

October 27, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-3442-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via <https://www.regulations.gov/commenton/CMS-2023-0144-0001>

Re: Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting (88 Fed. Reg. 61352, proposed Sept. 6, 2023)

Dear Administrator Brooks-LaSure:

On behalf of the National Association of Social Workers (NASW), I am submitting comments on the notice of proposed rulemaking (NPRM) on CMS-3442-P (RIN 0938-AV25), which addresses nurse minimum staffing standards for long-term care (LTC) facilities and Medicaid institutional payment transparency reporting.

Founded in 1955, NASW is the largest membership organization of professional social workers in the United States, representing more than 110,000 social workers. We work to enhance the professional growth and development of our members, to create and maintain professional standards, and to advance sound social policies.

Social workers are integral members of interdisciplinary teams within LTC facilities (hereafter also referred to as “nursing homes”). These teams include three nursing disciplines: certified nursing assistants (CNAs), licensed practical nurses—licensed vocational nurses (LPNs—LVNs), and registered nurses (RNs). Social workers and nursing staff strive to enhance the quality of life and quality of care for residents. Yet, their efforts are often hindered by exceedingly high workloads.

NASW has long supported the Nursing Home Reform Act of 1986 (S. 2604), which was signed into law as part of the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203, hereafter “OBRA ‘87”).¹ This law requires the Secretary of Health and Human Services (HHS) to assure that facilities provide each resident with high-quality care and grants the Secretary full authority to set minimum staffing

¹ Omnibus Budget Reconciliation Act, 42 U.S.C. §§ 1395i-3, 1396r (1987).

standards. OBRA '87 also 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.

Consequently, NASW has strongly supported the Biden Administration's initiative to improve the quality of care in nursing homes,² of which the current NPRM is a primary component. The NPRM represents a paradigm shift in nursing home oversight to promote quality of care. For decades, health researchers, geriatricians, nurses, and other experts have recommended minimum nursing staffing requirements to improve the quality of care at nursing homes; a wide range of peer-reviewed literature demonstrates the connection between nursing home staffing and quality of care.^{3,4,5,6,7,8} As early as 2001, a study by Abt Associates Inc., conducted for the Centers for Medicare & Medicaid Services (CMS), noted the “strong and compelling” evidence for minimum staffing levels, even in an economy with a chronic workforce shortage.⁹ Moreover, a blue-ribbon panel convened by the National Academies of Sciences, Engineering, and Medicine (NASEM) noted in its 2022 report that increasing overall nurse staffing (including RN staffing 24 hours per day, seven days per week) has been a consistent and long-standing recommendation for improving the quality of care in nursing homes.¹⁰ Likewise, the NASEM report addressed the importance of professional qualifications for nursing home social workers and made clear the impact of financial transparency and accountability on quality of care.

NASW's comments address the following topics:

- Section II.B.1: Nursing Services
 - A. Sufficient Staff (§ 483.35(A)(1))
 - B. Registered Nurse (§ 483.35(B)(1))
- Section II.B.2: Administration (§ 483.70)

² The White House. (2022). *Fact sheet: Protecting seniors by improving safety and quality of care in the nation's nursing homes*. <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/>

³ 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 (proposed Apr. 15, 2022).

⁴ Castle, N. (2008). Nursing home caregiver staffing levels and quality of care: A literature review. *Journal of Applied Gerontology*, 27(4), 375–405. <https://doi.org/10.1177/0733464808321596>

⁵ Castle, N. G., & Anderson, R. A. (2011). Caregiver staffing in nursing homes and their influence on quality of care. *Medical Care*, 49(6), 545–552. <https://doi.org/10.1097/MLR.0b013e31820fbca9>

⁶ Castle, N., & Engberg, J. (2008). Further examination of the influence of caregiver staffing levels on nursing home quality. *The Gerontologist*, 48(4), 464–476. <https://doi.org/10.1093/geront/48.4.464>

⁷ Dellefield, M. E., Castle, N. G., McGilton, K. S., & Spilsbury, K. (2015). The relationship between registered nurses and nursing home quality: An integrative review (2008–2014). *Nursing Economic\$,* 33(2), 95–108, 116.

⁸ Schnelle, J. F., Simmons, S. F., Harrington, C., Cadogan, M., Garcia, E., & Bates-Jensen, B. (2004). Relationship of nursing home staffing to quality of care? *Health Services Research*, 39(2), 225–250. <https://doi.org/10.1111/j.1475-6773.2004.00225.x>

⁹ Centers for Medicare & Medicaid Services, Abt Associates Inc. (2001) *Appropriateness of minimum nurse staffing ratios in nursing homes. Report to Congress: Phase II final, Volumes I-III*. Baltimore, MD: CMS. [Quote is from p. 6.]

¹⁰ National Academies of Sciences, Engineering, and Medicine. (2022). *The national imperative to improve nursing home quality: Honoring our commitment to residents, families, and staff*. The National Academies Press. <https://doi.org/10.17226/26526>

- Section II.B.3: Hardship Exemption from the Minimum Hours Per Resident Day Requirements for Registered Nurses and Nurse Aides*
- Section II.B.4: Implementation Timeframe
- Section III: Medicaid Institutional Payment Transparency Reporting Provisions (§§ 483.72 and 442.43)
- Additional Feedback: Social Work Staffing Standards (staffing ratios and professional qualifications)
- Resident Access to Mental Health Services Provided by Clinical Social Workers

* NASW notes that CMS has referred to nurse aides (NAs) rather than certified nursing assistants (CNAs) in the NPRM. We urge CMS to use the term “CNA,” consistent with the federal requirement. CNAs are required to meet certification standards within a specified period. NHs are not allowed to rely on NAs to provide basic care unless they meet the training requirements as required. NASW opposes the use of NAs and other uncertified staff to fulfill CNA responsibilities. Accordingly, we use “nurse aide” only when quoting the NPRM, opting for the more appropriate and accurate “CNA” within our comments.

Section II.B.1: Nursing Services

A. Sufficient Staff (§ 483.35(A)(1))

NASW appreciates that CMS has proposed a minimum staffing standard for nursing care provided directly to residents. Research has shown that in the absence of federal LTC facility nurse staffing standards, many nursing homes—especially for-profit facilities—have routinely maintained low levels of staffing.¹¹ We concur with CMS’s statement that

Given the growing body of evidence demonstrating the importance of staffing to resident health and safety, the continued insufficient staffing, and variability in nurse-to-resident ratios across States, creating a consistent floor will reduce the risk of residents receiving unsafe and low-quality care.¹²

Moreover, NASW appreciates CMS’s recognition that a federal minimum nurse staffing standard not only would benefit nursing home residents but also would improve the quality of jobs for nursing staff. When a facility is short staffed, nursing staff are unable to care for residents without significant delays and omissions in care. These delays and omissions lead to stress, moral distress, and burnout, which result in high staff turnover and chronic job vacancies.¹³ NASW particularly commends CMS’s affirmation of the essential role CNAs play in serving nursing home residents, improving health

¹¹ Hawk, T., White, E. M., Bishnoi, C., Schwartz, L. B., Baier, R. R., & Gifford, D. R. (2022). Facility characteristics and costs associated with meeting proposed minimum staffing levels in nursing homes. *Journal of the American Geriatrics Society*, 70(4), 1198–1207. <https://doi.org/10.1111/jgs.17678>

¹² Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting, 88 Fed. Reg. 61353 (proposed Sept. 6, 2023) (to be codified at 42 C.F.R. pts. 438, 442, 483). [Quote is from p. 61367.]

¹³ White, E. M., Aiken, L. H., & McHugh, M. D. (2019). Registered nurse burnout, job dissatisfaction, and missed care in nursing homes. *Journal of the American Geriatrics Society*, 67(10), 2065–2071. <https://doi.org/10.1111/jgs.16051>

outcomes and quality of life for Medicaid and Medicare beneficiaries, and strengthening the economy. In particular, we applaud CMS’s recognition of the following realities:

- CNAs are poorly compensated.
- Low compensation contributes to low retention and high turnover.
- Low retention and high turnover reduce the quality of care provided to residents and limits access to LTC facility services.
- Sufficient compensation levels are vital to creating a stable workforce with well-qualified staff, reduced turnover, and safe, high-quality care.

These strengths of the NPRM notwithstanding, NASW believes that CMS’s laudable goals will not be reached unless the proposed nurse staffing standards are strengthened significantly. CMS has proposed that nursing homes provide 3.0 hours per day of resident care (hours per resident day, or HPRD): 2.45 HPRD of nurse aide care and 0.55 HPRD of RN care. The proposed standard does not require either LPN–LVN HPRD or total nurse staffing levels.

CMS’s proposed staffing standards contrast dramatically with the findings of the 2001 CMS–Abt study. The previous study asserted the importance of a minimum staffing standard of 4.1 nursing 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.¹⁴ A 2004 observational study confirmed those findings.¹⁵ 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.¹⁶ 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.¹⁷

Given the increasing acuity of nursing home residents,¹⁸ the ongoing impact of respiratory syncytial virus (RSV) and COVID-19, and the inevitability of future public health crises, the benefits of minimum staffing requirements for nursing staff cannot be overestimated. Research has found a strong

¹⁴ Centers for Medicare & Medicaid Services, Abt Associates Inc. (2001) *Appropriateness of minimum nurse staffing ratios in nursing homes. Report to Congress: Phase II final, Volumes I–III*. Baltimore, MD: CMS. [Quote is from p. 6.]

¹⁵ Schnelle, J. F., Simmons, S. F., Harrington, C., Cadogan, M., Garcia, E., & Bates-Jensen, B. (2004). Relationship of nursing home staffing to quality of care. *Health Services Research*, 39(2), 225–250. <https://doi.org/10.1111/j.1475-6773.2004.00225.x>

¹⁶ Schnelle, J. F., Schroyer, L. D., Saraf, A. A., & Simmons, S. F. (2016). Determining nurse aide staffing requirements to provide care based on resident workload: A discrete event simulation model. *JAMDA: The Journal of Post-Acute and Long-Term Care Medicine*, 17(11), 970–977. <https://doi.org/10.1016/j.jamda.2016.08.006>

¹⁷ Harrington, C., Kovner, C., Kayser-Jones, J., Berger, S., Mohler, M., Burke, R., & Zimmerman, D. (2000). Experts recommend minimum nurse staffing standards for nursing facilities in the United States. *The Gerontologist*, 40(1), 5–16. <https://doi.org/10.1093/geront/40.1.5>

¹⁸ Fry, L., Fry, L., Philip, A., Von Der Ahe, L., Doan, E., & Ahmed, F. (2018). High acuity unit in SNF: Novel program to improve quality of care for post-acute patients. *JAMDA: The Journal of Post-Acute and Long-Term Care*, 19(3), PB18. <https://doi.org/10.1016/j.jamda.2017.12.058>

relationship between nursing staffing levels and improved quality of care, as reflected in both process and outcome measures.^{19,20,21,22,23} At the beginning of the COVID-19 pandemic, low staffing levels were associated not only with virus transmission but also with many of the deaths of nursing home residents and staff, which totaled more than 200,000.^{24,25} Thus, NASW is concerned that CMS’s proposed nurse staffing minimums are well below those found to be necessary more than 20 years ago.

Furthermore, NASW is dismayed that the proposed nurse staffing minimums omit LPNs–LVNs. Each nursing discipline offers a distinct contribution within LTC facilities:

- CNAs are primarily responsible for assisting residents with activities of daily living, such as dressing, eating, toileting, and transferring.
- LPNs–LVNs provide practical care. The tasks they are licensed to perform vary by state but usually include responsibilities such as administering medications and treatments—activities that NAs are not trained to do and that are not within the NA scope of practice.
- RNs are responsible for the coordination and overall delivery of care, which includes assessing residents and planning, implementing, and evaluating residents’ care plans. They work independently and provide more complex direct care (such as administering certain treatments) than LPNs. RNs also manage and supervise LPNs–LVNs and CNAs, assist with problem solving, and collaborate with other interdisciplinary team members (such as physicians, rehabilitation staff, social workers, and social service staff) regarding care goals and interventions. Additionally, RNs are responsible for implementation of new or modified regulatory requirements.

The exclusion of LPNs–LVNs from the proposed nurse staffing standards creates ambiguity regarding the mix of direct care staffing and conveys (albeit unintentionally) that the work of these professionals is not valuable. Nursing homes and extended care settings in the United States employ 4.4 percent of the country’s RNs, compared with 27.5 percent of the country’s LPNs–LVNs (down from 31.7 percent in

¹⁹ Castle, N. (2008). Nursing home caregiver staffing levels and quality of care: A literature review. *Journal of Applied Gerontology*, 27(4), 375–405. <https://doi.org/10.1177%2F0733464808321596>

²⁰ Dellefield, M. E., Castle, N. G., McGilton, K. S., & Spilsbury, K. (2015). The relationship between registered nurses and nursing home quality: An integrative review (2008–2014). *Nursing Economic\$,* 33(2), 95–108, 116. <https://www.proquest.com/docview/1674728394/4A87F4114BDB4C4EPQ/1>

²¹ Castle, N. G., & Anderson, R. A. (2011). Caregiver staffing in nursing homes and their influence on quality of care. *Medical Care*, 49(6), 545–552. <https://doi.org/10.1097/mlr.0b013e31820fbca9>

²² Castle, N., & Engberg, J. (2008). Further examination of the influence of caregiver staffing levels on nursing home quality. *The Gerontologist*, 48(4), 464–476. <https://doi.org/10.1093/geront/48.4.464>

²³ Schnelle, J. F., Simmons, S. F., Harrington, C., Cadogan, M., Garcia, E., & Bates-Jensen, B. (2004). Relationship of nursing home staffing to quality of care. *Health Services Research*, 39(2), 225–250. <https://doi.org/10.1111/j.1475-6773.2004.00225.x>

²⁴ Li, Y., Temkin-Greener, H., Shan, G., & Cai, X. (2020). COVID-19 infections and deaths among Connecticut nursing home residents: Facility correlates. *Journal of American Geriatrics Society*, 68(9), 1899–1906. <https://doi.org/10.1111/jgs.16689>

²⁵ Harrington, C., Ross, L., Chapman, S., Halifax, E., Spurlock, B., & Bakerjian, D. (2020). Nursing staffing and coronavirus infections in California nursing homes. *Policy, Politics, & Nursing Practice*, 21(3), 174–186. <https://doi.org/10.1177/1527154420938707>

2017).²⁶ Although LPNs–LVNs cannot substitute for RNs, they are integral members of the nursing home workforce.

Given the preceding considerations, NASW urges CMS to strengthen the proposed changes to § 483.35(A)(1) by establishing a minimum staffing standard of 4.2 total nursing HPRD, composed of three components: (a) 0.75 RN HPRD, (b) 1.4 licensed nurse (total of RN and LPN–LVN) HPRD, and (c) 2.8 CNA HPRD. Our rationale follows.

a. 0.75 RN HPRD

- This standard would match that of the simulation model conducted by Abt Associates as part of its 2023 staffing study.²⁷
- Increasing RN staffing from a national average of 40 minutes per resident day (0.67 HPRD) to 45 minutes (0.75 HPRD) would increase average RN staffing by only 5 minutes a day for each resident. However, this small amount would improve safety and quality of care.

b. 1.4 licensed nursing (total RN and LPN–LVN) HPRD

- The 1.4 licensed nursing HPRD figure matches that of the 2023 Abt simulation model.²⁸ This model found that facilities needed 1.4 licensed nursing HPRD to keep omitted and delayed care below 10 percent. (It is worth noting that Abt found licensed nurse staffing levels of 1.4 to 1.7 HPRD were needed to eliminate delayed and omitted clinical care.)
- If CMS fails to set a specific minimum standard for licensed nurses, nursing homes will likely reduce their LPN–LVN hours to save money. A total minimum licensed nursing standard would require NHs to maintain an overall minimum nursing standard.
- NASW respectfully disagrees with CMS’s assumption that nursing homes will retain their existing LPNs–LVNs while hiring more RNs and CNAs, as needed, to meet the proposed staffing requirements. Without adequate LPN–LVN HPRD (and given the limited RN HPRD), many residents would have delayed or omitted medications and treatments that could result in harm and jeopardy to their health, safety, and well-being.

c. 2.8 CNA HPRD

- This recommendation is consistent with the landmark 2016 simulation study by Schnelle and colleagues, which found that 2.8 CNA HPRD were needed to ensure adequate care to residents with the *lowest* staffing care needs; residents with moderate care needs required 3.2 CNA HPRD, and residents with the highest care needs required 3.6 CNA HPRD.²⁹

²⁶ National Academies of Sciences, Engineering, and Medicine. (2022). *The national imperative to improve nursing home quality: Honoring our commitment to residents, families, and staff*. The National Academies Press. <https://doi.org/10.17226/26526>

²⁷ Abt Associates. (2023). *Nursing home staffing study: Comprehensive report* [Prepared for the Centers for Medicare & Medicaid Services]. <https://www.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf>

²⁸ Please refer to footnote 27 (Abt Associates, 2023).

²⁹ Schnelle, J. F., Schroyer, L. D., Saraf, A. A., & Simmons, S. F. (2016). Determining nurse aide staffing requirements to provide care based on resident workload: A discrete event simulation model. *JAMDA: The Journal of Post-Acute and Long-Term Care Medicine*, 17(11), 970–977. <https://doi.org/10.1016/j.jamda.2016.08.006>

- The 2016 Schnelle et al. study found that CNA staffing at a level of 2.45 HPRD would result in 15 percent omitted care for residents with the *lowest* acuity needs. Omitted basic care by CNAs can result in serious harm and jeopardy to residents, including weight loss, dehydration, pressure ulcers, urinary tract infections, and loss of physical functioning.³⁰ Other research has found that poor care outcomes in nursing homes—including falls, malnutrition, pressure ulcers, and avoidable hospitalizations—are associated with high economic costs to Medicaid and Medicare³¹ and that high quality is associated with better financial performance for facilities.³² Such research concluded that “prevention can be done cost-effectively”³³ and that “there is a business case for quality, whereas nursing homes that have better processes and outcomes of care perform better financially.”³⁴
- The 2023 Abt Associates study (which did not include a simulation model for either nurse aides or CNAs) documented that CNA staffing above the 2.45 HPRD level significantly increases safety outcomes and affirmed that CNA staffing at the 2.8 HPRD level substantially improved both care quality and resident safety.³⁵

d. 4.2 total nursing staff HPRD

- NASW disagrees with CMS’s assertion that the 3.0 HPRD is not a minimum nurse staffing standard because facilities will still be required to have sufficient nursing staff to meet residents’ needs. The “sufficient” language has been in regulation for decades and has failed for multiple reasons, including inadequate specificity of the standard, lack of knowledge regarding resident acuity, and ineffective enforcement. (For example, a recent report by the Majority Staff of the Senate Special Committee on Aging detailed the critical staffing shortages in state survey agencies.³⁶) This failure prompted President Biden to propose the idea of a minimum staffing standard in his nursing home quality initiative.³⁷
- CMS’s proposed 3.0 HPRD total nursing minimum standard would allow for a *reduction* in total staffing to levels below both prepandemic (March 2019) and May 2022 national staffing averages.

³⁰ Schnelle, J. F., Schroyer, L. D., Saraf, A. A., & Simmons, S. F. (2016). Determining nurse aide staffing requirements to provide care based on resident workload: A discrete event simulation model. *JAMDA: The Journal of Post-Acute and Long-Term Care Medicine*, 17(11), 970–977. <https://doi.org/10.1016/j.jamda.2016.08.006>

³¹ Gallagher, L. G. (2011). *The high cost of poor care: The financial case for prevention in American nursing homes*. National Consumer Voice for Quality Long-Term Care. <https://theconsumervoice.org/uploads/files/issues/The-High-Cost-of-Poor-Care.pdf>

³² Weech-Maldonado, R., Pradhan, R., Dayama, N., Lord, J., & Gupta, S. (2019). Nursing home quality and financial performance: Is there a business case for quality? *Inquiry*, 56, 0046958018825191. <https://doi.org/10.1177/0046958018825191>

³³ Please refer to footnote 31 (Gallagher, 2011). The quote is from p. 5.

³⁴ Please refer to footnote 32 (Weech-Maldonado et al., 2019). The quote is from para. 1.

³⁵ Abt Associates. (2023). *Nursing home staffing study: Comprehensive report* [Prepared for the Centers for Medicare & Medicaid Services]. <https://www.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf>

³⁶ U.S. Senate Special Committee on Aging, Majority Staff. (2023). *Uninspected and neglected: Nursing home inspection agencies are severely understaffed, putting residents at risk*. <https://www.aging.senate.gov/press-releases/casey-unveils-new-report-detailing-nursing-home-oversight-crisis>

³⁷ The White House. (2022). *Fact sheet: Protecting seniors by improving safety and quality of care in the nation’s nursing homes*. <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/>

- i. March 2019: 3.87 total nursing HPRD, composed of 0.69 RN HPRD, 0.87 LPN–LVN HPRD, and 2.31 CNA HPRD
- ii. May 2022: 3.76 HPRD, composed of 0.68 RN HPRD, 0.88 LPN–LVN HPRD, and 2.20 CNA HPRD³⁸
- In the NPRM, CMS has stated that it would consider a minimum total nurse staffing standard of 3.48 HPRD, rather than the proposed 3.0 HPRD standard. Although NASW considers a 3.48 total nursing HPRD minimum standard an improvement over the proposed 3.0 HPRD requirement, no clinical evidence supports a 3.48 HPRD as adequate to maintain resident safety and health.
- Proposing a minimum standard of 4.2 total nursing HPRD (including 0.75 RN HPRD, 1.4 licensed nursing hours, and 2.8 CNA HPRD) is financially feasible. A recent nursing home industry study found that 25 percent of nursing homes met a minimum standard of 4.1 total nursing HPRD, 31 percent met the 0.75 RN HPRD threshold, 85 percent met the 0.65 LPN–LVN HPRD threshold, and 11 percent met the 2.8 HPRD CNA threshold.³⁹ These figures illustrate that meeting the standard is possible. Another study estimated that achieving the proposed federal minimums across nursing homes nationwide would cost an additional \$7.25 billion annually, or only 4.2 percent of overall federal nursing home spending—a cost of approximately \$16 per resident per day.⁴⁰

Implementation of the proposed rule with NASW’s suggested changes would increase the likelihood that facilities reach the goal identified in the 2001 CMS–Abt study: to meet the requirements of OBRA ’87 by identifying “staffing thresholds below which quality of care was compromised and above which there was no further benefit of additional staffing concerning quality.”⁴¹

B. Registered Nurse (§ 483.35(B)(1))

Nursing homes care for residents with complex medical issues, necessitating the expertise of an RN,⁴² and higher levels of RN care are associated with better health outcomes for residents.⁴³ NASW strongly supports CMS’s proposal to require the presence of an RN in every nursing home 24 hours per day,

³⁸ Nursing Home Compare. (2022, May, & 2019, March). *Nursing homes including rehab services archived data snapshots* [Provider files]. Centers for Medicare & Medicaid Services. <https://data.cms.gov/provider-data/archived-data/nursing-homes>

³⁹ CliftonLarsonAllen Wealth Advisors, LLC. (2022). Staffing mandate analysis: In-depth analysis on minimum nurse staffing levels and local impact. <https://www.ahcancal.org/News-and-Communications/Fact-Sheets/FactSheets/CLA-Staffing-Mandate-Analysis.pdf>

⁴⁰ Hawk, T., White, E. M., Bishnoi, C., Schwartz, L. B., Baier, R. R., & Gifford, D. R. (2022). Facility characteristics and costs associated with meeting proposed minimum staffing levels in nursing homes. *Journal of the American Geriatrics Society*, 70(4), 1198–1207. <https://doi.org/10.1111/jgs.17678>

⁴¹ Centers for Medicare & Medicaid Services, Abt Associates Inc. (2001) *Appropriateness of minimum nurse staffing ratios in nursing homes. Report to Congress: Phase II final, Volumes I–III*. Baltimore, MD: CMS. [Quote is from p. 5.]

⁴² Harrington, C., Dellefield, M. E., Halifax, E., Fleming, M. L., & Bakerjian, D. (2020). Appropriate nurse staffing levels for U.S. nursing homes. *Health Services Insights*, 13, 1178632920934785 (eCollection). <https://doi.org/10.1177/1178632920934785>

⁴³ Dellefield, M. E., Castle, N. G., McGilton, K. S., & Spilsbury, K. (2015). The relationship between registered nurses and nursing home quality: An integrative review (2008–2014). *Nursing Economic\$,* 33(2), 95–108, 116. <https://www.proquest.com/docview/1674728394/4A87F4114BDB4C4EPQ/1>

seven days per week. We also appreciate CMS use of research literature to support this proposed requirement; this 24-hour, seven-day recommendation has been promulgated by researchers and organizations for many years.^{44,45,46,47,48} We recommend that CMS strengthen this proposed requirement in the following manner:

- Change the proposed regulatory language to read, “... the facility must have a registered nurse on site 24 hours per day, for 7 days a week that *is providing* direct resident care” instead of “... *is available to provide* direct resident care.”
- Reinforce that a direct care RN must be physically present in each nursing home at all times, not off site or on call.
- Clarify that the 24–7 RN staffing requirement excludes (or is in addition to) the director of nursing (DON) and other administrative nurses, such as assistant DONs and nurses responsible for completing Minimum Data Set assessments. (It is worth noting that under federal regulations, the DON may also serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents (§483.35(b)(3).) NASW also recommends that this section be amended to require a separate DON in all facilities, regardless of size. No evidence supports decreasing licensed staffing requirements for facilities with fewer than 60 beds; even a small nursing home with fewer than 30 residents should have both a DON and a direct care RN on site 24 hours per day, seven days per week.
- Eliminate the waiver provision for RN and licensed nurse staffing. Every nursing home resident deserves to have access to RNs and other licensed nurses at all times. We offer additional comments on CMS’s proposed waivers in a subsequent section.

Section II.B.2: Administration (§ 483.70)

NASW appreciates CMS’s consideration of potential unintended consequences associated with the NPRM. The NPRM sets a minimum nursing staffing standard; it does not create a ceiling on staffing or impose a “one-size-fits-all” solution. Furthermore, the NPRM does nothing to change the ethical and legal obligations to provide resident-centered care. OBRA ‘87 requires all nursing homes to provide “nursing services and specialized rehabilitative services to attain or maintain the highest practicable

⁴⁴ Harrington, C., Kovner, C., Mezey, M., Kayser-Jones, J., Burger, S., Mohler, M., Burke, B., & Zimmerman, D. (2000). Experts recommend minimum nurse staffing standards for nursing facilities in the U.S. *The Gerontologist*, 40(1), 5–16. <https://doi.org/10.1093/geront/40.1.5>

⁴⁵ Institute of Medicine. (2004). *Keeping patients safe: Transforming the work environment of nurses*. The National Academies Press. <https://doi.org/10.17226/10851>

⁴⁶ American Nurses Association. (2014). *Nursing staffing requirements to meet the demands of today’s long term care consumer: Recommendations from the Coalition of Geriatric Nursing Organizations (CGNO)* [CGNO position statement endorsed by ANA]. <https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/id/nursing-staffing-requirements-to-meet-the-demands-of-todays-long-term-care-consumer/>

⁴⁷ Kolanowski, A., Cortes, T. A., Mueller, C., Bowers, B., Boltz, B., Bakerjian, D., Harrington, C., Popejoy, L., Vogelsmeier, A., Wallhagen, M., Fick, D., Batchelor, M., Harris, M., Palan-Lopez, R., Dellefield, M., Mayo, A., Woods, D. L., Horgas, A., Cacchione, P. Z., ... Gerdner, L. (2021). A call to the CMS: Mandate adequate professional nurse staffing in nursing homes. *American Journal of Nursing*, 121(3), 24–27. <https://doi.org/10.1097/01.NAJ.0000737292.96068.18>

⁴⁸ National Academies of Sciences, Engineering, and Medicine. (2022). *The national imperative to improve nursing home quality: Honoring our commitment to residents, families, and staff*. The National Academies Press. <https://doi.org/10.17226/26526>

physical, mental, and psychosocial well-being of each resident.”⁴⁹ Facilities with a higher acuity case mix would still be required to staff at a level appropriate to meet the needs of those residents. Thus, a minimum staffing standard sets a floor for care, not a ceiling.

Section II.B.3: Hardship Exemption from the Minimum HPRD Requirements for RNs and CNAs

As the NPRM makes clear, a minimum nurse staffing requirement is necessary to safeguard both residents (through improving care quality) and direct care nursing staff (by reducing physical risk, emotional stress, and burnout). Therefore, NASW strongly discourages CMS from granting hardship exemptions (also known as waivers) based on payer or geographic location. A nursing home resident in a rural or underserved area has the same right to high-quality care as one in an urban or well-served area.

No evidence supports the idea that rural nursing homes are not able to meet the same standards as urban facilities. Findings from the 2023 Abt Associates study conducted for CMS do not support the assumption that staffing for rural facilities is scarcer than for urban facilities.⁵⁰ The study determined that on average, staffing in rural settings was very similar to urban settings. Indeed, CNA staffing was on average slightly higher in rural settings than in urban settings, and RN and LPN–LVN staffing in rural settings were only slightly lower in rural settings than in urban settings (a difference of 0.03 RN HPRD lower and LPN–LVN 0.11 HPRD). The report concluded: “Differences in staffing levels by urbanicity are not large, with average staffing levels slightly higher for nursing homes in an urban location (3.80 HPRD) than for nursing homes in a rural location (3.66 HPRD).”⁵¹

NASW appreciates the NPRM’s stipulation of four criteria that must be met before CMS would grant a hardship exemption from the minimum HPRD requirements for RNs and CNAs. However, granting exemptions from minimum nurse staffing levels would threaten the health and well-being of residents. Moreover, exemptions are contrary to workforce issues CMS has recognized as critical: enhancing the safety of working environments, improving wages and benefits, and decreasing turnover rates. Thus, NASW opposes the use of exemptions for facilities unable to meet minimum nurse staffing requirements. When a nursing home does not meet the minimum nurse staffing standards, CMS should halt payment to the facility for new admissions until CMS determines that the standards are met in an ongoing fashion.

Should CMS decide to proceed with exemptions, those waivers should be limited in number and frequency. NASW strongly recommends that CMS apply the following additional criteria to exemptions:

⁴⁹ Omnibus Budget Reconciliation Act, 42 U.S.C. §§ 1395i-3, 1396r (1987).

⁵⁰ Abt Associates. (2023). *Nursing home staffing study: Comprehensive report* [Prepared for the Centers for Medicare & Medicaid Services]. <https://www.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf>

⁵¹ Please refer to footnote 50 (Abt Associates, 2023). Quote is from p. 46; preceding data are from Exhibit 4-2.

a. A nursing home should only be granted an exemption if it meets three conditions:

- The facility has demonstrated clearly identifiable progress on nursing staffing, including documentation of increased wages (specifically, that the facility has offered what constitutes a living wage for the community served) and reduced nurse staffing turnover.
- The facility’s staffing plans demonstrate consideration of nationally recognized best practices, such as PHI’s *5 Pillars of Direct Care Job Quality*.⁵²
- The facility has provided evidence related to best practices beyond offering prevailing wages. For example, implementation steps could include enhancing benefits, expanding training programs, conducting worker surveys to inform workplace improvements, improving scheduling policies, and participating in job fairs and partnerships with schools. Requiring execution of workforce strategies in addition to recruitment documentation sets a higher bar for nursing homes to demonstrate they have made every effort to hire and retain staff.

b. Any facility granted an exemption should be under more intense scrutiny. For example, survey frequency should be increased, and CMS and state survey agencies could appoint an independent entity to monitor the facility’s performance.

c. Any exemption that is granted should be prominently displayed on the Nursing Home Compare website, along with a warning about the possible consequences of nursing understaffing. NASW recommends that CMS require a similar notice to be posted in the nursing home and provided to any individual seeking admission to the facility.

Section II.B.4: Implementation Timeframe

The implementation and enforcement of a nurse minimum staffing standard is vital both to the biopsychosocial well-being of nursing home residents and to the safety and well-being of staff. Therefore, NASW urges CMS to implement minimum nursing staffing standards as expeditiously as possible. Specifically, we urge CMS to implement all nurse staffing requirements within two years of the final rule and on the same timeline, regardless of geographic area. (Please refer to our preceding comments regarding rural areas.) We oppose CMS’s proposed phase-in of three to seven years. Such a long phase-in would benefit facility owners and operators at the expense of residents and staff. As noted previously, NASW believes that when a nursing home is unable to meet the minimum nurse staffing standards, a hold on payment for new admissions should be placed until the problem is remedied.

Additionally, NASW encourages CMS to achieve the two-year phase-in by establishing reasonable benchmarks for each year. Such an approach would promote the realization of safety and quality more quickly for residents while discouraging last-minute hiring practices by facilities.

⁵² PHI. (2020). *The 5 pillars of direct care job quality*. <https://www.phinational.org/resource/the-5-pillars-of-direct-care-job-quality/>

Section III: Medicaid Institutional Payment Transparency Reporting Provisions (§§ 483.72 and 442.43)

NASW applauds CMS for seeking to increase the transparency of Medicaid reimbursement to nursing homes. Yet, we believe facilities should be required to show how much of their total revenue goes to resident care. Specifically, reporting requirements should include both the percentage of revenue spent on direct care workers and support staff as well as median hourly wages for each category of employee. Further, the data should be disaggregated by job duty, given that wages for different types of direct care workers and support staff vary substantially; posting broad categorical percentages or median hourly wages for a range of job classifications does not provide transparency as to how each type of worker is compensated.

Moreover, NASW strongly urges CMS to implement the Medicaid transparency recommendations of the 2023 Medicaid and CHIP Payment and Access Commission.⁵³ As stated in our April 2023 comments on the nursing home ownership NPRM,⁵⁴ NASW also believes that nursing homes should be required to detail other expenses, including any payments to related parties.⁵⁵ A strong nurse minimum staffing standard and greater financial transparency in the sector are prerequisites to any discussion of increased Medicaid reimbursement for nursing homes.

Lastly, NASW urges CMS to adopt changes in Medicare financial transparency and accountability—requirements not addressed in the current NPRM. Again, we refer CMS to our April 2023 comments on ownership transparency for more specific recommendations.

Additional Feedback: Social Work Staffing Standards

As the preceding comments illustrate, NASW upholds the importance of interdisciplinary care, including care provided by CNAs, LPNs–LVNs, and RNs. We simultaneously urge CMS to conduct research and engage in rulemaking to enhance social work staffing in nursing homes. Our remaining comments address this topic. (We have used the term “social work” in this paragraph intentionally to refer to professional services provided by an individual with a baccalaureate [hereafter, “BSW”], master’s [hereafter, “MSW”], or doctoral [hereafter, “DSW–PhD”] in social work. Throughout the remainder of this section, we use the term “social service” in contexts that are not *specific to* a BSW, MSW, or DSW–PhD or to the work done by these individuals.)

⁵³ Medicaid and CHIP Payment and Access Commission (MACPAC). (2023). Principles for assessing Medicaid nursing facility payment policies. In MACPAC, *March 2023 Report to Congress on Medicaid and CHIP* (pp. 27–60). <https://www.macpac.gov/wp-content/uploads/2023/03/Chapter-2-Principles-for-Assessing-Medicaid-Nursing-Facility-Payment-Policies.pdf>

⁵⁴ Medicare and Medicaid Programs; Disclosures of Ownership and Additional Disclosable Parties Information for Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs), 88 Fed. Reg. 9820 (proposed Feb. 15, 2023) (to be codified at 42 C.F.R. pts. 424, 455).

⁵⁵ Bedney, B. (2023, April 14). *NASW comments to the Centers for Medicare & Medicaid Services regarding a proposed rule addressing disclosures of ownership and additional disclosable parties information for skilled nursing facilities and nursing facilities (CMS–6084–P)*. National Association of Social Workers. https://bit.ly/NASW_nursing-home-ownership_comments_2023

The social work role includes multiple responsibilities essential to meeting federal requirements for LTC facilities:

- promoting quality of life (§ 483.24) and quality of care (§ 483.25) 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, culturally competent, trauma-informed 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)

The nursing home social work role also involves collaboration with and support for family members, recognizing and upholding each resident’s definition of “family.”

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,⁵⁶ 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 States⁵⁷—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:

⁵⁶ The White House. (2022). *Fact sheet: Protecting seniors by improving safety and quality of care in the nation’s nursing homes*. <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/>

⁵⁷ Bern-Klug, M., Carter, K. A., & Wang, Y. (2021). More evidence that federal regulations perpetuate unrealistic nursing home social services staffing ratios. *Journal of Gerontological Social Work*, 64(7), 811–831. <https://doi.org/10.1080/01634372.2021.1937432>

- 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.⁵⁸ 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.⁵⁹
- Similarly, two nongovernmental studies indicated that large social service caseloads were associated with survey inspection deficiencies in psychosocial care.^{60,61}
- 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—discipline⁶²

The study concluded, “Nursing homes interested in improving quality in the most cost-effective manner should consider increasing the level of social service staffing.”⁶³
- 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.⁶⁴ This study yielded other important findings:

⁵⁸ Office of the Inspector General. (2003). *Psychosocial services in skilled nursing facilities* (OEI-02-01-00610). U.S. Department of Health and Human Services. <https://oig.hhs.gov/oei/reports/oei-02-01-00610.pdf>

⁵⁹ Office of the Inspector General. (2013). *Medicare nursing home resident hospitalization rates merit additional monitoring* (OEI-06-11-00040). U.S. Department of Health and Human Services. <https://oig.hhs.gov/oei/reports/oei-06-11-00040.asp>

⁶⁰ Bonifas, R. P. (2008–2009). Nursing home work environment characteristics: Associated outcomes in psychosocial care. *Health Care Financing Review*, 30(2), 19–33. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/downloads/08Winterpg19.pdf>

⁶¹ Zhang, N. J., Gammonley, G., Paek, S. C., & Frahm, K. (2008–2009). Facility service environments, staffing, and psychosocial care in nursing homes. *Health Care Financing Review*, 30(2), 5–17. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/downloads/08Winterpg5.pdf>

⁶² Restorick Roberts, A., Smith, A. C., & Bowblis, J. R. (2019). *Impact of social service staffing on nursing home quality and resident outcomes [Research brief]*. Scripps Gerontology Center, Miami University. <http://bit.ly/2sUcApp>

⁶³ Please refer to footnote 62 (Restorick Roberts et al., 2019). Quote is from p. 2.

⁶⁴ Bern-Klug, M., Carter, K. A., & Wang, Y. (2021). More evidence that federal regulations perpetuate unrealistic nursing home social services staffing ratios. *Journal of Gerontological Social Work*, 64(7), 811–831. <https://doi.org/10.1080/01634372.2021.1937432>

- 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.”⁶⁵
- Social service directors’ self-reported barriers to psychosocial care decreased as the number of social service staff members increased.⁶⁶ 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.”⁶⁷

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 (as defined in the subsequent section on qualifications). 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 facilities⁶⁸ (and supported by NASW⁶⁹) but excluded from the 2016 final rule.⁷⁰

NASW also encourages CMS to require enhanced 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

⁶⁵ Wang, X., Simons, K., Gammonley, D., Restorick Roberts, A., & Bern-Klug, M. (2021). Social service directors’ roles and self-efficacy in suicide risk management in US nursing homes. *Journal of Gerontological Social Work*, 64(7), 791–810. <https://doi.org/10.1080/01634372.2021.1936331> [Quote is from p. 791]

⁶⁶ Restorick Roberts, A., Smith, K., Bern-Klug, M., & Hector, P. (2021). Barriers to psychosocial care in nursing homes as reported by social services directors. *Journal of Gerontological Social Work*, 64(7), 832–850. <https://doi.org/10.1080/01634372.2021.1937766>

⁶⁷ Please refer to footnote 65 (Wang et al., 2021). Quote is from p. 791

⁶⁸ Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, 80 Fed. Reg. 42168 (proposed July 6, 2015) (to be codified at 42 C.F.R. pts. 405, 431, 447, 482, 483, 485, 488).

⁶⁹ McClain, A. (2015, October 14). *NASW comments to the Centers for Medicare & Medicaid Services regarding a proposed rule addressing reform of requirements for long-term care facilities (CMS-3260-P)*. National Association of Social Workers. <https://bit.ly/NASW-LTC-comments-2015>

⁷⁰ Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, 81 Fed. Reg. 68688 (Oct. 4, 2016) (to be codified at 42 C.F.R. pts. 405, 431, 447, 482, 483, 485, 488, 489).

protections^{71,72} 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.⁷³ 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 and social service staff, 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.⁷⁴ These findings are consistent with data from a similar nationally representative study of social service directors conducted in 2006.⁷⁵ Furthermore, the National Consumer Voice for Quality Long-Term Care proposed to CMS in 2012⁷⁶ and 2015⁷⁷ 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:

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- ⁷¹ Centers for Medicare & Medicaid Services. (2021). *Jimmo settlement*. <https://www.cms.gov/Center/Special-Topic/Jimmo-Center>
- ⁷² Center for Medicare Advocacy. (2022). *Jimmo update: CMS reminds providers and contractors of Medicare coverage to maintain or slow decline*. <https://medicareadvocacy.org/jimmo-update-cms-reminds-providers-and-contractors-of-medicare-coverage-to-maintain-or-slow-decline/>
- ⁷³ Restorick Roberts, A., Smith, K., Bern-Klug, M., & Hector, P. (2021). Barriers to psychosocial care in nursing homes as reported by social services directors. *Journal of Gerontological Social Work*, 64(7), 832–850. <https://doi.org/10.1080/01634372.2021.1937766>
- ⁷⁴ Bern-Klug, M., Smith, K. M., Restorick Roberts, A., Kusmaul, N., Gammonley, D., Hector, P., Simons, K., Galambos, C., Bonifas, R. P., Herman, C., Downes, D., Munn, J. C., Rudderham, G., Cordes, E. A., & Connolly, R. (2021). About a third of nursing home social services directors have earned a social work degree and license. *Journal of Gerontological Social Work*, 64(7), 699–720. <https://doi.org/10.1080/01634372.2021.1891594>
- ⁷⁵ Bern-Klug, M., Kramer, K. W. O., Sharr, P., & Cruz, I. (2010). Nursing home social services directors' opinions about the number of residents they can serve. *Journal of Aging & Social Policy*, 22(1), 33–52. <https://doi.org/10.1080/08959420903396426>
- ⁷⁶ Wells, S., & Grant, R. (2012, July 16). *The Consumer Voice comments to the Centers for Medicare & Medicaid Services regarding the conditions of participation for long-term care facilities, pursuant to executive orders 13563 and 13610* [Letter]. National Consumer Voice for Quality Long-Term Care. <https://theconsumervoice.org/uploads/files/issues/Consumer-Voice-Recommendations-Requirements-of-Participation.pdf>
- ⁷⁷ Smetanka, L., & Grant, R. (2015, October 14). *The Consumer Voice comments to the Centers for Medicare & Medicaid Services regarding a proposed rule addressing reform of requirements for long-term care facilities (CMS-3260-P)* [Letter]. National Consumer Voice for Quality Long-Term Care. http://theconsumervoice.org/uploads/files/issues/CV_comments_-proposed_nursing_home_rules_10-14-15_final.pdf

- 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 practice⁷⁸) to provide incentives for paraprofessional social service staff to obtain a BSW or MSW. Other disciplines, such as CNAs and activities staff, may also be interested in pursuing social work degrees.
- 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 and coalitions, such as those affiliated with the American Health Care Association, LeadingAge, and the Pioneer Network, to recruit BSWs and MSWs.
- Foster partnerships among state organizations, 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^{79,80}

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 reported they were the only social worker employed in their organization.

⁷⁸ Council on Social Work Education. (n.d.) *Accreditation: Directory*. Retrieved October 20, 2023, from <https://www.cswe.org/accreditation/directory>

⁷⁹ Liu, J., & Bern-Klug, M. (2013). Nursing home social services directors who report thriving at work. *Journal of Gerontological Social Work*, 56(2), 127–145. <https://doi.org/10.1080/01634372.2012.750255>

⁸⁰ Simons, K. V., & Jankowski, T. B. (2008). Factors influencing nursing home social workers' intentions to quit employment. *Administration in Social Work*, 32(1), 5–21. https://doi.org/10.1300/J147v32n01_02

- 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.⁸¹

Furthermore, NASW recognizes that the federal government could play a more active role in attracting social workers to nursing facility 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,⁸² could encourage CNAs, paraprofessional social service staff, and others to obtain a BSW or MSW. 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.”⁸³ 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* (which are currently being revised), 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.⁸⁴

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

⁸¹ Whitaker, T., Weismiller, T., & Clark, E. (2006). *Assuring the sufficiency of a frontline workforce: A national study of licensed social workers. Special report: Social work services for older adults*. National Association of Social Workers. <https://www.socialworkers.org/LinkClick.aspx?fileticket=Rlc1kLerL3c%3d&portalid=0>

⁸² National Association of Social Workers. (n.d.). *Student loan debt relief for social workers*. Retrieved October 20, 2023, from <https://www.socialworkers.org/Advocacy/Policy-Issues/Student-Loan-Forgiveness>

⁸³ NASW Press. (2021). Long-term services and supports. In *Social work speaks: National Association of Social Workers policy statements* (12th ed., pp. 350–360). [Quote is from p. 355.]

⁸⁴ National Association of Social Workers. (2003). *NASW standards for social work services in long-term care facilities*. <https://bit.ly/NASW-LTC-standards-2003>

- Demonstrate ethical and professional behavior
- Advance human rights and social, racial, economic, and environmental justice
- Engage anti-racism, diversity, equity, and inclusion (ADEI) in practice
- 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 communities⁸⁵

These competencies are congruent with the competency-based emphasis of the 2016 final rule reforming requirements for LTC facilities.⁸⁶ 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.⁸⁷ 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.⁸⁸ 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.⁸⁹ 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.^{90,91}

Individuals with a BSW, MSW, or DSW–PhD 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

⁸⁵ Council on Social Work Education. (2022). *2022 educational policy and accreditation standards for baccalaureate and master’s social work programs*. <https://www.cswe.org/getmedia/bb5d8afe-7680-42dc-a332-a6e6103f4998/2022-EPAS.pdf>

⁸⁶ Please refer to footnote 85 (Council on Social Work Education, 2022 standards).

⁸⁷ Council on Social Work Education. (2022, July). *Frequently asked questions (FAQs) | Baccalaureate and master’s accreditation*. <https://www.cswe.org/getmedia/012705e9-9325-4a85-a790-cae16006bd5e/Accreditation-FAQs-7-20-22.pdf>

⁸⁸ Please refer to footnote 85 (Council on Social Work Education, 2022 standards).

⁸⁹ Leedahl, S. N., R. K. Chapin, & Little, T. D. (2015). Multilevel examination of facility characteristics, social integration, and health for older adults living in nursing homes. *Journals of Gerontology, Series B: Psychological Sciences and Social Sciences*, 70(1), 111–122. <https://doi.org/10.1093/geronb/gbu112>

⁹⁰ Bern-Klug, M., Kramer, K. W. O., Chan, G., Kane, R., Dorfman, L. T., Saunders, J. B. (2009). Characteristics of nursing home social services directors: How common is a degree in social work? *JAMDA: The Journal of Post-Acute and Long-Term Care Medicine*, 10(1), 36–44. <https://doi.org/10.1016/j.jamda.2008.06.011>

⁹¹ Simons, K., Bern-Klug, M., & An, S. (2012). Envisioning quality psychosocial care in nursing homes: The role of social work. *JAMDA: The Journal of Post-Acute and Long-Term care Medicine*, 13(9), 800–805. <https://doi.org/10.1016/j.jamda.2012.07.016>

- 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^{92,93,94,95}

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^{96,97} 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.⁹⁸ 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.⁹⁹
- The same study found that BSWs and MSWs report self-efficacy in training a colleague on how to report suspected elder abuse.¹⁰⁰
- Degreed social workers play significant roles in assessing for and intervening to address the widespread problem of resident-to-resident aggression in nursing homes.¹⁰¹
- 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

⁹² National Association of Social Workers. (2003). *NASW standards for social work services in long-term care facilities*. <https://bit.ly/NASW-LTC-standards-2003>

⁹³ National Academies of Sciences, Engineering, and Medicine. (2020). *Social workers and other social care providers play a key role in promoting better health for all: Findings from integrating social care into the delivery of health care: moving upstream to improve the nation's health*. https://www.nap.edu/resource/25467/Social_Care_Social%20Workers%20and%20Social%20Care%20Providers%20FINAL_06092020.pdf

⁹⁴ Greene, R. R., Dubus, N. M., Wright, M. A., Cole, T. S., Cohen, H. L., & Greene, N. A. (2021). *Social work practice with older adults: A resilience-enhancing guide*. NASW Press.

⁹⁵ Greene, R. R., & Dubus, N. (2017). *Resilience in action: An information and practice guide*. NASW Press.

⁹⁶ Simons, K., Connolly, R. P., Bonifas, R., Bailey, K., Downes, D., & Galambos, C. (2011). Psychosocial assessment of nursing home residents via MDS 3.0: Recommendations for social service training, staffing, and roles in interdisciplinary care. *JAMDA: The Journal of Post-Acute and Long-Term Care Medicine*, 13(2), 190.e9–190.e15. <https://doi.org/10.1016/j.jamda.2011.07.005>

⁹⁷ Zimmerman, S., Connolly, R., Zlotnik, J. L., Bern-Klug, M., & Cohen, L. W. (2012). Psychosocial care in nursing homes in the era of the MDS 3.0: Perspectives of the experts. *Journal of Gerontological Social Work*, 55(5), 444–461. <https://doi.org/10.1080/01634372.2012.667525>

⁹⁸ Bern-Klug, M., Smith, K. M., Restorick Roberts, A., Kusmaul, N., Gammonley, D., Hector, P., Simons, K., Galambos, C., Bonifas, R. P., Herman, C., Downes, D., Munn, J. C., Rudderham, G., Cordes, E. A., & Connolly, R. (2021). About a third of nursing home social services directors have earned a social work degree and license. *Journal of Gerontological Social Work*, 64(7), 699–720. <https://doi.org/10.1080/01634372.2021.1891594>

⁹⁹ Bern-Klug, M., Kramer, K. W. O., Sharr, P., & Cruz, I. (2010). Nursing home social services directors' opinions about the number of residents they can serve. *Journal of Aging & Social Policy*, 22(1), 33–52. <https://doi.org/10.1080/08959420903396426>

¹⁰⁰ Bern-Klug, M., & Sabri, B. (2012). Nursing home social services directors and elder abuse staff training. *Journal of Gerontological Social Work*, 55(1), 5–20. <https://doi.org/10.1080/01634372.2011.626016>

¹⁰¹ Bonifas, R. P. (2015). Resident-to-resident aggression in nursing homes: Social worker involvement and collaboration with nursing colleagues. *Health & Social Work*, 40(3), e101–e109. <https://doi.org/10.1093/hsw/hlv040>

licensed MSWs) to assist residents and significant others with advance care planning.^{102,103,104} The model was associated with reductions in hospitalization- and emergency department-related utilization and expenditures.¹⁰⁵

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.)

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).¹⁰⁶ 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, MSW, or DSW–PhD. 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.

Resident 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 Medicare 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

¹⁰² Rantz, M. J., Alexander, G., Galambos, C., Vogelsmeier, A., Popejoy, L., Flesner, M., Lueckenotte, A., Crecelius, C., Zwygart-Stauffacher, M., & Koopman, R. J. (2014). Initiative to test a multidisciplinary model with advanced practice nurses to reduce avoidable hospitalizations among nursing facility residents. *Journal of Nursing Care Quality*, 29(1), 1–8. <https://doi.org/10.1097/NCQ.0000000000000033>

¹⁰³ Rantz, M. J., Flesner, M. K., Franklin, J., Galambos, C., Pudlowski, J., Pritchett, A., Alexander, G., & Lueckenotte, A. (2015). Better care, better quality: Reducing avoidable hospitalizations of nursing home residents. *Journal of Nursing Care Quality*, 30(4), 290–297. <https://doi.org/10.1097/NCQ.0000000000000145>

¹⁰⁴ Galambos, C., Starr, J., Rantz, M. J., & Petroski, G. F. (2016). Analysis of advance directive documentation to support palliative care activities in nursing homes. *Health & Social Work*, 41(4), 228–234. <https://doi.org/10.1093/hsw/hlw042>

¹⁰⁵ Ingber, M. J., Feng, Z., Khatutsky, G., Baker, R., Bercaw, L., Coomer, N., Coots, L., DiBello, J., Eng, T., Ferrell, A., Husick, C. B., Jones, J. M., Kafali, E. N., Kaganova, Y., Knowles, M., Lyda-McDonald, B., Ormond, C., Porter, K. A., ... Zoromski, P. (2017). *Evaluation of the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents: Final report* (RTI Project Number 0212790.006.004.012, submitted by RTI International to the Centers for Medicare & Medicaid Services). U.S. Department of Health and Human Services. <https://downloads.cms.gov/files/cmmti/irahnfr-finalevalrpt.pdf>

¹⁰⁶ Simons, K., Bern-Klug, M., & An, S. (2012). Envisioning quality psychosocial care in nursing homes: The role of social work. *JAMDA: The Journal of Post-Acute and Long-Term Care Medicine*, 13(9), 800–805. <https://doi.org/10.1016/j.jamda.2012.07.016>

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**.¹⁰⁷

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 bbedney.nasw@socialworkers.org if you need additional information or have any questions.

Sincerely,

Barbara Bedney, PhD, MSW

Barbara Bedney, PhD, MSW
Chief of Programs

¹⁰⁷ National Academies of Sciences, Engineering, and Medicine. (2022). *The national imperative to improve nursing home quality: Honoring our commitment to residents, families, and staff*. National Academies Press.
<https://doi.org/10.17226/26526> [Quote is from p. 512]