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COMMENTARY

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Nursing home financial transparency and accountability are needed to assure minimum staffing levels

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The article published in this journal by Hawk and colleagues (February 2022)[1] concluded from their review of the literature that changes in staffing levels are strongly associated with improved outcomes for nursing home (NH) residents. They compared actual NH staffing with the Center for Medicare & Medicaid services (CMS) staffing recommendations necessary to prevent harm and jeopardy to residents.[2] They found that 95% of NHs failed to meet all the recommended minimum staffing levels (4.1 total nurse staffing hours per resident day [hprd]), including 0.75 registered nurses (RNs) hprd, 0.55 licensed practical nurses (LPNs) hrpd, and 2.8 certified nursing assistants (CNAs) hrpd. Seventy-five percent of NHs failed to have 4.1 hprd, and 69% did not have 0.75 RN hprd in 2019. In their discussion (p. 7) Hawk and colleagues[1] estimated that the cost to attain the recommended minimum staffing was $7.25 billion based on current wage rates and stated that this cost represents only 4.2% of the $172.2 billion of national NH expenditures in 2019. NHs with higher percentages of Medicaid residents were found to have lower staffing levels. Hawk and colleagues argue that the NH median operating margins of 0.7% indicate inadequate Medicaid funding.[1] They assume that new Medicaid funding is needed for NHs to meet the recommended staffing minimums.[1]

We question the need for additional funding. Hawk and colleagues[1] do not discuss the financial practices of for-profit NHs that result in the failure to fund adequate and appropriate staffing.[3–6] Given these problems, providing additional government funding for NHs, would, alone, not fix the problem of poor staffing.

This commentary discusses (1) the lack of financial transparency and accountability that allows NHs to hide profits and divert funds away from staffing and into related-party organizations, and (2) proposed reforms that would require NHs to dedicate funds for adequate staffing.

LACK OF NH FINANCIAL TRANSPARENCY AND ACCOUNTABILITY

Hawk and colleagues show that for-profit ownership, which represents the most NHs, is strongly associated with not meeting the recommended staffing minimums.[1] Their finding is consistent with previous studies showing low staffing in for-profit homes.[3–6] Many NHs are part of for-profit chains, and a growing number are owned by private equity companies that have been shown to have lower staffing and poorer quality outcomes compared to other NHs.[7,8] The Government Accountability Office (GAO) has reported increased operational and capital costs together with higher profit margins in these private equity facilities.[9]

Complex corporate ownership structures are common practice in for-profit NHs.[10] These corporate structures include the separation of property from operating companies, enabling property companies to charge high rents, and the multiple layers of related-party entities providing services such as management, nursing services and therapy to their own organization often at above market rates. In one example, a NH chain was found to have 430 corporate entities to manage its 228 nursing homes and senior facilities.[3] Such practices protect operating companies from litigation, reduce regulatory oversight, and hide profits, while increasing administrative and management costs at the expense of resident care.[3]

Nursing homes are funded largely by a combination of payments from Medicare and Medicaid.[11] During the pandemic, additional financial relief was afforded to NHs through various sources that included: the suspension of percentage reductions in federal spending (Medicare sequestration), the CARES Act, Federal Medical Assistance Percentage Program and temporary savings put in place that included deferral of payroll taxes, suspension of certain requirements and increases in Medicare and Medicaid reimbursement rates.[3,12] At this point, it is too early to know how the government funds were used during the pandemic.

State Medicaid NH payment policies are generally more restrictive in regards to how funds can be used compared to Medicare funds, and states generally conduct financial audits of individual NH operating companies.[13] The Medicare prospective payment system is based on estimated costs for staffing based on resident acuity and other service costs and is not based on actual expenditures. This system allows nursing homes to keep staffing and operating expenses low in order to maximize profits.[14] Medicare cost report data must be provided for individual facility operating companies,[11] but they are generally not audited, so accountability is limited.[14]

NHs have many ways to make money through hidden profits, by contracting with their own related-party companies (with whom they share ownership) including separate companies that provide management, staffing, therapy, pharmacy, and property leases and real estate companies.[3–6] In 2015, nearly 75% of NHs had related-party business transactions that totaled $11 billion, and these facilities were more likely to have lower staffing and more quality problems.[15]

NHs do not have to provide consolidated cost reports for their entire company and the cost reports do not have be audited by a certified accounting firm prior to submission.[14] As a result of the lack of required financial transparency by the government, it is unknown whether NHs have sufficient funds to pay for higher staffing. Therefore, Hawk and colleagues' assumptions[1] that new federal and state government funding is needed to meet minimum staffing requirements, is not based on evidence. Indeed, given the magnitude of related-party transactions, it seems that NHs could meet higher staffing standards without additional funds.

PROPOSED NURSING HOME REFORMS

In February 2022, President Biden introduced a new initiative to improve the safety and quality of care in the nation's nursing homes that would specifically conduct new research on staffing with plans to issue minimum standards for staffing. As part of this initiative, he proposed new plans to increase both ownership and financial transparency and accountability.[16] In April 2022, the National Academies of Science, Engineering, and Medicine released a new report urging improvements in nursing home quality.[17] As part of its comprehensive report, recommendations are made for research on minimum and optimal staffing levels and regulatory requirements for staffing. In addition, the report recommends increases in the transparency and accountability for finances, operations, and ownership. These efforts highlight the need for reform.

States have also been addressing some of the nursing home staffing and quality issues by introducing new legislative reforms. The lack of financial transparency and accountability could be achieved by:

- Requiring each nursing home to provide an annual consolidated and certified audited financial cost report for the *entire* company, meaning the parent company and all related-party companies, including the management and property companies. Legislation requiring NHs to file annual consolidated financial reports was passed in California (S.B. 650) in 2021.[18]
- Placing a ceiling each year on the combined profits, administrative costs and property costs of each nursing home, its related-parties, and parent companies. Three states (New Jersey, New York, and Massachusetts) have passed such legislation requiring that most expenditures are for direct care services.[19]

In New York, the 2021–2022 budget legislation required that nursing facilities spend 70% of reimbursement on care, with 40% on direct care staff. They also limited profits over 5%.[20] According to a complaint filed against the state by 238 out of 615 nursing homes, these 238 facilities would have had to give up $824 million if the law had been in effect in 2019.[20] In California, proposed Assembly Bill 2079 (2022) has a requirement that 85% of revenues should be allocated to direct resident care (in 2020 only 64% of revenues were used for direct resident care in California).[21] If this bill had been law in 2020, it would have shifted $2.28 billion (21% of $10.85 billion in NH revenues) to direct care services and away from profits, administration, and property.

CONCLUSION

It is common sense that the most essential systemic issue in an environment that cares for vulnerable people is adequate and appropriate staffing to ensure that quality

care is provided. Inadequate staffing affects resident care in two ways: residents do not receive the care they need and therefore suffer harm, and overburdened staff suffer poor working conditions, compassion fatigue and burnout, contributing to high turnover.

Despite understanding this, US NHs have for decades had a pattern of chronic short staffing and high turnover. The recommendation for a minimum total nursing staff of 4.10 hprd and 0.75 RN hprd should be considered a threshold because federal regulations require that staffing must be increased as resident acuity increases to meet the needs of residents.

Hawk and colleagues have clearly identified how few NHs currently meet these minimum standards, and what factors are associated with not meeting them, thereby adding valuable data to understand how low staffing can be resolved.[1] Rather than making further financial investments in an industry whose revenues primarily come from public funding, would it not be important first to hold NHs accountable for the funding they already receive?

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Drafting of the commentary, Elizabeth Halifax; critical revision of the manuscript, both authors.

CONFLICT OF INTEREST

The authors have no conflicts.

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