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NASW
National Association of Social Workers

June 10, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS–1765–P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via **http://www.regulations.gov**

Re: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2023; Request for Information on Revising the Requirements for Long-Term Care Facilities To Establish Mandatory Minimum Staffing Levels (87 F.R. 22720, proposed April 15, 2022)

Dear Administrator Brooks-LaSure:

On behalf of the National Association of Social Workers (NASW), I am submitting comments on CMS-1765-P, which addresses skilled nursing facilities (SNFs) and long-term care (LTC) facilities.

NASW represents more than 110,000 social workers nationwide. Social workers play an essential role in serving Medicare and Medicaid beneficiaries across an array of settings, including SNFs and other LTC facilities (hereafter also referred to as "nursing homes" or "nursing facilities"). Nursing home social workers are dedicated professionals whose daily efforts enhance residents' quality of life and quality of care. Yet, these social workers struggle to provide psychosocial care in the face of daunting systemic challenges.

NASW's comments address the following topics:

- request for information (RFI) regarding overarching principles for measuring equity and health care quality disparities across CMS Quality Programs (Section VI.E of the proposed rule)
- RFI regarding establishment of mandatory minimum nursing staffing standards in LTC facilities (section VIII of the proposed rule)
- beneficiary access to mental health services provided by independent clinical social workers under Medicare Part B

We begin with a brief overview of the workforce issues that affect the health and well-being of nursing home residents across the United States.

Overview of workforce issues

NASW affirms the Administration's recognition that staffing levels affect nursing home residents' safety and quality of care.[i] Thus, we wholeheartedly support the Administration's consideration of setting mandatory minimum staffing levels for nursing staff—registered nurses (RNs), licensed practical and licensed vocational nurses (LPNs–LVNs), and certified nursing aides (CNAs). Similarly, we strongly recommend that CMS establish both minimum staffing ratios and professional qualifications for nursing home social workers. We address these topics in detail following our brief comments on health equity. Finally, NASW reminds CMS of the restriction that prohibits beneficiaries who receive SNF services under Medicare Part A from accessing mental health services provided by independent clinical social workers under Medicare Part B—a restriction we strongly recommend be removed.

Health equity

NASW applauds CMS's focus on health equity within the proposed rule. We support the inclusion of health equity measures within the SNF quality reporting program (QRP) and concurs with the importance of the factors named by CMS in determining which equity measures could be prioritized for development for SNF QRP:

- Measures should be actionable in terms of quality improvement.
- Measures should help beneficiaries and their caregivers make informed healthcare decisions.
- Measures should not create incentives to lower the quality of care.
- Measures should adhere to high scientific acceptability standards. (p. 22759)

We also affirm CMS's proposal to begin collecting standardized resident-reported data about race, ethnicity, preferred language, health literacy, transportation, and social isolation as part of QRP. NASW strongly encourages CMS to add sex, gender identity, intersex status, and sexual orientation to the data elements collected, recognizing that some residents may choose not to volunteer such information. In offering this recommendation, we acknowledge that collection of such data is complex, and we encourage CMS to draw on the recommendations of a new report by the National Academies for Sciences, Engineering and Medicine (NASEM): *Measuring Sex, Gender Identity, and Sexual Orientation*.[ii,iii]

Additionally, NASW is pleased that CMS is considering ways to identify meaningful performance differences among SNFs and to report health care disparity confidential reporting of measures. We support reporting of stratified measure data alongside overall measure results. Although the association recognizes that confidential reporting of disparity measures to SNFs may be of value for a limited time, we encourage CMS to proceed in a timely manner toward public reporting of such data. This move would help beneficiaries and families make informed choices about SNFs.

NASW also recognizes job conditions for CNAs—a theme addressed within the next section of these comments—as a significant health equity issue.

Staffing RFI: contextual overview

The Nursing Home Reform Act of 1986 (S. 2604)—signed into law as part of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87; P.L. 100-203) gives the Secretary of Health and Human Services (HHS) full authority to set minimum staffing standards.[iv] The law also requires the Secretary to assure that facilities provide each resident with high-quality care. Moreover, OBRA '87 requires facilities to spend Medicare and Medicaid payments on resident care, without diverting those public funds to profits, management fees, or inflated payments to self-related parties.

In April 2022, the National Academies of Sciences, Engineering, and Medicine (NASEM) released a report entitled *The national imperative to improve nursing home quality: Honoring our commitment to residents, families, and staff*.[v] This report included multiple recommendations to enhance nursing home staffing, including the establishment minimum staffing requirements for nursing staff (at all levels) and social workers. The establishment and implementation of a minimum nursing staffing standard by CMS would mark a critical step toward maximizing the health and well-being nursing home residents.

As the RFI acknowledges, staffing is a complex issue, with multiple interrelated factors affecting staffing levels. Consequently, although setting minimum staffing levels is essential to improving quality of care for residents, establishment of such levels is, in itself, insufficient. Recruitment and retention of nursing staff—especially CNAs, many of whom are women of color and immigrants—and of social workers (many of whom are also women) will not be successful without increased compensation, adequate benefits, improved training and working conditions, more respect for their invaluable contributions, and better treatment from employers, to name a few factors. Furthermore, NASW recognizes that some of the staffing issues CMS has raised will require additional federal regulations or actions by parties other than CMS.

Nonetheless, the establishment and implementation of a minimum nursing staffing standard by CMS would mark a critical step toward maximizing the health and well-being nursing home residents. NASW applauds the Secretary for considering this necessary step and responds to the RFI questions—first for nursing staff, then for social service staff—in the next two sections.

Nursing staffing

1. *Evidence that establishes appropriate minimum staffing requirements for nurses and other direct care workers; benefits of adequate staffing for residents and quality of care*

Substantive evidence supports minimum staffing requirements as essential to the health and well-being of nursing home residents. A 2001 CMS study found a clear association between nurse staffing ratios and nursing home quality of care.[vi] This study also asserted the importance of a minimum staffing standard of 4.1 nursing hours per resident day (HPRD) to prevent resident harm and jeopardy, dividing those hours in the following manner: 0.75 RN HPRD, 0.55 LVN–LPN HPRD, and 2.8 to 3.0 CNA HPRD. A 2004 observational study confirmed these findings.[vii] A 2016 simulation study not only confirmed the 2001 RN and LVN–LPN recommendation, but also found between 2.8 and 3.6 CNA HPRD

were needed to ensure adequate care to residents with varying staffing care needs.[viii] Moreover, some experts have recommended higher minimum staffing standards—a total of 4.55 HPRD—with adjustments for resident acuity (nursing need) or case-mix.[ix]

The benefits of minimum staffing requirements for nursing staff cannot be overestimated. Research has found a strong relationship between nursing staffing levels and improved quality of care, as reflected in both process and outcome measures.[x,xi,xii,xiii,xiv] The strongest relationships found to date have been between RN staffing levels and quality measures.[xv] Studies have demonstrated that higher nurse staffing levels are associated with improved resident outcomes, including better functional improvement; reduced incontinence, urinary tract infections, catheterizations; pain, pressure ulcers, weight loss, dehydration, infections, and falls; decreased use of antipsychotics and physical restraints; and decreased emergency department use, preventable hospitalizations, care omissions, adverse outcomes, and mortality rates.[xvi]

Higher RN staffing levels are also strongly associated with fewer deficiencies.[xvii,xviii,xix] In contrast, a recent data analysis found that infection control deficiencies were more common at nursing homes with fewer nurses and CNAs than at facilities with higher staffing levels—a particularly compelling finding during the COVID-19 pandemic.[xx]

2. *Resident and facility factors to consider in establishing minimum staffing requirements; impact of resident needs and acuity on such requirements*

NASW asserts that resident factors are the most important determinant of nursing staffing levels. Establishment of minimum staffing levels should be based on residents with the lowest care needs, as assessed using the Minimum Data Set (MDS) 3.0. In accordance with the Medicare prospective payment system (PPS) adjustment for resident acuity, LTC facilities are expected to increase the staffing levels as their resident care needs or acuity increases.[xxi] Similarly, federal regulations require nursing homes to conduct a facility self-assessment regarding the resources and qualified staff needed to meet resident needs and to fulfill all facility-level functions. This analysis must consider "the number, acuity and diagnoses of the facility's resident population" and must be updated at least annually (42 C.F.R. § 483.70(e)). Moreover, many state Medicaid payment rates to facilities are also based on resident acuity,[xxii] although widespread concerns about the adequacy of such payments exist.

3. *Evidence of the cost of implementing recommended thresholds*

A 2022 study comparing actual nursing home staffing with the 2001 CMS minimum staffing standard found that 95 percent of facilities failed to meet all the recommended minimum nursing staffing levels of 4.1 HPRD.[xxiii] The researchers estimated that the cost to attain the recommended minimum staffing, based on current wages, was $7.25 billion; this cost, they stated, represents only 4.2 percent of the $172.2 billion of national nursing home expenditures in 2019. Another 2022 study, using data from the Health Care Financing Administration's 1995 and 1997 Staff Time Measurement studies as a benchmark for minimum staffing, found that 60 percent of nursing homes did not meet the minimum for total nursing staff.[xxiv] This study estimated the costs of meeting staffing minimums would average $500,000 for each facility not meeting the standard, or a total of $4.9 billion annually. Such cost increases do not seem unrealistic. One recent study found that most major publicly traded nursing

home companies were highly profitable, even during the pandemic.[xxv] Another study found that the second largest publicly traded nursing home chain in the United States earned high profits during the COVID-19 pandemic while keeping its staffing levels low and having large COVID-19 resident infections and deaths.[xxvi] At the same time, NASW encourages CMS to explore whether increasing Medicaid reimbursement rates could be helpful in enabling facilities—especially nonprofit nursing homes—to implement recommended thresholds.

4. *Evidence that resources that could be spent on staffing are instead being used on expenses that are not essential to quality resident care*

Multiple studies indicate that for-profit nursing homes, both chain and nonchain facilities, often have lower staffing and poorer quality of care than nonprofit and government nursing homes, as demonstrated by the following indicators:

- poorer quality indices and more deficiencies,[xxvii,xxviii] with the most deficiencies in facilities with the highest profit margins[xxix]
- increased quality and compliance problems in for-profit chains[xxx]
- decreased nursing staffing (especially for RNs) and reduced wages, benefits, and pensions[xxxi,xxxii,xxxiii,xxxiv]
- more 30-day rehospitalizations and less improvement in mobility, pain, and functioning[xxxv]

Moreover, for-profit nursing home companies have developed increasingly complex corporate ownership structures, with most having a separate property company from the operating company, with some facilities having as many as seven or eight layers of companies in control.[xxxvi,xxxvii,xxxviii] This complexity of interlocking corporations is designed to protect operating companies from litigation by moving assets into a separate company, thereby reducing both liability and regulatory oversight. For example, a recent study found that one large, highly profitable nursing home chain (a publicly traded company) had 430 corporate entities to manage 228 nursing homes and other facilities.[xxxix]

Private equity (PE) firms have also been found to increase nursing home costs and reduce staffing. These firms use loans to acquire nursing homes, usually for a three- to five-year period, and then seek profit upon sale of the nursing home. A Government Accountability Office study found that private equity investments resulted in increased costs for facilities and capital, along with higher profit margins, as compared to other for-profit nursing homes or nonprofit facilities.[xl] Moreover, a study of PE buyouts of nursing homes from 2000 to 2017 found robust evidence of declines in resident health and compliance with care standards related to cuts to direct nursing staff and increased occupancy, as compared to acquisitions by non-PE corporates and chains.[xli] Yet, evidence also suggests that staffing by PE firms varies based on geographic competition.[xlii]

Another factor that obscures nursing home profits is the growth in related-party transactions. By contracting with related-party individuals and organizations for services such as facility management, nursing, therapy (physical, occupational, and speech–language), lease agreements, and loans, facilities are able to siphon money out of the facilities as expenses. One study found that such related-party business transactions were used by nearly three-quarters (or more than 11,000) of nursing homes in the United States, accounted for $11 billion—or one-tenth of costs—of facility spending in 2015.[xliii] This same study found that nursing homes that used related-party contracts employed 8 percent fewer

nurses and CNAs, were 9 percent more likely to have hurt residents or put them in immediate jeopardy of harm and had 53 substantiated complaints for every 1,000 resident beds, compared with 32 per 1,000 beds at homes without related-party transactions. The study also found that for-profit nursing homes used related corporations more frequently than do nonprofits, incurring fine increases of 10 percent and receiving 24 percent more substantiated complaints from residents in relation to nonprofits. These nursing homes also employed overall staffing levels 4 percent lower than at independent for-profit facilities.

5. *Factors impacting a facility's capacity to recruit and retain nursing staff; strategies facilities could employ to increase nursing staffing levels; risks associated such strategies and mitigation strategies*

One of the most significant barriers to successful recruitment and retention of staff is job quality, which can be measured by facility staff turnover. CMS estimates that the average nursing staff turnover for a nursing home is 52.6 percent annually.[xliv] Research has found that high turnover in nursing homes leads to poorer outcomes for nursing home residents.[xlv] High turnover most commonly results from poor wages and benefits, lack of training, poor management, lack of career advancement, and unreasonable workloads.[xlvi,xlvii,xlviii,xlix] Labor–management disputes, such as attempts by facilities to thwart unionization, are also problematic.

NASW recommends the following strategies to increasing staff recruitment and retention, thereby improving the quality of resident care:

- payment of living and competitive wages, along with health insurance and paid leave (including sick and family and medical leave), to all nursing home staff, including CNAs[l]
- tailored, ongoing training programs,[li,lii] including increasing the minimum federal training requirements for CNAs from 75 to 120 hours, in accordance with the recommendation in NASEM's 2022 nursing home report;[liii] free access from the state and federal government, and nursing home payment for hours spent participating in, entry-level and continuing education training programs, also per NASEM recommendations
- involving CNAs in interdisciplinary team meetings; increasing career opportunities for CNAs to reduce racial and ethnic disparities among different types of nursing staff[liv,lv,lvi]
- establishment of job equity metrics that include staff members' perspectives on areas such as respect; incorporation of such metrics into CMS's five-star rating system
- promotion of positive labor–management partnerships

NASW also suggests that CMS reduce turnover in nursing home management and administration—which contributes to turnover among direct care staff and poor health outcomes for residents—by (1) incorporating administrator turnover into CMS's value-based purchasing (VBP) program and (2) implementing the 2022 NASEM recommendation that CMS require all nursing home administrators to possess, at a minimum, a bachelor's degree and training in topics relevant to their role. (The National Association of Long Term Care Administrator Boards, for example, offers both accreditation and continuing education programs designed specifically for nursing home administrators.)

6. *CMS's response to facilities that are unable to obtain adequate staffing; definition of good-faith efforts to recruit staff*

Inadequate staffing is a threat to the health and well-being of residents. Consequently, NASW believes that when a nursing home is unable to obtain an adequate number of nursing staff members, CMS should require the facility to cease admissions until the staffing requirement is met. We oppose any federal waiver, based on a "good faith effort," of a minimum nursing staffing standard. Moreover, Should CMS apply such a good faith measure to an assessed penalty, NASW suggests that the measure (1) be based on empirical data, (2) include a facility's documentation of efforts to hire and retain staff by investing in high-quality jobs, and (3) be used in case of infrequent emergencies.

7. *Impact of nursing staff turnover on establishment of a staffing standard; use of short-term nurses*

Turnover is a significant indicator of how nursing homes treat staff. CMS currently estimates that the average annual turnover rate is 52.6 percent. NASW applauds CMS's recent implemented practice of posting turnover rates for total nursing staff and RNs on Care Compare and encourages CMS to explore other ways to incentivize facilities to reduce nursing turnover, including using facility turnover rate as a measure in the SNF VBP program.

The use of agency nursing staff is a complicated question. CNAs, LPNs, and RNs from staffing agencies fill essential gaps in care and deserve respect and appreciation for their work. However, providing the person-centered, coordinated care residents deserve (and which federal regulations specify) is extremely difficult when agency staff don't know either the residents or their colleagues. Use of agency staff (both RNs and CNAs) has been associated with poorer health outcomes for nursing home residents;[lvii] during the COVID-19 pandemic, NASW members have reported similar observations, based on both their professional and personal experiences. Additionally, long-term use of agency staff may indicate a facility's failure to address underlying job quality issues. Recognizing that agency staff may be needed at times (such as during emergencies or pandemics), however, NASW encourages CMS to continue to monitor the use of agency staff and to investigate the impact of such staffing on resident care. Potential solutions to discourage frequent or long-term agency staff use could include incorporating this metric in the SNF QRP or VBP.

8. *Disciplines to count toward a minimum staffing requirement; grouping of RNs, LPNs–LVNs, and CNAs under a single nursing care standard; inclusion of mental health workers as direct care staff*

Based on the available research, NASW encourages CMS to include only RNs, LPNs–LVNs, and CNAs in its minimum nursing staffing standard. Similarly, we encourage establishment and implementation of separate minimum requirements for each of these three groups; studies have shown that failure to implement separate staffing requirements has resulted in facilities' use of the least costly nursing option, CNAs, to meet the minimum standard.[lviii,lix]

NASW appreciates CMS's consideration of adding mental health workers—of which social workers are an integral component—as direct care staff. At the same time, we recognize that the responsibilities

and training of RNs, LPNs–LVNs, and CNAs are quite different from those of social workers and that these roles cannot be regarded as interchangeable. Therefore, NASW encourages CMS to create staffing standards for social workers (a topic addressed subsequently in greater detail).

9. Consideration of administrative nursing time

NASW strongly recommends that CMS exclude administrative nursing time from minimum resident care standards. Direct care involves *direct* contact with residents to "provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being" (42 C.F.R. § 483.70 (q)(i)), and CMS's current staffing requirements recognize that administrative duties can inhibit time spent on resident care.

Consequently, studies regarding nursing HPRD (as cited previously within these comments) have not accounted for administrative or other nonclinical responsibilities. On the contrary, the purpose of HPRD standards is to ensure a baseline of CNA, LPN–LVN, and RN staffing necessary to prevent illness or death resulting from insufficient direct care.[lx] In fact, research found that one nursing home model removed administrative responsibilities from clinical staff and subsequently reported fewer hospitalizations, infections, and deaths than other nursing homes.[lxi]

Current regulations allow a Director of Nursing (DON) to serve as charge nurse only if sixty or fewer beds are occupied by residents (42 C.F.R. § 483.35(b)(3)). Similarly, several states with minimum nursing staffing standards require an additional RN if the RN providing direct care is subject to administrative duties.[lxii]

10. Minimum staffing requirement and measurement; inclusion of non-nursing requirements

Given the complexity of nursing staffing, NASW recommends that CMS use both minimum nursing HPRD and staff-to-resident ratios. As previously stated, an HPRD standard clarifies the direct care hours residents require to meet their basic needs and prevent negative outcomes.[lxiii] However, relying solely on HPRD can be confusing for staff, residents, and families in determining whether a facility has adequate staffing. Staff-to-resident ratios for CNAs, LPNs–LVNs, and RNs provide a clearer way to identify adequate staffing capacity. The Quality Care for Nursing Home Residents and Workers in COVID-19 and Beyond Act (H.R. 598, Title II, §§ 201(a)(1)(C)(ii)(II–IV), 2021) includes HPRD-to-ratio translations for daytime, evening, and nighttime shifts.[lxiv]

NASW recommends that all nursing homes, regardless of size, employ a full-time DON—one who possesses an RN license but is distinct from RNs providing direct care—seven days a week, rather than the five days currently required (42 C. F. R. § 483.35(b)(2)). As facilities grow in size, the administrative nursing requirements should increase accordingly.

NASW also recommends that CMS require at least one RN on site and awake in every nursing home 24 hours per day, seven days per week. Nursing homes care for residents with complex medical issues, necessitating the expertise of an RN.[lxv] As noted previously, higher levels of RN care are associated with better health outcomes for residents.[lxvi] Furthermore, RNs provide essential training, supervision, and support for CNAs—many of whom did not receive the requisite 75 hours of training (42 C.F.R.

483.35(d)) because CMS waived (through June 6, 2022) training requirements to alleviate workforce shortages during the COVID-19 pandemic.[lxvii]

CMS's aforementioned research (2001) has established the importance of having a minimum of 2.8 CNA HPRD.[lxviii] Accordingly, CNAs should care for no more than six residents per day and evening shifts and no more than 13 residents per night shift. This benchmark contrasts sharply with widespread practice, however; on average, nursing home CNAs care for 13 residents per shift, and one in 10 CNAs is responsible for 17 or more residents per shift.[lxix] A more recent study focused on CNAs—who provide 90 percent of hands-on care to residents—found that nursing homes need to adjust CNA staffing for acuity, with average CNA staffing levels at 2.8 HPRD for the lowest level of resident acuity to 3.6 HPRD for the highest level of resident acuity needed to maintain a rate of below 10 percent for care omissions.[lxx]

CMS has requested information on whether a minimum staffing requirement should include any "non-nursing requirements." As previously stated, minimum HPRD staffing standards should not include administrative duties. Although RNs, LPNs–LVNs, and CNAs should participate in training on requirements that are not specific to nursing (such as residents' rights and cultural competence), those activities should not count as part of residents' direct care hours. (It is also worth noting that conflation of nursing and non-nursing responsibilities tends to create confusion and decrease morale among RNs.[lxxi]) Again, NASW recommends that non-nursing specialists—such as social workers—should be included in nursing home staff but not counted toward nursing or direct care hours. We address minimum staffing requirements for social workers in a subsequent section.

11. *Interaction of new quantitative direct care staffing requirement with existing qualitative staffing requirements; impact of state laws limiting or otherwise restricting overtime for health care workers*

NASW recommends that CMS combine the existing qualitative requirement that facilities have enough nursing staff to meet residents' needs with the quantitative 4.1 HPRD (segmented by RN, LVN–LPN, and CNA training, as noted previously) as a minimum nursing staffing standard. The 4.1 HPRD standard provides a clear baseline for direct resident care but does not address the needs of residents with increased acuity. Retaining the "sufficient nursing staff" requirement with the minimum HPRD would make clear that many residents will need nursing care exceeding more than 4.1 HPRD.[lxxii,lxxiii,lxxiv] Consequently, NASW suggests that facilities use MDS data—which reflect residents' functional and health status[lxxv]—to help determine resident acuity for purposes of minimum staffing requirements. We also encourage CMS to use facility assessments to determine the number of residents with specialized needs requiring a higher staffing standard of 5.6 to 6.8 total HPRD.

NASW strongly believes that overtime restrictions should not be considered for purposes of establishing minimum nursing staffing standards. Facilities should, instead, be encouraged to recruit and train an adequate number of direct care staff rather than relying on a small number of staff members with significant overtime.

12. Effectiveness of minimum staffing requirements at the state level; facilities' experiences transitioning to these requirements

Several studies have demonstrated that a state's implementation of minimum staffing standards led to increased nursing hours, better health outcomes, and reduced deficiencies.[lxxvi,lxxvii,lxxviii] Minimum staffing requirements have been found to improve quality of care primarily by reducing adverse outcomes for residents.[lxxix] As noted previously, minimum staffing levels must set a standard for each type of staff (CNAs, LVNs–LPNs, and RNs); otherwise, state-level research has found that facilities achieve minimum levels by relying disproportionately on less expensive staff with lower levels of training.[lxxx,lxxxi]

13. Success of existing state approaches; consideration of adopting one of the existing state approaches, in full or in part; other approaches to consider in determining adequate direct care staffing

NASW discourages CMS from relying on state models to implement nursing staffing standards. At this time, only the District of Columbia has set a minimum staffing standard that meets the recommended standard of 4.1 HPRD; the majority of states (29) require less than 3.5 HPRD, with 15 of those states falling below 2.5 HPRD.[lxxxii]

At the same time, NASW encourages CMS to learn from mistakes made by states when implementing staffing standards. For example, when California, Florida, and Ohio implemented minimum standards, they failed to specify minimums for each category of direct care staff (RN, LPN–LVN, and CNA), resulting in a decline in RN hours in all three states.[lxxxiii,lxxxiv]

14. Institute of Medicine (IOM)–NASEM recommendations of at least one RN within every facility at all times; costs and benefits of 24-hour RN presence

As noted previously, NASW strongly recommends that CMS require nursing facilities to have an RN on site to provide direct care to residents 24 hours per day, seven days per week. This standard is supported both by the 1986 IOM and 2022 NASEM studies and by other research, including a study published in 2020.[lxxxv,lxxxvi] Multiple studies have demonstrated that increased RN staffing is particularly instrumental (in relation to other types of nursing staffing) in improving care for residents.[lxxxvii] Moreover, improved resident health outcomes related to increased RN staffing reduce Medicare and Medicaid expenditures by reducing preventable hospitalizations and other expensive medical interventions.[lxxxviii,lxxxix]

15. Unintended consequences of implementing a minimum staffing ratio and mitigation thereof; concerns about shifting non-nursing tasks to nursing staff, thereby reducing other categories of staff

As noted previously, one unintended consequence of minimum staffing ratios in a couple of states has been the decrease in substitution of lesser trained, less expensive nursing staff for more highly trained nursing staff. To prevent these unintended consequences, nurse staffing ratios must identify the distinct categories of nursing staff (CNAs, LPNs–LVNs, and CNAs). In addition, CMS should prohibit

facilities from shifting non-nursing tasks to nurses or reducing the work hours of non-nursing staff, such as activities, food services workers, housekeeping staff, and social workers.

16. Effect of geographic disparity in workforce numbers on minimum staffing requirements, especially in rural and underserved areas

The needs of nursing home residents in rural or underserved areas are no less important than those of residents in other areas. Consequently, a minimum nurse staffing standard must be met by all nursing homes. Although additional efforts are needed to increase the numbers of nursing staff working in rural and underserved areas, these efforts should not undermine the need for appropriate staffing levels as a mandate for all facilities, regardless of location.

The challenge of recruiting and retaining nursing staffing in rural and underserved areas was addressed nearly 40 years ago by the IOM, whose recommendations included educational outreach (including educational loan repayment programs, upgrading existing nursing home staff, and ensuring appropriate government payments.[xc] In one study, administrators and DONs in rural facilities with higher staffing levels "attributed their success to having a good reputation, being flexible, and offering individual growth opportunities (e.g., school reimbursement)."[xci] The study concluded that complex labor pool challenges "require complex solutions": "better wages, better health insurance, and better pensions, as well as improved training, supervision, and mentoring."

17. Defining "an unacceptable level of risk of harm"; outcomes and care processes to consider in determining adequate staffing levels

NASW believes no risk of harm to nursing home residents is acceptable as a result of a facility's failure to employ sufficient nursing staff. The 1987 Nursing Home Reform Law and its implementing regulation place specific responsibilities on the HHS Secretary and facilities to define and meet outcomes and care processes. The law excludes any mention of an acceptable or unacceptable risk of harm as a metric for care quality or a measure of what level of care facilities must provide to residents. Rather, federal law requires that facilities, through comprehensive assessment and care planning, "provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident" (42 U.S.C. § 1395i(b)(2)). This requirement means that facilities are required not only to meet the minimum mandatory staffing standards that the Secretary establishes, but also to increase those staffing levels, as needed, to meet residents' individual needs.

Specifically, 42 C.F.R. § 483.35 states:

> The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

In summary, federal law and regulation make clear that any risk of resident harm resulting from a facility's failure to employ sufficient staff to meet the needs of residents is unacceptable.

Social work staffing

Nursing home social service staff play active, sometimes primary, roles in meeting the following federal requirements for LTC facilities:

- promoting quality of life (§ 483.24) and quality of care (§ 483.25), including trauma-informed care, for all residents
- advocating for the rights of residents (§ 483.10)
- preventing and addressing abuse, neglect, and exploitation of residents (§ 483.12)
- facilitating transitions of care and discharge planning (§ 483.15)
- conducting biopsychosocial assessments (§ 483.20) and participating in comprehensive person-centered care planning, (§ 483.21)
- assessing the need for, supporting, or providing mental and behavioral health interventions (§ 483.40), including personalized practices to complement or replace psychotropic drugs (§ 483.45)
- helping to identify cultural and other psychosocial factors that may influence resident choices related to food and nutrition (§ 483.60)
- participating in quality assurance and performance improvement efforts (§ 483.75)
- identifying and responding to ethical issues (§ 483.85)
- recognizing concerns in the physical environment (§ 483.90)
- helping to train interdisciplinary colleagues in a variety of topics (§ 483.95)

Given the breadth and depth of these responsibilities, the importance of social work staffing cannot be overemphasized. NASW's comments address two topics: staffing ratios and professional qualifications.

1. *Staffing ratios*

Meeting the goals not only of the Nursing Home Reform Law and its implementing regulations, but also of the Administration's strategy to improve the quality of care and safety in nursing homes,[xcii] requires sufficient staffing not only for CNAs, LPNs–LVNs, and RNs, but also for social workers. Federal regulation stipulates that all nursing homes—regardless of size—are required to provide medically related social services to residents (42 C.F.R. § 483.40(d)). Yet, current CMS regulation requires one social service staff member only in nursing homes with the capacity to care for more than 120 residents (42 C.F.R. § 483.70(p)). Consequently, nursing homes that care for 120 or fewer residents—constituting nearly two-thirds of nursing homes in the United States[xciii]—are not required to employ social service staff. Similarly, federal regulations do not require facilities caring for more than 120 residents to increase social service staffing in response to either resident census or acuity.

Practitioners, researchers, and policymakers have long raised the question of caseload manageability for nursing home social service staff. The evidence for increased staffing is growing:

- An investigation by the HHS Office of the Inspector General (OIG) found that more than one-third of nursing home residents with identified psychosocial needs had inadequate care plans, and almost half of those with care plans did not receive all planned services.[xciv] Moreover, although almost all facilities reviewed in the OIG investigation had complied with or exceeded federal staffing regulations, 45 percent of social service staff reported that barriers such as lack

of time, burdensome paperwork, and insufficient staffing decreased their ability to provide comprehensive psychosocial services.

- A more recent OIG report found that skilled nursing facilities often failed to meet Medicare requirements for care planning and discharge planning; failure to address psychosocial needs was among the problems cited in the report.[xcv]
- Similarly, two nongovernmental studies indicated that large social service caseloads were associated with survey inspection deficiencies in psychosocial care.[xcvi,xcvii]
- Research examining social service staffing trends in nursing homes—drawing on multiple studies using national data from the MDS, the Online Survey Certification and Reporting (OSCAR) system, and the Certification and Survey Provider Enhanced Reports (CASPER)—revealed that
    - social service staffing levels were the lowest of all departments–disciplines (activities, CNAs, food service, housekeeping, LPNs, RNs with administrative duties, RNs providing direct care) in both 1998 (0.09 HPRD) and 2016 (0.11 HPRD)
    - social service staffing experienced the smallest increase among all departments–disciplines between 1998 and 2016 (0.02 HPRD)
    - increasing the level of social service staffing was more effective (by a range of 53 to 95 percent for every department–discipline other than activities) in reducing survey deficiency scores than increasing any staffing in any other department–discipline[xcviii]

  The study concluded, "Nursing homes interested in improving quality in the most cost-effective manner should consider increasing the level of social service staffing."[xcix]
- The most recent (2019) nationally representative study of social service directors found that the 121:1 ratio of social service staff to residents is insufficient to meet the psychosocial needs of nursing home residents.[c] This study yielded other important findings:
    - Examining social service directors' roles and self-efficacy in suicide risk management, researchers concluded that "sufficient staffing qualified NH [nursing home] social service providers is critically important given the acute and chronic mental health needs of NH residents."[ci]
    - Social service directors' self-reported barriers to psychosocial care decreased as the number of social service staff members increased.[cii] The three barriers particularly common among social service departments with only one staff member were (1) insufficient social service staffing, (2) pressured discharge of short-stay residents, and (3) prioritization of residents' medical and nursing needs over socioemotional needs. (It is also worth noting that an insufficient number of CNAs was found to be a major barrier to psychosocial care, regardless of social service department size.)
    - Examining social service directors' roles and self-efficacy in suicide risk management, researchers concluded that "sufficient staffing qualified NH [nursing home] social service providers is critically important given the acute and chronic mental health needs of NH residents."[ciii]

Consequently, NASW strongly recommends that CMS implement, as a baseline, the 2022 NASEM nursing home study recommendation (2b) that *every* LTC facility—regardless of size—be required to employ at least one full-time social worker (to be defined subsequently within these comments). Thus, 42 C.F.R. § 483.70(p) would read, "Every facility must employ a qualified social worker on a full-time

basis. …" With this requirement in place, CMS would also be equipped to require that every facility include a social worker in the interdisciplinary team (42 C.F.R. § 483.21(b)(2)(ii))—a change proposed by CMS in the 2015 proposed reforms to requirements for LTC facilities[civ] (and supported by NASW[cv]) but excluded from the 2016 final rule.[cvi]

NASW also encourages CMS to set more specific social service staffing ratios to enable nursing home social workers to provide high-quality psychosocial care to all residents. Consideration of high acuity and turnover among SNF–Medicare (commonly referred to as "postacute" or "short-stay," *Jimmo* settlement protections[cvii,cviii] notwithstanding) residents will be especially important in the development of such ratios; the 2019 study of nursing home social service directors found that staff who spent less time on short-stay residents reported fewer overall barriers to psychosocial care.[cix] At the same time, the needs and goals of non-Medicare (commonly referred to as LTC or long-stay) residents are equally important, but are often overlooked because of SNF demands.

Research findings from nursing home social workers, social work consultants, and social work educators illustrate the glaring inadequacy of the current "120-bed rule." When asked their perceptions of appropriate staffing ratios in the 2019 nursing home social service director study, participants recommended one full-time equivalent (FTE) social worker for 20 or fewer postacute residents and one FTE social worker for up to 60 LTC residents.[cx] These findings are consistent with data from a similar nationally representative study of social service directors conducted in 2006.[cxi] Furthermore, the National Consumer Voice for Quality Long-Term Care proposed to CMS in 2012[cxii] and 2015[cxiii] that each nursing home employ at least one full-time social worker for every 50 long-stay residents and at least one full-time social worker for every 15 short-stay residents. This recommendation, which is rooted in the experiences of nursing home residents, is also worth consideration by CMS.

At the same time, NASW recognizes that some nursing homes have reported difficulties in locating adequate numbers of BSWs or MSWs. We encourage facilities in this situation to consider the following recruitment and retention strategies:

- Partner with both traditional and online BSW and MSW programs (especially those that offer certificates in gerontology or medical social work or that include areas of specialization in health, health and mental health, or aging and gerontological practice[cxiv]) to provide incentives for paraprofessional social service staff to obtain their social work degrees. Other disciplines, such as CNAs and activities staff, may also be interested in such career ladders.
- Partner with social work associations, including NASW chapters (https://www.socialworkers.org/About/Chapters); advertise job openings in various professional media, such as NASW chapter media and the NASW Career Center (https://www.socialworkers.org/Careers/NASW-Career-Center).
- Partner with state associations, such as those affiliated with the American Health Care Association and LeadingAge, to recruit BSWs and MSWs.
- Foster partnerships among state associations, NASW chapters, and BSW and MSW programs.

NASW also believes that nursing facilities can enhance their recruitment and retention efforts by making social work jobs more appealing. Research has found that the following factors influence job satisfaction among nursing home social service staff:

- sufficient time to identify and meet the social and emotional needs of residents
- being treated as an integral part of the team
- job autonomy
- level of stress and variety on the job
- equity in pay and benefits
- promotional opportunities
- support by coworkers and supervisors[cxv,cxvi]

Similarly, several findings from NASW's benchmark study of licensed social workers in the United States highlight challenges that decrease job satisfaction and retention among gerontological social workers—persistent challenges that have been consistently expressed by numerous nursing home social workers:

- MSWs employed in nursing homes received the lowest wages of all MSWs in aging, and the median salary of gerontological social workers across settings is slightly less than median salary for all social workers.
- Nursing home social workers (both BSWs and MSWs) were more likely to have caseloads of 50 or more than gerontological social workers in any other setting.
- Gerontological social workers were more likely to report engaging in tasks below their skill level than were social workers in other specialty practice areas.
- Gerontological social workers were more likely to be isolated professionally than were social workers in other specialty practice areas; more than one-quarter reporting they were the only social worker employed in their organization.
- Gerontological social workers were slightly more likely than were social workers in other specialty practice areas to list ethical challenges as a factor in influencing a decision to change jobs.[cxvii]

Furthermore, NASW recognizes that the federal government could play a more active role in attracting social workers to nursing home work. For example, the Health Resources and Services Administration could devote additional resources to support social work recruitment and retention efforts by nursing facilities in documented workforce shortage areas, such as in frontier areas and certain rural counties. Establishment of a federal program similar to the Title IV-E Education for Public Child Welfare Program could provide stipends and field education for social workers specializing in work with older adults, including in nursing homes. (Decades ago, the Older Americans Act helped fund social work education for individuals specializing in aging.) Enhanced relief for student loan debt, including expanded access to public service loan forgiveness,[cxviii] could encourage paraprofessional social service staff, CNAs, and others to obtain social work degrees. The latter two recommendations align with the need to enhance CMS's definition of "qualified social worker" in nursing homes.

2. Staffing qualifications

NASW's policy statement on long-term services and supports calls for "access to professional social work services in all settings, regardless of medical diagnosis, payer, or involvement of other disciplines throughout the long-term care spectrum."[cxix] Federal regulation governing LTC facilities currently defines a *qualified social worker* in this manner:

> (1) An individual with a minimum of a bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology; and
>
> (2) One year of supervised social work experience in a health care setting working directly with individuals. (42 C.F.R § 483.70(p)(1))

This definition contrasts sharply not only with that of the *NASW Standards for Social Work Services in Long-Term Care Facilities*, but also that of the 2022 NASEM nursing home study (recommendation 2b): an individual with a baccalaureate or advanced degree in social work from a CSWE-accredited program.[cxx] The NASEM study also recommends that nursing home social workers have "1 year of supervised social work experience (including field placements and internships) in a health care setting working directly with individuals to address behavioral and psychosocial care" (pp. 510–511)—a qualification NASW supports.

CSWE-accredited programs provide competency-based education that integrates and applies social work knowledge, skills, and values. The CSWE *Educational Policy and Accreditation Standards* (EPAS) are based on the following nine competencies and component behaviors:

- Demonstrate ethical and professional behavior
- Engage diversity and difference in practice
- Advance human rights and social, economic, and environmental justice
- Engage in practice-informed research and research-informed practice
- Engage in policy practice
- Engage with individuals, families, groups, organizations, and communities
- Assess individuals, families, groups, organizations, and communities
- Intervene with individuals, families, groups, organizations, and communities
- Evaluate practice with individuals, families, groups, organizations, and communities[cxxi]

These competencies are congruent with the competency-based emphasis of the 2016 final rule reforming requirements for LTC facilities.[cxxii] Furthermore, each CSWE-accredited program includes field education of at least 400 hours for baccalaureate (BSW) students and at least 900 hours for master's-level (MSW) students.[cxxiii] This field education, which is supervised by social workers, enable students to integrate knowledge, theory, and skills in practice. Moreover, field placements provide a rich context for the assessment of student learning outcomes, which is integral to competency-based education.[cxxiv] A 2015 study found that nursing homes with degreed social workers "have the capacity to provide better psychosocial care" than those without such professional staff.[cxxv] In contrast, staff with degrees in other "human services fields" may have no field education experience, do not possess the breadth of social work knowledge, and may not be adequately prepared to identify and address psychosocial issues.[cxxvi,cxxvii]

Individuals with baccalaureate or advanced degrees in social work are equipped to fulfill multiple responsibilities that complement the LTC facility requirements:

- identifying how social determinants of health influence each resident's experience and working to ameliorate social risk factors
- providing individual, family, and group education and counseling related to illness, disability, treatment, interpersonal relationships, grief, loss, dying, and death
- promoting resident, family, and staff adaptation and resilience
- facilitating financial and medical decision making, including advance care planning
- strengthening communication among residents, families, and facility staff
- participating in facility planning and policy development to promote optimal quality of life
- promoting facility–community interaction[cxxviii,cxxix,cxxx,cxxxi]

The need for BSWs and MSWs in nursing homes became even more urgent after the implementation of enhanced psychosocial screening requirements within the MDS 3.0[cxxxii,cxxxiii] and the introduction of more robust requirements for LTC facilities in 2016. Yet, the 2019 study of nursing home social service directors found that only 37 percent of participants had social work degrees and state-issued licenses and that large nursing homes (especially those that are nonprofit and not part of a chain) were more likely to hire individuals with a social work degree and license.[cxxxiv] Moreover, the COVID-19 pandemic has drastically underscored the importance of psychosocial care for nursing home residents. Research underscores the value of hiring BSWs and MSWs in nursing homes:

- The 2006 study of social service directors found that BSWs and MSWs were more likely than those without a social work degree to screen at-risk residents for depression.[cxxxv]
- The same study found that BSWs and MSWs report self-efficacy in training a colleague on how to report suspected elder abuse.[cxxxvi]
- Degreed social workers play significant roles in assessing for and intervening to address the widespread problem of resident-to-resident aggression in nursing homes.[cxxxvii]
- A CMS-funded initiative to reduce avoidable hospitalizations among Missouri nursing facility residents, used teams of advanced practice RNs and social workers (clinical social workers and licensed MSWs) to assist residents and significant others with advance care planning.[cxxxviii,cxxxix,cxl] The model was associated with reductions in hospitalization- and emergency department–related utilization and expenditures.[cxli]

Thus, NASW strongly recommends that CMS modify the definition of a "qualified social worker" (42 C.F.R. § 483.70(p)(1)) in the following manner: "An individual with a minimum of a *bachelor's or master's degree in social work*." NASW opposes the inclusion of other "human service fields" as sufficient preparation for nursing home social work and opposes use of the term "social worker" to apply to anyone who does not have a baccalaureate, master's, or doctoral degree in social work. (Incorrect use of the term "social worker" on the federal level is especially problematic in states in which the term is defined by title protection laws, thereby creating confusion for consumers and facilities alike.) As stated previously, NASW also supports retention of the requirement of at least one year of supervised social work experience working directly with individuals in a health care setting (42 C.F.R. § 483.70(p)(2)).

NASW recognizes that some LTC facilities may decide to retain or hire such paraprofessional social service staff to help fulfill administrative functions (such as completing financial paperwork) and to meet instrumental needs of residents (such as arranging appointments or locating lost items).[cxlii] NASW

strongly recommends that such personnel be referred to as "social service assistants" and that they be supervised directly by nursing home employees with a BSW or MSW. Moreover, because such social service assistants do not meet NASW's recommended definition of "qualified social workers," they should not count toward a facility's minimum social work staffing ratios.

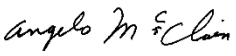
Beneficiary access to mental health services provided by clinical social workers

NASW has been working with CMS and Congress for years to remove the restriction that prohibits beneficiaries who receive SNF services under Medicare Part A from accessing mental health services provided by independent clinical social workers under Medicare Part B. We appreciate the technical assistance CMS has provided to members of Congress on this issue. Although we continue to focus our efforts on legislative solutions to the problem, we call to CMS's attention the following recommendation from the 2022 NASEM nursing home study (emphasis added):

> Recommendation 2D: To enhance the available expertise within a nursing home:
> • Nursing home administrators, in consultation with their clinical staff, should establish consulting or employment relationships with **qualified licensed clinical social workers at the M.S.W. or Ph.D. level**, advanced practice registered nurses (APRNs), clinical psychologists, psychiatrists, pharmacists, and others for clinical consultation, staff training, and the improvement of care systems, as needed.
> • The Centers for Medicare & Medicaid Services should create incentives for nursing homes to hire **qualified licensed clinical social workers at the M.S.W. or Ph.D. level** as well as APRNs for clinical care, **including allowing Medicare billing and reimbursement for these services**.[cxliii]

Thank you for the opportunity to comment on the proposed rule and for your consideration of NASW's comments. We look forward to collaborating with CMS to improve nursing home residents' quality of care and quality of life. Please contact me at naswceo@socialworkers.org if you need additional information.

Sincerely,



Angelo McClain, PhD, LICSW
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