State Policy Levers to Address Nursing Facility Staffing Issues

Many nursing facilities have fewer direct care staff than needed to meet the care needs of their residents, a problem more common in nursing facilities that serve a high share of Medicaid-covered residents. Because such facilities also have a higher share of Black and Hispanic residents, the low staffing rates in these facilities contribute to health disparities. The COVID-19 pandemic exacerbated these disparities further (Weech-Maldonado 2021).

Although the federal government plays an important role in monitoring compliance with its staffing standards, states can also help address staffing challenges in several ways, including:

- increasing Medicaid payment rates to help facilities hire more direct care staff and pay them higher wages;
- changing Medicaid payment methods to incentivize facilities to spend more of their revenue on staff (e.g., wage pass-through payment policies that require facilities to spend a specified portion of the Medicaid rate on staff wages); and,
- requiring that facilities meet minimum staffing standards that exceed federal requirements.

MACPAC has documented state policies related to nursing facility staffing in *State Policies Related to Nursing Facility Staffing* (MACPAC 2022). This brief provides background information about staffing challenges before the COVID-19 pandemic, summarizes current state policies related to staffing, and discusses prior research about the effectiveness of these policies.

Background

Nursing facilities are staffed by a variety of direct care staff with different levels of training, including:

- registered nurses (RNs), who have at least a two-year degree and are responsible for overseeing residents' care;
- licensed practical nurses (LPNs), who have a one-year degree and typically provide routine bedside care (such as taking vital signs); and
- certified nurse aides (CNAs), who have at least 75 hours of training and generally assist residents with activities of daily living (GAO 2021).[1]

CNAs account for about two-thirds of the direct care workforce. They are often paid close to the minimum wage and more than half of CNAs are people of color (ASPE 2020).

The relationship between higher staffing levels and better quality care has been well-documented. For example, a recent systematic review found that higher RN staffing levels were associated with fewer

pressure ulcers, decreased urinary tract infections, reduced emergency department (ED) use, fewer hospitalizations, and decreased mortality (Dellefield 2015). Although RN staffing has the strongest link to quality, higher levels of total direct care staffing (i.e., RNs, LPNs, and CNAs) are also associated with improved outcomes (Harrington et al. 2020).

Federal staffing standards

Since 1987, the Centers for Medicare & Medicaid Services (CMS) has required nursing facilities to have an RN or LPN available 24 hours a day and a RN-level director of nursing available 8 hours a day. For a typical 100-bed nursing facility, this minimum federal standard is equivalent to 0.3 hours per resident day (HPRD).

In 2001, a CMS expert panel recommended that facilities have 0.75 HPRD of RN staffing and 4.1 HPRD of total direct care staffing (RNs, LPNs, and CNAs) in order to reduce the risk of harm for long-stay nursing facility residents (CMS 2001). Although some stakeholders have argued that 4.1 HPRD is too high a standard for most nursing facilities, this standard has been supported by subsequent research and continues to be endorsed by a variety of nursing groups (CGNO 2014; Schnelle et al. 2016). Yet, according to CMS's Nursing Home Compare website, approximately 72 percent of nursing facilities had total staffing rates below 4.1 HPRD in 2019.

CMS assigns star ratings to facilities based on how their staffing rates compare to other facilities. In this brief, we examine the share of facilities with a one- or two-star rating, which is equivalent to less than 0.5 HPRD of RN care and 3.6 HPRD of total nurse staffing.

Staffing rates by facility payer mix

In 2019, Medicaid was the primary payer for 59 percent of nursing facility residents. [2] However, the share of Medicaid-covered nursing facility residents varies widely by facility, and differences in payer mix are associated with differences in staffing levels and other facility characteristics.

In 2019, facilities that served a high share of Medicaid-covered nursing facility residents were much more likely to have 1- or 2- star staffing ratings compared to other facilities (Table 1). For example, 49 percent of facilities serving the highest share of Medicaid-covered residents had 1- or 2- star staffing ratings, compared to only 21 percent of facilities serving the lowest share of Medicaid-covered residents.

TABLE 1. Staffing Ratings and Other Characteristics, by Payer Mix of Facility, 2019

Characteristics	All facilities	Share of residents whose primary support was Medicaid			
		Lowest quartile (<48%)	Second quartile (48 – 61%)	Third quartile (61-71%)	Highest quartile (>71%)
Share of facilities with a 1- or 2- star staffing rating	**38%**	21%	37%	44%	49%
Race and ethnicity					
White, non-Hispanic	**77**	86	81	74	65
Black, non-Hispanic	**13**	7	10	15	21
Hispanic	**5**	3	4	6	7
Other	**5**	5	5	6	6
Ownership					
Private, for-profit	**74**	56	73	82	84
Private, non-profit	**21**	38	22	13	11
Public	**5**	6	5	5	5

Note: Analysis excludes hospital-based nursing facilities and those that are not dually certified by Medicaid and Medicare. A 1- or 2-star staffing rating is equivalent to less than 0.5 hours per resident day (HPRD) of registered nurse (RN) care and 3.6 HPRD of total direct care staffing (RN, licensed practical nurses (LPNs) and certified nurse assistants (CNAs)).
Source: MACPAC, 2022, analysis of Nursing Home Compare, Medicare cost reports, and the Minimum Data Set.

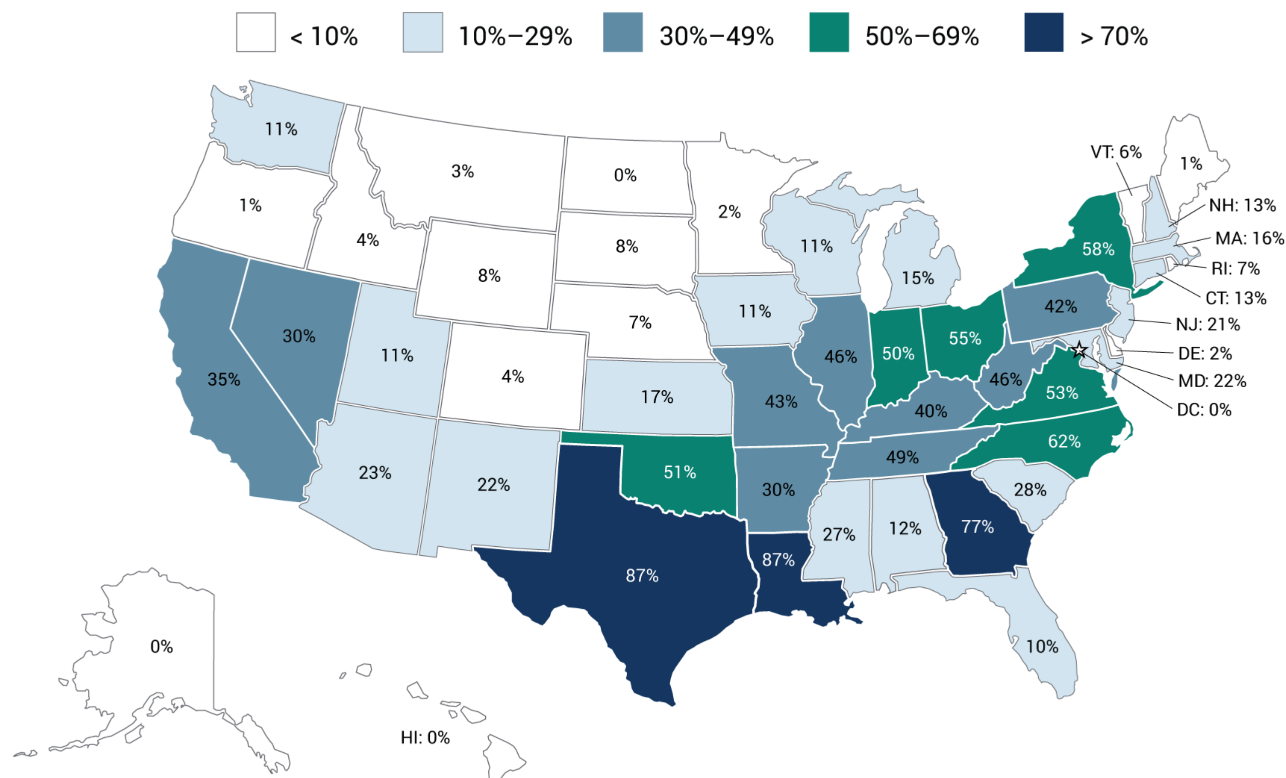
Facilities serving a high share of Medicaid-covered residents also serve more racial and ethnic minorities and so the poor staffing rates in these facilities also contribute to health disparities. In general, Black Medicaid beneficiaries are more likely than white beneficiaries to receive care in nursing facilities and when they do, they are less likely to be admitted to high-quality facilities (Nolen et al. 2020; Zuckerman et al. 2018).

It is also worth noting that for-profit facilities are more likely to serve a high share of Medicaid patients. These facilities generally have lower staffing rates than other facilities and may be particularly motivated to reduce staffing in order to increase profits (Paul et al. 2016).

Staffing rates by state

Overall, nursing facility staffing rates vary widely across states (Figure 1). For example, in three states (Alaska, Hawaii, and North Dakota) and the District of Columbia, fewer than 10 percent of freestanding nursing facilities have 1- or 2- star staffing ratings, while in three other states (Georgia, Louisiana, and Texas) more than 70 percent of facilities have low ratings.[3]

FIGURE 1. Share of Nursing Facilities with 1- or 2-Star Staffing Ratings, by State, 2019



Notes: Analysis excludes hospital-based nursing facilities and those that are not dually certified by Medicaid and Medicare. A 1- or 2-star staffing rating is equivalent to less than 0.5 hours per resident day (HPRD) of registered nurse (RN) care and 3.6 HPRD of total direct care staffing (RN, licensed practical nurses (LPNs) and certified nurse assistants (CNAs)).
Source: MACPAC, 2022, analysis of Nursing Home Compare, Medicare cost reports, and the Minimum Data Set.

State policies that may affect staffing rates

Stakeholders often attribute low staffing rates to Medicaid payment rates (the total amount paid per resident per day) and payment methods (the formula for determining payment rates to particular providers). For example, the CMS Commission on Safety and Quality in Nursing Homes (CCSQNH), which was formed to make recommendations to improve infection control and care during the COVID pandemic, recently highlighted the need for long-term reform of Medicaid payment policies to address staffing issues (CCSQNH 2020).

States have considerable flexibility to establish Medicaid payment rates and methods for nursing facility services. MACPAC has documented each state's fee-for-service nursing facility payment policies in a policy compendium and issue brief (MACPAC 2019a, MACPAC 2019b).

Low Medicaid payment rates may affect a facility's ability to pay for needed staff and may affect their willingness to accept new Medicaid patients. According to the Medicare Payment Advisory Commission (MedPAC), in 2019, freestanding nursing facilities reported a 11.3 percent margin on Medicare-covered patients in the aggregate, compared to an aggregate non-Medicare margin of negative 2 percent (MedPAC 2021). Although Medicare and Medicaid payments are not directly comparable because of differences in patient acuity, MedPAC has long argued that it is inefficient for high Medicare payment rates to offset low Medicaid payment rates. These payment differences may also exacerbate disparities, including the fact that high-quality facilities are less likely to admit patients dually eligible for Medicare and Medicaid compared to other Medicare patients (Sharma et al. 2020).

Even if a facility receives adequate overall payment from the state, it may not allocate that revenue to direct care staff if it does not have an incentive to do so. To counteract these incentives, several states have adopted minimum staffing standards that exceed the federal requirements and have designed Medicaid payment methods to incentivize greater spending on staffing.

Findings from Review of State Staffing Policies

To understand state policy levers to address staffing issues, MACPAC contracted with RTI International to compile information on current state staffing policies and changes since the start of the COVID-19 pandemic. Relevant state officials helped to validate RTI's findings.

The compendium includes information on three common state policy approaches, which are discussed further below:

- state minimum staffing standards that exceed federal requirements;
- wage pass-through policies and other payment policies that tie Medicaid payments to wage costs; and,
- Medicaid value-based payment (VBP) approaches related to staffing, such as pay-for-performance (P4P) programs.

MACPAC also contracted with Abt Associates to review prior research about the factors that affect staffing rates and the effectiveness of various state policy approaches. Relevant findings from peer-reviewed literature published since 2008 and grey literature published since 2016 are also summarized below.

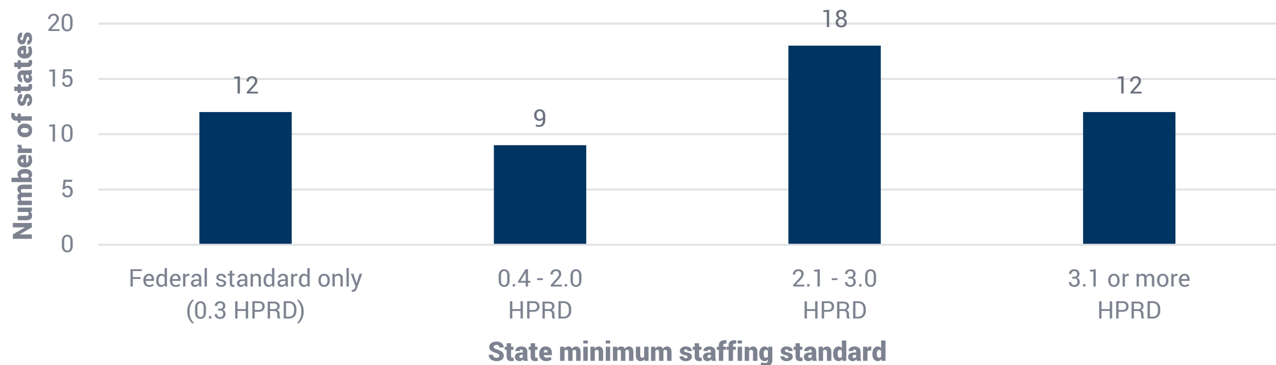
Our review of state payment methods did not include analyses of Medicaid payment rates because this information is not readily available in a format that enables cross-state comparisons. However, prior analyses have suggested that state Medicaid payment rates vary widely and that changes in Medicaid payment rates may also affect staffing.[4] For example, studies of past rate increases in California, Ohio, and Pennsylvania found that they were associated with improved staffing, particularly for RNs and LPNs (Bishop 2014; Bowblis and Applebaum 2017; Hackman 2019).

Minimum staffing standards

Thirty-eight states and the District of Columbia have minimum staffing standards that exceed the federal requirements of 0.3 HPRD (Figure 2). However, state standards vary widely. For example, 9 states have

standards that are less than 2.0 HPRD and 11 states and the District of Columbia have standards that are greater than 3.0 HPRD for a 100-bed facility. The District of Columbia is unique in having a minimum staffing standard of 4.1, the level recommended by CMS's 2001 staffing study. In addition, states vary in whether they have specific requirements for licensed nurse staff (RNs and LPNs) or whether the HPRD requirements apply to all direct care staff (including CNAs).

FIGURE 2. Number of States with State Minimum Staffing Standards at Various Thresholds, 2021



Notes: HPRD is hour per resident day. HPRD calculations are based on a 100-bed facility. Number of states includes the District of Columbia.
Source: RTI, 2021, analysis for MACPAC of state staffing policies as of October 2021.

Prior research found that increases in minimum staffing standards are associated with improvements in staffing, particularly for CNAs. For example, one review of new minimum staffing requirements in California and Ohio found a 5 percent increase in HPRD overall, but a reduction in skill mix (i.e., the ratio of RNs to all direct care staff) (Chen and Grabowski 2015).[5] In another study that examined the effects by payer mix, facilities that served a higher share of Medicaid patients reported larger increases in staffing, including RN staffing, in response to increases in minimum staffing requirements, resulting in larger gains in other measures of quality of care (Bowblis 2011).

Cost-based and wage pass-through payment methods

Currently, 32 states and the District of Columbia pay nursing facilities based on the costs of direct care and 11 states have wage pass-through policies.[6] Both of these methods base Medicaid payments on staffing costs. Cost-based payment methods generally pay facilities more if they increase staffing expenditures, in contrast to a price-based payment method which pays facilities the same amount regardless of what they spend.[7] However, states do not typically pay 100 percent of allowable costs. Wage pass-through policies allocate a specified portion of the rate toward staff wages and are often used as a mechanism to ensure that Medicaid payment rate increases result in increased wages for staff.

Prior research suggests that cost-based payment and wage-pass through payments are associated with higher staffing rates, but the most recent research we could find was more than 10 years old. One multivariate study using 2002 data found that cost-based payment methods were associated with both higher RN staffing and higher total staffing (Harrington et al. 2007). A review of wage pass-through

policies implemented between 1996 and 2004 found CNA staffing rates increased in the initial years after implementation, but did not find a statistically significant effect on RN or LPN staffing (Feng et al. 2010).

Value-based payment

Our review of state policies identified 16 states with Medicaid incentive payments to providers related to staffing measures. In all cases, these value-based payment arrangements were structured as pay-for-performance (P4P) incentives that either increased base payment rates or made a separate quality-based supplemental payment to facilities. In many cases, staffing was one of many quality metrics used to determine the P4P incentive.

The existing literature on the effects of nursing facility P4P incentives is mixed. One review of eight Medicaid P4P programs compared to a nationwide control group found that only one state had a statistically significant effect on staffing measures and that the effects on resident-level outcomes were also limited (Werner et al. 2013). The federal evaluation of the CMS Nursing Home Value-Based Purchasing Demonstration also found mixed results (L&M Policy Research 2013).[8] In both cases, researchers speculated that the incentives may have been too small and too complex to administer to motivate changes in nursing facility behavior.

Policy Changes During the COVID-19 Pandemic

The COVID-19 pandemic has raised awareness about the importance of adequate staffing in nursing facilities, and as a result, several states recently changed their policies. In our review, we identified 10 states that increased minimum staffing standards, 1 state that added a new wage pass-through policy, and 4 states that implemented new payment incentives since 2020.[9] Two states (Maine and New Jersey) added new minimum wage requirements specifically for direct care staff, a new type of policy that we did not find in states before the pandemic. New Jersey added a new minimum loss ratio requirement that caps nursing facility profits and requires facilities to spend a minimum amount on staffing, which is another novel policy approach.[10]

During the pandemic, several states also implemented temporary policies intended to support nursing facility staffing. Twelve states implemented increased payments to direct care workers during the pandemic (often referred to as hazard pay), but it is unclear whether these increased payments will end after the pandemic. Fifteen states reduced staff training requirements for direct care staff to make it easier to hire workers, but four of these states have already rescinded this flexibility.

Because of the pandemic, CMS has not updated Nursing Home Compare staffing star ratings since 2019. However, other analyses of federal staffing data found that the number of direct care hours declined 9.8 percent between January and September 2020. During this period, the average nursing home census also declined 10.5 percent, and so the average HPRD was relatively unchanged. However, facilities that serve the highest share of Medicaid-covered residents continue to report the lowest staffing levels (Werner and Coe 2021).

Endnotes

[1] During the COVID-19 pandemic, CMS has allowed states to waive or reduce training requirements for CNAs.

[2] The vast majority (84 percent) of Medicaid-covered nursing facility residents are dually eligible for Medicare and Medicaid (Abt Associates 2020). For dually eligible beneficiaries, Medicare pays for skilled nursing care during the initial portion of their stay and Medicaid pays for subsequent days of care after the Medicare benefit is exhausted.

[3] The analyses in this brief focus on freestanding nursing facilities (i.e., not part of a hospital) that are dually certified by Medicare and Medicaid, which account for the vast majority (91 percent) nursing facilities (Abt Associates 2020). However, the share of nursing facilities that are freestanding varies by state, which may explain some of the state variation that we observed.

[4] For example, a study commissioned by the American Health Care Association (AHCA), which represents for-profit nursing facilities, found that Medicaid base payment rates in 28 states varied from 74 to 100 percent of costs in 2015 (HHC 2018). In addition, the non-Medicare margins calculated by MedPAC varied widely by state in 2019: nursing facilities in 21 states had positive non-Medicare margins, and facilities in 15 states had non-Medicare margins of 3 percent or greater in the aggregate in 2019 (MedPAC 2021). Non-Medicare margins also include payments and costs for private-pay nursing facility residents, which accounted for 18.7 percent of nursing facility residents in 2019n (Abt Associates 2020).

[5] Specifically, this study reviewed California's increase of minimum standards from 3.0 to 3.2 HPRD in 2000 and Ohio's increase of minimum staffing standards from 1.6 to 2.75 HPRD in 2002 (Chen and Grabowski 2014).

[6] In two states (Kansas and Texas), the wage pass through policy is voluntary and it is unclear what share of facilities participate.

[7] Staffing accounts for more than half of nursing facility operating costs (GAO 2021).

[8] The CMS Nursing Home Value Based Purchasing demonstration tested pay for performance models in three states (Arizona, New York, and Wisconsin). Thirty percent of the P4P incentive was based on staffing rates.

[9] We also identified four states with pending legislation to increase minimum staffing requirements.

[10] Two other states (Massachusetts and New York) have pending legislation to cap nursing facility profits and require facilities to spend a minimum amount on staffing.

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