January 17, 2022

Katherine Ceroalo
NYS Department of Health
Bureau of Program Counsel
Regulatory Affairs Unit
Corning Tower, Room 2438
Empire State Plaza
Albany, NY 12237

RE: HLT-46-21-00007-P: Minimum Staffing Requirements for Nursing Homes

Dear Ms. Ceroalo:

I am writing on behalf of the membership of LeadingAge New York to provide input on the proposed amendment of Sections 415.2 and 415.13 of Title 10 NYCRR. This regulation would require each nursing home to provide an average of 3.5 hours of direct nursing care per resident per day, of which at least 2.2 hours must be provided by a certified nurse aide (CNA) (or nurse aide only during calendar year 2022) and at least 1.1 hours must be provided by a registered nurse (RN) or licensed practical nurse (LPN). While LeadingAge NY and its not-for-profit (NFP) and publicly-sponsored provider members always strive to optimize staffing and to deliver the highest possible quality of care, we have grave concerns that this proposed regulation and the associated statute (NYS Public Health Law Section 2895-b) impose infeasible and arbitrary ratios. Given the current healthcare workforce state of emergency and inadequate nursing home reimbursement, these regulations will trigger mandatory penalties on nearly every nursing home in the state that will further deplete nursing homes of the resources they need to recruit and retain staff. Notably, the penalty provisions of these regulations go beyond the requirements of the statute with respect to nursing homes that fail to satisfy staffing standards due to extraordinary circumstances beyond their control. Rather than enhancing nursing home staffing, they will have the opposite effect.

Further, these regulations will have ripple effects on the rest of the health care system. **Nursing homes that are unable to hire additional nurses and CNAs to meet nursing hours ratios will be forced to further reduce their admissions in an effort to come closer to the required ratios. This will exacerbate capacity and staffing challenges in hospitals that are seeking to discharge stable patients to nursing homes for post-acute care services.**

Governor Hochul recognized the impossibility of these requirements and the negative impacts they will have on the health care system when she temporarily suspended their effectiveness by executive order until January 30, 2022. While our members appreciate the brief respite from the mandates, the staffing crisis will not be resolved in one month. Temporary, month-to-month suspensions of the requirements will not eliminate the prospect of sizeable penalties nor allow facilities to plan for the reopening of units and resumption of admissions. Instead of imposing infeasible and punitive requirements on nursing homes, we ask that the State work with nursing homes to develop constructive solutions to the staffing crisis.

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GENERAL COMMENTS

Arbitrary Nurse Staffing Ratios Will Not Result in Additional Nursing Hours or Improved Quality; Only Adequate Medicaid Rates Can Enable Those Goals.

The shortage of direct care staff in nursing homes is a product of demographic and labor market trends and inadequate Medicaid rates. Between 2015 and 2040, the number of adults aged 65+ in New York will increase by 50 percent, and the number of adults over 85 will double.[1] At the same time, the proportion of people available to care for an expanding older adult population (i.e., the age 18-64 cohort) is declining. Both informal caregivers and direct care workers in the long-term care system are already in short supply, and the gap will only grow.

Adding to the demographic challenges are other labor market realities. For example, although nursing is one of the most rapidly growing fields, nursing education programs simply cannot keep up with current demand. Further, shortages have boosted wages for New York's nurses and aides. According to the U.S. Bureau of Labor Statistics, nurse aides in New York are already paid more than in other Northeastern states and receive higher hourly mean wages than in any other state save Alaska.[2] Given the already existing shortage, nursing homes will be unable to recruit and retain the additional nurses that could be needed to meet the ratios proposed in this rulemaking. Rigid staffing mandates will not create more nurses and aides – they will only result in steep fines that drain providers of resources they need to recruit and retain staff.

Even if the demographic and training challenges were addressed, meaningful improvements in the quality of care and staffing levels in New York's nursing homes are simply not possible without addressing the inadequacy of Medicaid reimbursement. As the predominant payer for nursing home care in New York, the Medicaid program bears significant responsibility for the ability of our nursing homes to recruit and retain staff. Yet, New York's Medicaid nursing home rates are based on 2007 costs, with no cost-of-living increase since 2008. Not only has the State failed to raise rates to keep up with rising labor and other costs; it has actually imposed significant cuts. In fact, even in 2020 during the pandemic the State cut nursing home rates by $168 million annually, while most states increased funding for nursing homes.[3]

The State's Medicaid rates do not enable nursing homes to compete with hospitals, physician practices and health insurers, or even with retail and hospitality establishments, for licensed and unlicensed staff in a highly competitive labor market. Nursing homes cannot raise prices in order to raise wages because they are paid almost entirely through Medicaid and Medicare. Unlike hospitals and other providers, nursing homes are unable to cost shift to private payers when government rates are cut or when the government imposes new and costly requirements without fully funding them.

Finally, from a public and fiscal accountability standpoint, nursing homes are already responsible for ensuring adequate staffing under federal and state regulations, which is measured, publicized, and incentivized through the CMS 5 Star System and the NYS Nursing Home Quality Pool. Available research does not support the conclusion that specific staffing ratios contribute to improved quality of care or quality of life. According to a

[1] Cornell University Program on Applied Demographics New York State Population Projections; http://pad.human.cornell.edu/; accessed Jan. 4, 2019, p. 32.

[2] U.S. Bureau of Labor Statistics, Occupational Employment and Wages, May 2020, available at https://www.bls.gov/oes/current/oes311131.htm.

[3] These cuts include a 1.5 percent across-the-board cut to Medicaid payments and a cut to capital reimbursement. Musumeci, M. State Actions to Sustain Medicaid Long-Term Services and Supports During COVID-19. Kaiser Family Foundation. Aug. 26, 2020.

study commissioned by the Department of Health (DOH) and conducted in part by Cornell University,[4] evidence from two states (California and Massachusetts) that have mandated nursing ratios does not support significant patient care impact as a result of the mandates.

Given these realities and the need to cover shifts and recruit and retain staff, nursing homes are doing everything within their power to recruit and retain staff and have deployed executives and managers to direct care roles, housekeeping and dining. They are paying bonuses, shift differentials, and extortionate rates for staffing agencies, but even limited staff supplied by staffing agencies will leave without warning when they are offered a more lucrative shift in a hospital.[5] Facilities are already suspending admissions and closing units, and some are considering transferring residents. These extreme measures are enabling facilities to remain in operation for the short-term, but staff are weary, and at some point, the bonuses will not be enough to entice these staff to take on more hours. Furthermore, the added expense is simply not sustainable given rising operating losses due to chronic Medicaid under-reimbursement.

Lawmakers and regulators should fundamentally reevaluate these ill-conceived minimum staffing requirements. Rather than mandating staffing ratios, the State should raise Medicaid rates for nursing homes to enable them to pay competitive wages, assist struggling nursing education programs and subsidize the cost of nursing education, and expand access to aide training and certification.

SPECIFIC COMMENTS

Within the context of our general comments, we provide in this section detailed feedback on the specific elements of the proposed rulemaking together with the applicable regulatory references in order of their appearance in the regulation, not necessarily in order of priority:

§ 415.13(a): Staffing Standards

The proposed rulemaking would modify the second sentence of this existing subdivision as follows:

> "The facility shall further assure that staffing levels enable each resident to receive[s] treatments, medications, diets and other health services in accordance with individual care plans."

However, personnel other than nurses and aides (e.g., medication assistants, dietary aides, feeding assistants, therapy personnel, etc.) may play a role in providing medications, diets and other health services. The enabling statute (Public Health Law Section 2895-b) authorizes only the establishment of staffing standards for RNs, LPNs, CNAs and nurse aides. These revisions appear to exceed the intended scope of the rulemaking. Accordingly, the proposed revisions to this sentence should be omitted from the proposed rulemaking.

Notably, the proposed revision to this subdivision prohibiting the assertion of compliance with staffing standards as a defense to a claim of inadequate care supports our position that arbitrary "one-size-fits-all" staffing ratios do not ensure high-quality care for residents whose care needs vary considerably and involve personnel other than nurses and aides (see below).

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[4] Study of Nurse Caregiver Minimum Staffing Levels and Other Staffing Enhancement Strategies and Patient Quality Improvement Initiatives, NYS Dept. of Health, Aug. 2020. See: https://www.health.ny.gov/press/reports/docs/2020-08_staffing_report.pdf.

[5] Notably, even though they have no choice but to expand their reliance on staffing agencies at unaffordable rates, these expenditures would be discounted by 15 percent for purposes of the proposed minimum direct spending requirements [see HLT-46-21-00005-P: Nursing Home Minimum Direct Resident Care Spending].

§ 415.13(b)(2): Sufficient Staff

This paragraph would require each nursing home to provide an average of 3.5 hours of direct care per resident per day, of which at least 2.2 hours must be provided by a CNA or nurse aide (only during calendar year 2022) and at least 1.1 hours must be provided by an RN or LPN. The proposed rulemaking does not offer any empirical or other basis for utilizing these specific hourly requirements.

This proposed reliance on an arbitrary allocation of nurse and aide hours to ensure high-quality care is fundamentally flawed. It does not account for varying levels of resident acuity and care needs, which may suggest greater amounts of nurse time for clinically complex residents and more aide time for residents with cognitive impairments. Even the State's Medicaid reimbursement methodology, despite its own flaws, takes these factors into account. Furthermore, by arbitrarily focusing exclusively on the numbers of nurses and aides, the rulemaking also fails to account for several other professionals and paraprofessionals who also contribute significantly to the resident experience of care and quality outcomes, including rehabilitation therapy personnel, nurse practitioners, physician assistants, and physicians, respiratory therapists, recreation therapists and activities aides, social workers, and others.

In this regard, DOH's August 2020 report[6] on minimum staffing levels did not endorse the use of nurse staffing ratios, stating that "opinion and published studies differ as to whether mandating specific, statewide nurse-to-patient ratios is the most effective approach to achieving those goals." It concluded: "While the Department supports measures to improve quality of care and patient outcomes, the COVID-19 pandemic has only highlighted the need to maintain workforce flexibility."

Within the overall requirement of 3.5 hours of nursing staff time per resident day, the arbitrary numbers of hours that must be furnished by RNs/LPNs versus nurse aides will lead to unintended consequences. For example, several LeadingAge NY member facilities have *exceeded* the 3.5 hour overall requirement but provided more than 1.1 hours of RN/LPN care and *less than* 2.2 hours of nurse aide time. Given financial constraints occasioned by the pandemic and Medicaid underpayment, the proposed rulemaking would perversely force these facilities to lay off nurses in order to hire more CNAs. Similarly, facilities that serve greater numbers of residents with dementia who are ambulatory and require more social activities and supervision than clinical care, will have to lay off recreation and art therapy staff to hire more CNAs. Neither facility administrators nor residents' families would view this as a way to improve the quality of life of the residents, nor would the relevant quality measures reflect improvement. DOH and lawmakers should reconsider this "cookie cutter" approach to minimum staffing hours and allow for a more resident-centered, realistic, and flexible approach.

Section 415.13(b)(2) would also make an unjustified distinction between the hours of care provided by nurse aides and CNAs, such that nurse aide care furnished on or after January 1, 2023 will not count towards the 2.2 hour per resident day minimum requirement [see also proposed § 415.13(f)]. Proposed § 415.13(d)(1) defines nurse aides as those who have:

> "…not yet been certified as a certified nurse aide, including individuals who are in the first four months of employment and who are receiving training in a Department-approved nurse aide training and competency evaluation program and are providing nursing or nursing-related services for which

[6] Study of Nurse Caregiver Minimum Staffing Levels and Other Staffing Enhancement Strategies and Patient Quality Improvement Initiatives, NYS Dept. of Health, Aug. 2020. See: https://www.health.ny.gov/press/reports/docs/2020-08_staffing_report.pdf.

they have been trained and are under the supervision of a licensed or registered nurse, or individuals, other than a licensed professional, who have been approved by the Department to administer medications to residents."

These "temporary nurse aides" have been providing nursing or nursing-related services under a federal 1135 waiver since the beginning of the pandemic. CMS is allowing them to be reported in the payroll-based journal as "aides in training," even though they are not necessarily enrolled in a DOH-approved nurse aide training program. The regulation should be modified to align with the CMS waiver and PBJ reporting conventions.

In addition, we do not know when the public health emergency will end or when this waiver will be terminated. Accordingly, the regulations should not specify a date (i.e., January 1, 2023) for excluding non-certified, temporary nurse aides from the minimum hours count. Instead, it should align with the termination of the 1135 waiver. Given shortages of nurse aides and facility difficulties in recruiting and retaining these personnel as of January 2023, is arbitrary and counterproductive. We urge the Department and State lawmakers to reconsider the timing of this exclusion.

The existing regulation at 10 NYCRR § 415.13(c), which would not be modified by this rulemaking, also defines other individuals who may undertake nurse aide functions, including graduates of nursing programs and individuals who are on other states' CNA registries and are awaiting New York State certification. The proposed rulemaking should specify that hours of care provided by these individuals will also be counted towards the 2.2 hour per resident day minimum requirement during 2022 and beyond.

Further, the method used to determine the number of nurse and aide hours may not capture the services provided by executives or therapy staff who are deployed to fill nurse or CNA shifts during the staffing crisis, their hours may not be captured in the payroll-based journal data, and a facility could be fined under these regulations, even if the hours requirements were actually met.

§ 415.13(d): Nurse aide

Our comments above regarding the distinction between nurse aides and CNA also apply to this provision. We were pleased to see the reference in this subdivision to *"…individuals, other than a licensed professional, who have been approved by the Department to administer medications to residents."* LeadingAge NY has been advocating for several years for legislation that would authorize the use of Medication Technicians -- CNAs who receive advanced training to administer medications in nursing homes under the supervision of an RN. Such legislation would improve the quality of care delivered in nursing homes, ease the effects of nursing shortages, provide a career ladder opportunity for CNAs, and promote professionalism in the workplace through education and certification processes. We are hopeful that including this reference in the proposed rulemaking signals the Department's support for such legislation and understand that the associated hours of care provided by these individuals will count as CNA time for purposes of the minimum staffing requirements.

We take issue with the exclusion of feeding assistants from the calculation of minimum direct care hours. As noted above, nursing homes are facing severe labor shortages and are taking extraordinary measures to ensure sufficient staffing. Assistance with feeding is an extremely important function that most often is undertaken by nurse aides, but may be carried out by other non-certified staff with appropriate training. DOH should promote greater use of feeding assistants and other allied personnel as a way to alleviate worker shortages and extend the potential supply of individuals who can provide direct care in nursing homes.

§ 415.13(f): Non-Compliance with Staffing Standards

LeadingAge NY has no objection to the proposed quarterly interval for measuring compliance with the minimum nursing staff requirements, which we believe is reflective of the enabling legislation and affords greater simplicity and administrative ease than a more frequent measurement interval.

However, we strongly object to the Department's decision to go beyond the requirements of the statute with regard to the imposition of penalties when mitigating factors are found. The regulations require the commissioner to impose a fine of "up to $2,000 per day" for each day that a facility fails to comply with the minimum nursing standards and to impose penalties of "no lower than $300 per day" for non-compliance in the face of extraordinary circumstances or labor shortages. *The statute, by contrast, authorizes the commissioner to promulgate regulations that "shall include a range of penalties to account for mitigating factors," but does not specify the level of the penalties.* Nor does the statute require the imposition of a penalty in every case when mitigating factors are found – "a range" may include no fine at all. In fact, penalties for violations of the Public Health Law, including willful violations, generally are described in "not to exceed" terms, allowing the commissioner to impose no fine and no period of incarceration. (Public Health Law §§12, 12-b).

Unlike virtually every other violation of the Public Health Law, these regulations require nursing homes that are faced with extraordinary circumstances beyond their control to pay at least $300 per day for non-compliance with unrealistic and arbitrary staffing standards. A $300 per day fine is a steep penalty for facilities to have to pay for circumstances that are beyond their control. Draining facilities of funds during a pandemic will not support improved care or quality of life for residents. Penalties should not be levied at all in cases when facilities demonstrate the existence of one or more mitigating factors. The decision by the Department to limit its own discretion in this way, despite the staffing emergency is inexplicable.

It is indisputable that extraordinary circumstances and acute labor supply shortages as defined in proposed §415.13 exist and are likely to continue for the foreseeable future. We were relieved by the Governor's decision issue an executive order to suspend of the minimum nursing hours requirements until January 30, 2022. However, the effects of the pandemic, along with demographic changes, on facilities' ability to recruit and retain nurses and aides are likely to continue well-beyond January 30 through 2022. In light of these circumstances, in order to alleviate administrative burdens on the State and individual facilities, the Governor should provide some predictability to nursing homes, enabling them to plan for admissions and staffing beyond the next 13 days, and suspend the proposed minimum nursing staff requirements for as long as the Federal and/or State COVID-19 emergency declarations remain in place.

At a minimum, the existence of the short-term respite provided by the executive order should not serve as a justification for adopting these regulations as drafted. The final regulations should allow the Department to waive penalties in the event of extraordinary circumstance or acute labor shortages.

Although the Department expanded upon the statutory text by imposing more severe penalties than required by the law, the proposed regulations do not fill in in key details concerning the enforcement process that would contribute to transparency, consistency, and predictability in implementation. Specifically, the regulations fail to address the following key issues:

- What process will facilities be required to follow to demonstrate the existence of one or more of these mitigating factors? How will DOH make determinations that mitigating factors exist? Will nursing

homes be able to appeal these determinations? The proposed rulemaking should provide further information in this regard so that the public may offer input.

- In reviewing relevant State and Federal government websites, we can find no definition of the term "acute labor supply shortage," nor is one included in the proposed rulemaking. To ensure transparency and opportunity for public comment, the proposed rulemaking should define this term and include the methodology for determining the existence of an acute labor supply shortage in Metropolitan and Nonmetropolitan Areas.
- The determination of whether such labor shortages exist is to be made by the Commissioner of Health on a quarterly basis. Will these determinations be made on a contemporaneous basis with the proposed quarterly determinations as to whether nursing homes are complying with the minimum nursing staff requirements?
- The only factor identified in the regulation for consideration by the Commissioner in making this determination is "job availability metrics" developed by the NYS Department of Labor, which may include the list of job openings in New York State. These metrics do not appear to be specific to nursing homes. As previously noted, nursing homes occupy a very different position in the market for nurses and aides than hospitals and physician practices, due to the disparities in the pay scales that the different settings are able to offer. In order to determine whether there is an acute labor shortage in nursing homes, the Commissioner will need to consider nursing home-specific metrics. These data and metrics are not published by the Department of Labor, and is unclear whether they exist.
- In order for an acute labor supply shortage to qualify as a mitigating factor, the regulations require the facility to demonstrate that it has closed units, suspended admissions and/or transferred residents to other facilities. Unit closures and suspension of admissions can have damaging effects on consumers, acute care hospitals, and other providers. *Transferring residents from their home to another facility is a drastic step that is very distressing to the residents and their families.* Furthermore, if there is an acute labor supply shortage in the area within which the facility is located, this adds to the likelihood that residents may need to be transferred out of the area, adding to the impact on residents and their families. The State should not incentivize a decision to transfer residents to other facilities.

§ 415.13(g): Eligibility for Funding to Comply with Minimum Nursing Staff Requirements

Proposed § 415.13(g) conditions eligibility to receive additional funding for compliance with these requirements on a facility's compliance with Public Health Law § 2828, the nursing home minimum direct resident care spending requirements. A separate DOH rulemaking (HLT-46-21-00005-P) would require each nursing home to spend a minimum of 70 percent of its revenue on direct resident care and 40 percent of its revenue on resident-facing staffing. LeadingAge NY agrees in principle that eligibility for additional funding should consider facility investment in resident care activities and avoid rewarding under-investment in staffing. However, LeadingAge NY has identified several general and technical flaws with Public Health Law § 2828 and the proposed minimum direct resident care spending regulations, which are addressed in our separately filed comments on that rulemaking. These concerns have a material bearing on conditioning eligibility for minimum nurse staffing compliance funding on direct resident care spending requirements.

There is also a timing issue inherent in this proposal. Compliance with the minimum direct care spending requirements is based on data from the most recent Medicaid cost report filed by each facility. There is typically a 21- to 23-month lag between the start of a cost reporting year and the availability of the associated cost data, whereas compliance with minimum staffing requirements would be based on current quarterly data. This mismatch could result in conditioning a facility's current eligibility for minimum nurse staffing funding on older cost report data that may not be reflective of its current spending.

Once a facility is deemed eligible for funding, the proposed rulemaking states:

> "Any such nursing home that the Department finds will be required to expend additional funds to comply with this Section shall be eligible to receive from the Department additional funds, subject to availability from the New York State Division of the Budget, to hire nursing staff necessary to achieve the minimum nursing staff requirements set forth in paragraph (2) of subdivision (b) of this Section."

The enacted budget for State Fiscal Year 2022 devotes a total of $64 million per year for two years for this purpose. However, New York State cut 2.5 times that amount (i.e., $168 million) from annual nursing home Medicaid funding beginning in 2020, putting facilities in a substantially worse position to comply with the proposed nurse staffing requirements. Under the "Costs" section of the Regulatory Impact statement, no attempt is made to quantify the estimated cost on regulated entities of this major new mandate or to relate the available "additional" Medicaid funding to the added costs that nursing homes will need to incur.

LeadingAge NY is also concerned that those few (if any) facilities that are already meeting the minimum nursing staff requirements would not be eligible for funding under this construct and would effectively be penalized for their commitment to their residents and their staff. Such facilities should be eligible to receive incentive funding for their ongoing compliance. They should not have to continue to use funding from other sources to subsidize their inadequate Medicaid payments.

Posting Requirements (PHL §2895-b(4))

The regulations neglect to elaborate on two statutory requirements that demand the Department's instructions. First, the statute requires nursing homes to post information regarding nurse staffing that the facility is required to make available to the public under Public Health Law §2805-t, "in a form approved by the department" and "in a manner which is visible and accessible to residents, their families and the staff, as required by the commissioner." In addition, facilities are required to post a summary of the law provided by the Department, in proximity to the other postings. Nursing homes are waiting for the form and manner of these postings and the summary of the statute from the Department.

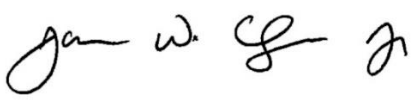
CONCLUSION

The proposed rulemaking and Public Health Law § 2895-b represent an ill-conceived attempt to regulate away a problem that simply cannot be solved through regulations. The proposed regulation: (1) is not based on empirical evidence that specific ratios of nurses and aides will improve the quality of care and quality of life of nursing home residents with diverse needs; (2) does not address the growing gap between Medicaid payments and actual costs of care; (3) will not somehow create nurses and aides "out of thin air" to fill thousands of new nurse and aide positions in an environment where shortages already exist and are worsening; (4) imposes more severe penalties than the statute requires; and (5) will only exacerbate the already dire staffing shortages by depleting nursing homes of financial resources they desperately need to hire and retain staff.

New York State lawmakers and regulators must revisit the genuine underlying threats to nursing home quality – Medicaid underpayment, labor shortages, and regulations and inflexible oversight that focus on administrative issues rather than resident-centeredness – if meaningful improvements are to be made. "Cookie-cutter" nurse staffing ratios that do not consider residents' unique needs and additional financial penalties will only make matters worse and must be revisited.

Thank you in advance for carefully considering our comments and recommendations.

Sincerely yours,



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