ADDING INSULT TO INJURY: HOW THE ACA'S "FIX" FOR NURSING HOME COMPARE STAFFING DATA MISSES THE MARK

ABSTRACT

The Baby Boomers are aging, and soon many will require more long-term health care services, looking to the Nursing Home Compare Website (Website) to help guide their choices. The staffing rating on the Website, which rates nursing homes on a scale of one to five, uses a biased formula to generate its ratings. It counts registered nurses twice, completely excludes other important care staff, and uses outdated case-mix adjustments left over from the early 1990's. In light of the pressing need for accurate data but no mechanism to obtain it, the staffing rating must be eliminated from the Website. Some studies suggest that the number of registered nurses in a facility directly correlates with better care, but these studies fail to account for the changing landscape of nursing home populations and advances in medical technologies.

In order to avoid misleading consumers making nursing home care decisions, the staffing rating needs to be fixed, but there is no enforcement mechanism in place to ensure that the Centers for Medicaid and Medicare Services (CMS) will do so. Faced with the competing pressures of providing good care within budget constraints while also getting high ratings, nursing homes have come under scrutiny with allegations that they "game the system" by submitting false staffing data to the Website. Section 6106 of the Patient Protection and Affordable Care Act attempts to address this concern by requiring staffing data to be more controlled, but this mandate fails to solve any underlying issues. This paper explores these issues behind the staffing ratings, debunks the dated assumption that more registered nurses inherently leads to better care, and implores CMS to change its ways so that nursing home consumers can make accurately informed choices.

I. INTRODUCTION

Since its inception in 2008, the Five-Star Quality Rating System on the Nursing Home Compare Website (Website) has been riddled with inaccurate measures.[1] To address these concerns, the Patient Protection and Affordable Care Act (ACA) mandates that the Comptroller General launch an investigation of the system and present its findings to Congress with suggestions for improvement.[2] Accordingly, the Government Accountability Office (GAO), under the direction of the Comptroller General, announced in August 2015 its plans to investigate the reliability of the rating system.[3] What remains unclear, however, is whether all concerns will be addressed in such investigation and whether Congress will act on the findings, as the law does not require any further action once the GAO presents its findings to Congress.[4] Congressional history indicates that Congress has little concern for enforcing a particular order to develop reliable data mechanisms, as evidenced by the failed mandate of the Omnibus Budget Reconciliation Act of 1987 (OBRA), which required a valid method to be created for assessing quality in skilled nursing facilities.[5]

Of paramount concern is the rating system's explicit bias toward staffing more registered nurses (RNs). The rating formula factors in the number of RNs twice, assuming that more RNs on staff necessarily creates better care.[6] This assumption is flawed because many patients, such as those with dementia, need more attention paid to their activities of daily living (ADL) than complex medical conditions.[7] An increase in RN hours does not necessarily lead to better health outcomes in this population. But in order to have good staffing ratings, facilities find themselves under pressure to increase their RN staff.[8] Thus, the bias toward RN staffing has a directly opposite effect than intended—a decrease in the quality of care for some of this country's most vulnerable people. In an attempt to make the staffing ratings more accurate, section 6106 of the ACA requires all nursing homes to submit their staffing

---

1. Malcolm J. Harkins, III, *The Broken Promise of OBRA '87: The Failure to Validate Survey Data Protocol*, 8 ST. LOUIS U. J. HEALTH L. & POL'Y 89, 118 (2014).

2. Patient Protection and Affordable Care Act, Pub. L. No. 11-148, § 6107, 124 Stat. 713 (2010) [hereinafter ACA].

3. Jackie Oberst, *GAO to Investigate CMS Five-Star Quality Rating System*, PROVIDER (Aug. 28, 2015), http://www.providermagazine.com/news/Pages/2015/0815/GAO-To-Investigate -CMSFive-Star-Quality-Rating-System.aspx.

4. *See* ACA § 6107.

5. *See generally* Harkins, *supra* note 1.

6. COMMITTEE ON NURSING HOME REG., INST. OF MED., *Improving the Quality of Care in Nursing Homes* 101 (1986) [hereinafter IOM REPORT].

7. *See* R.S. Bucks et al., *Assessment of Activities of Daily Living in Dementia: Development of the Bristol Activities of Daily Living Scale*, 25 AGE & AGEING 113 (1996).

8. *See, e.g.*, U.S. v. N. Am. Health Care, 2015 WL 6871781 at *1 (N.D. Cal. Nov. 9, 2015).

data in a uniform format so that it can be audited for accuracy.[9] This pressure imposes financial strain on facilities, decreases job satisfaction of RNs, and results in lowered quality of care. Unfortunately, the ACA fails to address the underlying erroneous bias that more RN staff creates better care.

Section II briefly describes the Website and then introduces how the staffing rating formula is objectively erroneous by double counting RNs and excluding other important care staff. Instead of counting all types of nursing home care staff, the Centers for Medicare and Medicaid Services (CMS), the entity responsible for collecting and analyzing the data, selectively chooses to count only those staff that it has identified as preferable. Section III demonstrates that the formula's method to adjust for case mix is outdated and has not been appropriately modified for the types of issues nursing homes experience today. Next, Section IV argues that in addition to the formula being incorrect, the concept of merely counting numbers of staff, regardless of which staff are counted or the accuracy of the count, is not a reliable indicator of quality. Many other factors influence the care provided in a nursing facility, like management and workplace environment.[10]

Section V discusses the allegations that nursing homes have begun to "game the system" by submitting false data to the Website and how section 6106 of the ACA attempts to address this concern by requiring staffing data to be more standardized and scrutinized. This mandate may very well exacerbate the problem, however, since requiring more accurate data will impose even greater financial stress on nursing homes. This stress will, in turn, make addition of more RNs to the payroll more difficult. Lastly, Section VI emphasizes that there is no mechanism in place to ensure that the staffing formula is adjusted after the Comptroller General submits its report to Congress. Although some sort of oversight possibility may exist, the most practical solution to the problem is to remove the staffing rating from the Website. CMS has a duty to provide data that is meaningful and accurate, and the staffing star is neither.

Further, section 6106 requires more resources to be devoted to a faulty input measure. By removing the staffing star rating, CMS can allow truer measures of quality to shine on the Website. Finally, this paper concludes by asserting that now is the time to create a change in the Website. As the population continues to age and enter skilled nursing facilities, the faulty information consumers find on the Website may color their entire perception of the care they or their loved ones will receive, before they have even had a chance to assess the quality of care for themselves.

---

9. ACA § 6106.

10. IOM REPORT, *supra* note 6, at 171.

II. BACKGROUND

A. *History of Nursing Home Quality Data Analysis*

Nursing homes care for very vulnerable people who often suffer from physical and cognitive ailments that leave them unable to be fully self-sufficient.[11] Current trends indicate that as the Baby Boomers age and require more long-term health care services, consumers will interact more with nursing homes and raise fresh concerns about quality of care.[12] Of course, such concerns are not new.

As part of OBRA in 1987, Congress passed the Nursing Home Reform Act, which in part mandated that a study be designed and validated within the next three years that would find a method to properly assess the quality of care in nursing homes.[13] To start, Congress asked the Institute of Medicine Committee on Nursing Home Regulation (IOM) to develop recommendations for improving the quality of care in nursing homes.[14] One aspect concerning quality of care was determining appropriate staffing ratios for nursing homes.[15] The IOM conducted an extensive project by assessing current research, interviewing professionals, interpreting regulations, and seeking input from stakeholders, and it concluded that "[b]ecause of the complexities of case mix—that is, the widely differing needs of individual residents in the same facility—prescribing simple staffing ratios clearly is inappropriate."[16] Further, the IOM believed that an appropriate remedy to improving quality of care through staffing would be to increase the ratio of better-trained staff in facilities, rather than simply increasing the number of staff available.[17] "Better-trained staff" was loosely implied to mean that both professional and nonprofessional nursing personnel should be trained in geriatrics to ensure meeting the needs of all types of residents in each facility.[18]

---

11. Christina Boccuti et al., *Reading the Stars: Nursing Home Quality Star Ratings, Nationally and by State*, KAISER FAM. FOUND. 2 (May 2015), http://files.kff.org/attachment/issue-brief-reading-the-stars-nursing-home-quality-star-ratings-nationally-and-by-state.

12. Carina Storrs, *The 'Elder Orphans' of the Baby Boom Generation*, CNN (May 18, 2015, 4:22 PM), http://www.cnn.com/2015/05/18/health/elder-orphans/ (stating that in 2012, about 1.3 million Americans lived in nursing homes, but by 2030, the number of residents in nursing homes is projected to reach 5.3 million people).

13. Harkins, *supra* note 1, at 90.

14. *See* IOM REPORT, *supra* note 6, at 2.

15. *Id.* at 101.

16. *Id.* at 102.

17. *Id.* at 103.

18. *Id.* The IOM placed emphasis on training in geriatrics, not necessarily on skill or education level. *See* IOM REPORT, *supra* note 6, at 103.

The validated methods that OBRA hoped to create were to be implemented for nursing home surveys by January 1, 1990.[19] Prior to this date, an assessment method for nursing homes was developed, but the method was never validated.[20] Instead, the mandate prescribed by the Nursing Home Reform Act was forgotten, despite a clear determination that the current nursing home survey methods "were inaccurate and not clearly indicative of quality."[21] Instead, CMS moved on to a new project: creating an online platform to display the inaccurate survey data, so that consumers of nursing home care would rely on the data when trying to make informed nursing home choices.[22] This platform is now known as Nursing Home Compare, which includes the Five-Star Quality Rating System.[23] Rather than complying with OBRA's mandate to develop more accurate quality indicators, CMS moved in an opposite direction—publicizing the inaccurate data as reliable indicators of nursing home quality. In effect, this data publication acts as a marketer of nursing homes, generating reliance by consumers, practitioners, and anyone else invested in making informed skilled nursing care decisions.[24]

B.   Overview of the Five-Star Quality Rating System

The Website displays four different star ratings for each nursing home: overall, health inspections, staffing, and quality measures. A brief overview of each measure is provided below.

STAR RATINGS DISPLAY ON NURSING HOME COMPARE[25]

---
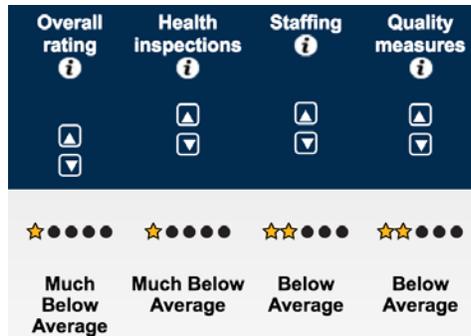
19.   Harkins, *supra* note 1, at 90.

20.   *See id.* at 94.

21.   *Id.* at 119.

22.   *Id.*

23.   Donna R. Lenhoff, *LTC Regulation and Enforcement: An Overview from the Perspective of Residents and Their Families*, 26 J. LEGAL MED. 9, 18–19 (2005) (stating that "[i]n November, 2002, CMS launched a nationwide Nursing Home Quality Initiative (NHQI) to develop, select, and report nursing home quality measures. This data is available to consumers on the Nursing Home Compare website").

24.   Oberst, *supra* note 3.

25.   NURSING HOME COMPARE, https://www.medicare.gov/nursinghomecompare/ (search zip code "63130", then arrange results by staffing in ascending order) (last visited Dec. 14, 2016).

1.   Health Inspection Star

State surveys of all facilities are completed at least annually, assessing for deficiencies in compliance with federal and state requirements.[26] The health inspection rating is calculated using the three most recent state survey results, weighting more recent deficiencies heavier and accounting for the number of re-visits a surveyor is required to make before the problem is solved.[27] Surveys include, in part, assessments of "medication management, proper skin care, assessment of resident needs, nursing home administration, environment, kitchen/food services, and resident rights and quality of life."[28] CMS uses this survey data to construct the Five-Star Quality Rating on the Website, despite it being well established that survey results are inaccurate and unreliable.[29] Further, instead of assigning stars based on an average bell curve distribution, CMS skews downwards, only awarding the top ten percent a five-star rating and the bottom twenty percent a one-star rating.[30]

2.   Staffing Star

The staffing star, which is the focus of this paper, is highly problematic. In fact, the staffing ratings have been under scrutiny for years, with most criticisms surrounding the fact that the staffing star ratings rely on facility-reported data, with no measures to check the data's accuracy (until section 6106's attempt).[31] The staffing rating consists of two measures: 1) total RN hours per resident day, and 2) the total of RN, licensed practical nurse (LPN) or licensed vocational nurse (LVN) (they are essentially the same[32]), and nurse aide (NA) hours per resident day.[33] The two measures are given equal weight

---

26. CTRS. FOR MEDICARE & MEDICAID SERVS., DESIGN FOR NURSING HOME COMPARE FIVE-STAR QUALITY RATING SYSTEM: TECHNICAL USERS' GUIDE 3 (2015) [hereinafter CMS TECHNICAL USERS' GUIDE].

27. *Id.* at 4.

28. *Id.* at 3–4.

29. Harkins, *supra* note 1.

30. CMS TECHNICAL USERS' GUIDE, *supra* note 26, at 6.

31. *See Administration Plans Major Improvements to Nursing Home Compare*, CTR. FOR MEDICARE ADVOCACY, http://www.medicareadvocacy.org/administration-plans-major-improve ments-to-nursing-home-compare/ (last visited Aug. 8, 2016); Katie Thomas, *Medicare Star Ratings Allow Nursing Homes to Game the System*, N.Y. TIMES (Aug. 24, 2014), https://www.ny times.com/2014/08/25/business/medicare-star-ratings-allow-nursing-homes-to-game-the-sys tem.html.

32. LPN and LVN describe the same kind of professional who works under the direction of an RN. The biggest difference between the two is mere preference in terminology, so for the purposes of this paper the two terms are identical. *See* BUREAU OF LABOR STATS., *Occupational Outlook Handbook: Licensed Practical and Licensed Vocational Nurses*, U.S. DEP'T OF LABOR, https://www.bls.gov/ooh/healthcare/licensed-practical-and-licensed-vocational-nurses.htm#tab-2 [hereinafter *Licensed Practical and Licensed Vocational Nurses*].

33. CMS TECHNICAL USERS' GUIDE, *supra* note 26, at 7.

in the overall staffing rating reported on the Website.[34] Put another way, the staffing formula *double counts* the RN hours per resident day, creating a formula that looks (when simplified) like: RN + (RN + LPN + NA) = overall staffing rating. Recognizing that different types of staff are needed for different levels of care, the staff numbers are weakly "adjusted for case-mix differences" by using the Resource Utilization Group (RUG-III) categories.[35] A more detailed description of the staffing formula and case-mix adjustment will follow later.

3.   Quality Star

While the health inspections rating is based on the past three annual assessments, the quality rating looks at a much shorter time frame—the three most recent quarters—to assess how well the nursing home is able to meet the residents' needs.[36] Arguably, taking care of the residents' needs should be the overall quality indicator, as that is the ultimate concern for consumers.[37] And in all practicality, as long as the nursing home is meeting its residents' needs, it may not matter if the facility has fewer staff. Using a complex formula, CMS analyzes data including increase in residents' needs for help with ADLs, pressure ulcers, use of physical restraints, incidences of urinary tract infections, use of antipsychotic medicines, resident reports of pain, and more.[38] Unlike the health inspection stars, which are awarded on an asymmetrical bell curve, the final quality score that a nursing home receives is determined according to ranges of raw points awarded.[39]

---

34.   *Id.* at 9.

35.   *Id.* at 8; RUG-III groups are classifications of patient needs developed for the purpose of Medicare payments. OFFICE OF INSPECTOR GEN., OEI-02-99-00041, NURSING HOME RESIDENT ASSESSMENT RESOURCE UTILIZATION GROUPS 3 (2001).

36.   CMS TECHNICAL USERS' GUIDE, *supra* note 26, at 11.

37.   *See* CTRS. FOR MEDICARE & MEDICAID SERVS., YOUR GUIDE TO CHOOSING A NURSING HOME OR OTHER LONG-TERM CARE 18 (2015).

38.   Data for each quality indicator is "risk-adjusted" to accommodate different factors associated with circumstances unique to different nursing homes. CMS TECHNICAL USERS' GUIDE, *supra* note 26, at 11. Then, the adjusted quality indicator data is plugged into a formula: QM3Quarter = [(QM Q1 * DQ1) + (QMQ2 * DQ2) + (QMQ3 * DQ3)]/(DQ1 + DQ2 + DQ3), "[w]here QM Q1, QM Q2, and QM Q3 correspond to the adjusted QM values for the three most recent quarters and DQ1, DQ2, and DQ3 are the denominators (number of eligible residents for the particular QM) for the same three quarters." *Id.* Once the formula is figured for each nursing home, raw scores are ranked according to quintile, and then each quality indicator's raw score is added to get a sum for the nursing home overall. *Id.* at 13. Scores range between 220 and 1100 points. *Id.* at 15.

39.   *Id.*

4. Overall Star

While common sense suggests the overall star rating would be an average of the individual star ratings, CMS adopts a convoluted method to determine the overall rating. Starting with the health inspection rating, a star is added or subtracted based on specific criteria concerning the results of the staffing component.[40] Then, another star is either added or subtracted based on the quality measure rating, and barring some exceptions, the overall quality star rating is figured.[41] To explain its rationale for adding and subtracting stars instead of averaging, CMS states that it views the health inspection, staffing, and quality measures ratings as carrying different levels of importance.[42] Despite the established facts that survey results are inaccurate and unreliable[43] and that the staffing rating is erroneous, CMS places ultimate importance on health inspections and staffing for determining the overall quality rating.[44]

C. Portraying Quality of Care

Since its debut in 2008, the Website has been a significant resource for people to assess their nursing home choices.[45] By being a principal source of nursing home information, the Website becomes a driver of the market, strongly influencing consumers' choices.[46] CMS states that it created the Five-Star Quality Rating System with the purpose of "provid[ing] residents and their families with an easy way to understand assessment of nursing home quality, making meaningful distinctions between high and low performing nursing homes."[47] Thus, by publicizing data about the quality of care, consumers can rely on the data to inform their choices as to where their loved one will receive the best care.

At first glance, the star ratings would have consumers believe that they reflect the overall quality of care a resident receives in a facility. Quality of care is a complex concept, however, and not easily summarized in a few stars. One common conceptual framework used to describe quality is to consider it in three necessary parts: structural, process, and outcome indicators[48] (the

---

40. CMS TECHNICAL USERS' GUIDE, *supra* note 26, at 15.

41. *Id.*

42. *Id.* at 16.

43. Harkins, *supra* note 1.

44. CMS TECHNICAL USERS' GUIDE, *supra* note 26, at 16.

45. *Nursing Home Compare 3.0: Revisions to the Nursing Home Compare 5-Star Quality Rating System*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Feb.12, 2015), https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-02-12-2.html (stating that "the [W]ebsite gets more than 1.4 million visitors per year").

46. Oberst, *supra* note 3.

47. CMS TECHNICAL USERS' GUIDE, *supra* note 26, at 2.

48. Mary Ellen Dellefield et al., *The Relationship Between Registered Nurses and Nursing Home Quality: An Integrative Review (2008-2014)*, 33 NURSING ECON. 95, 98 (2015).

Donabedian Model).[49] Structural measures include the number and skill mix of staff, as well as overall organization and management of the facility.[50] The staffing star is a pure structural indicator, measuring the input of the number of staff, but the number of staff alone is insufficient to determine the quality of care received. Another equally important piece includes the process by which care is delivered in a nursing home.[51]

Unfortunately, process measures historically have been very difficult to measure and are therefore frequently not studied.[52] Process quality indicators assess the way that care is provided in order to better residents' experiences.[53] Examples of process quality indicators include the kinds of relationships the care staff have with the residents and the ways in which problematic residents are approached and erratic behaviors de-escalated. Further, "[c]are processes used will differ based on resident characteristics, acuity, length of stay, and types and numbers of nursing staff included in the nursing skill mix."[54] The Five-Star Quality Rating System does not identify or assess these kinds of process indicators. But how care is provided cannot be easily separated from the structural measure of staff, because the two influence one another.[55] To measure only one reflects an inaccurate concept of quality. The third prong of quality, outcome measures, assesses data including survey deficiency findings, incidences of adverse events, and staffing turnover.[56]

It is imperative that all three prongs are considered.[57] CMS, however, has developed the faulty Five-Star Quality Rating System by using only the staffing measure to assess structural indicators, by completely disregarding procedural measures, and by relying predominately on outcome measures to assess quality of care in nursing homes. Because the staffing rating only addresses structural indicators and measures inputs (the numbers of staff), it cannot accurately predict that good care will be provided. Although other measures on the Website exist to better indicate quality, the staffing star remains highly scrutinized and continues to be modified for accuracy.

---

49. JiSun Choi et al., *Nursing Practice Environment and Registered Nurses' Job Satisfaction in Nursing Homes*, 52 GERONTOLOGIST 484, 486 (2011) (explaining the Donabedian Model wherein structure affects processes, which then affect care outcomes).

50. Dellefield et al., *supra* note 48.

51. *Id.* at 100.

52. *Id.*

53. *Id.*

54. *Id.*

55. Dellefield et al., *supra* note 48, at 100.

56. *Id.*

57. *See* Choi et al., *supra* note 49.

III. THE STAFFING STAR

A.   *Accounting for Specific Types and Numbers of Staff*

Numbers and types of staff employed by a nursing home are often considered important quantitative evidence used by plaintiffs' attorneys and the government to support arguments against nursing homes when issues arise.[58] Specifically, evidence of the numbers and types of staff are often used to argue that nursing homes failed to respond to residents' needs, were overly concerned with profit at the expense of resident care, and were negligent in resident supervision.[59] To assess the numbers of staff available for care at a given facility, CMS double counts RNs and also includes counts of LPNs and NAs.[60] Relying on the numbers and types of staff alone, however, is insufficient to give an accurate picture of the type of care an individual receives. Additionally, the formula implicitly forces nursing homes to hire RNs over other types of staff because the presence of RNs impacts the staffing rating that displays on the Website.

An RN is an individual who has obtained at a minimum an associate's degree or a diploma from a nursing program, although many RNs have bachelor degrees.[61] Additionally, RNs must pass a national licensure exam and maintain other state-specific requirements.[62] In practice, RNs are responsible for administering patients' medicines and treatments, establishing care plans, collaborating with physicians, and educating patients on illness management and ongoing care.[63] To count the RNs at a nursing home, CMS includes all RNs who provide direct patient care, the RN Director of Nursing, and any RNs who perform administrative duties.[64]

To become an LPN or LVN, a person completes a one-year degree or diploma program and passes a licensure exam.[65] In practice, LPNs perform basic medical tasks such as changing wound dressings and inserting catheters,

---

58. Jennifer Smith, *Lawsuits Rattle Nursing Home Chains*, WALL STREET J. (October 3, 2014), http://www.wsj.com/articles/lawsuits-rattle-nursing-home-chains-1412368400.

59. *See id.*

60. CMS TECHNICAL USERS' GUIDE, *supra* note 26, at 7.

61. BUREAU OF LABOR STATS., *Occupational Outlook Handbook: Registered Nurses*, U.S. DEP'T OF LABOR, https://www.bls.gov/ooh/healthcare/registered-nurses.htm#tab-1 [hereinafter *Registered Nurses*].

62. *Id.*

63. BUREAU OF LABOR STATS., *Occupational Outlook Handbook: What Registered Nurses Do*, U.S. DEP'T OF LABOR, https://www.bls.gov/ooh/healthcare/registered-nurses.htm#tab-2.

64. CMS TECHNICAL USERS' GUIDE, *supra* note 26, at 7.

65. BUREAU OF LABOR STATS., *Occupational Outlook Handbook: How to Become a Licensed Practical or Licensed Vocational Nurse*, U.S. DEP'T OF LABOR, https://www.bls.gov/ooh/healthcare/licensed-practical-and-licensed-vocational-nurses.htm#tab-4.

personal care tasks like bathing and dressing, and ongoing monitoring of patients' health statuses.[66]

An NA is "any individual providing nursing or nursing-related services to residents in a nursing facility."[67] NAs provide most care pertaining to feeding, exercise, ADL "independence enhancement," toileting, and incontinence care.[68] An NA can take a short training course to become a certified nursing assistant (CNA).[69] CNAs provide more than ninety percent of direct care to residents of nursing homes, involving tasks like bathing, turning to avoid pressure sores, toileting, meal assistance, and other personal care tasks that are "necessary for comfort and avoiding further debilitation, disease, and unnecessary death."[70] Despite the brunt of labor-intensive work that CNAs provide (often at minimum hourly wages), this type of care is largely undervalued.[71]

When counting the number of aides at a facility, CMS includes CNAs, NAs, aides in training, and medication technicians.[72] These staffing categories include many of the caregivers at a nursing home, but not all. For example, the CMS calculations fail to include other vital staff who often provide other kinds of direct care such as: activity assistants, hospice staff, and physical therapists.[73] On any given day, a nursing home resident may be bathed and dressed by a CNA, fed by a feeding assistant, have her social and emotional needs addressed by activity assistants and social workers, be toileted by one of many staff, receive medication from a medication technician, receive physical therapy, have her blood pressure checked by an LPN, and her chart reviewed by an RN. Failing to account for all of the staff who touch that resident's care in a given day reflects an inaccurate understanding of the multidisciplinary approach to care in a nursing home.

Despite the wealth of staff at any facility that may impact patient care, the Website star staffing ratios only reflect the numbers of staff with the specific qualifications of RN, LPN, and CNA.[74] Considering the hypothetical resident above, the staffing ratio therefore may only account for the staff who provide the resident's bathing and dressing, feeding, blood pressure check, medicine

---

66. *Licensed Practical and Vocational Nurses*, *supra* note 32.

67. 42 U.S.C. § 1395i-3(b)(5)(F); 42 U.S.C. § 1396r-3(b)(5)(F).

68. John F. Schnelle et al., *Relationship of Nursing Home Staffing to Quality of Care*, 39 HEALTH SERVS. RES. 225, 226–27 (2004).

69. BUREAU OF LABOR STATS., *Occupational Outlook Handbook: Nursing Assistants and Orderlies*, U.S. DEP'T OF LABOR, https://www.bls.gov/ooh/healthcare/nursing-assistants.htm#tab-4 [hereinafter *Nursing Assistants and Orderlies*].

70. Lenhoff, *supra* note 23, at 15.

71. *Id.* at 18.

72. CMS TECHNICAL USERS' GUIDE, *supra* note 26, at 7.

73. *Id.*

74. *Id.*

administration, and chart review. However, the resident's physical therapy, palliative care, and social and cognitive needs are unaccounted for by the current staffing ratio, and these are all services that are also important to the health and quality of life of every resident.[75] By omitting other staff in its calculations, CMS has placed a bias on certain types of staff with specific credentials, implying that those credentials directly correspond with better care. This bias by CMS, however, begs consideration of the question: why shouldn't the presence of *all* staff who contribute to the teamwork for caring for residents be the consideration for awarding stars on the Website? For example, disregarding activity staff, who plan and implement engaging activities for the residents, neglects the fact that psychosocial health can largely impact physical health.[76] The staffing selection that CMS uses turns a blind eye to the interrelationship of factors that contribute to overall patient well-being.

Further, CMS relies on data reported by facilities concerning the number of staff the facility had during the past two weeks.[77] Compiling an accurate view of staffing ratios in a facility, however, is much more complicated and involves assembling and analyzing data from a variety of sources including the staff schedules, punch cards, agency invoices, and daily census reports, among others.[78] In an effort to reduce inaccurate reporting by nursing homes, section 6106 of the ACA mandates that by 2016, facilities shall report their staffing statistics "based on payroll and other verifiable and auditable data."[79] CMS remains hopeful that its new database for submission of this data "will allow staffing and census information to be collected on a regular and more frequent basis than currently collected."[80] The ACA requirement stops there, however; no mandate is given to adjust the staffing rating formula to reflect more realistic norms, and it still leaves open the possibility that data be compiled by a mix of sources, as long as it is auditable.

---

75. *See* Anita DeLongis et al., *The Impact of Daily Stress on Health and Mood: Psychological and Social Resources as Mediators*, 54 J. PERSONALITY & SOC. PSYCHOL. 486, 487 (1988).

76. *Id.*

77. Christina Williams et al., *Measuring Nursing Home Quality–The Five-Star Rating System*, SAS GLOBAL F. 2010 5 (2010), http://support.sas.com/resources/papers/proceedings10/161-2010.pdf.

78. Proskauer Rose LLP, Nursing Facility Staffing: A Proactive and Defensive Look at Nurse/Aide Staffing in SNFs 30, 46 (2008) (unpublished PowerPoint presentation).

79. Patient Protection and Affordable Care Act, Pub. L. No. 11-148, § 6106, 124 Stat. 713 (2010).

80. *Staffing Data Submission PBJ*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Jan. 14, 2016, 3:18 PM), https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Staffing-Data-Submission-PBJ.html [hereinafter *Staffing Data Submission PBJ*].

Although the ACA attempts to fix issues surrounding staffing data, using only one source of staffing data (i.e., payroll records) still may not be an accurate representation of staff for a proper staff analysis because it is often recorded in many places within an organization. For example, a single employee may work multiple shifts, but in different units with individuals requiring different levels of care, which may not be well-reflected on the payroll data.[81] Additionally, the numbers of staff continue to be compared against a prescribed ratio that is considered the optimal staff requirement; however, the IOM has long held that simple staffing ratios are inadequate to assess care due to the complex nature of case mixes in nursing homes.[82] Furthermore, while adding RNs can correlate with better quality, the relationship is non-linear, and a point exists where adding more RNs produces little to no quality improvement in a facility.[83] Thus, collecting the same type of data, albeit more accurately, will not address the underlying problem that numbers of staff are not reliable measures of quality.

B. Adjusting for Case Mix Improperly

To adjust for differences in populations at different facilities, CMS claims that it adjusts the required nurse staffing ratios for each facility according to case mix.[84] Case mix is defined as the make up of residents with differing levels of acuity in a given facility.[85] To begin its adjustment, CMS uses the same RUG-III classification system it uses in its Medicare prospective payment system to determine the different levels of care residents need.[86] Then, for each RUG-III group, a number is assigned for the expected minutes of care by RNs, LPNs, and NAs.[87] These expected minutes were developed from two CMS-sponsored Staff Time Measurement studies in 1995 and 1997.[88] Twenty years later, however, CMS still applies the same expected minutes of care, despite advances in technology and care processes.[89]

Since these criteria were developed, much has changed in health care services, and it is important that the standards by which nursing homes are judged reflect current care trends. Models of care have begun shifting from a medical model to a person-centered model, which has brought about new processes for interacting with residents and new design of nursing home

---

81. *Id.*
82. IOM REPORT, *supra* note 6, at 102.
83. Ning Jackie Zhang et al., *Minimum Nurse Staffing Ratios for Nursing Homes*, 24 NURSING ECON. 78, 80 fig.1 (2006).
84. Williams et al., *supra* note 77, at 3.
85. *Id.* at 5.
86. CMS TECHNICAL USERS' GUIDE, *supra* note 26, at 2.
87. *Id.* at 18 tbl. A1.
88. *Id.*
89. *Id.* at 8.

facilities.[90] One study found that nursing homes that had implemented a person-centered care model tended to have fewer health-related survey deficiencies as well as fewer RN and LPN staff,[91] which further indicates that staff levels may not be a reliable indicator of health outcomes in facilities. Additionally, implementation of new technologies in the nursing home setting can reduce medical errors and increase resident safety.[92] For example, the rise in electronic health records has helped coordinate care and allowed remote access to important patient information.[93] This increased ability to access a patient's full records helps care teams "make knowledgeable decisions in respect to [residents'] care plans" from more remote locations.[94] It follows, therefore, that fewer on-site RN staff may be required if they can still perform their chart review duties and make care plan decisions while off-site, without a decline in patient care.

Another limitation on the current case-mix adjustment is that it does not accurately represent individuals in facilities with cognitive impairments. CMS makes Website users believe that the appropriate staffing standards to which nursing homes are held are adjusted for each facility based on the different RUG-III groups that are assigned to its specific residents.[95] Data compiled on each individual in a facility helps determine which RUG-III group applies to each resident, taking into account the resident's needs.[96] Since the RUG-III system was developed, efforts to more accurately represent the complexities of patient conditions while maintaining some sort of uniformity has led to continuing addition of RUG-III groups.[97] Now, the system that nursing homes use comprises fifty-three different categories of patient conditions.[98] Additionally, there are two different methods (hierarchal and index) of determining which category fits a patient, leading to potential confusion for providers when selecting the appropriate RUG-III group to submit for billing purposes.[99]

---

90. Sonya E. Bowen & Sheryl Zimmerman, *Understanding and Improving Psychosocial Services in Long-Term Care*, HEALTH CARE FIN. REV., Winter 2008–2009, at 1, 3.

91. David C. Grabowski et al., *Who Are the Innovators? Nursing Homes Implementing Culture Change*, 54 GERONTOLOGIST S65, S72 (2014).

92. INT'L FED'N ON AGEING, LONG TERM CARE AND TECHNOLOGY: FINAL REPORT 8 (2012), http://www.ifa-fiv.org/wp-content/uploads/2012/11/som-2012-ltc-and-technology-final-re port.pdf.

93. *Id.* at 5.

94. *Id.*

95. CMS TECHNICAL USERS' GUIDE, *supra* note 26, at 8.

96. *Id.*

97. Rena Shephard, *Making the Most of RUG-53*, LONG-TERM LIVING MAG. (Feb. 1, 2006), http://www.ltlmagazine.com/article/making-most-rug-53.

98. *Id.*

99. *Id.*

Further complicating the categorization system is the fact that many residents in nursing homes are long-term residents, not expecting any major improvement in health conditions or rehabilitation. In 2015, the Kaiser Family Foundation (KFF) released a report indicating that as many as eighty-one percent of Medicare beneficiaries in nursing homes require assistance with one or more ADLs, and seventy-six percent of the same population suffers from mental or cognitive impairments.[100] For all of these residents requiring ADL assistance, CNAs are the appropriate care staff to assist in the bathing, dressing, toileting, and other personal care needs.[101] The same KFF report indicated that only fifty-five percent of Medicare beneficiaries in nursing homes suffer from "fair/poor health," requiring the kind of care that an LPN or RN would normally provide.[102] This data indicates that a majority of residents in nursing homes may not be expected to gain improved function or renewed health; rather, they reside there for the ADL assistance and supervision the facility can provide (often because of degenerative cognitive impairments like dementia).

Of the fifty-three RUG-III groups currently identified, only four cover impaired cognition, with another four under the category of "behavior."[103] The remaining RUG-III categories are all specific to physical conditions, many of which may not be applicable to facilities with large populations of relatively physically healthy individuals with dementia.[104] For these types of nursing homes, the wide range of residents with different cognitive impairments are limited to only four (or eight if including "behavioral" RUGs) different groups with expected staff time standards. For example, cognitive impairment can be caused by a variety of different conditions, including stroke, traumatic brain injury, Alzheimer's disease, or other types of dementia, and each one of these conditions creates different cognitive, physical, and behavioral effects.[105] This lack of diversity among the "cognitive impairment RUGs" fails to represent the wide diversity of needs that different individuals with dementia can require. Although section 6106 requires the data that facilities report to include case-mix data,[106] little will change if the underlying way in which case-mix is identified remains unchanged.

---

100. Boccuti et al., *supra* note 11, at 2 fig. 1.

101. Lenhoff, *supra* note 23, at 15.

102. Boccuti et al., *supra* note 11.

103. CMS TECHNICAL USERS' GUIDE, *supra* note 26, at 19 tbl. A1.

104. *Id.* at 18–19 tbl. A1.

105. *Cognitive Impairment: A Call for Action, Now!*, CTRS. FOR DISEASE CONTROL & PREVENTION 2 (Feb. 2011), https://www.cdc.gov/aging/pdf/cognitive_impairment/cogimp_poili cy_final.pdf.

106. Patient Protection and Affordable Care Act, Pub. L. No. 11-148, § 6106, 124 Stat. 713 (2010) (amending § 1128I of the Social Security Act to include (g)(2)).

IV. STAFFING: AN INCOMPLETE MEASURE OF QUALITY

Even if the current method for compiling staff data was reliable and the case-mix adjustment was more appropriately sensitive, measuring the numbers of staff in a facility is still not a reliable indicator of quality. Some nursing homes exist with exemplary staffing and poor quality according to CMS standards,[107] but if the number of staff is positively correlated with quality, then how can a facility have a five-star staff rating and only a two-star quality rating? The formula that CMS uses to award stars on the Website for numbers of staff comes from one CMS-sponsored study, and that study found that nurse staffing ratios had a positive correlation with nursing home quality of care.[108] This *one* study was CMS's basis for creating its current formula that double counts RNs.[109]

A NURSING HOME WITH FIVE STARS FOR STAFFING AND TWO STARS FOR QUALITY[110]

Other independent studies have concluded that the correlations are much more complex, however. For example, one study found that "some care processes were poorly implemented in even the highest-staffed facilities, despite the fact that these facilities had sufficient numbers of NAs to potentially provide 100 percent of care to all residents."[111] Another study found no significant relationship between measuring staff time (hours per resident day) and quality outcomes, even though the CMS staffing formula compares the facility's hours per resident day to the national and expected

---

107. *See* NURSING HOME COMPARE, https://www.medicare.gov/nursinghomecompare/ (search zip code "63017", then arrange results by staffing in descending order) (last visited Dec. 14, 2016).

108. Williams et al., *supra* note 77.

109. *Id.*

110. NURSING HOME COMPARE, *supra* note 107.

111. Schnelle et al., *supra* note 68, at 246–47.

hours per resident day.[112] It has therefore been shown multiple times that staff numbers cannot guarantee or even predict good care outcomes. Actually, thirty years ago, the IOM even admitted that quality of care and quality of life are dependent on the *attitudes* and *behavior* of staff, not necessarily the *number* of staff in nursing homes.[113] Further, the IOM stated that quality in nursing homes is complex, and even "regulation is not sufficient to ensure high quality of care and quality of life in nursing homes."[114] CMS failed to account for these recognitions, however, by limiting the staff star ratings to purely staff numbers. Admittedly, using a quantitative measure of staff is significantly easier than qualitative measures, but taking the easy route at the expense of accuracy produces incomplete measurements and unreliable data. These incomplete indicators about staff at a facility are then published on the Website, where consumers rely on the information to make their long-term care choices.

One reason that the quantity of staff is not a reliable indicator of care is that management and other workplace matters factor largely into the staff composition in any workplace environment. Poor workplace environments and job dissatisfaction contribute to high staff turnover.[115] The nursing home industry is notorious for high staff turnover rates, in large part because of the labor intensive nature of jobs in nursing homes.[116] The kind of care that residents require can be physically and emotionally taxing, which can lead to "far-reaching consequences, including increased facility operating costs and lower caregiver job satisfaction . . . . The most serious consequence of caregiver turnover is the potential negative health outcomes for residents."[117] Staff turnover may have serious effects including interference with continuity of care, lack of experienced staff, weakened standards of care, and psychological distress for some residents.[118] Rightfully, CMS is concerned about health outcomes for residents,[119] but its analysis stops too short: it fails to address workplace factors that affect the staff numbers. This incomplete analysis disregards the larger picture by focusing only on a snapshot of the quantity of staff at a specific time.

---

112. Greg Arling et al., *Nursing Effort and Quality of Care for Nursing Home Residents*, 47 GERONTOLOGIST 672, 680 (2007).

113. IOM REPORT, *supra* note 6, at 171.

114. *Id.*

115. *Id.* at 101.

116. Lenhoff, *supra* note 23, at 21; Nicholas G. Castle et al., *Nursing Home Staff Turnover: Impact on Nursing Home Compare Quality Measures*, 47 GERONTOLOGIST 650, 650 (2007).

117. Castle et al., *supra* note 116.

118. *Id.* at 652.

119. IOM REPORT, *supra* note 6 (referring to the correlation its study found between outcomes and the number of staff in nursing homes).

If a workplace can provide higher wages, benefits, scheduling flexibility, advancement opportunities, and better working conditions, however, staff may find better job satisfaction.[120] A strong positive correlation has been found between RN job satisfaction and the chance to participate in facility affairs, supportive managers, and access to adequate resources to perform their jobs.[121]

Perhaps the most interesting aspect of these findings was the correlation between RN job satisfaction and availability of adequate resources. The term "adequate resources" is defined as "the presence of appropriate support services and sufficient staffing that enable RNs to accomplish their work, spend adequate time with their residents, and provide a high level of quality care."[122] While these resources may include technology and tools provided by the facility, another very important resource is care staff, including the CNAs, aides, feeding assistants, activity assistants, social workers, and other integral (and often overlooked) staff in the nursing home. Therefore, what RNs may need in order to improve their job satisfaction is more care staff to perform the personal care tasks, so that RNs can better focus on the true medical needs of residents. This finding suggests that an emphasis on providing greater numbers of support staff may go a long way in helping RNs experience higher job satisfaction, and subsequently, decreased turnover rates.[123] Encouraging facilities to improve these other measures like wages, participation in facility affairs, better management, and resources, staff turnover would decrease, and longer tenure of staff would allow for deeper relationships to be created among staff and residents.[124]

In sum, it has been long held that because of the complexities of the population within each nursing home, simple staffing ratios are improper. Additionally, the care residents receive is affected by many more factors than merely the number of RNs, LPNs, and CNAs that a nursing home employs. Workplace environment, available resources, and management structure are some of the few interrelated aspects of working in a nursing home that contribute to the care provided, and addressing those aspects may produce greater effects than simply increasing the RNs on payroll. Although the staffing star will continue to remain an incomplete predictor of care, the ACA attempts to ensure that the data used in the faulty formula is correct.[125]

---

120. Lenhoff, *supra* note 23, at 21.

121. Choi et al., *supra* note 49, at 489.

122. *Id.* at 490.

123. *Id.*

124. Lenhoff, *supra* note 23, at 21.

125. *See generally* Patient Protection and Affordable Care Act, Pub. L. No. 11-148, § 6106, 124 Stat. 713 (2010).

V. SECTION 6106: A RESPONSE TO "GAMING THE SYSTEM"

A. *Allegations of "Gaming the System"*

The Five-Star Quality Rating System has recently come under scrutiny due to allegations that nursing homes falsify the staffing data that they submit to the Website in order to achieve greater star ratings,[126] and a 2015 study found evidence that as many as eighty percent of nursing homes were inflating their staffing data for the Website.[127] Although other studies have not yet reaffirmed these results, such a high percentage of nursing homes alleged to be falsifying data is cause for concern. Eighty percent is a large majority of the industry, which indicates a systemic problem rather than a few bad actors. As discussed at length in this paper already, the systemic problem is the formula which awards having more RNs on staff, although such a measure does not adequately measure care.

B. *Section 6106*

Section 6106 of the ACA, which requires that "the Secretary shall require a facility to electronically submit to the Secretary direct care staffing information (including information with respect to agency and contract staff) based on payroll and other verifiable and auditable data,"[128] attempts to solve the problem of data falsification. Additionally, the statute requires specific data to be reported regularly, including the level of certification of each staff member, resident case mix, hours of care provided by each type of staff member, and "information on employee turnover and tenure."[129] In order to facilitate section 6106's requirement, CMS has implemented a uniform data collection system, called the Payroll-Based Journal.[130]

The goal behind this new reporting system is to curb the "gaming of the system" that is cause for concern in the industry,[131] but the concern with false staffing data should not be the main priority because the underlying staffing data is still mostly meaningless. Ideally, with standardized data requirements, nursing homes will no longer submit staffing data with inflated numbers of RNs. But if the allegation that as many as eighty percent of nursing homes are inflating their data is correct, after section 6106 implementation, the same

---

126. *See, e.g.*, N. Am. Health Care, 2015 WL 6871781, at *1.

127. Jeff Kelly Lowenstein, *Analysis Shows Widespread Discrepancies in Staffing Levels Reported by Nursing Homes*, CTR. FOR PUB. INTEGRITY (Feb. 13, 2015, 2:49 PM), https://www.publicintegrity.org/2014/11/12/16246/analysis-shows-widespread-discrepancies-staffing-levels-reported-nursing-homes.

128. *See* ACA § 6106(g).

129. *Id.*

130. *Staffing Data Submission PBJ*, *supra* note 80.

131. *See id.*

formula will be creating star ratings but with data that implicates lower staff numbers. Therefore, the only apparent trend will be an overall decrease in staffing ratings for most nursing homes on the Website.

Section 6106 therefore risks undermining any confidence consumers may have in the nursing home industry to provide good care. For example, a caregiver who visits the Website for updates on a loved one's nursing home may see that the staffing rating has declined. The consumer may then implicitly equate a lower rating on the Website with a lower standard of care and begin imagining greater faults with her loved one's facility. This paper has shown, however, that the staffing star does not accurately implicate quality of care; an overall decrease of star ratings will only further disillusion consumers with the industry as long as CMS continues to claim its staffing stars are reliable indicators of any valuable information about a nursing home.

Perhaps behind the motivation of section 6106 is the attempt to encourage nursing homes to actually improve their staffing numbers, rather than merely inflating the data. What section 6106 fails to account for, however, is the fact that nursing homes will still not be able to meet the demands that the faulty rating system requires. Doing so would require nursing homes to actually increase the amount of RNs on staff, which is likely to prove cost prohibitive for such a narrow-margin industry.[132]

C.   *Nursing Homes Will Still Be Unable to Meet the Higher Staffing Standards*

In order to increase RN numbers, nursing homes will have to spend more money on payroll, and that money has to come from somewhere, whether it is from increased reimbursement rates, raising the rates for private pay patients, or some other income-generating activity. In 2006, a study about the economics of nursing assessed the relative costs a nursing home would incur in order to increase its RN staffing.[133] The study found that an increase of twenty-five percent in quality measures via addition of more staff RNs would cost an average of $23.51 extra per resident, per day;[134] this amount translates to a monthly increase in expenses of $2,233 per month for additional RNs to meet the increase in quality measures. A majority of nursing homes are funded predominately by Medicare and Medicaid, however, which already reimburse

---

132. J. K. Wall, *Nursing Home Profits Surge as Owners Seek Moratorium*, INDIANAPOLIS BUS. J. (Feb. 15, 2014), http://www.ibj.com/articles/46158-nursing-home-profits-surge-as-owners -seek-moratorium (noting that most nursing homes operate on a two-to-four percent net profit margin).

133. *See generally* Zhang et al., *supra* note 83.

134. *Id.* at 85.

facilities at below market rates.[135] Without any evidence that Medicare and Medicaid will suddenly begin reimbursing nursing homes at break-even rates, nursing homes will have to bear the cost themselves.[136]

Yet, the Five-Star Quality Rating System is blind to the economic pressures of nursing homes, adding its own pressures for nursing homes to employ more RNs and figure out the finances regardless.[137] Despite the fact that the government is the largest payer for nursing homes and consistently underpays for the services provided, it remains a common perception that every nursing home "put[s] revenue over residents," and cuts corners at the expense of patients to maximize profits.[138] But the numbers show otherwise: to provide adequate care for residents, a typical nursing home loses almost twenty dollars per day per Medicaid resident due to the under-reimbursement by the federal health programs.[139] Most nursing homes operate on a two-to-four percent net profit, which leaves very little room to plan for unexpected expenses, upgrade facilities, or employ more staff.[140]

These opposing pressures—adding more RNs and working within the inadequate reimbursement rates—are both supplied directly by CMS, and it makes the financial situation for nursing homes appear unsustainable. Seventy percent of an average nursing home's budget already is spent on payroll.[141] Further, RNs are the costliest of the employees a nursing home may hire; the average hourly wage for an RN is $32.45,[142] while the average hourly wage for an LPN and CNA is $20.76,[143] and $12.36, respectively.[144]

For most facilities operating on very tight income margins, operating under the pressure to hire more RNs, which cost significantly more than other care staff, may result in a facility filling jobs better suited for LPNs and/or CNAs

---

135. *See generally* Charlene Harrington et al., *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 2009 Through 2014*, KAISER FAM. FOUND. (Aug. 4, 2015), https://kaiser familyfoundation.files.wordpress.com/2015/08/8761-nursing-facilities-staffing-residents-and-facility-deficiencies.pdf.

136. *See* Mary Ellen Biery, *Taking the Pulse of Nursing Care Centers*, FORBES (Mar. 22, 2012, 9:53 am.), http://www.forbes.com/sites/sageworks/2012/03/22/taking-the-pulse-of-nursing-care-centers/.

137. *See* ELJAY, L.L.C. & HANSEN HUNTER & CO., P.C., A REPORT IN SHORTFALLS IN MEDICAID FUNDING FOR NURSING CENTER CARE 22 (2015), https://www.ahcancal.org/re search_data/funding/Documents/2014%20Medicaid%20Underfunding%20for%20Nursing%20 Center%20Care%20FINAL.pdf.

138. Smith, *supra* note 58.

139. Biery, *supra* note 136.

140. Wall, *supra* note 132.

141. Lois A. Bowers, *2015 Business Outlook: Staffing*, LONG-TERM LIVING MAG., Dec. 17, 2014, http://www.ltlmagazine.com/article/2015businessoutlookstaffing.

142. *Registered Nurses*, *supra* note 61.

143. *Licensed Practical and Licensed Vocational Nurses*, *supra* note 32.

144. *Nursing Assistants and Orderlies*, *supra* note 69.

with RNs instead. To balance its budget, a facility may even replace three CNAs with one RN. Such a move may help increase the facility's rating on the Website because the staffing ratio rewards RNs. However, forcing an RN to fill the job duties usually assigned to LPNs or CNAs is likely to be dissatisfying for the RNs who hoped to perform the types of judgment calls and assessment tasks they learned about in school. This sentiment was highlighted in one research study where one RN reported, "as a new grad I need to be exposed to a hospital environment to hone my skills and I just do not see getting that clinical experience [in this nursing home]."[145] Instead, RNs in nursing homes will continue to perform mostly personal care like toileting, bathing, and dressing because the majority of care in a nursing home that is required is personal care assistance.[146] In 2014, the average nursing home resident received RN care for 0.47 hours each day, while the average care received by direct care staff was 3.73 hours per day.[147] Further, the kind of work required of RNs in nursing homes usually involves minimally basic nursing skills.[148] Thus, if RNs find themselves filled into jobs where a majority of their tasks are to assist residents with ADLs, the RNs are likely to become dissatisfied and possibly even disgruntled.

The aforementioned study also found that as RN education level increased (diploma level, associate's degree, bachelor's degree, and master's degree), job satisfaction of working in the nursing home setting drastically decreased.[149] This inverse linear relationship alludes to the desires among highly educated professionals to employ their knowledge and critical thinking skills in their jobs at a greater level, and if those skills are not properly used, job dissatisfaction tends to result.[150] Not only is a reduction in RN job satisfaction a concern for patient care, it can also lead to higher staff turnover, as RNs seek more complex experiences in acute care settings like hospitals.[151] However, hospitals themselves are currently experiencing issues maintaining a steady workforce of RNs, and to encourage staff loyalty, hospitals are able to provide

---

145. Michael Shipley, Factors Contributing To Registered Nurse Job Satisfaction In the Nursing Home, at 94 (May 14, 2015) (unpublished PhD dissertation, Seton Hall University), http://scholarship.shu.edu/cgi/viewcontent.cgi?article=3052&context=dissertations.

146. *See* Dellefield et al., *supra* note 48, at 95 (noting that historically a majority of direct care provided to residents has been by LPNs and CNAs).

147. *Id.*

148. Lenhoff, *supra* note 23, at 23.

149. Shipley, *supra* note 145, at 80 fig. 5.

150. *Introduction: The Workplace and Society*, U.S. DEP'T OF LABOR, https://www.dol.gov/_sec/media/reports/dunlop/section1.htm (last visited Feb. 3, 2016).

151. *See* Shipley, *supra* note 145 (quoting an RN's desire to hone her skills in an acute care environment).

salary increases and bonuses in attempts to recruit or keep the good RNs.[152] Nursing homes, however, working usually on minimal income budgets,[153] lack the financial resources to make an already unappealing workplace environment for nurses financially appealing.

In sum, the ability to recruit and keep RNs in the nursing home setting is only getting worse. With the government continuing its pressure for nursing homes to have more RNs, facilities find themselves in difficult positions—needing the numbers of staff to have a good Website rating while not being able to incentivize enough RN staff to want to work for them. Such competing pressures are unsustainable. Additionally, without an increase in funding for staffing to accommodate the increased mandatory staff ratios, nursing homes may have to cut costs in other areas, which could further impact the overall quality of care that the facility can provide.[154]

In order to meet staffing requirements, many facilities are forced to hire outside agency staff on a temporary basis, even though use of agency staff is more costly and has been linked with lower quality of care.[155] Hiring more staff under these circumstances "affect[s] equilibrium wages, alter[s] non-staff resources, and [changes] the mix of quality through a substitution effect as nursing homes change their use of labor."[156] But, as this paper has demonstrated, in order to bump up an extra star online (or to avoid a loss in star rating), this shift in labor comes with high costs and decline in care. Therefore, the pressures that the Website creates for nursing homes to maintain a certain amount of RNs, without accounting for other staffing factors or the costs involved, has strong forces that inhibit improvements in quality; it actually may be worsening quality of care rather than improving it.

VI. CALL FOR ACTION: STRIKE THE STAFFING STAR

A. *No Oversight Over CMS Exists*

The monumental impact that CMS continues to impose on the nursing home industry highlights the great extent to which this administrative agency has been allowed to act outside the scope of its authority. Although Congress

---

152. Beth Kutscher, *Stronger Economy Drives More Nursing Turnover, Higher Wages*, MOD. HEALTHCARE (Nov. 17, 2015), http://www.modernhealthcare.com/article/20151117/NEWS/1511 19897.

153. Wall, *supra* note 132.

154. John R. Bowblis, *Staffing Ratios and Quality: An Analysis of Minimum Direct Care Staffing Requirements for Nursing Homes*, 46 HEALTH SERVS. RES. 1495, 1496 (2011).

155. Nicholas G. Castle & John Engberg, *The Influence of Staffing Characteristics on Quality of Care in Nursing Homes*, 42 HEALTH SERVS. RES. 1822, 1843 (2007).

156. Bowblis, *supra* note 154, at 1500.

delegated some authority to the agency through statute,[157] CMS has clearly overstepped what it was granted—through both inaction and action. By failing to comply with OBRA's mandate through inaction, CMS has been permitted to continue its operations while virtually ignoring Congress's instructions.[158] In the private sector, if an employee refuses to perform a task requested by a supervisor, the employee would be reprimanded or terminated. Yet here, no sanctions have been imposed that would enforce Congress's authority to mandate that CMS take action. Instead of being censured for failure to act, CMS and other administrative agencies have continued to operate virtually unchecked, gaining power and authority to a point where they are sometimes referred to as the "fourth branch of government."[159] Although administrative agencies historically have helped administer law in a growing nation, being described as another branch of government indicates their powers have grown too large; this growth interferes with the nation's constitutional tripartite system.

As if Congress has recognized the overreaching of CMS in its rating systems, it has mandated an investigation of the rating system through section 6107. But Congress has fallen short of creating any enforceable change; the statute provides no enforcement mechanism to ensure CMS complies, leaving CMS with no incentive to change.

In addition to its inaction concerning OBRA, CMS has added insult to injury by creating the Website and the Five-Star Quality Rating System. Where CMS admits the standards of assessing quality of care are faulty, and a lengthy discussion in this paper has highlighted the extreme degree to which the staffing standard is erroneous, no mandate exists for the standards to ever be rectified. CMS only has had the ability to move forward with this action due to a lack of oversight and enforcement mechanisms to ensure CMS's assessments of data are first and foremost reliable. Continuation of this lack of oversight will only perpetuate CMS's ability to impose standards that work against quality, an issue that creates widespread negative implications for health care provision and the sustainability of an industry that provides a vital service.

---

157. Social Security Act of 1935, 42 U.S.C. § 1395hh(a) (2006) (pursuant to this authority the Secretary created the Health Care Financing Administration, which was eventually renamed as the Centers for Medicare and Medicaid Services). *See also generally* CTRS. FOR MEDICARE AND MEDICAID SVCS., MILESTONES 1937-2015 (2015), https://www.cms.gov/About-CMS/Agency-Information/History/Downloads/Medicare-and-Medicaid-Milestones-1937-2015.pdf.

158. *See generally* Harkins, *supra* note 1. *See also* Heckler v. Chaney, 470 U.S. 821, 839 (1985) (noting that an agency decision not to act is presumptively non-reviewable by courts).

159. Elizabeth Slattery, *Who Will Regulate the Regulators? Administrative Agencies, the Separation of Powers, and Chevron Deference*, HERITAGE FOUND. 3 (May 7, 2015), http://www.heritage.org/research/reports/2015/05/who-will-regulate-the-regulators-administrative-agencies-the-separation-of-powers-and-chevron-deference.

Imposing oversight mechanisms for such a powerful and longstanding government agency is likely outside the reach of the near future. First, the Administrative Procedure Act (APA), which governs administrative agencies, does not apply to "agency action that is committed to agency discretion by law."[160] Usually the enforcement decisions of an agency fall under this category,[161] which means that if CMS chooses not to enforce something, the APA limits a court's power to review the agency's choice. If the solution were to increase judicial oversight over CMS, precedent shows us that the judiciary is likely to continue giving deference to administrative agencies.[162] Additionally, in order for a case to have standing in court, a demonstrable harm would have to occur to a nursing home as a result of CMS's use of an erroneous staffing formula. Such proof would be nearly impossible to provide, and thus, judicial oversight of CMS in this respect is unlikely. Further, taking this issue to the courts requires an increase in nursing home litigation, a process which requires vast resources that are better spent on providing services and amenities to improve residents' qualities of life. Litigation would also take many years to resolve, and with the imminently growing elderly population, the problem needs to be fixed sooner rather than later. The policy implication remains, however, that CMS should not able to unilaterally determine that greater numbers of RNs necessarily leads to better quality of care.

B. CMS as a Market Power

As both a government agency and the largest payer of health care services, CMS sits in a delicate position where it must regulate for the good of all yet also perform as a business to ensure its funds are being spent appropriately.[163] Through Medicare and Medicaid, CMS dominates the health care market, thereby having enormous power to control how the industry is run.[164] If CMS decides that more RNs are necessary, it can choose to set standards that risk decertifying nursing homes, or it can publish data that makes certain nursing homes appear to the public to be poor providers.[165] No matter what the standards, nursing homes rely on payments from CMS, so if CMS says

---

160. Administrative Procedure Act § 701(a)(2), 5 U.S.C. § 701.

161. *See* Chevron U.S.A., Inc. v. Nat. Resources Def. Council, Inc., 467 U.S. 837, 842–44 (1984).

162. *Id.* at 844.

163. Bruce Patsner, *Marketing Approval Versus Cost of New Medical Technologies in the Era of Comparative Effectiveness: CMS, not FDA, Will Be the Primary Player*, 3 J. HEALTH & LIFE SCI. L. 38, 55 (Apr. 2010).

164. *Id.* at 43.

165. *See generally* NURSING HOME COMPARE, *supra* note 25.

"jump," a nursing home must jump, or risk serious financial consequences.[166] Thus, CMS has the ultimate power to destroy a nursing home's business if CMS believes the facility is not meeting the agency's self-determined standards. Such power over such a vital industry should be taken seriously and exercised correctly.

With this power, CMS interrupts the free market trends that would normally exist between consumers and skilled nursing facilities.[167] If the free market were able to influence quality in nursing homes, the poorer performing facilities would flounder while the exceptional facilities would shine, by virtue of public opinion and free consumer choice.[168] By publishing the star ratings, however, CMS provides its own opinion of the provision of care in nursing homes, which consumers often rely on before developing their own opinions first.[169] Those consumers looking to find skilled nursing care are typically vulnerable, having experienced a decline in the health of oneself or a loved one that requires transition to twenty-four hour care.[170] At this point, consumers use the Website information to choose which facility will be the care provider, and although transfers between homes are possible, significant barriers— including financial constraints (like Medicaid as payment source), "not having a spouse (who can advocate for transfers),"[171] psychological and physical risks, and limited information about actual quality of care—exist as pressures keeping transfer rates low between facilities.[172] The low incidence of transfers between facilities shows that when an initial place of care is determined, it is likely to be the sole provider of care for a resident.

Therefore, the information that a consumer uses to decide where to receive care is extremely important, and because CMS advertises that its data represents the quality of care one can expect to receive, it should be meaningful, correct, and impartial. But CMS is not impartial—it has a strong

---

166. James E. Utterback, *Substituting an Iron Fist for the Invisible Hand: The False Claims Act and Nursing Home Quality of Care – A Legal and Economic Perspective*, 10 QUINNIPIAC HEALTH L. J. 113, 167 (stating that "[nursing homes] must adapt or risk going out of business").

167. *Id.* at 164.

168. *See id.*

169. Barbara Peters Smith, *Nursing Home Star Ratings Change Make it Tougher to Shine*, HERALD-TRIB. (Feb. 20, 2015), http://health.heraldtribune.com/2015/02/20/nursing-home-star-ratings-change-makes-tougher-shine/.

170. *Long Term Care: Transfers Between Nursing Homes are Fairly Common, but Barriers to Transfer Exist for Some Patients*, AGENCY FOR HEALTH CARE RES. & QUALITY (June 2000), http://archive.ahrq.gov/research/jun00/0600RA15.htm.

171. *Id.*

172. Richard A. Hirth et al., *Does Quality Influence Consumer Choice of Nursing Homes? Evidence from Nursing Home to Nursing Home Transfer*, 40 INQUIRY 343, 344 (Winter 2003–2004).

interest in making sure the money it spends is used wisely.[173] And it has found how to meet that interest by guiding the public's choices. In 2015, a CMS administrator even admitted that the star ratings are important because they help guide the decisions of consumers.[174] Even if the original intent behind the Website was to promote access to information about the quality of care in nursing homes,[175] left to its own devices, CMS has used the Website to guide consumers towards facilities that perform well according to the erroneous standards it dictates.

In sum, consumers usually approach the Website seeking information as new entrants to the skilled nursing care market, yet they lack substantive background knowledge of what factors are important, so the Website provides that information for them. Since this information comes from CMS, which should be an impartial agency, consumers rely on what the Website says. If CMS rates one facility higher than another, it better have accurate and important data to back up such an assertion. But as this paper has shown, CMS does not have accurate data to indicate that the staff a facility provides will provide better care.

C. *Remove the Staffing Rating*

It is clear that the current portrayal of staffing data on the Website cannot continue. The data is a highly inaccurate indicator of the care that is provided in facilities, and it is a strong driver of the choices that consumers make about which facility to use. Further, the probability of bringing action to courts to enforce that CMS is advertising accurate data is unlikely.

The easiest solution, therefore, is to eliminate the Website's staffing star. The staffing formula is inaccurate, and it places a bias on one specific quantitative measure—the number of RNs. Highlighting this one data point reflects to consumers that it is necessarily more important than other potential measures, and if a nursing home performs poorly on this one data measure, it implies to consumers the nursing home *will* provide poor care. Section 6106 continues to place emphasis on this one point of data and requires even greater resources to focus on adjusting this measure, but as shown herein, it still does not fix anything.

By getting rid of staffing altogether as a measure, the actual quality measures become more visible and more important. Staffing is an input-based

---

173. 2016 CMS QUALITY STRATEGY REP. 2 (discussing CMS's initiatives to "transform the health care system into one that . . . spend[s] our health care dollars in a smarter way").

174. Smith, *supra* note 169 (quoting Patrick Conway, Deputy Administrator for Innovation and Quality and Chief Medical Officer at CMS: "when there's bunching or grouping at the high point of the scale, it doesn't help [consumers] make decisions").

175. Jan P. Clement et al., *Nursing Home Price and Public Quality Information*, 47 HEALTH SERVS. RES., Feb. 2012, at 86, 87.

structural measure,[176] yet as this paper has shown, the input of more RNs does not necessarily create better care. Without the staffing star, consumers will be able to focus on the important output-based quality measures that the Website displays—namely the quality star and overall star associated with each facility. If quality of care is the main concern for consumers and CMS, then the quality measures should shine without being displayed alongside the staffing star, which is effectively meaningless.

VII. CONCLUSION

With the GAO investigation under way pursuant to section 6107, the time is ripe for revision of the standards that CMS uses in determining its ratings. By creating a new data reporting method, section 6106 impliedly admits that a problem exists with the current model of staffing data and Nursing Home Compare, but the solution that it proffers fails to address the underlying faulty formula that is improperly biased towards more RN staff. Without an adjustment of the way in which the staffing ratings are determined, nursing homes will still face pressure to employ more RNs or falsify staffing data despite the fact that increasing RNs does not necessarily lead to better care outcomes. And as this paper has shown, it can lead to exactly the opposite—a decline in care quality.

Additionally, although the GAO is ordered to report its findings of its investigation to Congress, the ACA stops short by requiring neither Congress nor CMS to act on those findings. Much like the failure to act on the finding that assessing quality in nursing homes was not easily measurable in the late 1980's, no oversight exists to ensure that whatever the results of the GAO investigation reveal will actually be used to implement meaningful change.

Rather than encouraging more judicial oversight over CMS or proposing legislation to hold CMS accountable, the single most practical solution to rectify the inaccurate staff data is to simply remove it from the Website and to revert to IOM's message from over two decades ago: "Because of the complexities of case mix—that is, the widely differing needs of individual residents in the same facility—prescribing simple staffing ratios clearly is inappropriate."[177] As the Baby Boomers age, more elders will be placed in nursing homes,[178] regardless of the staffing star's impact on quality of care. Without a change in the staffing rating, however, consumers' perception of the quality of care they receive will decline because the Website is a strong driver

---

176. *See* Dellefield et al., *supra* note 48; Choi et al., *supra* note 49 (explaining the Donabedian Model).

177. IOM REPORT, *supra* note 6, at 102.

178. Storrs, *supra* note 12.

of consumers' opinions. Yet as nursing homes fill with residents and transfers between facilities remain rare, consumers will enter the facilities with already marred opinions, which may color their entire experience in skilled nursing care.

ELIZABETH J. TUCKER*

---

* Elizabeth J. Tucker, M.S.W., is a candidate for J.D. (2017) at Saint Louis University School of Law.