JOINT COMMISSION ON HEALTH CARE

EVALUATION OF VIRGINIA'S NURSING HOME WORKFORCE AND CONSIDERATIONS FOR A STATE NURSING HOME STAFFING STANDARD

REPORT TO THE GOVERNOR AND THE
GENERAL ASSEMBLY OF VIRGINIA



REPORT DOCUMENT #838

COMMONWEALTH OF VIRGINIA
RICHMOND
2026

Code of Virginia § 30-168.

The Joint Commission on Health Care (the Commission) is established in the legislative branch of state government. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care. Further, the Commission shall encourage the development of uniform policies and services to ensure the availability of quality, affordable and accessible health services and provide a forum for continuing the review and study of programs and services.

The Commission may make recommendations and coordinate the proposals and recommendations of all commissions and agencies as to legislation affecting the provision and delivery of health care. For the purposes of this chapter, "health care" shall include behavioral health care.

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Page 17 of the *Final Report on the Evaluation of Virginia's Nursing Home Workforce and Considerations for a State Nursing Home Staffing Standard* has been revised to accurately summarize Item 291.LLL.1.b of the 2026 Appropriation Act, which provides $35 million from the general fund and $35 million from the nongeneral fund to increase nursing home per diem rates for one year for fee-for-service and Medicaid managed care members.

Evaluation of Virginia's Nursing Home Workforce and Considerations for a State Nursing Home Staffing Standard

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Evaluation of Virginia's Nursing Home Workforce and Considerations for a State Nursing Home Staffing Standard

POLICY OPTIONS IN BRIEF

Option: Establish a nursing home staffing standard that includes the following thresholds:

- Beginning Fiscal Year 2029, 3.09 adjusted total nurse staffing hours per resident day (HPRD),
- Beginning Fiscal Year 2031, 3.32 adjusted total nurse staffing HPRD, including 0.54 adjusted RN staffing HPRD and 2.06 adjusted CNA staffing HPRD, and
- Beginning Fiscal Year 2034, 3.43 adjusted total nurse staffing HPRD, including 0.60 adjusted RN staffing HPRD and 2.23 adjusted CNA staffing HPRD.
  (Option 1, page 24)

Additional Options:

If the JCHC recommends establishing a staffing standard, the JCHC could also:

- Establish a hardship fund for nursing homes unable to meet the Fiscal Year 2029 threshold (Option 1a, page 29)
- Make the Fiscal Years 2031 and 2034 thresholds contingent upon additional state appropriations (Option 1b, page 31)

FINDINGS IN BRIEF

State and federal regulations are meant to ensure the health and safety of nursing home residents

Nursing homes serve individuals with significant nursing care needs who cannot be safely supported in less intensive care settings. State and federal regulations set standards for the type and quality of care nursing home residents should receive and establish the process for monitoring compliance with those regulations. State and federal regulations do not establish specific staffing standards for nursing staff. State complaint investigators point to insufficient nursing staff as the root cause of many complaints about resident quality of care in nursing homes.

Nurse staffing levels and nursing skill mix drive quality of care in nursing homes

A substantial body of evidence associates higher nurse staffing levels and balanced nursing skill mix in nursing homes with improvements in quality of care and resident health outcomes, such as reduced pressure ulcers, urinary tract infections, and hospitalizations. Registered nurses (RNs) demonstrate the strongest relationship with resident quality of care, followed by certified nurse aides (CNAs). While licensed practical nurses (LPNs) provide important services in nursing homes, the statistical relationship between LPN hours alone and quality of care is not consistent.

Nurse staffing levels and nursing skill mix are inadequate in some of Virginia's nursing homes

Virginia's average nurse staffing level for nursing homes falls below the national average. In addition, the nursing skill mix in Virginia nursing homes is imbalanced, with higher levels of LPN staffing and lower levels of RN and CNA staffing. Virginia nursing homes also report higher turnover rates among all nursing staff and among RNs compared to the national average. Virginia's lower-staffed nursing homes have lower quality ratings.

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- Require the Board of Health to promulgate regulations incorporating staffing standards in the state's licensing requirements
(Option 1c, page 32)

- Establish a good faith exception for nursing homes unable to meet the staffing standard
(Option 1d, page 32)

- Provide funding to the Virginia Department of Health (VDH) to increase the agency's capacity to enforce the staffing standard
(Option 1e, page 33)

- Require the Department of Medical Assistance Services (DMAS) to collect information from nursing homes on how additional public funds are used to support the nursing workforce
(Option 1f, page 33)

- Provide funding to VDH to evaluate the impact of the staffing standard
(Option 1g, page 34)

- Require DMAS to update the Nursing Facility Value-Based Purchasing Program's thresholds for staffing measures to align with the state staffing standard
(Option 1h, page 34)

October 2026

Virginia funds incentive programs to address nursing home workforce shortages

Persistent nursing workforce shortages across Virginia's health care settings impacts nursing home staffing levels. The nursing home workforce has returned to pre-pandemic levels but the longstanding gap between nursing supply and demand remains. Virginia offers scholarship and loan repayment programs for nursing staff in long-term care settings and a value-based purchasing program for nursing homes.

Most states have staffing standards for nursing homes

Staffing standards are one tool states can use to improve quality of care by requiring nursing homes to meet minimum nurse staffing levels. When states tie staffing standards to the process for licensing nursing homes, states see improvements in staffing with few negative consequences. Thirty-two states and Washington, D.C. have enacted a staffing standard. Virginia enacted a nursing home staffing standard in 2023, then repealed it when the Centers for Medicare and Medicaid Services (CMS) established federal staffing standards.

Virginia should re-establish a nursing home staffing standard

Virginia does not require nursing homes to meet a staffing standard even as compelling evidence supports higher nurse staffing levels. The General Assembly could address this gap by re-establishing a staffing standard that increases nurse staffing levels and improves skill mix in Virginia nursing homes. Coupling staffing standards with funding to address the anticipated increased costs of care and considerations for enforcement, increased accountability, policy evaluation, and support for the nursing workforce may ease implementation and feasibility concerns and amplify the effectiveness of staffing standards over time.

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Evaluation of Virginia's Nursing Home Workforce and Considerations for a State Nursing Home Staffing Standard

Nursing homes serve the sickest, most medically needy individuals who cannot safely be cared for at home, in assisted living facilities, or in other community-based settings. The Virginia Department of Health (VDH) licenses and inspects nursing homes to ensure that members of this vulnerable population, who are often unable to advocate for themselves, receive quality care in a safe environment. Evidence shows that the level of nursing staff in nursing homes is associated with quality of care measures. Virginia's lack of a nursing home staffing standard has raised concerns about the state's ability to ensure the quality of care in nursing homes.

Virginia law currently requires nursing homes to staff at levels sufficient to meet the needs of residents. Virginia legislators are considering a change to state law to instead require nursing homes to provide a specific number of hours of nursing care per day for each resident. Most recently, House Bill 605 (Willett), introduced during the 2026 General Assembly session, attempted to establish a minimum standard for the number of hours of nursing care that nursing homes must provide per resident per day. However, stakeholders raised concerns about the feasibility of implementing a staffing standard given anticipated costs to nursing homes and to the state, workforce shortages, and the risk of reduced access to care if nursing homes could not reach the proposed standard. The bill was subsequently amended to instead direct the Joint Commission on Health Care (JCHC) to study the nursing home workforce and provide considerations for adoption of a nursing home staffing standard in Virginia (see APPENDIX 1 for bill text).

This report examines the relationship between nursing home quality of care and nurse staffing levels, analyzes current nurse staffing levels in Virginia nursing homes, assesses the effectiveness of staffing standards implemented in other states, and provides a series of recommendations for legislators to consider if Virginia were to adopt a nursing home staffing standard. This report also addresses components of House Bill 1357 (McQuinn) related to nursing home staffing. House Bill 1357 requires the JCHC to conduct a comprehensive assessment of quality of care, resident safety, and operational practices of nursing homes in the Commonwealth (see APPENDIX 2 for bill text). JCHC staff will address the remaining components of House Bill 1357 in a separate report by December 1, 2027.

High levels of qualified and trained nursing staff, particularly Registered Nurses (RNs) and Certified Nurse Aides (CNAs), are consistently associated with better resident outcomes, fewer complaints, and higher quality ratings. At the same time, staffing levels in Virginia

nursing homes remain below national averages, particularly for CNA staffing, with substantial variation across nursing home payer-mix and ownership types. Nursing homes with lower staffing levels demonstrate poorer quality ratings, while workforce shortages and high turnover continue to challenge nursing homes' ability to recruit and retain staff (see APPENDIX 3 for study methodology). Virginia could improve nursing home quality of care and resident outcomes through the phased implementation of a nursing home staffing standard that is adjusted for residents' complexity of care and that includes a staffing threshold for total nurse staff and separately, for RNs and CNAs that counts toward satisfaction of the total nurse staffing threshold. The General Assembly could support implementation of a staffing standard with state funding to offset the anticipated increased costs of care and by pairing the standard with enforcement mechanisms, additional accountability measures, ongoing evaluation, and continued investments in programs that incentivize nursing workforce recruitment and retention efforts.

State and federal regulations are meant to ensure the health and safety of nursing home residents

Nursing homes serve individuals with substantial physical, cognitive, or medical care needs who cannot be safely supported in less intensive care settings.[1] State and federal regulations set standards for the type and quality of services nursing home residents should receive and establish the process for monitoring compliance with those regulations. Virginia and federal regulations require nursing homes to staff sufficiently to meet the needs of residents, but do not establish specific standards for nursing staff. State complaint investigators point to insufficient nursing staff as the root cause of many complaints about resident care in nursing homes.

Nursing homes provide care for vulnerable, medically complex individuals

The 291 nursing homes operating in Virginia care for approximately 27,000 residents per day.[2] Nursing home residents require continuous supervision, ongoing nursing care, and assistance with activities of daily living (ADL) such as bathing, eating, or toileting. Nationally, 64 percent of nursing home residents stay fewer than 100 days, typically for post-acute care following a hospital stay.[3] The remaining 36 percent of residents live with multiple conditions that require ongoing medical care and will reside in a nursing home for the remainder of their lives. In Virginia, the average age of a nursing home resident is 77 years old, although approximately 17 percent of nursing home residents are under the age of 65.[4] Most residents in Virginia nursing homes are living with one or more chronic conditions, including hypertension (79 percent of residents), Alzheimer's or a related dementia (42 percent), congestive heart failure (24 percent), or schizophrenia or bipolar disorder (12 percent). Only five percent of nursing home residents in Virginia can walk independently.

Nursing homes provide a range of health and personal care services to meet resident needs. Services offered in a nursing home typically include nursing care, 24-hour supervision, three meals a day, and assistance with everyday activities. Rehabilitation services, such as physical, occupational, and speech therapy, are also available.[5] In addition to nursing and rehabilitation services, 25 percent of Virginia nursing homes also offer dedicated Alzheimer's and related dementia services, 18 percent offer distinct palliative care services, and 14 percent offer specialized wound care services.[2]

State agencies license and inspect nursing homes and investigate complaints

Virginia protects vulnerable nursing home residents by setting licensing requirements for nursing homes, conducting regular inspections to ensure compliance with both federal and state requirements, investigating complaints alleging violations of federal or state requirements, and imposing sanctions for violations. The Virginia Department of Health (VDH) licenses nursing homes in Virginia. To be licensed, nursing homes must meet the requirements set forth in *12VAC5-371-10* et seq., including providing administrative services such as developing and implementing policies that ensures residents' rights; resident services such as nursing care, physician services, and social services; support services such as a dietary and food service program and housekeeping; and physical building specifications.

Ninety-nine percent of nursing homes in Virginia, or 289 of 291 nursing homes, are certified nursing facilities, meaning they are qualified to participate in the Medicaid program, the Medicare program, or both.[6] Certified nursing facilities must comply with federal regulations set forth in 42 CFR Part 483 Subpart B. The 23 sections of Subpart B include requirements for person-centered care planning; quality of care and quality of life; physician, nursing, and pharmacy services; food and nutrition services; emergency planning and infection control; and facility operations, among other matters.

VDH conducts on-site inspections of nursing homes to document compliance with state regulations. Pursuant to 42 U.S.C. § 1395aa, VDH is authorized to conduct on-site surveys of nursing homes that are qualified to participate in the Medicaid or Medicare programs, on behalf of the Centers for Medicare and Medicaid Services (CMS), to document compliance with federal regulations. State law provides that VDH must conduct state licensure inspections at least every two years, and federal regulations state that VDH must conduct certification surveys at least once every 15 months. However, as of October 2026, VDH indicates approximately 52 percent of nursing homes in Virginia are overdue for inspections.[7]

VDH may impose sanctions against nursing homes that violate state regulations, and CMS may act or direct the state to act if nursing homes are out of compliance with federal regulations. The type of sanction imposed depends on the scope and severity of the violation. Currently, VDH may restrict or prohibit new admissions or revoke or suspend a nursing home's license. The General Assembly recently expanded the types of sanctions

available to the Commissioner of Health, which include placing a nursing home on probation and imposing civil penalties.[8] VDH may implement these sanctions once the agency promulgates updated regulations. CMS may also impose a broad array of sanctions, including civil monetary penalties, denying Medicare or Medicaid payments for existing residents or new admissions, or terminating agreements with nursing homes for Medicare or Medicaid participation, if they fail to comply.[9]

State agencies conduct complaint investigations in response to specific allegations from residents, family members, nursing home staff, and others. Complaint investigations allow the state to identify and address potential violations of state and federal regulations that VDH may not detect during routine inspections. VDH investigates complaints against nursing homes, as does Virginia's long-term care ombudsmen program, a federally required program funded through the Older Americans Act (42 U.S.C. § 3001 et seq.) and housed within the Virginia Department of Aging and Rehabilitative Services (DARS). Local departments of social services investigate complaints that rise to the level of adult abuse, neglect, or exploitation with support from DARS's Adult Protective Services Unit.[10] In addition, the Virginia Board of Nursing and the Virginia Board of Long-Term Care Administrators investigate complaints against staff in nursing homes who are licensed or certified by their respective boards.[11]

Discretionary staffing regulations may limit the Commonwealth's ability to proactively address staffing concerns

Both state and federal regulations permit nursing home operators broad discretion to staff their nursing homes at the levels they deem sufficient for the residents in their care. Per *12VAC5-371-210,* state-licensed nursing homes must provide qualified nurses and CNAs on all shifts, seven days per week, in sufficient number to meet the assessed nursing care needs of all residents. Per 42 C.F.R. § 483.35, certified nursing facilities must provide licensed nurses and nurse aides in sufficient numbers to address resident care needs on a 24-hour basis and must have the services of a registered nurse (RN) at the facility for at least eight consecutive hours a day, seven days a week.

Some stakeholders view state and federal regulations as too imprecise to support enforcement activities.[12] Without a staffing standard to measure nursing homes against, the state can only address insufficient staffing retroactively when it results in resident harm or other regulatory violations. Agencies tasked with investigating complaints against nursing homes believe that insufficient nursing staff, either for the number of residents in the nursing home or the complexity of residents' care needs, is the root cause of many common complaints. Insufficient staffing in nursing homes can lead to inadequate training, reduced supervision, increased nursing staff burnout, and administrator's reluctancy to remove underperforming nursing staff from employment.[12] Complaint investigators provided multiple examples of complaints they attribute to insufficient nursing staff:

- Complaints about inadequate care, such as pressure ulcers, lack of food or water, or missed medications;
- Complaints about failure to monitor patients, such as unanswered call bells or unsupervised residents; and
- Complaints about nursing staff, such as falsely documenting care, improper medication administration, or practices exceeding scope.

Complaint investigators also note that complaints about nursing home care tend to cluster in certain types of nursing homes, an indication that underlying facility conditions, such as insufficient staffing, are contributing to complaint volume rather than isolated incidents.

Nurse staffing levels and nursing skill mix drive quality of care in nursing homes

The connection between nursing staff and quality of care is multifaceted, influenced by nurse staffing levels; nursing skill mix, or the ratio of different nursing professionals available in a nursing home; staff training; the complexity of resident care needs; and the organizational context in which care is delivered.[13] A substantial body of evidence associates better performance on two of these factors, higher nurse staffing levels and balanced nursing skill mix, with the greatest improvements in quality of care and resident health outcomes in nursing homes.[14]

Nurse staffing levels significantly influence nursing home quality of care

Thirty years ago, the Institute of Medicine's (IOM's) report on nursing home quality concluded that a significant, positive relationship exists between nurse staffing levels and the quality of nursing home care.[15] Since the IOM report, increasingly rigorous studies using better quality staffing data continue to demonstrate a strong relationship between nurse staffing levels and quality of care.

In 2022, the National Academies of Science, Engineering, and Medicine's (NASEM's) report on nursing home quality cited "decades of evidence" that support the association between inadequate nursing staff and poor quality of care in nursing homes.[16] NASEM draws its conclusion from five systematic literature reviews conducted between 2006 and 2015 that examined the relationship between nursing staff and quality of care in nursing homes. Four of the reviews demonstrate a positive and significant relationship between nurse staffing levels and quality of care. The strongest evidence for this relationship was among quality indicators such as improved resident functional ability, fewer pressure ulcers, decreased urinary tract infections, reduced weight loss, less physical restraint use, and fewer hospitalizations.[17,18,19,20] One review found the relationship to be inconsistent but positive, particularly for the relationship between increased nursing staff and reduced pressure ulcers, urinary tract infections, and hospitalizations.[21]

Studies of the coronavirus (COVID-19) pandemic and its outsized impact on nursing homes further demonstrate the relationship between nurse staffing levels and quality of care. Nursing homes with higher levels of nursing staff had greater success in reducing COVID-19 outbreaks and deaths among residents.[22,23] Following the pandemic, nursing homes with higher levels of nursing staff continued to demonstrate reductions in delayed or omitted clinical care, a lower prevalence of pressure ulcers, less use of physical and chemical restraints, lower rates of acute care transfers, and lower short-term mortality. In contrast, nursing homes with lower levels of nursing staff saw resident declines in ADLs, mobility, weight, and increases in the prevalence of pressure ulcers.[22,24,25]

Nursing skill mix significantly contributes to residents' quality of care

The ratio of nursing professionals available in a nursing home, referred to as nursing skill mix, strongly influences the quality of care provided. RNs, Licensed Practical Nurses (LPNs), and CNAs each provide unique nursing services to nursing home residents. Nursing homes that have too many or too few of one type of nursing professional demonstrate declines in resident quality of care and safety outcomes.

RNs, LPNs, and CNAs work together to provide comprehensive care to nursing home residents

RNs, LPNs, and CNAs have unique sets of responsibilities in nursing homes that, together, meet the comprehensive care needs of residents. RNs supervise and train nursing staff while also delivering and coordinating resident care. RNs administer prescribed medications, initiate treatment, and oversee residents' progress, continuously assessing their clinical condition to address developments in their care.[16] Under the direction and supervision of RNs, LPNs carry out prescribed treatments, administer medications as authorized, monitor residents, document care, and report significant changes in residents' conditions to an RN or other appropriate provider.[16] CNAs provide direct resident assistance under the supervision of an LPN or RN. CNAs responsibilities include assisting residents with bathing, dressing, grooming, toileting, eating, mobility, and repositioning.[16] In Virginia, CNAs who complete additional education and training are recognized by the Board of Nursing as advanced registered medication aides (ARMAs) or advanced certified nurse aides (ACNAs).[26] ARMAs may administer permitted drugs to nursing home residents if the drugs are typically self-administered or do not otherwise require an evaluation by an RN or LPN. ACNAs have expanded direct care capability and may conduct additional tasks, such as wound care or restorative care.

The ratio of RNs, LPNs, and CNAs in a nursing home impacts resident outcomes

The relationship between nursing staff and quality of care varies by nurse type. RNs demonstrate the strongest relationship with resident quality of care, followed by CNAs. While LPNs provide important services to residents in nursing homes, based on currently available evidence, the relationship between LPN staffing hours alone and quality of care is

not consistent.[27] Increased RN presence in nursing homes is consistently and strongly associated with positive resident outcomes, including fewer pressure ulcers, fewer infections, lower rates of moderate to severe pain, and decreases in excess emergency department (ED) utilization for both long-stay and short-stay residents.[28,29,30] A higher RN skill mix in nursing homes also lowers the likelihood of receiving deficiencies on state inspections related to inappropriate antipsychotic drug use and increases the odds of a facility receiving higher quality ratings.[31,32]

Nursing homes with higher ratios of CNAs see improvements in ADLs for long-stay residents, functioning for short-stay residents, and more favorable ratings by family members on overall quality.[33] In one study, ADLs among long-stay residents and functioning among short-stay residents improved only with higher CNA staffing, compared to higher RN or LPN staffing.[29] Nursing homes with higher CNA staffing also see reductions in delayed or omitted care and a decrease in injurious falls.[22,34] While higher numbers of licensed nursing staff, including RNs and LPNs, are associated with reduced ED visits and hospitalizations, increases in LPN staffing levels alone show no evident upward or downward trend in quality measures.[22,30]

Nurse staffing levels and nursing skill mix are inadequate in some of Virginia's nursing homes

Virginia's average nurse staffing levels fall below the national average for nursing homes. In addition, the nursing skill mix in Virginia is imbalanced with higher levels of LPN staffing and lower levels of RN and CNA staffing, which could impact quality of care.

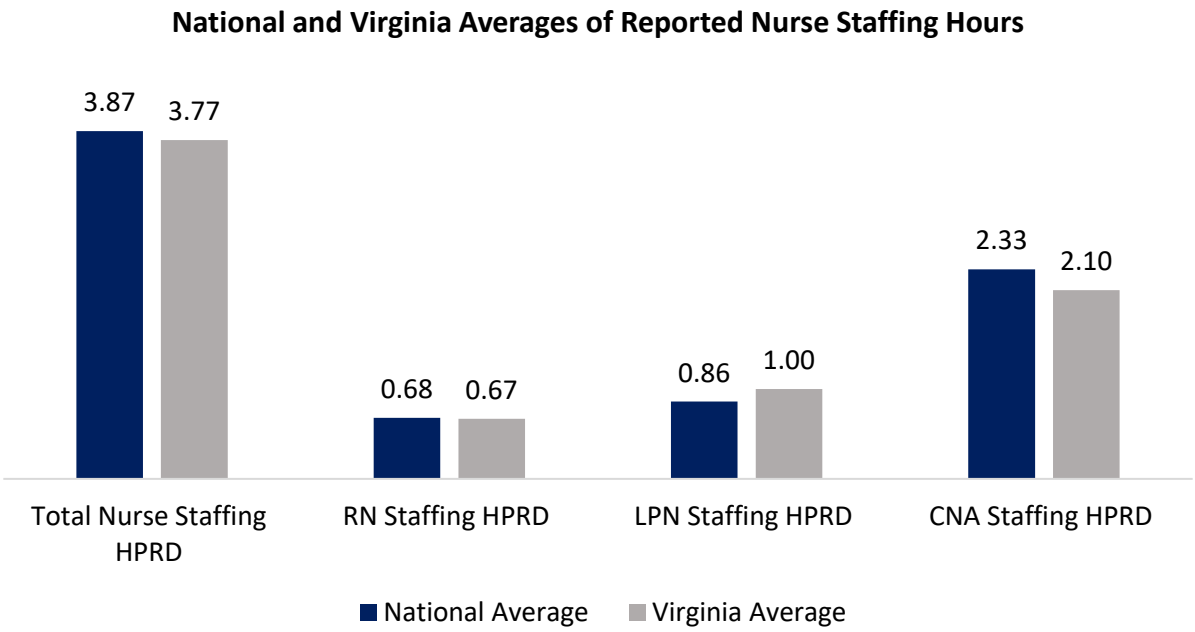
Virginia is lower than the national average, and in some cases, lower than most other states on multiple staffing metrics

Virginia's average total nurse staffing hours per resident day (HPRD), average RN staffing HPRD, and average CNA staffing HPRD are lower than the national average. CMS collects and reports staffing data for all certified nursing facilities, permitting standardized comparisons among facilities and across states.[i] CMS calculates the HPRD metric by dividing nurse staffing hours worked by the number of residents receiving care in the nursing home. A higher staffing HPRD metric indicates that residents receive more contact with nurses each day. Total nurse staffing HPRD reflects the total amount of direct nursing care (RNs, LPNs, and CNAs) residents receive each day. In 2026, Virginia's total nurse staffing hours per resident day was 3.77, with a gap of approximately six minutes or 0.10 hours between the state and national average (FIGURE 1). Virginia's reported RN staffing, at 0.67 HPRD, is 0.01 hours below the national average of 0.68 HPRD. And at 2.10 HPRD,

[i] CMS collects data from certified nursing facilities that meet requirements to admit Medicaid or Medicare residents. Approximately one percent of nursing homes in Virginia are not certified nursing facilities.

Virginia average CNA staffing is 0.23 hours, or approximately 14 minutes, lower than the national average of 2.33 HPRD. The one exception to Virginia's nurse staffing metrics is LPN HPRD which is above the national average. In 2026, Virginia's 1.00 LPN staffing HPRD is approximately 8 minutes higher than the national average of 0.86 LPN staffing HPRD. However, additional LPN staffing HPRD on its own is not associated with increased quality, and nursing homes with higher LPN staffing tend to have lower RN staffing, which may negatively impact quality.[22]

FIGURE 1. Virginia is lower than the national average on three of four nurse staffing metrics



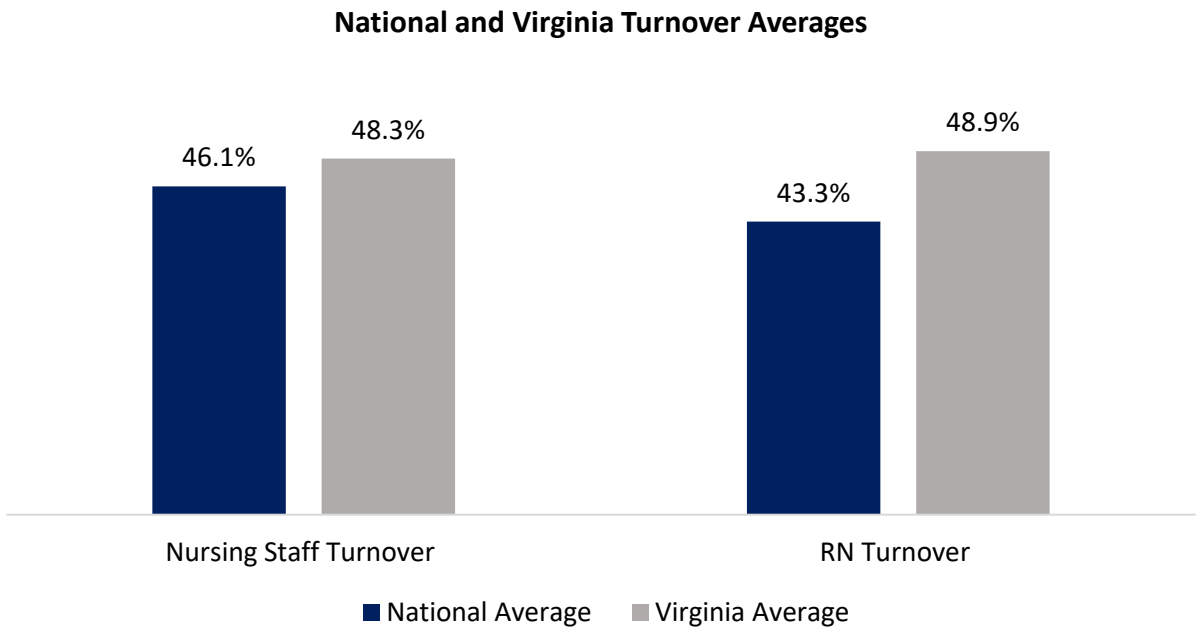
HPRD = hours per resident day; RN = registered nurse; LPN = licensed practical nurse; CNA = certified nurse aide
SOURCE: Centers for Medicare & Medicaid Services. (2026). *Nursing homes including rehab services.* Skilled Nursing Facility Quality Reporting Program – US and State Average Data. U.S. Department of Health and Human Services.

Virginia ranks in the bottom third of states and territories on total nurse staffing, RN staffing, and CNA staffing HPRD. Virginia ranks 42nd out of 53 states and territories on reported total nurse staffing HPRD, 38th on RN staffing HPRD, and 50th on CNA staffing HPRD. Such low levels of CNA staff may impact nursing homes' ability to meet residents' basic care needs.[33] Virginia ranks 8th out of 53 states and territories on LPN staffing HPRD.

Virginia nursing homes also report higher turnover rates among all nursing staff and among RNs compared to the national average (FIGURE 2). High turnover rates make it difficult for nursing homes to maintain appropriate staffing levels and to direct sufficient hours to resident care when also providing constant nurse training. In 2026, Virginia reported an annual nursing staff turnover rate of 48.3 percent, higher than the national rate

of 46.1 percent by 2.2 percentage points. Virginia's average RN turnover rate is 48.9 percent, 5.6 percentage points higher than the national rate of 43.3 percent. Virginia ranks 34th among 53 states and territories on nursing staff turnover and 47th on RN staff turnover.

FIGURE 2. Virginia's nursing staff and RN staff turnover rate is higher than the national average



RN = registered nurse
SOURCE: Centers for Medicare & Medicaid Services. (2026). *Nursing homes including rehab services.* Skilled Nursing Facility Quality Reporting Program – US and State Average Data. U.S. Department of Health and Human Services.

Nurse staffing levels and skill mix vary by payer type and ownership model

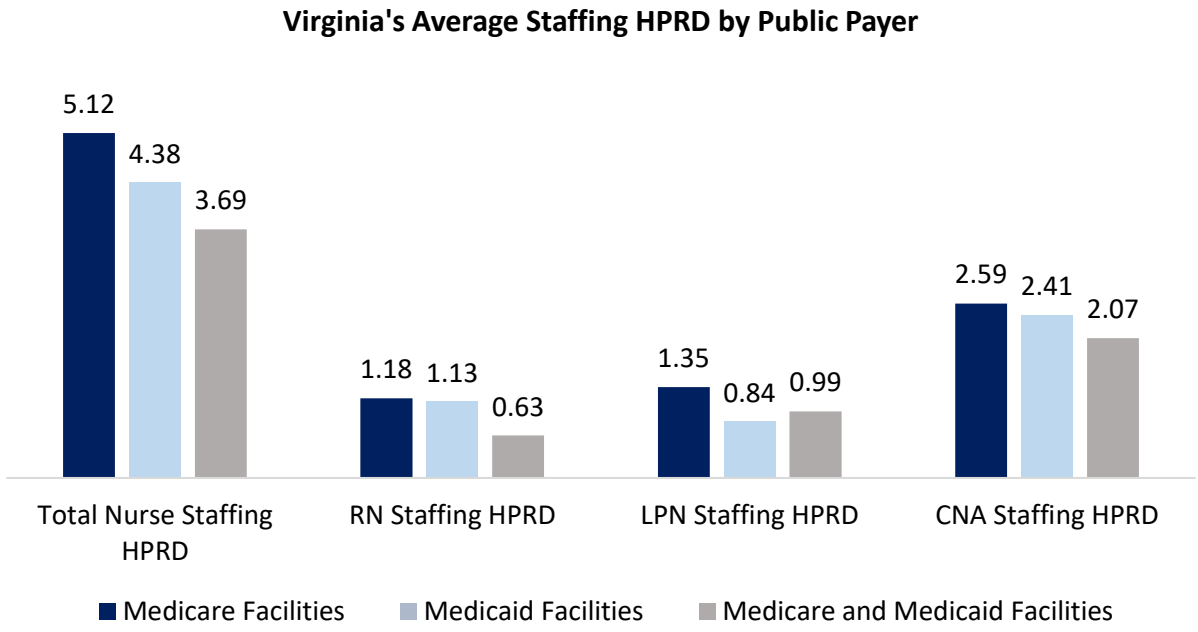
Disaggregating staffing data by nursing home characteristics reveals significant differences in nurse staffing levels by type of public payer the facility accepts and nursing home ownership. Staffing metrics were not statistically significantly different for rural and urban nursing homes, indicating that factors other than location may impact staffing levels.

Nurse staffing hours are significantly different by the type of public payer the nursing home accepts.[ii] Medicaid is the primary payer for Virginia nursing home residents and covers both short-term and long-term care needs. Medicaid beneficiaries encompass 58 percent of all resident bed days in nursing homes.[2] Medicare only covers short-term skilled nursing and rehabilitation, and Medicare beneficiaries encompass a smaller proportion of resident

[ii] For total nurse staffing HPRD, $F(2, 283) = 14.30$, $p < .001$, $\eta^2 = .092$. For RN staffing HPRD, $F(2, 283) = 7.60$, $p < .001$, $\eta^2 = .051$. For LPN staffing HPRD, $F(2, 283) = 10.82$, $p < .001$, $\eta^2 = .071$. For CNA staffing HPRD, $F(2, 280) = 8.09$, $p < .001$, $\eta^2 = .055$.

bed days in nursing homes, at 12 percent. Certified nursing facilities that accept both Medicaid and Medicare report approximately 1.5 less hours of total nurse staffing, 0.5 less hours of RN staffing, and 0.5 less hours of CNA staffing per resident per day than facilities that accept Medicare only (FIGURE 3). For LPN staffing hours, facilities that accept Medicaid only have lower LPN staffing hours than facilities that accept both Medicare and Medicaid. Facilities that accept only Medicare have the highest average nurse staffing hours across all metrics.

FIGURE 3. Nursing homes that accept Medicare and Medicaid have the lowest average staffing hours



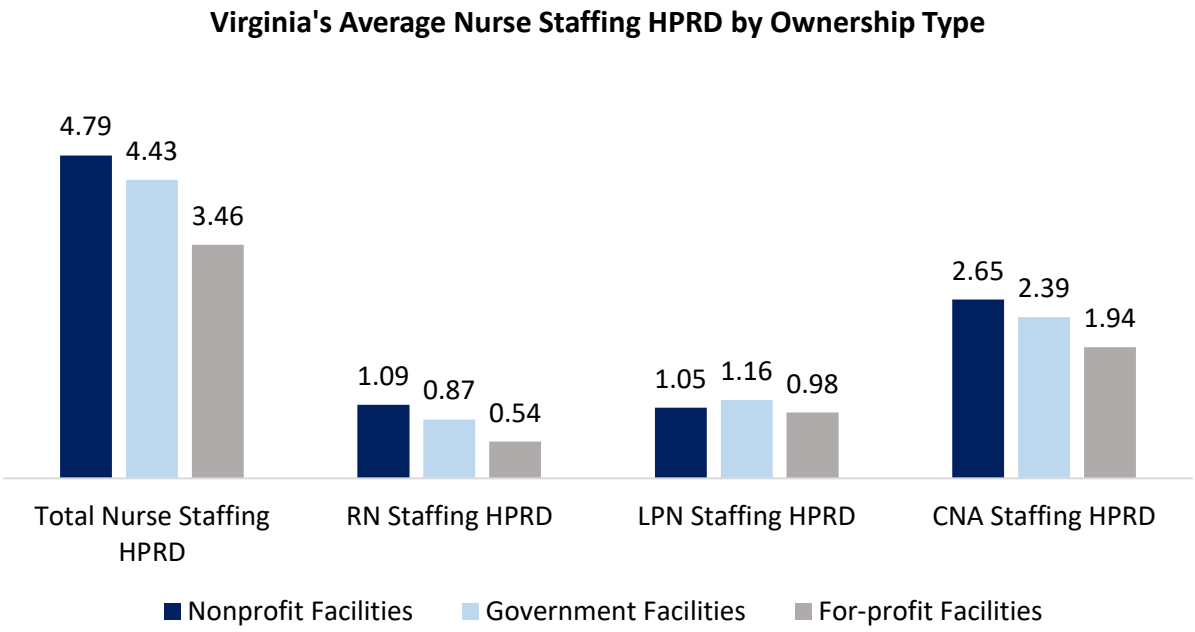
HPRD = hours per resident day; RN = registered nurse; LPN = licensed practical nurse; CNA = certified nurse aide
SOURCE: Centers for Medicare & Medicaid Services. (2026). *Nursing homes including rehab services.* Skilled Nursing Facility Quality Reporting Program - Provider Data. U.S. Department of Health and Human Services.

Significant differences in nurse staffing levels also exist among for-profit, nonprofit, and government nursing homes and between nursing homes operating as a chain compared to nursing homes that operate independently.[iii] For-profit nursing homes report approximately 1.5 less hours of total nurse staffing, 0.5 less hours of RN staffing, and 0.75 less hours of CNA staffing hours per resident per day than for-profit nursing homes (FIGURE 4). For LPN staffing, nonprofit nursing homes report higher HPRD than for-profit

[iii] By ownership type, total nurse staffing HPRD, $F(2, 283) = 58.99$, $p < .001$, $\eta^2 = .294$; RN staffing HPRD, $F(2, 283) = 21.82$, $p < .001$, $\eta^2 = .134$; CNA staffing HPRD, $F(2, 283) = 59.65$, $p < .001$, $\eta^2 = .297$. By operation type, total nurse staffing HPRD, $t(284) = 9.14$, $p < .001$; RN staffing HPRD, $t(284) = 4.87$, $p < .001$; LPN staffing HPRD, $t(284) = 2.20$, $p < .001$; CNA staffing, $t(284) = 10.12$, $p < .001$.

nursing homes, but the difference is not statistically significant. Government nursing homes' staffing HPRD metrics fall in between the levels of nonprofit and for-profit nursing homes, except for LPN staffing. Nursing homes that operate independently also have statistically significantly higher average total nurse, RN, LPN, and CNA staffing HPRD than nursing homes that operate as part of a chain.

FIGURE 4. For-profit nursing homes report the lowest average nurse staffing hours



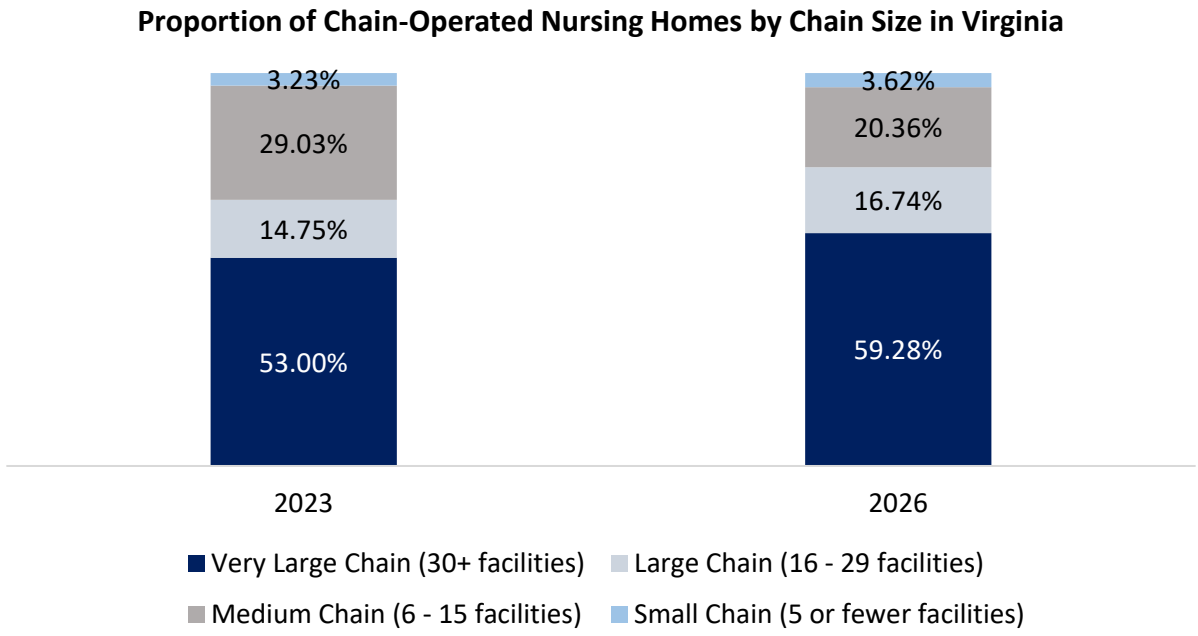
HPRD = hours per resident day; RN = registered nurse; LPN = licensed practical nurse; CNA = certified nurse aide
SOURCE: Centers for Medicare & Medicaid Services. (2026). *Nursing homes including rehab services.* Skilled Nursing Facility Quality Reporting Program - Provider Data. U.S. Department of Health and Human Services.

While the number of nursing homes operating in Virginia is stable over time, the share of nursing homes operating as for-profit chains is increasing. Between 2019 and 2026, the proportion of for-profit nursing homes in Virginia increased by approximately five percentage points, from 71 percent to 76 percent. During the same period, the proportion of nonprofit nursing homes decreased by approximately six percentage points, from 27 percent to 21 percent. Similarly, the number of nursing homes operated by large chains (between 16 and 29 nursing homes) and very large chains (more than 30 nursing homes) has increased, indicating consolidation of operations (FIGURE 5). In 2023, large and very large chains operated 68 percent of nursing homes in the state. [iv] By 2026, large and very large chains operate 76 percent of Virginia nursing homes. Multiple stakeholders interviewed for this study raised concerns about the increase in for-profit chain nursing

[iv] CMS began reporting facility-level chain data in 2023.

homes in Virginia, given persistently low staffing and increased complaint volume from some of these nursing homes.[12]

FIGURE 5. The proportion of nursing homes operated by large and very large chains is increasing in Virginia



SOURCE: Centers for Medicare & Medicaid Services. (2026). *Nursing homes including rehab services*. Skilled Nursing Facility Quality Reporting Program - Provider Data. U.S. Department of Health and Human Services.

Virginia's lower-staffed nursing homes have lower quality ratings

In Virginia, more than half of nursing homes score poorly on CMS's nurse staffing domain. CMS calculates a staffing domain rating between one star (lowest rating) and five stars (highest rating) for each nursing home based on three measures of nurse staffing levels and three measures of nurse turnover.[35] Sixty percent of Virginia certified nursing facilities (169 of 284 facilities) received a one- or two-star rating on the staffing domain, the low end of the scale.

CMS combines staffing domain ratings with a quality measure domain and a health inspection domain to develop an overall nursing home rating between one and five stars for its Five-Star Quality Rating System. The quality measure domain is based on 15 measures of quality for both long-stay and short-stay residents, including pressure ulcers, urinary tract infections, falls with injuries, and hospitalizations. The health inspection domain is based on deficiencies identified during a nursing home's two most recent recertification health

inspections and the three most recent years of complaint inspections.[v] CMS displays the ratings for each domain and its overall rating for nursing homes on its *Care Compare* website so that consumers and their families can compare quality and safety information across nursing homes.[36]

Some nursing homes in Virginia with lower staffing ratings do have higher quality and health inspection ratings and it is possible that well-run nursing homes may achieve higher quality with fewer staff compared to nursing homes in which care delivery is poorly organized.[16] Across all nursing homes in Virginia, however, staffing ratings are positively and significantly correlated with quality measure ratings and health inspection ratings.[vi] This means that as staffing ratings increase, quality ratings and health inspection ratings also increase. In Virginia, nursing homes with a 1-star staffing rating have an average quality rating of 3.52 stars which increases with each additional star, except for nursing homes with a 4-star rating (TABLE 1). Nursing homes with a 1-star staffing rating have an average health inspection rating of 2.07 stars, increasing with each additional star to an average of 3.82 stars for nursing homes with a 5-star staffing rating.

TABLE 1. Average quality measure and health inspection ratings by staffing star rating

Staffing Rating	Average Quality Measures Rating	Average Health Inspection Rating
1 star (lowest)	3.52	2.07
2 stars	4.08	2.83
3 stars	4.13	2.85
4 stars	3.93	3.44
5 stars (highest)	4.32	3.82

SOURCE: Centers for Medicare & Medicaid Services. (2026). *Nursing homes including rehab services.* Skilled Nursing Facility Quality Reporting Program - Provider Data. U.S. Department of Health and Human Services.

Virginia funds incentive programs to address nursing home workforce shortages

Stakeholders report that the persistent nurse workforce shortage across Virginia's health care sector is a challenge for nursing homes.[12] During the COVID-19 pandemic, Virginia

[v] Results on this domain may be outdated depending upon the frequency with which the state inspects facilities. As of October 2026, VDH indicates approximately 52 percent of facilities in Virginia are overdue for recertification inspections.

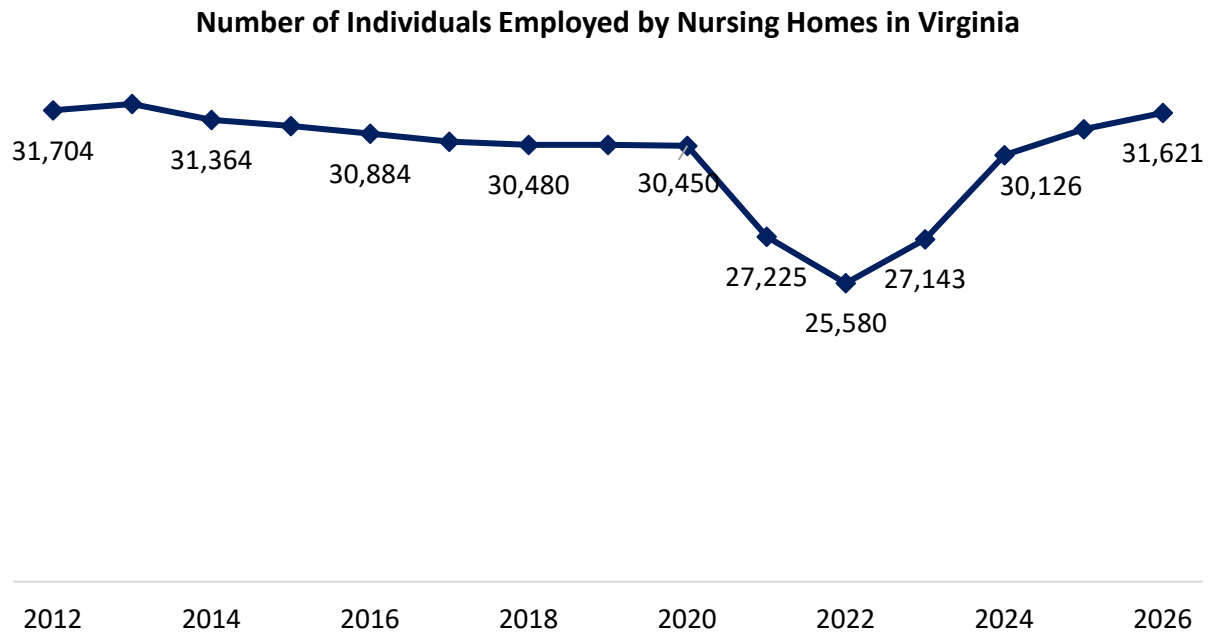
[vi] Using the Kendall rank correlation coefficient, for staffing and quality ratings, $r(248) = .186$, $p < .001$, and for staffing and health inspection ratings, $r(248) = .356$, $p < .001$.

nursing homes experienced a sharp decline in the nursing workforce. The nursing home workforce has returned to pre-pandemic levels but the longstanding gap between nursing supply and demand remains. Virginia funds scholarship and loan repayment programs for nurses in long-term care settings and administers a value-based purchasing program that provides additional payments to nursing homes for performance or improvement on staffing and quality metrics to help address challenges associated with nursing workforce shortages.

The nursing home workforce has returned to pre-pandemic levels, but shortages persist

The number of individuals working in nursing homes slowly declined before the COVID-19 pandemic, then rapidly declined in the initial years of the pandemic (FIGURE 6). Between 2012 and 2020, Virginia's nursing home workforce decreased by approximately 4 percent, followed by a 16 percent decrease between 2020 and 2022. By 2026, the nursing home workforce returned to pre-pandemic levels.

FIGURE 6. The number of individuals working in nursing homes declined sharply during the COVID-19 pandemic

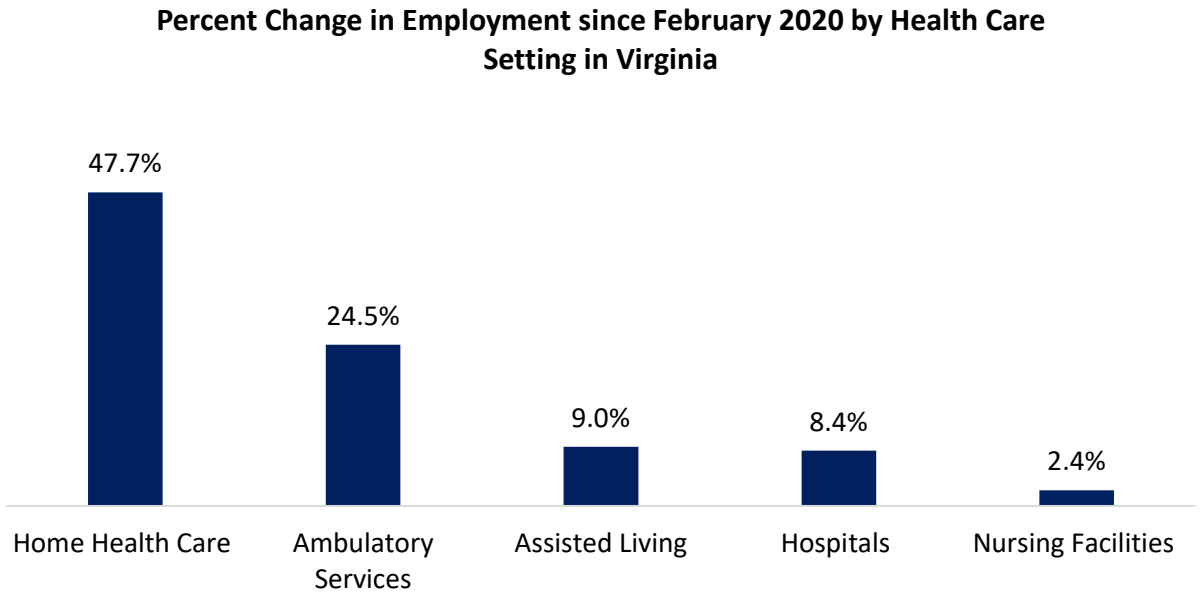


SOURCE: U.S. Bureau of Labor Statistics. (2026). Quarterly Census of Employment and Wages. U.S. Department of Labor.

Nursing homes compete with other health care settings for the same employees, and nursing homes have not demonstrated as much growth beyond pre-pandemic levels as other health care settings. By 2026, the nursing home workforce was just 2.4 percent above

pre-pandemic levels, whereas hospitals and assisted living facilities were greater than eight percent above pre-pandemic levels (FIGURE 7). Ambulatory services and home health care have experienced significant workforce growth following the pandemic.

FIGURE 7. Nursing homes have experienced slower workforce recovery since the pandemic than other health care settings



SOURCE: American Health Care Association & National Center for Assisted Living. (2026). *Facts and figures*. https://www.ahcancal.org/Data-and-Research/facts/Pages/default.aspx

The gap between the supply of nurses in long-term care settings and the number of nurses needed to meet demand continues to grow. The share of the population aged 65 and older is projected to grow steadily through 2050, increasing demand for long-term care services.[37] The Health Resources and Services Administration projects that the demand for nurses in Virginia's long-term care settings will grow by 26 percent for RNs, 28 percent for LPNs, and 30 percent for CNAs by 2036.[38] The Virginia nursing workforce is increasing, but not at that pace. In the last five years, the number of RNs and CNAs working in Virginia has increased by 14 percent and four percent respectively, while the number of LPNs has remained stable.[39] Many of these nurses choose to work in settings other than nursing homes.

The end of federal Temporary Protected Status (TPS) may also adversely impact nursing homes in Virginia. TPS allows eligible nationals to remain and work in the United States when their home country is experiencing extraordinary and temporary conditions that prevent their safe return.[40] Immigrants make up approximately one-quarter of the CNA workforce in Virginia, and the share of immigrant CNAs employed by nursing homes increased during the COVID-19 pandemic while the share of U.S. born staff members

decreased. Staffing shortages during the pandemic could have been worse if not for immigrant CNAs remaining in the workforce.[41] The exact impact that the end of TPS designations will have on Virginia nursing home staffing is unknown; however, stakeholders raised this issue as an emerging concern.

Virginia offers scholarship and loan repayment programs for nurses in long-term care settings

Lack of professional interest in long-term care settings and a lack of clinical training opportunities in nursing homes contribute to persistent staffing challenges.[12] The newly established Virginia Nursing Workforce Center (VNWC), under the direction of the Virginia Health Workforce Development Authority, has recently assumed oversight of state-funded scholarships, loan repayment programs, preceptor incentives, and the Earn-to-Learn program to address these challenges, with the goal of increasing recruitment and retention of nursing staff in long-term care settings where Virginia's need is greatest.[42]

Long-term care scholarship programs are currently available to RNs, LPNs, and CNAs in approved training programs who agree to work in a Virginia long-term care facility for at least one year after graduation. In addition, RNs, LPNs, and CNAs currently employed in long-term care settings can receive loan repayment upon completion of at least two years of service. Virginia also provides financial incentives to licensed health care professionals who serve as preceptors, including those who precept in Virginia nursing homes. Beginning in 2026, nursing homes are now eligible to receive up to $200,000 for two years to expand clinical training and paid employment pathways for nursing students in the Earn-to-Learn program.[43]

Virginia has also committed to participate in the launch of CMS's Nursing Home Staffing Campaign, intended to increase nursing home staffing through financial incentives and workforce training. The campaign will provide financial incentives for RNs and LPNs working in qualified nursing homes, including up to $40,000 in student loan debt repayment and stipends of up to $10,000. Civil Monetary Penalties (CMP) that CMS imposes upon certified nursing facilities that do not comply with Medicare or Medicaid requirements support the initiative. CMS returns a portion of CMP funds to the state to invest in nursing facility quality improvement initiatives. In SFY 2025, the Virginia General Assembly appropriated $4.1 million of state CMP funds to the Nursing Home Staffing Campaign,[44] which is the percentage of total CMP funds required to access the full amount of federal CMP funds that CMS designated for Virginia. CMS estimates a federal CMP contribution to Virginia of about $1.9 million, bringing the total available funding in Virginia to $6 million. The Virginia Department of Medical Assistance Services (DMAS) will operate the program and is awaiting further CMS guidance on program implementation.

Virginia offers enhanced payments to nursing homes for performance on staffing metrics

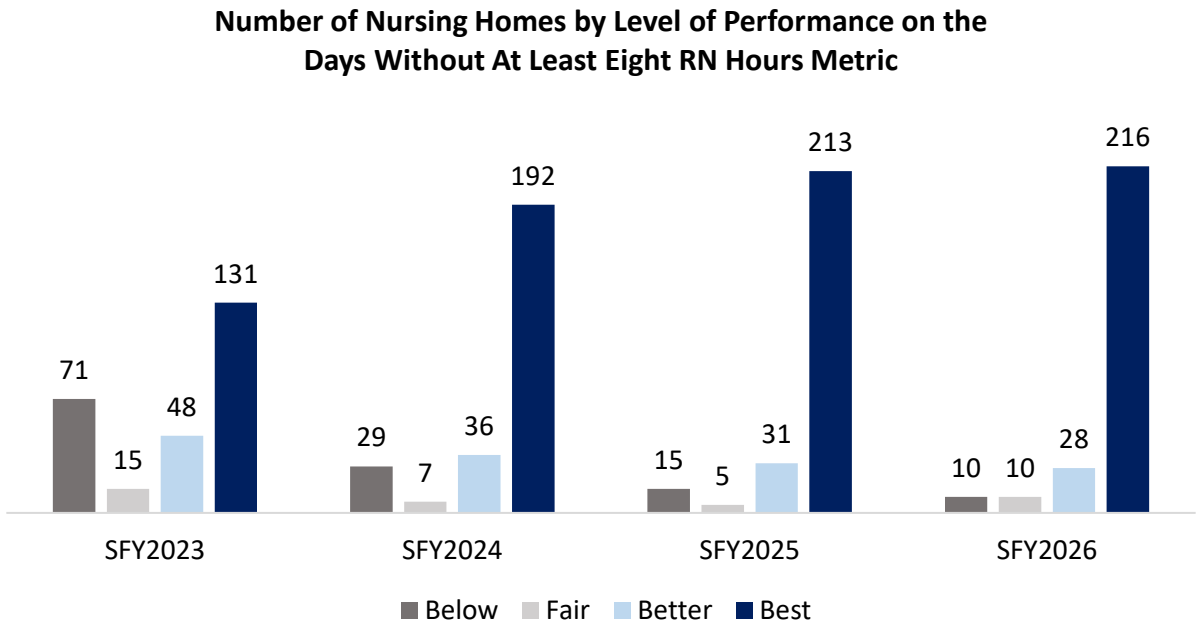
Beginning October 1, 2025, Virginia's Medicaid program transitioned to a Patient-Driven Payment Model for nursing home care where base rates for fee-for-service and managed care are adjusted based on each resident's specific clinical needs rather than the anticipated volume of services provided.[45] Nursing homes caring for residents with higher acuity, a measure of residents' severity, complexity, and intensity of clinical needs, now receive higher reimbursement rates for those residents. Even so, stakeholders continue to raise concerns about low Medicaid base rates that do not cover the full costs of care.[12] Nationally, Medicaid payment rates cover about 82 cents per dollar of estimated Medicaid costs in all nursing homes.[46]

At times, the Virginia General Assembly has appropriated additional one-time funds to nursing homes to address this concern. Beginning in July 2020, nursing homes received an enhanced payment of an additional $20 per Medicaid resident per day to build capacity and enhance quality of care for Medicaid members.[47] The enhanced payment was subsequently reduced to $15 per resident per day beginning July 1, 2021, and remained in effect through June 30, 2022. Most recently, the 2026 Appropriation Act provides $35 million from the general fund and $35 million from the nongeneral fund to increase nursing home per diem rates for one year for fee-for-service and Medicaid managed care members.[48]

The Virginia General Assembly also directed DMAS to implement a value-based purchasing program for nursing homes. The General Assembly intended the Nursing Facility Value-Based Purchasing Program (NF VBPP) to build on the enhanced payments provided during the COVID-19 pandemic by creating a permanent, performance-based approach to incentivizing quality improvement in nursing homes serving Virginia Medicaid members. DMAS began administering the program in state fiscal year (SFY) 2023 by awarding financial incentives to nursing homes who performed well or improved over time on measures of nursing staff and quality of care.[49] The NF VBPP uses performance tiers to determine the amount of funding a nursing home can receive for each measure. Since SFY 2023, Virginia has appropriated $721.2 million in performance-based incentives to the program.

Between SFY 2023 and SFY 2026, DMAS provided financial incentives to nursing homes that reduced the number of days without at least eight RN hours, as required by federal regulations, from year to year or had fewer days without at least eight RN hours compared to other nursing homes in the state. The number of nursing homes in the "best" tier, those that had four or fewer days without at least eight RN hours, increased over time from 131 nursing homes in SFY 2023 to 216 nursing homes in SFY 2026 (FIGURE 8). By SFY 2026, 82 percent of nursing homes were within the "best" tier for days without at least eight RN hours. Given these improvements, DMAS retired this measure from the NF VBPP beginning in SFY 2027.

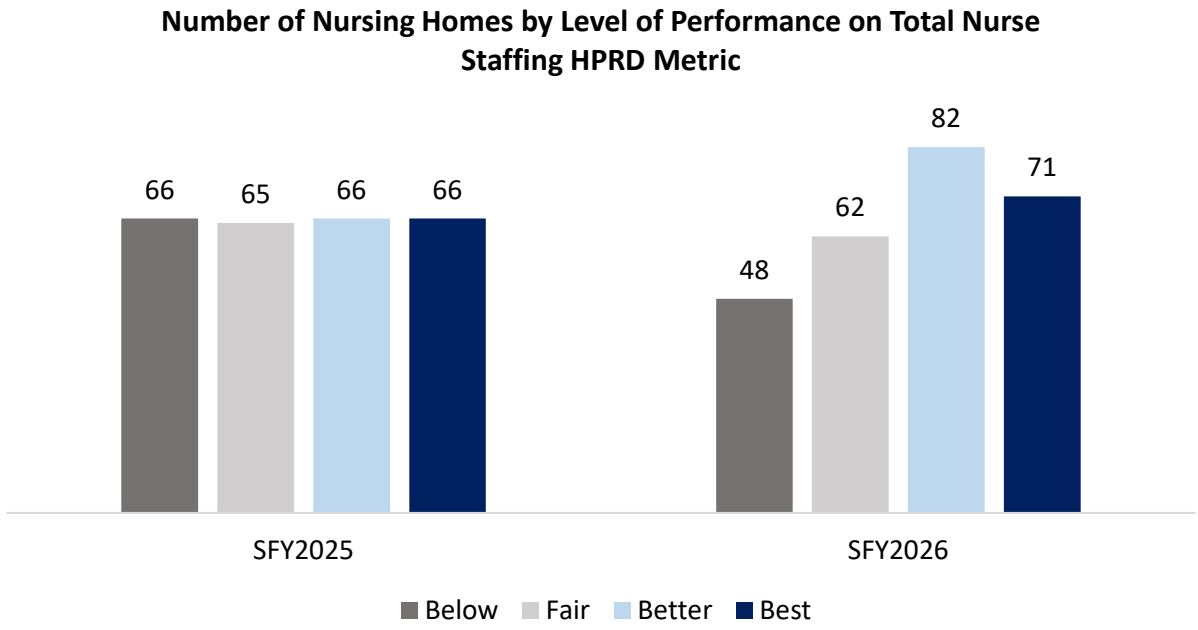
FIGURE 8. Most nursing homes are within the highest tier of performance on the days without at least eight RN hours metric



RN = registered nurse; SFY = state fiscal year
SOURCE: JCHC staff analysis of data from DMAS Nursing Facility Value-Based Purchasing Program Report, https://www.dmas.virginia.gov/data-reporting/value-based-purchasing/nursing-facility-value-based-purchasing-program/

The NF VBPP has also provided incentives to nursing homes based on tiers of performance for an adjusted total nurse staffing HPRD metric since SFY 2023. Performance tiers for this metric are not based on a specific standard but instead reflect the relative performance of nursing homes participating in the program. Changes in the underlying data required DMAS to reset performance thresholds for this metric in SFY 2025. As such, only one year of data is available to examine performance and improvements in the total nurse staffing HPRD metric. Changes in the distribution of nursing homes across performance thresholds between SFY 2025 and SFY 2026 indicate an initial shift towards higher levels of total nurse staffing HPRD (FIGURE 9). In SFY 2026, 27 percent of nursing homes scored in the "best" tier by reporting 3.65 or more total nurse staffing HPRD and 31 percent of nursing homes scored in the "better" tier by reporting between 3.27 and 3.64 total nurse staffing HPRD. DMAS continues to increase performance tier thresholds for the total nurse staffing HPRD metric. In SFY 2027, the "best" tier will include nursing homes at 3.84 or more total nurse staffing HPRD, and in SFY 2028, the "best" tier will include nursing homes at 3.99 or more total nurse staffing HPRD.

FIGURE 9. Nursing homes shifted towards higher total nurse staffing levels between SFY 2025 and SFY 2026



HPRD = hours per resident day; SFY = state fiscal year
SOURCE: JCHC staff analysis of data from DMAS Nursing Facility Value-Based Purchasing Program Report, https://www.dmas.virginia.gov/data-reporting/value-based-purchasing/nursing-facility-value-based-purchasing-program/

Most states have staffing standards for nursing homes

Staffing standards are one tool states can use to improve quality of care by requiring nursing homes to meet minimum nurse staffing levels.[50] When states tie staffing standards to the process for licensing nursing homes, states see improvements in staffing with few negative consequences. Thirty-two states and Washington, D.C. have enacted a staffing standard; Virginia repealed its staffing standard in 2024.

Staffing standards linked to state nursing home licensure processes increase staffing and improve quality of care

States with staffing standards that are incorporated into state licensing requirements see higher staffing levels, improved quality of care, and improved overall quality ratings in their nursing homes. In Massachusetts, for example, staffing levels increased significantly following implementation of a staffing standard, with the largest impact observed in nursing homes with a higher share of Medicaid residents and lower baseline staffing levels.[58] Among 16 states with staffing standards, states saw significant increases in total staff, RN, and nurse aide staffing among nonprofit nursing homes following implementation of the mandates.[51] In California and Ohio, total nurse staffing HPRD increased by five percent following implementation of their state standard, though this was mostly

attributable to increased levels of LPNs and nurse aides.[54] A study of 22 states with nursing home staffing standards found similar results. State standards were associated with a five percent increase in total direct care HPRD, again driven primarily by increases in LPN and nurse aide staffing.[52]

State staffing standards are also associated with improvements in nursing home quality of care. States with staffing standards demonstrate significant reductions in restraint use following implementation, and two studies of California's standard found nursing homes meeting the standard had fewer serious deficiencies during inspections and a decreased rate of contractures.[52,53,54] Higher state staffing standards are associated with a greater proportion of nursing homes receiving four- and five-star ratings under CMS's Five-Star Quality Rating System.[55]

Stakeholders expressed concern that nursing home staffing standards would lead to closures if nursing homes were unable to recruit sufficient staff or absorb the costs associated with meeting a staffing standard. However, available evidence does not indicate that state staffing standards increase nursing home closures. Nursing home closures have remained relatively stable, even though states with staffing standards have increased over time.[56] More directly, a comparison of states with and without standards found a minimal impact on nursing home finances and no significant difference in nursing home closures associated with the requirements.[52]

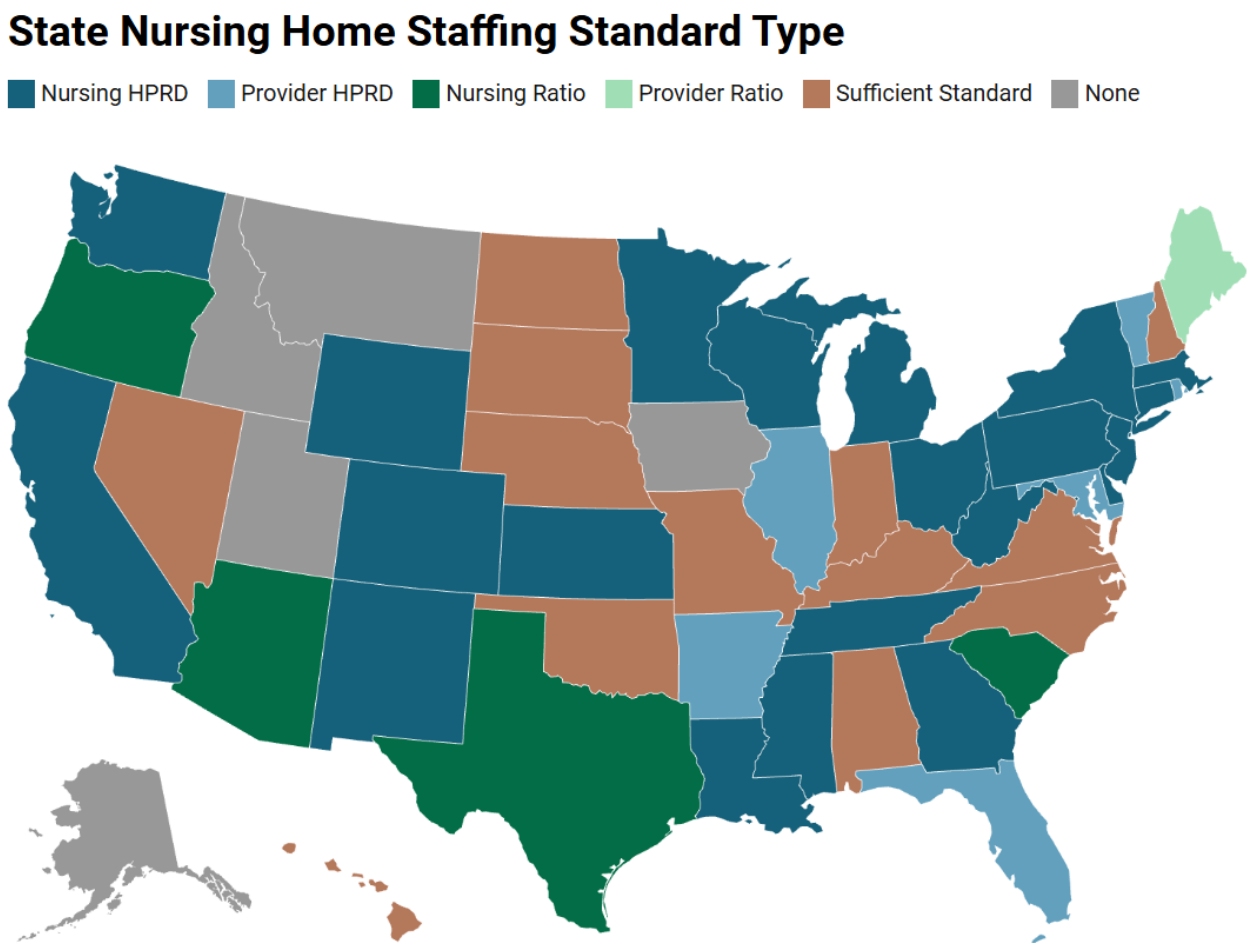
Thirty-two states and Washington, D.C. have established staffing standards for nursing homes

As of July 2026, 32 states and Washington, D.C. have established staffing standards for nursing homes. Most states tie standards to state licensure requirements. Requirements vary from state to state on the minimum threshold and the types of direct care staff included (see APPENDIX 4 for standards in each state).

Most states adopt an HPRD standard, though thresholds and included staff vary

Twenty-eight states and Washington, D.C. have enacted a specific HPRD threshold for their nursing home staffing standard (FIGURE 10). For the 21 states and Washington, D.C., which base their standard only on nursing staff, the HPRD threshold ranges from 2.0 HPRD to 4.1 HPRD, with an average of 2.4 hours. The seven other states with a HPRD threshold permit providers other than RNs, LPNs, or CNAs to count towards the threshold, such as physical, occupational, speech, and respiratory therapy staff, mental health professionals, feeding assistants, social workers, or physicians and physician assistants. For these states, the HPRD threshold is higher, ranging from 3.0 HPRD to 3.8 HPRD with an average of 3.4 hours. Four states require a ratio of nurses to residents and one state permits nurses and personal support specialists to count towards a ratio of staff to residents.

FIGURE 10. 32 states and Washington, D.C. have specific staffing standards for nursing homes



HPRD = hours per resident day
SOURCE: JCHC staff analysis of state laws and regulations, 2026.

In addition to a total staff HPRD or ratio standard, 13 states and Washington, D.C. also set standards for specific types of nurses. Nine of the 13 states and Washington, D.C. have additional staffing standards for licensed nurses, either RNs only or RNs and LPNs; three states have additional staffing standards for CNAs only; and one state has specific staffing standards for RNs, LPNs, and CNAs. Of the remaining states, 13 states, including Virginia, have language similar to current federal regulations that require sufficient staffing, and five states are silent on staffing expectations in their state law or regulation.

Virginia enacted a nursing home staffing standard in 2023, then repealed it when CMS established federal standards

Delegate Vivian E. Watts has introduced legislation to establish a nursing home staffing standard in Virginia since 2002. In 2023, the Virginia General Assembly enacted House Bill 1446 (Orrock) and its companion Senate Bill 1339 (Barker) to amend §32.1-127 of the *Code of Virginia* and require each certified nursing facility to maintain at least 3.08 adjusted total nurse staffing HPRD, effective July 1, 2025. The bills included enactment clauses that would repeal the state's staffing standard should the federal government establish a staffing standard. Before the effective date of Virginia's staffing standard, CMS published a final rule on staffing standards for nursing homes and, pursuant to the fourth enactment clauses of House Bill 1446 and Senate Bill 1339, subsequently, Virginia repealed its staffing standard.

CMS's final rule required an RN to be on site 24 hours per day, seven days per week and for certified nursing facilities to provide, at a minimum, 3.48 total nurse staffing HPRD, with 0.55 RN staffing HPRD and 2.45 nurse aide staffing HPRD, implemented and enforced independent of residents' acuity.[57] CMS acknowledges that there is no clear, consistent, and universal methodology for setting staffing standards and that its threshold selection was based on a report that the agency commissioned in 2022 from Abt Associates.[22] The report concluded that the relationship between staffing and quality of care varies by staff type and level as follows:

- 3.30 or more total nurse staffing HPRD has a strong association with safety and quality care.
- 0.45 or more RN staffing HPRD has a strong association with safety and quality care.
- 2.45 or more nurse aide staffing HPRD has a strong association with safety and quality care.
- LPN staffing HPRD, at any level, does not appear to have any consistent association with safety and quality of care.

Staffing standards are intended to establish a floor rather than an optimal staffing level. Abt Associates notes that a threshold of 4.1 total nurse staffing HPRD, cited in a 2001 report by the same firm,[58] reflects the threshold at which point there were no further benefits with respect to quality when nursing homes used additional staff. Advocates, including stakeholders interviewed for this study, emphasize the 4.1 total nurse staffing HPRD threshold as a staffing minimum, but Abt Associates did not intend for their work to reflect minimum staffing levels required for adequate care.

CMS later rescinded federal staffing standards following legal challenges and the passage of H.R. 1 (2025), which delayed implementation until 2034

Following publication of CMS's final rule, nursing home industry groups and several states challenged the rule in federal court. In *American Health Care Association v. Kennedy* (2025)

and *Kansas v. Kennedy* (2025), both courts vacated the requirements for 24-hour RN coverage and the nursing home staffing standard, holding that CMS exceeded its statutory authority in imposing those requirements. CMS appealed both decisions, but the appeals were dismissed before an appellate court ruled on the substance of the cases.

The U.S. Congress separately addressed federal staffing standards for nursing homes in Section 71111 of H.R. 1 (Public Law 119-21), which prohibits the U.S. Department of Health and Human Services from implementing, administering, or enforcing the 24-hour RN and staffing standard provisions through September 30, 2034. CMS subsequently repealed the 24-hour RN and staffing standard requirements, effective February 2, 2026. As a result, the 2024 federal staffing standards are not currently in effect.

Following rescission of both Virginia's state standards and federal standards, House Bill 605 (Willett), introduced during the 2026 General Assembly session, attempted to re-establish a state staffing standard by requiring nursing facilitates to provide at least 3.25 adjusted total nurse staffing HPRD. The patron later amended the legislation to require 3.08 adjusted total nurse staffing HPRD effective July 1, 2027, and 3.25 adjusted total nurse staffing HPRD effective July 1, 2031. However, stakeholders raised concerns about the feasibility of implementation given nursing staff shortages; the potential costs incurred to the state and to nursing homes for increased staffing; how staffing standards would be enforced; and the potential reduction in nursing home care if standards could not be met and nursing homes reduced admissions or closed.[12] House Bill 605 was amended again to instead direct the JCHC to study the workforce of Virginia's nursing homes.

Virginia should re-establish a nursing home staffing standard

Repeal of CMS's final rule left Virginia without a nursing home staffing standard. As a result, Virginia no longer requires nursing homes to meet nurse staffing or nurse skill mix standards even as compelling evidence supports the relationship between higher nurse staffing levels and quality of care. Families, residents, and staff continue to raise concerns about the quality of care in low staffed nursing homes in Virginia. Stakeholders express frustration with the disproportionate impact of low-quality care on the most vulnerable residents who have limited ability to advocate for their care or address deficiencies in the care they receive.[12]

The General Assembly could address this gap by reestablishing a staffing standard that increases nurse staffing levels and improves nursing skill mix in Virginia nursing homes. The standard could use metrics that account for the complexity of resident care needs and include a staffing threshold for total nurse staff and separately, for RNs and CNAs, that counts toward the satisfaction of the total nurse staffing threshold and ensures nursing home residents receive the appropriate nursing skill mix they require. Virginia could also implement the staffing standard over a period of several years to account for time needed to develop the nursing workforce.

➔ **Option 1:** The Joint Commission on Health Care could submit legislation to amend § 32.1-127 of the *Code of Virginia* to establish a staffing standard for nursing homes in Virginia that includes thresholds adjusted for residents' care needs for total nurse staffing, registered nurse staffing, and certified nurse aide staffing hours per resident day as follows:

- Beginning Fiscal Year 2029, 3.09 adjusted total nurse staffing hours per resident day.
- Beginning Fiscal Year 2031, 3.32 adjusted total nurse staffing hours per resident day, including 0.54 adjusted registered nurse staffing hours per resident day and 2.06 adjusted certified nurse aide staffing hours per resident day.
- Beginning Fiscal Year 2034, 3.43 adjusted total nurse staffing hours per resident day, including 0.60 adjusted registered nurse staffing hours per resident day and 2.23 adjusted certified nurse aide staffing hours per resident day.

Coupling staffing standards with funding to address the anticipated increased costs of care and considerations for enforcement, increased accountability, policy evaluation, and support for the nursing workforce may ease implementation and feasibility concerns and amplify the effectiveness of staffing standards over time. Eight ancillary policy options to address these considerations are presented below.

An acuity-adjusted standard reflects the staffing resources required to meet residents' needs

Virginia's standard could include acuity-adjusted staffing thresholds to better reflect resident care needs. Resident acuity is the degree of illness severity and clinical complexity that determines the intensity of health care services and staffing resources required to meet residents' care needs. Residents with higher acuity require more hours of direct care from nursing staff than residents with lower acuity. CMS requires certified nursing facilities to measure resident acuity using a standardized assessment. JCHC staff adjusted the thresholds selected for Virginia's proposed standard for acuity based on CMS's published formula, which uses the national average of resident acuity as a reference to determine whether each facility's level of resident acuity is more or less complex than average.[59] CMS uses the same acuity-adjusted metrics for its calculation of staffing ratings in its Five-Star Quality Rating System and publishes those metrics on the *Care Compare* website. DMAS also considers the same acuity-adjusted metrics for the NF VBPP. Using the same acuity-adjusted metrics across the national Five-Star Quality Rating System, the state's NF VBPP, and the state's staffing standard creates consistency and transparency for nursing homes, stakeholders, and consumers.

Federal standards, before CMS rescinded them, and most states relied on staffing thresholds that do not account for resident acuity. Acuity-adjusted staffing hours reflect residents' care needs but staffing hours that are not adjusted for acuity remain the same regardless of how much nursing care residents need. As a result, the Office of the Inspector

General noted that up to one-quarter of nursing homes that appear sufficiently staffed are actually understaffed when taking resident acuity into account.[60]

Stakeholders interviewed for this study expressed conflicting opinions on the use of acuity-adjusted metrics.[12] Some stakeholders noted that acuity-adjusted metrics create a higher standard for nursing homes and therefore would increase costs to the state and to nursing homes to meet such thresholds. Other stakeholders noted that nursing homes receive reimbursement from Medicaid and Medicare based on resident acuity to account for increased costs of care, and that resident acuity in nursing homes is changing, with residents trending younger, sicker, and with more behavioral health or substance use concerns. Although an acuity-adjusted staffing standard would increase costs of care more than an unadjusted standard, a staffing standard using metrics adjusted for resident acuity aligns with reimbursement processes and better reflects the reality of resident care.

Separate thresholds for total nurse, RN, and CNA staffing hours prioritize residents' nursing care needs and balance nursing skill mix

While numerous direct care professionals provide care to nursing home residents, the proposed staffing standard only counts nursing hours toward the HPRD threshold. The state could revisit the inclusion of additional direct care professionals in the future. Stakeholders expressed conflicting opinions on which type of health care professionals should count in a staffing standard.[12] Several stakeholders believed that nursing homes should meet minimum staffing levels with nurse staff first before the state considers other personnel who provide direct care to residents. Other stakeholders suggest staffing metrics should include a broader array of personnel who provide direct care to residents, such as physical therapists, respiratory therapists, social workers, or restorative nurses. Evidence on the impact of direct care professionals other than nurses is promising, indicating a small but positive impact on quality of care, resident outcomes, and resident complaints.[61] However, research is insufficient at this time to suggest optimal staffing thresholds for personnel beyond nurses or to understand how staffing thresholds for nurses should be adjusted to account for such personnel.[62]

Virginia's staffing standard could also include separate thresholds for RN and CNA staffing because of the unique role each nursing professional has within a nursing home and the positive relationship between those nurse roles and quality of care. Standards only focused on total nurse staffing HPRD without minimum requirements for specific nursing types allow nursing homes the discretion to determine the nursing skill mix most appropriate for their population. However, such standards can also inadvertently alter the nursing skill mix in nursing homes in ways that may impact resident care.[54] Studies of standards in other states without specific HPRD requirements by nurse type found that increases were concentrated primarily among LPN staff, which shows no consistent association with quality measures.[63] Virginia's current nursing skill mix is already imbalanced, with average RN and CNA staffing HPRD lower than most other states and average LPN staffing HPRD

higher than most other states. A staffing standard that includes RN and CNA specific staffing thresholds may help balance the skill mix in Virginia's nursing homes.

Phased implementation addresses the need for immediate action in some nursing homes while recognizing that workforce development takes time

Phasing implementation of Virginia's staffing standard across six fiscal years allows the Commonwealth to prioritize addressing nursing homes with critically low staffing while phasing state resources across multiple state budget biennia to address increased costs of care and allow time for workforce development.

Selected thresholds for each phase reflect measured increases in nursing staff and nursing skill mix over time

JCHC staff selected specific percentile values of total nurse, RN, and CNA staffing HPRD based on analysis of Virginia's nursing home staffing data and its relationship with quality measures from CMS's Five-Star Quality Rating System (see APPENDIX 5 for detailed methodology). For the SFY 2029 thresholds, JCHC staff selected the 25th percentile of total nurse staffing HPRD among Virginia nursing homes with median nursing home quality ratings. Selection of this threshold focuses initial implementation on the 25 percent of nursing homes in Virginia with the lowest staffing levels. For SFY 2031, JCHC staff selected the 40th percentile of total nurse staffing HPRD, with higher percentiles selected for RN (50th percentile) and CNA (60th percentile) hours, given Virginia's low national ranking for those nursing positions and their strong relationship with quality of care. For SFY 2034, JCHC staff selected the midpoint (50th percentile) for total nurse staffing HPRD and higher thresholds for RN (60th percentile) and CNA (75th percentile) hours. JCHC staff compared selected thresholds to Virgina's and CMS's previously adopted standards, standards in other states, and to percentiles of staffing metrics in all Virginia nursing homes for face validity.

Implementing a SFY 2029 staffing standard could allow Virginia to prioritize addressing nursing homes with critically low staffing

Based on currently available data, 79 nursing homes would require, on average, 6.7 additional full-time equivalent (FTE) nursing personnel to meet the proposed SFY 2029 state staffing standard of 3.09 adjusted total nurse staffing HPRD. The affected nursing homes show patterns in staffing and resident characteristics that suggest immediate intervention is necessary. Notably, nursing homes that do not meet the SFY 2029 threshold provide care to a significantly higher proportion of Medicaid residents and a significantly higher proportion of medically complex residents compared to nursing homes that meet the SFY 2029 threshold.[vii] Based on resident health and care needs, CMS estimates that

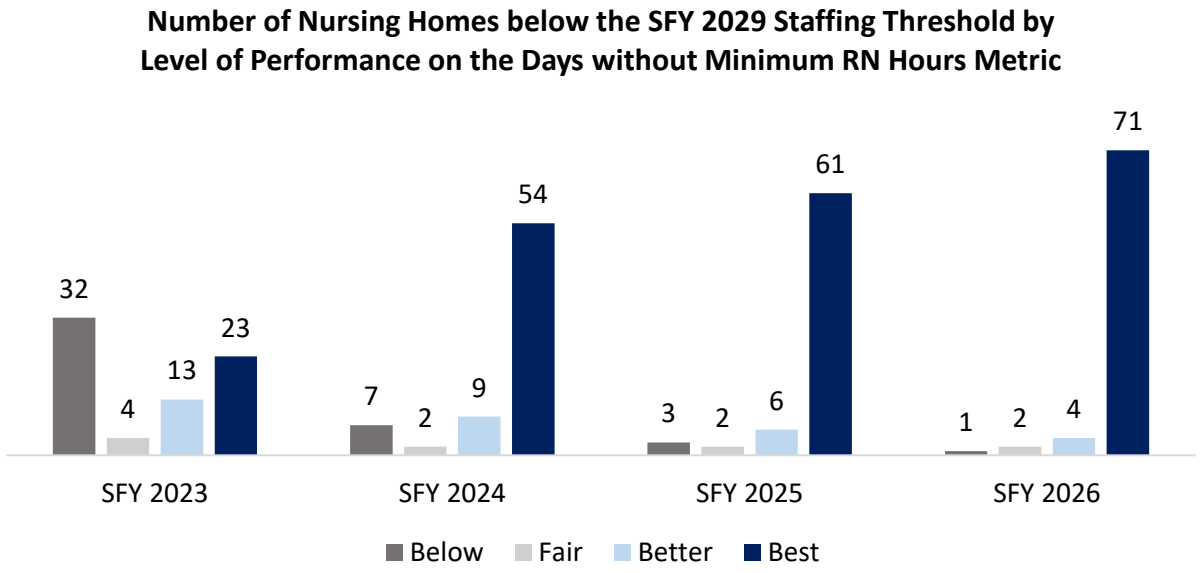
[vii] For Medicaid bed days, $t(284) = 8.76$, $p < .001$. For resident acuity, $t(284) = 5.54$, $p < .001$.

these nursing homes should be providing an average of 4.42 total nursing HPRD. However, these nursing homes provide an average of 2.79 total nursing HPRD, one hour and 38 minutes less per resident per day than expected. While the SFY 2029 threshold does not consider RN and CNA staffing HPRD, several nursing homes below the SFY 2029 threshold show exceptionally low staffing levels for these positions. Seven nursing homes report less than 15 minutes per resident per day of RN staffing, and three nursing homes report less than one hour per resident per day of CNA staffing.

JCHC staff estimate that implementing the SFY 2029 threshold would increase nursing home care costs for Medicaid members by approximately $24.7 million, of which half the costs, approximately $12.3 million, would require state general funds (see APPENDIX 6 for cost estimate methodology). Virginia has already invested $52.7 million in staffing performance or improvement among nursing homes that do not meet the SFY 2029 threshold through DMAS's NF VBPP. Results of that investment are mixed. Most nursing homes nearly immediately improved the number of days without eight hours of RN staffing following implementation of the NF VBPP (FIGURE 11). Ninety-one percent of nursing homes met the "best" threshold, meaning four or fewer days without at least eight minimum RN hours, by SFY 2026. Fewer nursing homes have shown progress on the total nursing HPRD metric. Between SFY 2025 and SFY 2026, the percentages of nursing homes with staffing levels below 3.26 total nurse staffing HPRD (meeting the "below" and "fair" thresholds) and at or above 3.27 total nurse staffing HPRD[viii] (meeting the "better" and "best" thresholds) remained unchanged (FIGURE 12).

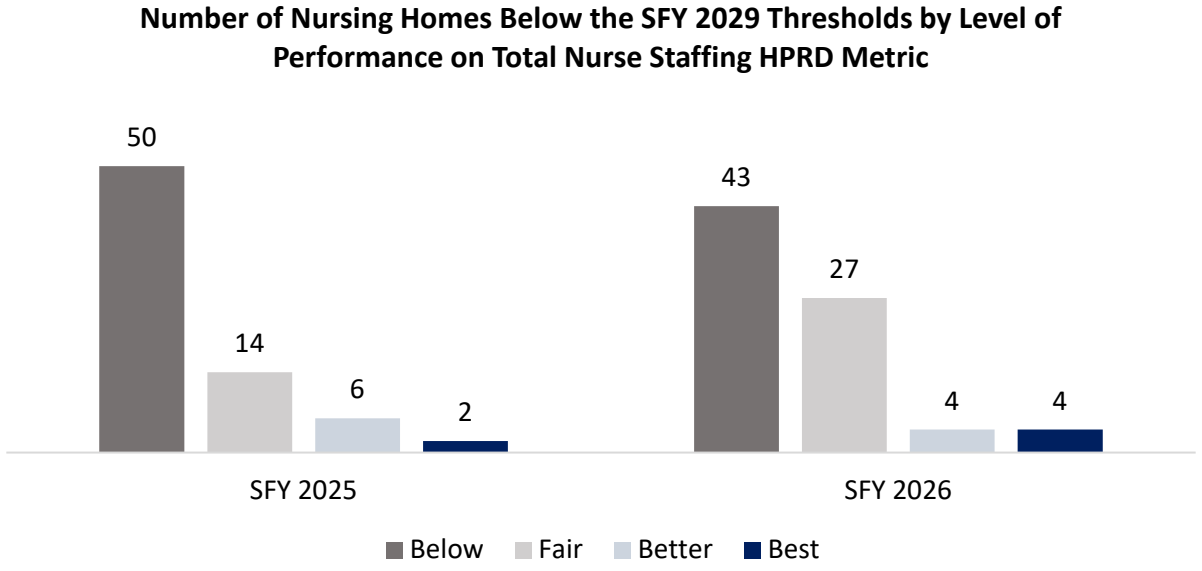
[viii] Nursing homes currently below the proposed SFY 2029 threshold of 3.09 adjusted total nurse staffing HPRD could have been the SFY 2026 NF VBPP threshold of 3.27 adjusted total nurse staffing HPRD based on the difference in the data collection period. The SFY 2026 NF VBPP staffing metrics are based on a data collection period from October 2024 to September 2025.

FIGURE 11. Most nursing homes below the SFY 2029 staffing threshold exceed NF VBPP performance expectations for days without eight RN hours



SFY = state fiscal year; RN = registered nurse
SOURCE: JCHC staff analysis of data from DMAS Nursing Facility Value-Based Purchasing Program Report, https://www.dmas.virginia.gov/data-reporting/value-based-purchasing/nursing-facility-value-based-purchasing-program/

FIGURE 12. Nursing homes demonstrate limited improvement on the total nurse HPRD metric



SFY = state fiscal year; HPRD = hours per resident day
SOURCE: JCHC staff analysis of data from DMAS Nursing Facility Value-Based Purchasing Program Report, https://www.dmas.virginia.gov/data-reporting/value-based-purchasing/nursing-facility-value-based-purchasing-program/

Among the 79 nursing homes below the SFY 2029 threshold, 72 are for-profit nursing homes affiliated with ten corporate chains, indicating a high degree of operational consolidation. The remaining nursing homes operating below the proposed SFY 2029 threshold include two government nursing homes (one federally operated and one locally operated) and five nonprofit nursing homes, one of which operates independently and four of which operate under three nonprofit corporations. Financial data from CMS Cost Reports indicate that nursing homes not meeting the SFY 2029 threshold are more profitable compared to those that meet the threshold.[64,65] Given the limited number of impacted nursing homes, the historic state investment in these nursing homes, and evidence of profitability, the General Assembly may wish to ensure such nursing homes are first using all available resources to meet the newly implemented staffing standards before additional public funds are provided. The General Assembly could create a special hardship fund to provide financial assistance for nursing homes that demonstrate hardship in meeting the staffing standard as a condition for obtaining additional public funds. Nursing homes that demonstrate hardship in meeting the staffing standard could receive hardship funds in addition to standard Medicaid reimbursement amounts to support additional recruitment and retention initiatives. The General Assembly may also wish to require nursing homes that receive additional public funds to use such funds only for nursing staff and to report to the state on how they use the funds.

➔ **Option 1a:** The Joint Commission on Health Care could submit a budget amendment to establish a hardship fund for which nursing homes could apply if they are unable to meet the Fiscal Year 2029 threshold after documenting and accounting for investments in the recruitment and retention of nursing staff, including but not limited to higher salary, improved benefits, and improved working conditions. The budget amendment could require nursing homes that receive hardship funds to use such funds only for nursing staff and to report to the state on how they used the funds.

The SFY 2031 and SFY 2034 staffing standards could impact most nursing homes in Virginia, requiring investment of state resources for increased costs of care

The SFY 2031 and SFY 2034 staffing standards would require more than 75 percent of nursing homes in Virginia to hire additional staff to meet the proposed thresholds. Stakeholders expressed conflicting views on the state's responsibility to pay for increases in costs of care associated with increased staffing. However, states commonly pair staffing standards with financial support to nursing homes, including increased Medicaid reimbursements, to offset the increased costs of care. While establishing state staffing standards may result in cost savings through reduced hospitalizations and ED visits as well as increased community discharges, such savings are not likely to offset the costs of increased staffing.[22]

The SFY 2031 threshold could affect 213 nursing homes and cost the state an additional $42.3 million per year. Based on currently available data, 213 nursing homes

would require additional nursing personnel to meet the proposed SFY 2031 staffing standard of 3.32 adjusted total nurse staffing HPRD, including at least 0.54 adjusted RN staffing HPRD and 2.06 adjusted CNA staffing HPRD. On average, nursing homes would need to hire an additional 3.0 RN FTEs and 7.2 CNA FTEs to meet the SFY 2031 thresholds. JCHC staff estimate that implementing the SFY 2031 thresholds would increase nursing home care costs for Medicaid members by $84.6 million, of which half the costs, approximately $42.3 million, would require state general funds while the remaining costs would be federally funded.

Nursing homes currently meeting the proposed SFY 2031 thresholds have a statistically significantly higher average quality measure rating than nursing homes that do not meet the threshold.[ix] Nursing homes meeting the total nurse staffing HPRD threshold have an average quality rating of 3.71 out of five stars, compared to nursing homes that do not meet the threshold, which have an average rating of 3.33 stars. For nursing homes meeting the RN staffing HPRD threshold, the average quality rating is 3.88 compared to 3.29 for nursing homes not meeting the threshold. Similarly, the average quality rating for nursing homes that meet the CNA staffing HPRD threshold is 3.73 stars compared to 3.43 stars for nursing homes that do not meet the threshold.

The SFY 2034 thresholds could affect 232 nursing homes and cost the state an additional $21.4 million per year. Based on currently available data, 232 nursing homes would require additional staff to meet the proposed SFY 2034 staffing standard of 3.43 adjusted total nurse staffing HPRD, including 0.60 adjusted RN staffing HPRD and 2.23 adjusted CNA staffing HPRD. On average, nursing homes would need to hire an additional 1.2 RN FTEs and 3.2 CNA FTEs to meet the SFY 2034 thresholds. JCHC staff estimate that implementing the SFY 2034 thresholds would increase nursing home care costs for Medicaid members by an additional $42.8 million, of which half the costs, approximately $21.4 million, would require state general funds while the remaining costs would be federally funded.

Nursing homes currently meeting the proposed SFY 2034 thresholds have a statistically significantly higher average quality measure rating than nursing homes that do not meet the threshold.[x] Nursing homes meeting the total nurse staffing HPRD threshold have an average quality rating of 3.75 out of five stars, compared to nursing homes that do not meet the threshold, which have an average rating of 3.35 stars. For nursing homes meeting the RN staffing HPRD, their average quality rating is 3.86 stars compared to 3.38 for nursing homes not meeting the threshold. Similarly, the average quality rating for nursing homes

[ix] For total nurse staffing HPRD, $F(1, 263) = 5.94$, $p < .05$, $\eta^2 = .022$. For RN staffing HPRD, $F(1, 263) = 14.75$, $p < .001$, $\eta^2 = .053$. For LPN staffing HPRD, $F(1, 263) = 10.82$, $p < .001$, $\eta^2 = .071$. For CNA staffing HPRD, $F(1, 263) = 4.54$, $p < .05$, $\eta^2 = .020$.

[x] For total nurse staffing HPRD, $F(1, 263) = 6.75$, $p < .05$, $\eta^2 = .025$. For RN staffing HPRD, $F(1, 263) = 8.84$, $p < .01$, $\eta^2 = .033$. For LPN staffing HPRD, $F(1, 263) = 10.82$, $p < .001$, $\eta^2 = .071$. For CNA staffing HPRD, $F(1, 263) = 5.79$, $p < .05$, $\eta^2 = .022$.

that meet the CNA staffing HPRD threshold is 3.86 stars compared to 3.43 stars for nursing homes that do not meet the threshold.

A phased approach spreads state resources across multiple state budget biennia to address increased costs of care from additional staffing. Officials in states with staffing standards highlight the risk of phasing staffing standards over multiple budget cycles.[50] When future increases in staffing standards depend on continued appropriations, fiscal constraints may prevent a phased requirement from reaching its originally intended staffing level. However, persistent nursing workforce shortages necessitate a phased approach to allow nursing homes time to recruit or develop additional staff.

➔ **Option 1b:** The Joint Commission on Health Care could include, in legislation amending § 32.1-127 of the *Code of Virginia* creating a staffing standard, an enactment that places the effective date of Fiscal Year 2031 and Fiscal Year 2034 staffing standard thresholds contingent upon an additional appropriation from the state to cover the increased costs of care for Medicaid members.

Staffing standards linked to state licensure requirements could strengthen the Commonwealth's ability to enforce staffing levels

Stakeholders disagree on whether Virginia should enforce or incentivize staffing standards. Some stakeholders indicate that without an enforcement mechanism, nursing homes lack adequate consequences to drive change in staffing measures.[12] Other stakeholders support only incentivizing staffing standards through DMAS's NF VBPP, with financial incentives provided to nursing homes that exceed or show progress towards meeting a staffing threshold. To date, however, significant financial incentives provided through the NF VBPP have demonstrated mixed results in staff improvements. In contrast, states with staffing standards tied to licensing requirements have seen increased staffing levels in nursing homes.[22]

Consistent with previous state legislation enacted in 2023 and introduced in 2026, Virginia could tie its staffing standard to nursing home licensure requirements to ensure the state has an enforcement mechanism to address persistently low staffed nursing homes. To do so, Virginia's Board of Health would need to update the regulations on nursing home licensure to reflect the inclusion of staffing standards.

If the General Assembly chooses to make the nursing home staffing standard a condition of licensure, the State Health Commissioner may impose sanctions on nursing homes that fail to meet the standard. House Bill 2253 (Wachsmann) and Senate Bill 1383 (Aird), enacted during the 2025 General Assembly session, amended the *Code of Virginia* by adding § 32.1-27.3 which expands the scope of sanctions the Commissioner may impose on licensed nursing homes that fail to comply with licensure requirements. Prior to the enactment of § 32.1-27.3, state law limited the Commissioner's authority to restricting or prohibiting new admissions, suspending nursing home licenses, and revoking nursing home certifications. These sanctions had the potential to detrimentally impact residents' access to care. The

new sanction structure enacted through House Bill 2253 and Senate Bill 1383 allows the Commissioner to impose intermediate sanctions, placing nursing homes on probation or imposing civil penalties that do not immediately impact residents' access to care. The legislation also requires the Commissioner to permit nursing homes to submit and implement a plan of correction before imposing sanctions and provides the Commissioner with discretion to extend the time for implementation of the plan of correction. This process allows nursing homes an extended opportunity to come into compliance with licensing requirements before the Commissioner imposes any sanctions. As directed by the 2025 legislation, VDH must promulgate regulations before implementing the new sanctions. VDH has developed the proposed regulations, and they are currently under regulatory review.

➔ **Option 1c:** The Joint Commission on Health Care could include, in legislation amending § 32.1-127 of the *Code of Virginia* creating a staffing standard, an enactment clause that requires the Board of Health to promulgate regulations incorporating staffing standards into the state's licensing requirements and gives the Commissioner of Health the authority to impose sanctions pursuant to § 32.1-27.3 of the *Code of Virginia* when nursing homes fail to meet staffing standards.

Linking staffing standards to licensure can provide states with a mechanism to enforce staffing standards; however, nursing homes may face challenges to comply with staffing standards. States can provide waivers or other flexibilities for nursing homes working to meet staffing standards. Several stakeholders endorsed a process that would exempt a nursing home from sanctions if the nursing home were unable to meet the staffing standard after a good faith effort to do so. Multiple states with staffing standards allow such waivers under limited and specific circumstances, which usually include demonstrating that serious recruitment efforts have failed to fulfill the staffing standard.[50] Consistent with state legislation enacted in 2023 and introduced in 2026, Virginia could add such an exemption to the staffing standard legislation.

➔ **Option 1d:** The Joint Commission on Health Care could include, in legislation amending § 32.1-127 of the *Code of Virginia* creating a staffing standard, a provision establishing a good faith exception for nursing homes that are unable to meet the staffing standard despite demonstrated, significant efforts to recruit and retain required nursing staff.

VDH indicates that enforcing staffing standards through licensure would require additional resources to avoid losing ground on the agency's existing backlog of licensure surveys, inspections, and complaint investigations. VDH estimates first-year costs of $726,500 and recurring annual costs of $701,500 to hire three Medical Facility Inspectors, one staffing compliance/data specialist, and one program support specialist. First-year costs include $5,000 sign-on bonuses to assist with recruitment. These positions would verify staffing records, analyze staffing data, investigate staffing-related complaints, and monitor corrective actions. Cost estimates are preliminary; actual resources needed would depend

on the standards adopted, the frequency and scope of compliance reviews, reporting requirements, and any exemption or waiver process.

➔ **Option 1e:** The Joint Commission on Health Care could submit a budget amendment to provide $726,500 in general funds in Fiscal Year 2028 for the Virginia Department of Health to hire five additional full-time equivalent positions to increase capacity for the agency to enforce nursing home staffing standards though the state licensure process.

Virginia could require nursing homes to report how they use additional public dollars to improve staffing

Virginia could couple additional investments in public dollars to support implementation of state staffing standards with requirements for nursing homes to spend such funds on nurse staffing. States have taken multiple strategies to ensure fiscal accountability for public dollars, including requiring nursing homes to report to the state how additional funds were expended, setting minimum requirements for total facility spending on nursing staff, and setting requirements for nursing homes to spend a specific proportion of their Medicaid reimbursement on nursing staff.[22] Strategies that limit spending on administrative or other operating expenses show some promise in improving care quality.[58] Additional analysis would be necessary to determine an appropriate threshold for nursing home staffing spending, given the different operational models in Virgina and each facility's Medicaid payer-mix. However, DMAS requires nursing homes to report annually on the hourly wage and benefit costs for nursing staff. This information is used to calculate an annual inflation factor for Medicaid rate setting.[66] As an interim solution, Virginia could increase transparency on the use of additional public funds for staffing by DMAS to collect and report on how nursing homes use such funds in its annual DMAS Wage Survey.

➔ **Options 1f:** The Joint Commission on Health Care could submit a language-only budget amendment requiring the Department of Medical Assistance Services to collect information from nursing homes on how they are using additional public funds to increase staffing levels, as part of the agency's annual Wage Survey.

Third party evaluation could provide important feedback on Virginia's staffing standard to the General Assembly

Few states with staffing standards require a formal evaluation of the implementation and impact of such policies. Conducting an evaluation allows the Virginia General Assembly and interested stakeholders an opportunity to assess changes in staffing levels and composition, facility compliance, resident outcomes, and any unintended effects over time, such as facility closures or reduced access to care. Policy evaluations focus on whether the program achieved its intended goal and typically include data analysis, stakeholder engagement, measurement of implementation processes and outcomes, and recommendations for improvement. To ensure a fair examination of staffing standard implementation and impact, Virginia could direct an external, independent evaluator to

conduct the evaluation, in collaboration with relevant stakeholders. VDH could oversee the selection of an evaluator and monitor the progress of the evaluation over time. VDH would need additional state funding to support the costs of the evaluation, estimated at $250,000 based on recent studies of comparable size and scope in Virginia.

➔ **Option 1g:** The Joint Commission on Health Care could submit a budget amendment for $250,000 in general funds for Fiscal Year 2028 requiring the Virginia Department of Health to contract with an external organization to evaluate the impact of the state staffing standard. The Joint Commission on Health Care could also direct the selected evaluator to convene stakeholders at least semi-annually to discuss the evaluation and for the reporting requirements to begin in Fiscal Year 2029 and annually thereafter until nursing homes fully implement the standards.

Virginia could pair staffing standards with continued support to the long-term care nursing workforce

Continuation of state support to incentive programs for the nursing home workforce is critical. The VNWC is currently in their first year of administering scholarship and loan repayment programs for nurses in long-term care settings and earn-to-learn programs for nursing homes. VNWC is anticipating submitting a report to the General Assembly in October 2027 that will address program funding and outcomes from the first fiscal year, from July 1, 2026 to June 30, 2027, as well as recommendations for future program improvements and investments.

DMAS's NF VBPP could play a vital role in incentivizing nursing home staffing levels beyond the state's staffing standard. The NF VBPP is, by design, a separate effort from the state staffing standard; however, Virginia could take steps to coordinate the two efforts. The state staffing standard is intended to represent a floor, not a ceiling, whereas the NF VBPP incentivizes nursing homes that exceed the state standard. Staffing above the state standard may provide additional benefits to nursing home residents. For example, in California, nursing homes exceeding the state's staffing standard experienced significantly fewer serious deficiencies upon inspection than nursing homes that met the state standard.[67] To ensure coordination between the two efforts, DMAS could update the NF VBPP's thresholds for total nurse staffing HPRD to align with the state staffing standard.

➔ **Option 1h:** The Joint Commission on Health Care could introduce a language-only budget amendment requiring the Department of Medical Assistance Services to update the Nursing Facility Value Based Purchasing Program's thresholds for total nurse staffing HPRD for the Fiscal Year 2029 performance period to align with the state staffing standard.

APPENDIX 1: House Bill 605 (Willett)

CHAPTER 407

An Act to direct the Joint Commission on Health Care to evaluate the workforce in Virginia's nursing facilities; report.

[H 605]

Approved April 8, 2026

Be it enacted by the General Assembly of Virginia:

1. *§ 1. That the Joint Commission on Health Care shall evaluate the workforce in Virginia's nursing facilities. In conducting its evaluation, the Joint Commission shall (i) review the findings of its 2021 report on "Workforce Challenges in Virginia's Nursing Homes" and assess current nursing facility direct care hours per resident compared to the current Centers for Medicare and Medicaid Services expected hours, (ii) examine direct care provided by registered nurses, licensed practical nurses, and certified nurse aides in nursing facilities and whether this level of care meets the hour requirement set by the Department of Medical Assistance Services for use in the Virginia Medicaid Nursing Facility Value-Based Purchasing program of case mix-adjusted total nurse staffing hours. The Joint Commission shall also review and develop recommendations on the efficacy of utilizing a measure of registered nurse coverage as an additional component of the minimum staffing requirement, in collaboration with relevant stakeholders. The review shall examine (i) the potential care benefits of increased registered nurse coverage, (ii) the practical impact of such a measure on staffing availability and costs, (iii) methods for reporting and calculating a measure of registered nurse coverage; and (iv) any other relevant factors necessary to determine compliance with such a measure. Additionally, such review shall consider other aspects of the hours per patient per day component of the staffing standards established pursuant to this act, including use of an adjusted per patient per day staffing requirement and the potential inclusion of other direct care professionals in the per patient day calculation. The Joint Commission on Health Care shall report on its findings and recommendations to the Governor and the Chairs of the House Committees on Health and Human Services and Appropriations and the Senate Committees on Education and Health and Finance and Appropriations by December 1, 2026.*

APPENDIX 2: House Bill 1357 (McQuinn)

CHAPTER 782

An Act to direct the Joint Commission on Health Care to conduct a comprehensive assessment of the quality of care, resident safety, and operational practices of nursing facilities in the Commonwealth.

[H 1357]

Approved April 13, 2026

Be it enacted by the General Assembly of Virginia:

1. *§ 1. That the Joint Commission on Health Care (the Joint Commission) shall conduct a comprehensive assessment of the quality of care, resident safety, and operational practices of nursing facilities in the Commonwealth. In conducting such assessment, the Joint Commission shall (i) examine nursing facilities licensed by the Virginia Department of Health and nursing facilities certified to participate in Medicaid or Medicare; (ii) conduct a statewide study and make recommendations to improve nursing facility quality, safety, transparency, accountability, and resident experience; and (iii) evaluate (a) quality and safety outcomes, including trends in preventable harms, avoidable hospitalizations, infection prevention and control, medication management, and management of other adverse events; (b) staffing levels and stability, including staffing patterns by shift, turnover and vacancy rates, use of agency staffing, training, competency, and supervision, and the relationship between staffing and resident outcomes; (c) complaint, survey, and enforcement systems, including the timeliness and effectiveness of inspections, complaint response, corrective action plans, sanctions, and repeat deficiencies; (d) resident rights and protections, including rights related to admissions and discharge practices, involuntary transfers and discharges, grievance procedures, family communication, and access to ombudsman services; (e) care coordination and transitions, including coordination with hospitals and community providers and discharge planning practices; (f) ownership and operational models and practices, including ownership structures, related party transactions, management agreements, real estate arrangements, and transparency of controlling interests, and how such practices affect staffing and quality; (g) financial and payment policy, including Medicaid reimbursement structure, the extent to which payments support direct care, and opportunities to align payment with quality outcomes; (h) emergency preparedness and continuity of operations, including outbreak response, staffing surge capacity, and readiness for severe weather and power disruptions; (i) data reporting and transparency, including public access to facility performance information and the availability of understandable information for residents and families; and (j) disparities in quality and access, including differences across regions and resident populations. The Joint Commission on Health Care shall report its findings and recommendations from its study to the Governor and the Chairs of the House Committees on*

Appropriations and Health and Human Services and the Senate Committees on Finance and Appropriations and Education and Health by December 1, 2027.

APPENDIX 3: Methods and data sources

JCHC staff used multiple data sources and methods to inform this study, including a literature review, administrative data analysis, state policy scan, and stakeholder interviews. Detailed methods for each source are documented below.

Literature Review

Relationship between Staffing and Quality of Care

The relationship between staffing and resident quality of care has been well studied. As such, JCHC's literature review sought to build upon previous systematic reviews by examining literature published since 2022 to identify any recent developments.

JCHC staff first identified and reviewed five comprehensive systematic reviews related to the research questions of interest for this review, published by legitimate organizations, and used to inform policy decisions on nursing home staffing and staffing standards. Following review of these reports, JCHC staff developed search terms consistent with the research questions to identify additional relevant literature:

"nursing home" AND "staffing" AND ("quality" or "safety")

"nursing home" AND ("state" OR "federal" OR "regulation") AND "staff" AND ("safety" OR "quality")

"nursing home" AND ("staff" OR "nurse") AND "role"

"nursing home" AND ("staff" OR "nurse") AND "cost"

JCHC staff searched PubMed, AgeLine, PsychInfo, and CINAHL databases, identifying 510 articles that included the search terms in the title or abstract, were published in English between 2022 and 2026, and for which full text was available. Following title and abstract review, 433 articles were excluded because they were either not relevant to the research questions or were not based in the United States. An additional 22 articles were excluded during full text review for lack of relevance. JCHC analysts reviewed and coded the remaining 55 articles for themes.

Effectiveness of State Staffing Standards

JCHC staff searched PubMed, AgeLine, and CINAHL databases using the following search terms:

"nursing home" AND "staffing" AND "complaint"

"nursing home" AND "staffing" AND "deficiency"

"nursing home" AND "staffing" AND "effectiveness"

"nursing home" AND "staffing" AND ("considerations" OR "consequences")

"nursing home" AND "staffing" AND "standard"

"nursing home" AND "staffing" AND "implementation"

"nursing home" AND "staffing" AND "access"

"nursing home" AND "staffing" AND "closure"

"nursing home" AND "staffing" AND "outcome"

JCHC staff identified 210 articles that were published in English between 2016 and 2026, and for which full text was available. Following title and abstract review, 185 articles were excluded because they were either not relevant to the research questions or were not based in the United States. An additional nine articles were excluded during full text review for lack of relevance. JCHC analysts reviewed and coded the remaining 16 articles for themes.

Administrative Data Analysis

JCHC staff analyzed data from multiple sources to inform this study (TABLE 2).

TABLE 2. Data sources

Data Source	Purpose
Centers for Medicare & Medicaid Services. (2026). *Nursing homes including rehab services.* Skilled Nursing Facility Quality Reporting Program U.S. Department of Health and Human Services.	Information on nursing facility location, size, ownership, staffing, quality measures, and health inspection deficiencies.
Centers for Medicare & Medicaid Services. (2026). *Healthcare Provider Cost Reporting Information System (HCRIS).* U.S. Department of Health and Human Services.	Information on nursing facility service revenue and operating costs.
Virginia Health Information. (2024). *Annual licensure survey data.*	Information on nursing home occupancy, patient bed days by payer, and dedicated service units.
Virginia Department of Medical Assistance Services. (2026). *Nursing facility rates and rate setting.*	Information on Medicaid reimbursement rates for nursing facilities.
Virginia Department of Medical Assistance Services. (2025). *Nursing facility annual wage survey.*	Information on hourly wage and benefit costs of nursing staff.

Data Source	Purpose
Virginia Department of Medical Assistance Services. (2026). *Nursing Facility Value-Based Purchasing Program (NF VBPP) report.*	Information on NF VBPP metric thresholds and incentive payments.
Brown University School of Public Health. (2023). *LTCFocus public use data.* (2023).	Information on nursing home resident demographics and conditions.

State Policy Scan

JCHC staff used LEXIS to examine nursing home staffing statutes, regulations, agency guidance, or program policies relevant to the licensure of nursing homes in all 50 states and Washington, D.C. Relevant statutes and regulations were evaluated for themes on staffing metric choice, included staff, and enforcement and reporting requirements.

Stakeholder Interviews

JCHC staff interviewed multiple stakeholders for this study to gain perspective on staffing in nursing homes, strategies to address staffing issues, the potential impact of staffing standards, and considerations about implementation of staffing standards in Virginia. The following agencies/organizations were interviewed for this study:

- Commonwealth Council on Aging
- LeadingAge Virginia
- Local department of social services representatives
- Virginia Board of Long-Term Care Administrators
- Virginia Board of Nursing
- Virginia Department of Aging and Rehabilitative Services
- Virginia Department of Health
- Virginia Department of Medicaid Assistance Services
- Virginia Health Care Association
- Virginia Health Workforce Development Authority
- Virginia Poverty Law Center
- Virginians Advocating for Seniors

APPENDIX 4: State staffing standard citations

TABLE 3. Citations and characteristics of state staffing standards

State	Citation	Standard Type	Includes Nurse Types
Alabama	Ala. Admin. Code 420-5-10 §11	Sufficient Standard	
Alaska	7 AAC 12.275	None	
Arizona	Arizona Admin. Code R9-10-412	Nursing Ratio	
Arkansas	A.C.A. 20-10-1402	Health Professionals HPRD	
California	Cal Health & Safety Code 1276.5 Cal Health & Safety Code 1276.65 22 CCR 72329.2 Nursing Service	Nursing HPRD	Yes
Colorado	6 CCR 1011-1 Chapter 5, Part 9	Nursing HPRD	Yes
Connecticut	Conn. Gen. Stat 19a-563h Regs., Conn. State Agencies 19-13-D8t	Nursing HPRD	
Delaware	16 Del. Code 1162 CDR 16 - 3000 - Chapter 3201	Nursing HPRD	
Florida	Title XXIX Chapter 400 Part II (ss 400.011-400.334), 400.23	Health Professionals HPRD	
Georgia	GA Comp. R & Regs R 111-8-56-04	Nursing HPRD	
Hawaii	HAR 11-94.2-39	Sufficient Standard	
Idaho	N/A	None	
Illinois	ILCS Chp. 210, Act 45, 3-202.05 77 Ill. Admin Code 300.1230 77 Ill. Admin Code 300.1240	Health Professionals HPRD	Yes
Indiana	IAC Title 410, Art 16.2, 3.1-17	Sufficient Standard	Yes
Iowa	IAC Title 481, 58.11(2)	None	
Kansas	KAR 28-39-154	Nursing HPRD	Yes
Kentucky	902 KAR 20:048	Sufficient Standard	
Louisiana	LAC 48:1:9757 LAC 48:1.9823	Nursing HPRD	
Maine	CMR 10-144-110, Section 9. Resident Care Staffing.	Health Professionals Ratio	
Maryland	COMAR 10.07.02.19	Health Professionals HPRD	Yes
Massachusetts	105 CMR 150.007	Nursing HPRD	
Michigan	MCLS 333.21720a	Nursing HPRD	Yes
Minnesota	MinnAdminCode 4658.0500 MinnAdminCode 4658.0510 MN code 144A.04	Nursing HPRD	
Mississippi	CMSR 15-016-045.4.1	Nursing HPRD	
Missouri	19 CSR 30-85.042	Sufficient Standard	
Montana	N/A	None	

State	Citation	Standard Type	Includes Nurse Types
Nebraska	Nebraska Admin. Code Title 175, Ch. 12 RRS Neb. 71-6018.01	Sufficient Standard	
Nevada	NAC 449.74517	Sufficient Standard	
New Hampshire	NH Admin Rules, He-P 803.14 NH Admin Rules, He-P 803.17	Sufficient Standard	
New Jersey	NJAC 8:39-25.1 NJAC 8:39-25.2	Nursing HPRD	Yes
New Mexico	NMAC 8.370.16.50 NMAC 8.370.16.51	Nursing HPRD	
New York	NY CLS Pub Health 2895-b 10 NYCRR 415.13	Nursing HPRD	Yes
North Carolina	10A NCAC 13D.2302 10A NCAC 13D.2303 10A NCAC 13D.2304	Sufficient Standard	
North Dakota	ND Admin Code 33-07-03.2-14	Sufficient Standard	
Ohio	OAC Ann. 3701-17-08	Nursing HPRD	
Oklahoma	OAC 310:675-13-1 OAC 310:675-13-5	Sufficient Standard	
Oregon	OAR 411-086-0020 OAR 411-086-0030 OAR 411-086-0100 OAR 411-086-0150	Nursing Ratio	
Pennsylvania	28 PA Code 211.12	Nursing HPRD	Yes
Rhode Island	R.I. Gen Laws 23-17.5-32	Health Professionals HPRD	
South Carolina	SC Code Ann 44-7-262 SC Code Regs. 60-17-605	Nursing Ratio	
South Dakota	ARSD 44:73:06:07	Sufficient Standard	
Tennessee	Tenn. Comp. R. & Regs. R. 0720-18-.06	Nursing HPRD	Yes
Texas	26 TAC 554.1001 26 TAC 554.1002	Nursing Ratio	
Utah	UAC R432-150-5 UAC R432-150-9	None	
Vermont	CVR 13-110-005	Health Professionals HPRD	Yes
Virginia	Va. Code Ann. § 32.1-127	Sufficient Standard	
Washington	RCW 74.42.360 WAC 388-97-1080 WAC 388-97-1090:	Nursing HPRD	
Washington, D.C.	22-B D.C. Mun. Regs. § 3211	Nursing HPRD	Yes
West Virginia	W.Va. CSR 71-15-8	Nursing HPRD	

State	Citation	Standard Type	Includes Nurse Types
Wisconsin	Wis. Stat. 50.04 Wis. Adm. Code DHS 132.62	Nursing HPRD	Yes
Wyoming	WCWR 048-0003-11	Nursing HPRD	

APPENDIX 5: Methods for selecting staffing standard thresholds

To develop staffing thresholds for SFY 2029, SFY 2031, and SFY 2034, JCHC staff examined the distribution and descriptive statistics of quarterly adjusted total nurse, RN, and CNA staffing HPRD metrics for a subset of Virginia nursing homes with median quality measure ratings on CMS's Five-Star Quality Rating System (TABLE 4). JCHC staff compared selected thresholds to the distribution of staffing metrics for all nursing homes as well as thresholds from previous federal standards, previous Virginia standards, and other state standards for face validity.

TABLE 4. Staffing measures percentile analysis

Statistics	Quarterly Adjusted Total Nurse Staffing HPRD	Quarterly Adjusted RN Staffing HPRD	Quarterly Adjusted CNA Staffing HPRD
Sample size	85	85	85
Mean	3.74	0.71	2.06
Median	3.43	0.54	1.91
20th Percentile	2.96	0.36	1.57
25th Percentile	3.09*	0.38	1.69
40th Percentile	3.32^	0.47	1.85
50th Percentile	3.43◊	0.54^	1.91
60th Percentile	3.53	0.60◊	2.06^
75th Percentile	3.98	0.70	2.23◊

*Selected for SFY 2029 staffing threshold. ^Selected for SFY 2031 staffing threshold. ◊Selected for SFY 2034 staffing thresholds.

SOURCE: Centers for Medicare & Medicaid Services. (2026). Nursing homes including rehab services. Skilled Nursing Facility Quality Reporting Program - Provider Data. U.S. Department of Health and Human Services.

APPENDIX 6: Methods for estimating costs of staffing standard

To develop a method for estimating costs to Medicaid for nursing facility staffing standards, JCHC staff analyzed assumptions of cost estimates for staffing standards from the 2021 JCHC study, *Workforce Challenges in Virginia's Nursing Homes,* and fiscal impact statements and budget amendments from the 2020 through 2026 Virginia General Assembly sessions. Based on this review, staff applied the following methods to calculate the costs to Medicaid for increases in staffing:

1. Calculate the difference between quarterly adjusted total nursing, RN, and CNA staffing hours per resident day and each respective proposed staffing standard threshold for each facility. For staffing thresholds beyond the initial year, nursing homes below the initial threshold are assumed to have at least met the threshold. Nursing homes above the initial threshold are assumed to have made no increase or decrease in staffing levels.
2. For nursing homes with staffing hours below the proposed thresholds for each staffing metric, convert the difference in adjusted hours calculated in Step 1 to the difference in reported hours by dividing the difference in adjusted hours by the national average case-mix hours per resident day,[xi] then multiplying by each facility's case-mix hours per resident day.[xii] This calculation results in the reported hours per resident day each facility is short of the proposed staffing threshold for each day.
3. Multiply the reported hours shortfall calculated in Step 2 by total facility patient days for the year and separately by total facility Medicaid patient days for the year. This is the reported hours per resident day the facility is short of the proposed staffing threshold for the year. A state average of 58 percent Medicaid patient days was assumed for nursing homes confirmed to accept Medicaid but missing data on Medicaid patient days for the years (4 of 289 nursing homes, 1.4 percent). For cost estimates beyond the current year, this assumes that total patient days and total Medicaid patient days are constant.
4. Multiply the annual reported hours shortfall calculated in Step 3 for all patients and for Medicaid patients separately by the hourly wage for RNs and CNAs, and a weighted hourly wage for total nurses. This is the total annual cost to nursing homes and the total cost to Medicaid of staffing increases to meet the staffing standard

[xi] National case-mix total nurse and RN staffing hours per resident day are reported in the US and State Averages Table from CMS's Provider Data Catalog for nursing homes and rehabilitation centers. National case-mix CNA staffing hours per resident day are calculated and reported in Harrington, C. A., McLaughlin, R. A., Saliba, D., & et al. (2025). Nursing home guide to adjusting nurse staffing for resident case-mix. *Journal of the American Geriatrics Society*, *73*(7), 2137–2145.

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threshold. This assumes that nursing homes will fill needed hours by hiring facility employees and not contract or agency staff, who can be more expensive. For proposed standards in SFY 2031 and SFY 2034 that have thresholds for different nurse types, the actual costs will depend on each facility's plans to staff to the total nurse threshold (e.g., with LPNs or additional RNs or CNAs beyond the threshold amount). Hourly wage data are calculated per facility from DMAS's annual nursing facility Wage Data Survey. The hourly wage for the total nurse hours per resident day metric is weighted based on the distribution of hours worked for each nurse type for each facility. For cost estimates beyond the current year, an annual salary increase of 2 percent for inflation is assumed. A state average hourly wage was used for nursing homes with missing wage data (53 of 289 nursing homes, 18.3 percent).

5. To calculate Virginia's share of Medicaid costs compared to federal costs, multiply the total costs to Medicaid calculated in Step 4 by 0.5. This reflects Virginia's current Federal Medical Assistance Percentage (FMAP) of 50.02% for the base Medicaid program enrollees. Nursing homes residents may also be Medicaid expansion enrollees or FAMIS/MCHIP enrollees; programs which have a higher FMAP percentage. Using the Medicaid base program FMAP permits a conservative estimate of costs.

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