The NEW ENGLAND JOURNAL of MEDICINE

Perspective

NOVEMBER 2, 2023

Minimum-Staffing Rules for U.S. Nursing Homes — Opportunities and Challenges

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U.S. nursing homes have faced staffing challenges for decades.[1] Registered nurses (RNs), licensed practical nurses (LPNs), and certified nurse aides (CNAs) are the primary caregivers in nursing homes. RNs and LPNs focus on the clinical tasks of resident assessment, treatment, and medication management, while CNAs provide the bulk of the hands-on care, such as assistance with eating, bathing, toileting, and dressing.

A recent report from the National Academies of Sciences, Engineering, and Medicine (NASEM) called for the establishment of a federal minimum standard for nurse staffing, among other reforms.[1] Although federal law currently requires nursing homes to have sufficient staff to ensure the safety and well-being of each resident, federal regulations do not define a minimum level of nursing staff, other than requiring that an RN or LPN be on site at all times. Nursing homes therefore currently have considerable flexibility in determining their staffing levels.

In September 2023, the Centers for Medicare and Medicaid Services (CMS) released a proposed rule mandating a specific minimum-staffing standard for U.S. nursing homes. It calls for 0.55 RN hours per resident day (HPRD) and 2.45 CNA HPRD but does not make any stipulation about LPN HPRD. The rule also calls for having an RN on site at all times, which would replace the current rule that an RN or LPN always be on site. To help nursing homes attract new workers, the rule provides $75 million in funding for staff training. In recognition of labor shortages in certain markets, nursing homes would be exempt from the staffing requirements if they can meet certain criteria and show good faith efforts to hire and retain staff, which includes demonstrating a financial commitment to staffing by documenting expenditures on nursing staff relative to revenue.

To give nursing homes time to adjust to the new rule, CMS proposed a delayed implementation. Urban nursing homes would be required to always have an RN on site 2 years after the publication date of the final rule, whereas rural nursing homes would have to meet this requirement in 3 years. Similarly, urban facilities would have to comply with the 0.55 and 2.45 HPRD requirements in 3 years, whereas rural facilities would have to comply in 5 years.

Discussions about a possible minimum-staffing rule date back at least to the 1980s. Over the years, nursing homes have vigorously resisted such a policy, while advocates have pushed heavily for it. This new rule has not been met favorably by either group: nursing homes have questioned how they will find enough staff and pay for the additional staff required, while advocates believe the policy is too weak.

CMS has asked for comments on the proposed rule, and we have a number of ideas for building on the rule's strengths while addressing shortcomings and minimizing unintended consequences.

Any standard for nursing staff must be broad in order to minimize potential unintended consequences, such as substantial reductions in LPN staffing levels.

First, the total level of nursing staff should be addressed. The proposed requirements would increase staffing levels for RNs and CNAs in many nursing homes. Using CMS's Payroll-Based Journal data from the first quarter of 2023, we estimated that roughly 51% of U.S. nursing homes would be in compliance with the RN requirement, and 28% would be in compliance with the CNA requirement, although the proportions vary by state (see table). As the proposed rule stands,[2] there would be nothing stopping a nursing home from staffing exactly at the 3.00 HPRD level — indeed, past research has revealed that some facilities respond to such regulations in that way[2] — though for some facilities, that level might not be high enough to ensure resident safety and well-being. CMS indicates in the proposed rule that it is also considering an overall minimum of 3.48 HPRD to accompany the specific RN and CNA requirements. Although some advocates would argue for an even higher minimum, we would recommend that CMS include some minimum total threshold for nursing staff as part of the new rule. Payroll-Based Journal data from the first quarter of 2023 show that 43% of nursing homes would need to increase their staff to meet a 3.48 HPRD threshold, but some states would be more affected than others (e.g., 72% of nursing homes in Texas vs. 2% in Delaware and Oregon).

Second, the proposed staffing regulations make no mention of LPNs. In the first quarter of 2023, the average U.S. nursing home employed LPNs at a level of 0.89 HPRD and licensed nurses (RNs and LPNs combined) at a level of 1.15 HPRD. The hope is that with the new rule, nursing homes will increase their use of RNs while continuing to employ LPNs at their current level, but the more likely result will be the substitution of CNAs in place of LPNs. In other words, nursing homes may staff RNs to the bare minimum of 0.55 HPRD and fill the remaining care team with CNAs. This type of substitution has happened under state minimum-staffing standards, as has a reduced use of ancillary service staff (e.g., housekeeping), who are not included in these policies.[3,4] Any standard for nursing staff must be broad in order to minimize potential unintended consequences, such as substantial reductions in LPN staffing levels.

Third, if certain facilities are exempted from the staffing requirements because they face hiring difficulties, they risk being insufficiently staffed. If nursing homes truly cannot attract staff at the prevailing market wage level and existing government payment rates, some sort of payment reform is in order. For example, CMS could increase government payments and require them to be spent on higher wages (a "wage pass-through" policy). Or it could revise federal rules for Medicaid payment systems, which may currently pay nursing homes less than their estimated costs, according to a recent government report.[1,5]

Fourth, aspects of the rule could be implemented faster. There is no reason to wait 3 to 5 years to implement parts of the proposed rule, especially in states where most nursing homes are already in compliance with it. Any staffing challenges present today will most likely still be present in 3 to 5 years. In view of the $75 million outlay for the training of new workers, we would recommend giving facilities a shorter period to prepare, or phasing in some aspects of the rule gradually.

Fifth, levels of nursing staff are a symptom, rather than the root cause of the problem. Staffing levels are a function of a broader set of system-level challenges related to how the United States pays for and regulates nursing home care. Addressing

Proportion of Nursing Homes Meeting Proposed Thresholds for Nursing Staff by State.*

State	Proposed Threshold				Sample
	0.55 RN HPRD	2.45 CNA HPRD	0.55 RN and 2.45 CNA HPRD	3.48 Total Nursing Staff HPRD	
	% of nursing homes meeting threshold				*no. of nursing homes assessed*
National	51	28	19	57	14,607
AK	100	100	100	100	13
AL	47	44	20	65	220
AR	9	44	5	70	215
AZ	60	26	21	61	141
CA	31	55	21	90	1,139
CO	81	26	23	56	210
CT	67	17	16	57	201
DC	100	53	53	88	17
DE	93	14	14	98	42
FL	56	27	20	75	688
GA	23	15	7	36	352
HI	100	54	54	83	41
IA	73	36	28	56	402
ID	84	34	30	84	79
IL	59	17	15	40	685
IN	53	20	11	53	513
KS	69	52	42	72	298
KY	62	29	20	67	268
LA	4	18	1	48	255
MA	63	15	13	64	344
MD	77	19	17	57	219
ME	95	78	75	93	85
MI	68	30	26	65	422
MN	92	44	41	78	342
MO	24	27	11	35	466
MS	48	29	19	72	198
MT	78	41	40	50	58
NC	39	24	14	51	406
ND	96	81	77	89	75
NE	67	53	39	68	178
NH	77	33	30	56	73
NJ	61	20	17	55	347
NM	55	24	15	36	66
NV	61	36	33	66	61
NY	52	17	14	45	597
OH	50	12	10	46	920
OK	10	44	5	58	276
OR	65	97	62	98	125
PA	71	15	14	46	668
RI	92	40	37	56	75
SC	41	27	21	57	186
SD	88	32	31	50	94
TN	41	11	7	57	301
TX	12	10	4	28	1,161
UT	96	33	32	73	98
VA	38	15	13	36	281
VT	73	45	36	85	33
WA	83	57	49	91	190
WI	87	39	38	60	327
WV	64	20	17	47	121
WY	86	37	34	60	35

* The proposed thresholds are the number of hours per resident day (HPRD) required for registered nurses (RNs), certified nurse aides (CNAs), and total nursing staff. The calculations were based on the average level of nursing staff for each nursing home from Payroll-Based Journal data for the first quarter of 2023. A nursing home was included in the sample if it reported staffing data for all days and did not have aberrant nursing-staff levels. Aberrant nursing-staff levels and types of nursing staff were defined according to the Care Compare website. For example, RNs include the director of nursing and RNs assigned to administrative duties and direct care. Total nursing staff includes all nursing staff assigned to administrative duties and direct care.

the staffing problem is just one piece of a bigger puzzle. The entire system needs to be transformed, which will require payment reform and financial transparency, including improvements to the Medicare Cost Reports. The recent NASEM report included a series of recommendations for this broader set of reforms,[1] which it suggested "should be viewed and implemented as an interrelated package." The federal minimum-staffing standards are long overdue, but until the broader payment and accountability issues are addressed, not all nursing homes will consistently deliver high-quality, person-centered, equitable care.

An audio interview with David Grabowski is available at NEJM.org

The Biden administration deserves credit for introducing what is probably the most important nursing home reform in decades. As policymakers work on the final rule, we hope the recommendations above can be incorporated to strengthen the policy. Moreover, we hope this minimum-staffing rule is the start of a bigger set of reforms to transform nursing home care over the coming years.

Disclosure forms provided by the authors are available at NEJM.org.

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This article was published on October 28, 2023, at NEJM.org.

1. National Academies of Sciences, Engineering, and Medicine. The national imperative to improve nursing home quality: honoring our commitment to residents, families, and staff. Washington, DC: National Academies Press, 2022.
2. Bowblis JR, Ghattas A. The impact of minimum quality standard regulations on nursing home staffing, quality, and exit decisions. Rev Ind Organ 2017;50:43-68.
3. Chen MM, Grabowski DC. Intended and unintended consequences of minimum staffing standards for nursing homes. Health Econ 2015;24:822-39.
4. Bowblis JR, Hyer K. Nursing home staffing requirements and input substitution: effects on housekeeping, food service, and activities staff. Health Serv Res 2013;48:1539-50.
5. Medicaid and CHIP Payment and Access Commission. Estimates of Medicaid nursing facility payments relative to costs. January 2023 (https://www.macpac.gov/wp-content/uploads/2023/01/Estimates-of-Medicaid-Nursing-Facility-Payments-Relative-to-Costs-1-6-23.pdf).

DOI: 10.1056/NEJMp2310544

Reforming Pharmacy Benefit Managers — A Review of Bipartisan Legislation

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This year, U.S. congressional leaders have been prioritizing legislation to lower prescription drug prices by regulating pharmacy benefit managers (PBMs). PBMs act as pharmaceutical intermediaries, managing prescription drug claims and establishing formularies on behalf of insurers, contracting with networks of pharmacies, and negotiating rebates from drug manufacturers. Through these activities, PBMs directly affect patients' premiums and out-of-pocket costs for drugs. At least six congressional committees have introduced bipartisan PBM reform bills in 2023 (see table); many politicians expect that some of these reforms will receive floor votes by the end of the year. Although the bills address several well-known problems with the PBM industry, we believe they are unlikely to substantially reduce prescription drug spending in the United States.

One of the key roles of PBMs involves controlling prescription drug costs. PBMs help control costs by designing formularies that steer patients toward using lower-priced medications and by negotiating lower costs with drug manufacturers in exchange for offering preferred formulary positions for their products. Rather than negotiating prices directly, PBMs typically arrange confidential rebates that are provided by manufacturers after patients fill prescriptions. The size of these rebates has grown in recent years and varies substantially by drug class: in 2021, for example, average rebates negotiated on behalf of Medicare Part D plans were less than 10% for oncology drugs and more than 50% for diabetes drugs.[1]

Although rebates have tempered increases in prescription drug spending, PBMs sometimes arrange with insurers to either keep a portion of the rebates they negotiate or collect fees that are based on drugs' prices. These