August 1, 2011

Office of Management and Budget
Office of Information and Regulatory Affairs
Attention: CMS Desk Officer
OIRA_submission@omb.eop.gov

Re: Proposed Information Collection of Skilled Nursing Facility Direct Care Expenditures (Form CMS-2540-10 Section S-3 Part V)
OMB Control No: 0938-0463

Dear CMS Desk Officer:

We appreciate the opportunity to submit comments on the proposed information collection of skilled nursing facility (SNF) direct care expenditures as part of the implementation of the nursing home transparency provisions of the Patient Protection and Affordable Care Act (ACA). PHI (formerly the Paraprofessional Healthcare Institute) is a national organization that works to improve the lives of people who need home or residential care – and of the direct-care workers who provide that care. Our work is grounded in the philosophy that **quality jobs** for direct-care workers will lead to **quality care** for long-term care consumers. Our goal is to ensure caring, stable relationships between consumers and workers, so that both may live with dignity, respect, and independence. We strongly believe that the availability of good quality data on the direct care workforce providing long-term services and supports is fundamental to developing policies and standards to ensure quality and access for consumers.

We commend the efforts of CMS and the Obama Administration to implement Section 6104 of the ACA in a timely manner. Many of the data points on the proposed form are

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valuable; however, we recommend you make key modifications that will "enhance the quality, utility, and clarity of the information to be collected"[1] before it is finalized.

The collection of adequate, relevant data on direct-care workers from SNFs is an important step forward. We urge that the proposed information collection be modified to include several essential data elements on direct-care workforce compensation, volume and stability. The additional elements and specific data points we recommend were outlined in a report to the Centers for Medicare and Medicaid Services (CMS) in February 2009[2] after careful research and analysis. These recommendations were developed by CMS's Direct Service Workforce Resource Center, an historic collaborative effort to examine the home and community-based services workforce by the nation's key workforce experts on a wide variety of home and community-based service systems. They are informed by the Resource Center's experience providing technical assistance to over half the states in order to help them strengthen their direct service workforces. We hope you will use the recommendations from this report as a basis for the proposed information collection.

Consumers and payers need to know how much of their payment for services is going to the actual provision of care, especially direct caregivers and support staff. The care of over 1.5 million nursing home residents in the U.S. is largely in the hands of CNAs as they provide 80-90% of the care in a nursing facility so it is essential that solid data is gathered on this frontline, primary workforce. The collection of wage and benefit expenditure data for nursing homes per the ACA provides an exciting opportunity to analyze this information for all of the nation's skilled nursing facilities for the first time. Such workforce and expenditure data is vital to efforts to improve workforce stability and to gauge the effectiveness of labor market interventions.

We believe the following recommended modifications to the proposed form will make the data more useful for policy makers, academics and researchers, consumers, employees, and the skilled nursing industry as a basis for comparison for investment in the direct-care workforce and the effectiveness of policy interventions to strengthen the workforce.

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[1] Federal Register Vol 76 No 127, Friday July 1, 2011 page 38657. The notice invited interested persons to send comments regarding any aspect of this collection of information, such as the subject of "(3) ways to enhance the quality, utility, and clarity of the information to be collected".

[2] "The Need for Monitoring the Long-Term Care Direct Service Workforce and Recommendations for Data Collection", National Direct Service Workforce Resource Center, February 2009, www.dswresourcecenter.org.

RECOMMENDED MODIFICATIONS TO THE PROPOSED SNF DIRECT CARE EXPENDITURE FORM

1. **Add columns for "Regular Wage and Hours" information and "Other Wage and Hours" to produce an accurate hourly wage estimate**
   One of the major benefits of this information is to understand and analyze the hourly wages of the various direct care job classifications. By separating regular (base) salaries and hours from other types of salaries and hours (e.g. overtime wages and hours, bonus payments), a more accurate average hourly wage can be calculated. The proposed form uses an average hourly wage based on total salary (regular, overtime, bonus, and other non-regular salary) and fringe benefits. The proposed methodology will result in an inflated average hourly wage estimate because the overtime and bonus salaries and hours, which are generally higher and are not a stable reliable predictable payments, are not differentiated from regular hours. Separating regular salary and hours information should not be an additional reporting burden since this information is generally separated out in payroll documentation that facilities will be supplying to CMS in accordance with Sec. 6103 of the ACA.

2. **Add a separate occupational category for "Certified Nursing Assistants (C.N.A.s)" rather than including C.N.As in one single "Nursing Assistant/Nurse Aide" occupational category.**
   Most direct care in skilled nursing facilities is provided by C.N.A.s, therefore it is important that their salaries, hours, and benefits are reported separately from non-certified aide staff. C.N.A.s differ from other aides since there is a federal standard as established by OBRA 1987 of at least 75 hours of training. [3] Additionally, in Section 6104 of the ACA (Section 1888 of the Social Security Act (f)(1)), Certified Nursing Assistants are specifically listed as one of the minimum categories for expenditure information collection. Additionally, non-certified aides do not constitute a large portion of the caregiving workforce but may be used in specific situations and for certain types of services (e.g., feeding assistant). As they are generally paid less, their inclusion with the C.N.A. wage and hours information may result in underestimating the average hourly wage of C.N.A.s.

3. **Add a "Labor Turnover" section**
   While the wage and benefits expenditures information requested in the proposed form is extremely useful, we also urge you to collect data on workforce stability. The eldercare/disability services industry is characterized by chronically high rates of

[3] Federal Regulations: 42 CFR 483 contain the minimum standard for nurse aide training http://edocket.access.gpo.gov/cfr_2002/octqtr/pdf/42cfr483.151.pdf

workforce instability and turnover. For the last decade, the vast majority of states have reported shortages of direct care workers generally, high turnover and vacancy rates, lack of qualified staff, and difficulty retaining workers.[4] An unstable workforce compromises both access to services and the quality of the services received by consumers. In addition, staff instability and turnover are expensive, resulting in financial burdens for providers as well as state and federal governments which foot a large part of the bill for this care. The ability to assess the trends in workforce turnover and its related costs is important. This data is also an indicator to consumers of quality and consistency.

4. **Add lines for support staff classifications**
   In anticipation of implementation of other aspects of Section 6104 Section 1888 of the Social Security Act (f)(3)(1)(B), which will require categorization of expenditures into functional accounts on an annual basis of direct care services, indirect care (including housekeeping and dietary services), and administrative services costs not later than 30 months after enactment, we recommend that wage and benefit information for support staff classifications be added to the form at this time. In California, SNFs are required to provide salary and hours information for support staff classifications along with nursing staff in the Medi-Cal cost report.[5]

5. **Add "Health Insurance" "Pension/Defined Benefit" and "Other" columns to distinguish between benefit categories[6]:**
   Although one lump fringe benefits amount is helpful, this information will not lead to detailed analysis of the type of fringe benefits that are provided to direct care employees. In light of the passage of the ACA with its emphasis on employer-sponsored insurance, understanding whether the employer is providing insurance and the quality of that insurance will be of particular interest. To collect this information, the expenditure form should be revised to include a separate line item for health benefits expenditures and specification of the number of enrollees (including the employee and their dependents if applicable) by job category. In addition, information on the number of employees with paid sick or vacation leave, by job title, is also important and we recommend its inclusion.

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[4] Since 2003, the National Survey of state Initiative son the Long-Term Care Direct Care Workforce has found that the vast majority of states consider direct-care turnover and vacancies to be a serious issue. The percentage of states has varied from 88 percent in 1999 to 97% in 2007. For more information, see other annual survey results at http://www.phinational.org/clearinghouse

[5] See worksheet 12.1 of California Integrated Disclosure and Medi-Cal Cost Report for skilled nursing facilities

[6] CMS Provider Reimbursement Manual Publication 15, Chapter 21 Section 2144 , available at http://www.cms.gov/Manuals/PBM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS021929&intNumPerPage=10

6. **Add "Number of Employees" column in each occupational category**
   It would be useful to collect the actual number of employees in each occupational category rather than create an estimate of full-time equivalents, which underestimates the number of employees since several SNFs use part-time employees. This data should separate out full-time (35 hours or more per week) and part-time (less than 35 hours per week) employees, and separate the number of direct-care workers employed by job title. Ideally, the data should separate employees who work less than 20 hours, and 20 to 35 hours, and over 35 hours per week.

   Given the historic and continuing problems of labor shortages and high caregiver turnover, workforce problems may be the most significant obstacles to improving quality in skilled nursing facilities. We believe that SNF direct-care wage and benefit expenditure information collection, if properly implemented, presents an unprecedented opportunity to understand basic economic employment characteristics of this workforce, to analyze trends, and identify potential solutions to improving workforce stability in this important industry which cares for some of the most vulnerable members of our society. Additionally, this data will enable consumers and payers to evaluate how much each facility spends on the provision of direct care and support services as part of its total budget. We urge OMB and CMS to include our recommended modifications to the cost report form and instructions.

   Respectfully submitted,

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