy.org/report-snf-financial-support-during-covid/>.

¹¹⁷ The Medicare Payment Advisory Commission (MedPAC) is an independent congressional agency established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise the U.S. Congress on issues affecting the Medicare program.

¹¹⁸ Carter C, MedPAC, “Assessing Payment Adequacy and Updating Payments: Skilled Nursing Facility Services,” (December 10, 2021). Available at <https://www.medpac.gov/wp-content/uploads/2021/09/SNF-update-MedPAC-Dec-2021.pdf>.

¹¹⁹ Harrington C, Hailer L, Mukamel D, and Mollot R, *Journal of the American Geriatrics Society*, “Examining California nursing home profitability and related factors before and during the COVID-19 pandemic,” (April 2023). Abstract available at <https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.18356?af=R>.

¹²⁰ These policies have different names in different states. See, LTCCC Policy Brief: Direct Care Minimum Spending Laws, <https://nursinghome411.org/wp-content/uploads/2022/04/Intro-Brief-Direct-Care-Min.-Spending.pdf>.

set limits on other categories of expenses. Passed in 2020 in Massachusetts and New Jersey and 2021 in New York, the laws are intended to ensure that the bulk of funds received by nursing homes are spent on resident care and not on items such as administrative costs, executive salaries, or profits, or syphoned off to related parties. In general, these laws have built in strong reporting and accountability measures, requiring reports on revenue and spending, authorizing audits of these reports for both accuracy and compliance, establishing penalties for facilities that fail to meet reporting and/or minimum spending requirements, and authorizing the state to collect penalties and recoup excess funds.

For direct care minimum spending requirements to be effective, they must be accompanied by strict financial and ownership reporting requirements along with strong oversight and enforcement provisions.

Direct care minimum spending legislation is intended to provide policymakers with an important tool to ensure that a reasonable amount of the money taxpayers provide to nursing homes is being used for resident care, including sufficient staffing.

This concept was endorsed by the National Academies of Science, Engineering and Medicine in April 2022, and is among the suite of nursing home quality strategies being considered by the Biden Administration. For direct care minimum spending requirements to be effective, they must be accompanied by strict financial and ownership reporting requirements along with strong oversight and enforcement provisions.

Conclusion and Recommendations

Chronic understaffing has been a longstanding and grim reality for U.S. nursing homes. The failure to provide sufficient staffing has resulted in untold misery and suffering for residents, their families, and nursing staff alike. While the causes of understaffing are complex and multifactorial, experts agree that the lack of clear, sufficient, and enforced minimum staffing requirements is paramount.

Researchers, resident advocates, nurses, and direct care workers have for years been recommending evidence-based policies designed to improve staffing levels in nursing. These include mandated minimum staffing standards; strong and comprehensive training requirements; better, full-time jobs; improved wages, benefits, and empowerment practices for direct care workers; carefully targeted Medicaid payment policies closely tied to improved compensation and staffing improvements; and effective and appropriately funded oversight and enforcement activities (including imposition of meaningful penalties for facilities that fail to meet minimum standards).

Most of these policies, however, have been opposed by a nursing home industry pushing for the same, tired approaches that have long and unsuccessful track records. These band-aid solutions involve seeking greater funding with little to no accountability – eliminating or reducing standards while ultimately weakening oversight and enforcement.

The movement to establish minimum staffing requirements at the federal level provides an opportune moment to redirect policymaking energies away from those piecemeal approaches

(that have had, at best, only temporary positive results) towards more comprehensive and long-lasting approaches. The policies outlined in this brief will need to be implemented in a thoughtful, timely, and synchronized manner. After more than five decades of failed approaches and insufficient levels of nursing care, nursing home residents, their loved ones, dedicated staff, and the taxpaying deserve no less.