MACPAC

Advising Congress on
Medicaid and CHIP Policy

June 10, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: Request for Information on Revising the Requirements for Long-Term Care Facilities to Establish Mandatory Minimum Staffing Levels

Dear Administrator Brooks-LaSure:

The Medicaid and CHIP Payment and Access Commission (MACPAC) appreciates the opportunity to respond to the request for information (RFI) included in the Centers for Medicare & Medicaid Services (CMS) proposed rule: 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 Fed. Reg. 22720 (April 15, 2022).

To address longstanding concerns with inadequate staffing in nursing facilities, CMS intends to propose new minimum staffing standards for nursing facilities. The RFI seeks stakeholder input to inform the development of policy options. In particular, CMS is interested in learning more about what facility factors should be considered when establishing minimum staffing standards and what can be learned from state experiences with minimum staffing requirements and other policies intended to promote adequate staffing.

MACPAC is also interested in exploring policies to ensure adequate staffing in nursing facilities because of the known link between staffing levels and quality care and the fact that Medicaid is the primary payer for most nursing facility residents. In doing so, we have aimed to apply a health equity lens, since facilities that serve a higher share of Medicaid-covered residents generally have lower staffing rates compared to other facilities and also serve more racial and ethnic minorities. We encourage CMS to apply a health equity lens in its analyses of staffing standards and consider the unique needs of Medicaid-covered nursing facility residents.

Medicaid and CHIP Payment
and Access Commission

1800 M Street NW
Suite 650 South
Washington, DC 20036

www.macpac.gov
202-350-2000
202-273-2452

We have conducted several studies that relate to the questions raised in the RFI. For example, MACPAC recently released a compendium of state policies related to nursing facility staffing and an issue brief titled *State Policy Levers to Address Nursing Facility Staffing Issues* (MACPAC 2022a; MACPAC 2022b). We hope that this compendium helps CMS to better understand the state effects of changing federal minimum staffing standards. In the sections that follow, we highlight key findings from this work.

Additionally, we have completed other analyses on nursing facility payment policy that may be of interest to CMS as it considers policy options related to staffing:

- a compendium of Medicaid fee-for-service (FFS) nursing facility payment policies and companion issue brief describing state payment methods (MACPAC 2019a; MACPAC 2019b);
- analyses of the characteristics of Medicaid-covered nursing facility residents, including patient acuity (Abt 2020); and
- interviews with state officials and stakeholders on factors that affected the development of Medicaid nursing facility payment methods (MACPAC 2020).

In the coming year, the Commission plans to examine how Medicaid payments can be structured to better assure adequate staffing for the care of Medicaid-covered nursing facility residents and discuss the results at a future MACPAC public meeting. As has been our practice, we will keep CMS staff informed of our findings.

Facility Characteristics Associated with Staffing Rates

MACPAC recently conducted a review of pre-pandemic staffing data and found that nursing facilities that serve a higher share of Medicaid-covered residents were much more likely to have lower staffing rates compared to other facilities. We looked at facilities with a Nursing Home Compare 1- or 2-star staffing rating to identify those with the lowest staffing rates. We found that in 2019, 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). Although our prior research has shown that long-stay Medicaid-covered residents generally have lower nurse staffing needs than short-stay residents covered by Medicare, this difference does not explain the disparities we observe since star ratings are adjusted for patient acuity (Abt 2020).

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, 2021, analysis of Nursing Home Compare, Medicare cost reports, and the Minimum Data Set.

Facilities with a high share of Medicaid-covered residents also serve more racial and ethnic minorities, and so worse staffing levels at these facilities may exacerbate health disparities. Prior research has found that 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). Other research has also found that for-profit facilities are more likely to serve a high share of Medicaid patients and generally have lower staffing rates than other facilities (Paul et al. 2016).

In our analyses, we also found considerable variation in nursing facility staffing at the state level. For example, in three states (Alaska, Hawaii, and North Dakota) and the District of Columbia, fewer than 10 percent of freestanding nursing facilities had 1- or 2- star staffing ratings in 2019, while in three other states (Georgia, Louisiana, and Texas) more than 70 percent of facilities had these low ratings (MACPAC 2022a). This finding suggests that differences in state policies may help explain some of this variation.

State Policies Related to Nursing Facility Staffing

To better understand state policy levers, MACPAC compiled information on current state staffing policies, including state minimum staffing standards and Medicaid payment methods. We also reviewed prior research about the effectiveness of various approaches. Key findings from this work are discussed in the following sections.

State minimum staffing standards

States can establish minimum staffing standards that exceed current federal minimum staffing standards of 0.3 hours per resident day (HPRD) for a 100-bed facility. In our review, we found that, 38 states and the District of Columbia had minimum staffing standards that exceeded the minimum federal requirements as of October 2021. However, only 11 states and the District of Columbia had standards that were greater than 3.0 HPRD, and only the District of Columbia had a minimum staffing standard of 4.1 HPRD, the level recommended by CMS's 2001 staffing study (CMS 2001). In addition, states varied in whether they had specific requirements for licensed nurse staff, such as registered nurses (RNs) and licensed practical nurses (LPNs), or whether the HPRD requirements applied to all direct care staff, including certified nurse aides (CNAs).

Prior research has found mixed results from increases in minimum staffing standards. For example, one review of new minimum staffing requirements in California and Ohio found a 5 percent increase in HPRD overall, which was primarily driven by an increase in CNA staff availability. However, the study also found that the policy had the unintended consequence of reducing RN staff HPRD and a reduction in skill mix (i.e., the ratio of RNs to all direct care staff) (Chen and Grabowski 2014).

Other research has found that facilities that served a higher share of Medicaid patients reported larger increases in staffing than other facilities in response to increases in minimum staffing requirements (Bowblis 2011). As a result, minimum staffing standards may help to reduce health disparities in these facilities.

Medicaid payment methods

States can develop Medicaid payment methods to incentivize facilities to spend more of their revenue on staff. Some examples of state Medicaid payment policies that are intended to promote adequate staffing include wage pass-through payment policies that require facilities to spend a specified portion of the Medicaid rate on staff wages and cost-based payment policies for direct care staff that pay facilities more if they spend more on staffing.

Our review found that 32 states and the District of Columbia paid nursing facilities based on the costs of direct care and 11 states had wage pass-through policies as of October 2021. Prior research suggests that cost-based payment and wage-pass through payments are associated with higher staffing rates (Harrington et al. 2007). During the COVID pandemic, we identified several states that temporarily increased nursing facility staff salaries using wage-pass through policies, but in our literature review, we were not able to identify peer-reviewed research on the effects of these policies.

In addition, we found that 16 states make Medicaid value-based payment (VBP) incentive payments to providers related to performance on staffing measures. However, the existing literature on the effects of nursing facility VBP incentives is mixed; two notable reviews of pay for performance programs speculated

that the incentives studied may have been too small or too complex to administer to motivate changes in nursing facility behavior (Werner et al. 2013; L&M Policy Research 2013).

During the COVID-19 pandemic, some states have begun implementing new policies to promote adequate staffing. Our review identified two states (Maine and New Jersey) that recently added new minimum wage requirements specifically for direct care staff. New Jersey also added a new minimum loss ratio requirement that requires facilities to spend at least 90 percent of the facility's aggregate revenue on direct care costs, such as staffing.

Next Steps for MACPAC Work

The Commission remains interested in exploring policies to ensure adequate staffing, particularly in nursing facilities that serve a high share of Medicaid patients. In the coming year, we plan to continue to examine principles that states should consider when setting Medicaid nursing facility payment policies in order to promote access to adequate staffing, promote an efficient use of resources, and reduce health disparities. We hope that these analyses will help federal policymakers understand the effects of changes to federal policies on states and will help states consider any policy changes that may be needed in response to any changes in federal minimum staffing requirements. We look forward to continuing to collaborate with CMS on these issues.

Sincerely,

Melanie Bella
Chair

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