June 10, 2022

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1765-P
P.O. Box 8016
Baltimore, MD 21244–8016
http://www.regulations.gov

**RE: Medicare Program: Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2023; Request for Information on Revising the Requirements for Long-Term Care Facilities to Establish Mandatory Minimum Staffing Levels (CMS-1765-P)**

Dear Ms. Brooks-LaSure:

I am writing on behalf of LeadingAge New York to provide comments on the above-captioned Proposed Rule. LeadingAge NY represents over 400 not-for-profit and public providers of long term care and senior services throughout New York State, including Skilled Nursing Facilities (SNFs) and continuing care retirement communities. Our national affiliate, LeadingAge, is an association of 5,000 not-for-profit organizations providing long term care services and supports throughout the United States. LeadingAge NY endorses the separately submitted comments of LeadingAge and would like to thank you for the opportunity to offer comments highlighting some concerns especially relevant to New York state providers.

New York State providers were devastated by COVID-19 earlier and more intensely than those in many other states. The state was also hit hard by Delta and Omicron variants. Most recently, Community Transmission rates calculated by the Centers for Disease Control and Prevention (CDC) were designated as "high" for almost all counties in the state for the months of April and May of this year. The continuing financial impact of the pandemic is exacerbated by a statewide (or nationwide) staffing crisis, which demands substantial increases in pay or agency costs when workers are available, and drives worrisome revenue losses due to closed units and restricted admissions when workers are not available.

Absorbing these financial blows has been extraordinarily challenging as New York's Medicaid operating rates are based on 2007 costs that have received no inflation adjustments since 2008.[1] This has resulted in negative margins for more than two thirds of the state's public and mission-driven nursing homes even before the pandemic. Accordingly, Medicare funding that appropriately covers costs is

[1] The SFY 2022-23 budget includes a 1 percent increase in the Medicaid rate, the first such increase in 14 years.


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especially critical for states like New York . Below are comments on individual provisions of the proposed rule.

**Recalibration of the PDPM Parity Adjustment & MBI**

***Recalibration of the PDPM parity adjustment should be made only after SNFs have achieved some level of financial recovery from the pandemic. Even with the significant efforts CMS has taken to try to construct a 12-month time period least impacted by COVID, the magnitude of COVID disruptions on the healthcare system demand that recalibration be based on a more stable timeframe.***

We appreciate the care that CMS has taken in its comparative analysis of budget neutrality and efforts to identify and adjust for both direct and indirect COVID-related impacts. We are grateful that CMS is seeking to make adjustments prospectively and that it has taken into account COVID-related provider financial stress in the timing of any recalibration.

To this end, the imposition of a parity adjustment that reduces funding by $1.7 billion (4.6%) at a time when providers in most, if not all, states are grappling with severe staffing shortages, record inflation, as well as continuing financial impacts of the pandemic, both through increased costs and lost revenue, is problematic. The reduction is exacerbated by the uniform Value Based Purchasing (VBP) cut to all providers that reduces funding by another $186 million and is further magnified by the re-imposition of the sequestration payment cut at 1% on April 1 and at 2% in July. While the national impact of recalibration seems muted when netted against the proposed MBI/FEA/Productivity Adjustment of 3.9%, it is critical to note that providers are experiencing cost increases well above the MBI due to inflation and staffing crises.

Federal Coronavirus Aid, Relief, and Economic Security (CARES) Act Provider Relief Funding (PRF) was a critical financial lifeline. However, for most New York providers, it covered just a fraction of the significant, unbudgeted expenses and lost revenue that they have experienced, and continue to experience, due to the pandemic. Just as demand for SNF services and census started to rebound towards the 94 percent median occupancy the state's nursing homes experienced prior to the pandemic (i.e., 2019), the staffing crisis has caused a significant proportion of not-for-profit and public homes to limit admissions and/or close units to meet their own safe staffing standards or to comply with newly implemented state staffing mandates.

The pandemic has highlighted some systemic vulnerabilities to such an outbreak and providers are making necessary adjustments. These include new investments in safety and protective equipment, changes to staffing patterns, capital improvements to HVAC systems, and facility reconfiguration to increase the availability of single rooms , improve staff workflow and mitigate infection transmission, and/or the implementation of small-house models. They are also grappling with costly new operational requirements precipitated by the pandemic, such as repeated rounds of outbreak testing and cohorting, quarantines, administering and tracking multiple rounds of vaccine doses for residents and staff, routine screening testing of staff, visitation controls, and extensive new state and federal data reporting.

Given these continuing changes and the likelihood that they would not be naturally reflected in the MBI, we urge CMS to analyze the prevalence and magnitude of SNF cost structure changes precipitated by the pandemic and seek strategies to incorporate them into reimbursement.

Concerningly, funding challenges are forcing providers that want to deliver high quality care to leave the market. Since 2014, approximately 20 nursing homes in New York State have consolidated or closed, and approximately 50 public and NFP nursing homes have been sold to for-profit entities. During the pandemic this trend has accelerated, with 6 closures, several non-profit homes sold or in sale negotiations, and additional quality providers planning to substantially reduce their available beds. We fully expect these numbers to grow. Analysis of staffing and other 5-star data suggests that there is value in analyzing quality differences based on ownership. We support the recent efforts by CMS to provide additional transparency on this front.

While the proposed rule notes that MeDPAC expressed concern about high Medicare margins, we would be interested in any analysis that CMS may have done on the impact of Medicare managed care. Penetration of Medicare Advantage is near 50 percent in New York state (48 percent in May 2022) and has been steadily increasing[2]. Although that proportion is lower among individuals receiving nursing home care, over 25% of the Medicare days provided in New York nursing homes in 2019 (i.e., pre-pandemic) were paid by Medicare Advantage. With some Advantage plan rates significantly lower than FFS rates, adequate Medicare FFS rates take on even more importance, especially in states with higher managed care penetration rates. We would also be interested in learning more on the CMS approach to QRP and VBP as it applies to Medicare managed care. Additionally, we wonder whether changes in volume, specifically between Medicare FFS and Medicare Advantage, have any bearing when budget neutrality calculations are done?

While cognizant of the agency's charge and limitations, we urge CMS to recognize that a key lesson of the recent years is the need for investment into nursing homes to ensure that they have the resources to respond to a health emergency. Instead of new investment, COVID funding has only partially covered the lasting financial impact of the pandemic and current funding is stretched thin as homes struggle with staffing shortages, inflationary costs increases, and growing operational challenges. This leaves homes hard pressed to make investments to better serve residents and optimize infection control capabilities and argues for a delay to recalibration reductions.

**SNF Value-Based Purchasing Multipliers**

***Given the concerns regarding the accuracy and comparability of the underpinning data, we support the suppression of VBP rate adjustments but urge CMS to use a give-back percentage of 70 percent instead of 60.***

We agree that risk-adjusted rehospitalization rates, which compare SNFs to each other nationally, are likely to reflect variation in COVID-19 prevalence rather than variation in quality of care at this point in time. Recognizing the frustration of providers who may have invested resources in rehospitalization prevention efforts despite the pandemic and face an associated reimbursement reduction, we strongly urge CMS to use its authority to maximize the percentage of the cut that is returned to providers. Additionally, we question the advisability of making the rehospitalization rates public given concerns about their veracity and comparability.

[2] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-State-County-Penetration

**SNF Wage Index**

***Wage Index reductions should be capped at 2 percent. Establishing a SNF wage index would support the PDPM goal of more accurately aligning reimbursement with costs. The impact of the healthcare workforce crisis may exacerbate the variation between costs and reimbursement to the extent that SNF staffing dynamics fail to mimic those experienced by hospitals.***

We agree that year-to-year payment decreases driven by wage index changes should be limited and support capping negative changes to the wage index. Given our concerns about the possibility of hospital wages failing to always accurately reflect SNF wage dynamics, we recommend that the cap be set at 2 percent.

Since direct care labor inputs represent a large proportion of SNF input costs, the wage index has a material bearing on the level of Medicare PPS payments received by a SNF, and whether those payments are predictive of the costs which must be incurred to provide SNF care. CMS has utilized the hospital wage index to adjust SNF payments to account for differences in area wage levels since the inception of the SNF PPS. CMS received legislative authority in 2000 [the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. 106-554] to establish a SNF-specific geographic reclassification procedure, provided the agency collects the data needed to establish a SNF wage index. However, CMS has declined to develop a SNF wage index on the basis that the existing SNF wage data are unreliable and that considerable resources would need to be expended by CMS and the MACs.

This year again, CMS proposes to continue to use the hospital inpatient wage data to adjust SNF payments for differences in area wage levels. We believe that continued use of the hospital inpatient wage data fails to appropriately account for significant variation in SNF paraprofessional wages across labor markets and the greater utilization of certified nurse aides and other paraprofessionals in the SNF setting than in the inpatient hospital setting. Underscoring our concern is enacted state legislation that has increased New York State's minimum wage to $15.00 per hour in areas near NYC and is phasing in a $15 hour minimum wage in the rest of the state. This, as well as persistent and increasing staff shortages may add to this variation if they impact hospitals and nursing homes, as well as professional and paraprofessional compensation, differently.

With the inception of the PDPM, CMS undertook an effort to modernize and increase the predictive power of the rate setting methodology. The wage index utilized in the SNF PPS has a major bearing on achieving the goal of creating a model that accurately measures and adjusts for regional staffing cost variations. Accordingly, we strongly recommend that CMS undertake the data collection necessary to establish a SNF wage index based on wage data from nursing homes with the data that are required under the Payroll-Based Journal initiative leveraged as a framework to make such an undertaking less resource intensive and provide easier access to standardized and verifiable wage data. Development of a SNF wage index would also make it possible to implement a SNF geographic reclassification procedure to better circumscribe labor markets further improving Medicare payment accuracy.

LeadingAge NY further urges CMS to explore ways to base wage index updates on more recent data. The current four-year lag means that providers (hospitals, home care agencies and hospices, as well as SNFs) in states that have increased minimum wage, experienced sharp increases in wages in response

to the pandemic or face staffing shortages that drive staff compensation will not have these major changes reflected in their wage index adjustments until four years after incurring these increases.

**Minimum Staffing Levels**

We agree that the quality of care that residents and patients receive in health care settings, including nursing homes, is critically important and depends significantly on the skills and dedication of direct care staff. Our members are committed to ensuring that the residents served by their organizations are provided the highest quality of care and enjoy the most meaningful quality of life possible. They are similarly dedicated to ensuring that their staff are empowered and appropriately compensated, although the increasing financial stress discussed above makes this a constant challenge.

As a group, our members, which include the vast majority of the non-profit and public nursing homes in New York State, out-perform statewide quality measure averages calculated by NY State and CMS (e.g., the average overall 5-star rating for homes sponsored by non-profit and government entities is 3.5; the state average for all homes is 3.1). NY non-profit and public homes also have higher nurse staffing levels than the statewide average (e.g., based on CMS Care Compare adjusted staffing figures, 3.9 nursing hours per resident per day vs. the 3.2 statewide average). According to our analysis of Medicaid cost report data, our members have paid higher than average wages and benefits to nursing staff even before the staffing crisis intensified.

In light of this, as well as the financial challenges described above, we support the comments provided by our national LeadingAge affiliate and ask that your staffing discussions and any staffing ratio proposals be informed by three key principles:

- ***Staff with the appropriate titles and in sufficient numbers must be available before any staffing requirements are imposed.*** A clear, empirically-based understanding of the staffing crisis, the availability of staff, the increasing need for backfilling existing positions as aging staff retires or leaves the field is needed. This knowledge, as well as the implementation of strategies to attract individuals to the field and support their training, is a prerequisite for requirements. This must take into account the dynamics in other settings that compete for the same talent.
- ***Medicaid and Medicare rates must be sufficient to enable recruitment and retention of needed staff before any staffing requirements are imposed.*** Similarly, providers must be appropriately reimbursed to ensure that they have the necessary financial resources to meet any new staffing mandate. This includes not only adequate Medicare, but Medicaid reimbursement as well, especially in states where government payers represent the vast majority of nursing home revenue. To be clear, this is not meant to suggest rewarding those that have operated with below average staffing for years. However, for providers that are doing their best, penalties do not help to recruit new people to the field or pay them more. Significant resources are needed to counter the demographic trends of increasing dependency ratios as it is, and it is critical that we ensure current rates are sufficient to meet the current and future needs
- ***Flexibility is needed to ensure high quality care and innovation.*** Staffing regulations should not specify the relative numbers of hours to be provided by staff with particular titles or certifications. Instead, nursing homes should have the flexibility to engage staff with the

training and certifications, and for the number of hours per resident, appropriate to address the needs of their residents. For example, if residents' medical needs demand a higher number of nurse hours than aide hours, homes should not be required to provide a specified number of aide hours in lieu of nurse hours. Similarly, facilities that serve residents with higher levels of social needs and lower levels of nursing needs should be permitted to satisfy staffing requirements through the use of activities and rehabilitation staff, as well as nursing staff. Further, if policymakers are indeed committed to restructuring how the nation organizes, funds and provides nursing home care by developing new and innovative models, CMS should avoid prescriptive requirements based on the current nursing home model that might stifle or disincentivize innovation.

Below we address several of the specific questions of the Staffing RFI included in the proposed SNF PPS rule. New York State enacted staffing level requirements for nursing homes in 2021 and intends to assess penalties on providers that do not comply with the requirements after April 1, 2022. Most, if not all, nursing homes in New York are struggling to meet the well-intentioned, but poorly-timed and unfunded, state staffing requirements. We address several questions posed in the Staffing RFI, specifically questions 5 (what factors impact ability to recruit and retain staff?), 8 (which fields and professions should be included in staffing ratios?), 12 (facility experiences with state staffing minimums) and 15 (unintended consequences).

**Staffing RFI Question 5:** ***What factors impact a facility's capability to successfully recruit and retain nursing staff? What strategies could facilities employ to increase nurse staffing levels, including successful strategies for recruiting and retaining staff? What risks are associated with these strategies, and how could nursing homes mitigate these risks?***

*Lack of available candidates and lack of adequate financial resources are the two key factors impacting a facility's capability to successfully recruit and retain nursing staff. While facility-level factors are important to consider, even more important are systemic efforts to ensure sufficient availability of qualified staff, especially given the demographic trends, and sufficient resources to pay staff appropriately.*

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.[3] 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. This dynamic is likely replicated in other states as well.

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. Even if they could, nurses cannot be trained and licensed overnight. Any new nurse staffing requirements would have to provide a lengthy lead time to allow for the expansion of nursing programs and the training and licensure of more nurses. In the absence of a significant increase in

[3] Cornell University Program on Applied Demographics New York State Population Projections; http://pad.human.cornell.edu/; accessed Jun. 1, 2022.

nursing school graduates, given existing shortages, nursing homes are likely to find it difficult to impossible to recruit and retain the additional nurses that would be required by staffing standards. Rigid staffing mandates will not create more nurses and aides – they may increase pressure on existing staff to work longer hours, and any resulting fines will only serve to drain providers of resources they need to recruit and retain staff.

Even if the demographic and training challenges were addressed, meaningful improvements in staffing levels in nursing homes are likely to be limited, if not accompanied by sufficient resources – namely appropriate reimbursement by Medicaid and Medicare. For New York State, where residents who rely on Medicaid account for 72 percent of resident days, this means addressing the inadequacy of Medicaid reimbursement. Medicare accounted for 13.4 percent of resident days in NY nursing homes in 2020. 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 inflation adjustments from 2008 until 2022 when New York provided a 1 percent across the board in increase in nursing home rates. Not only has the State failed to raise rates to keep up with rising labor and other costs, even during the pandemic; it has actually imposed significant cuts. The continuing negative financial impact of the pandemic, including depressed occupancy due to closed units and limited admissions due to the lack of staff, makes implementing staffing requirements before homes are able to recover an especially daunting challenge.

In New York, and likely other states, 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. NY 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 to raise revenue. CMS should not impose new and costly requirements without ensuring that they are fully funded.

Our members have implemented various initiatives to help attract and retain staff, in addition to paying wages and benefits that tend to exceed regional averages. These include sign-on bonuses, retention bonuses, child care assistance, flexible hours, raises, career ladders, nursing school tuition reimbursement, hazard pay, shift differentials, etc. When faced with an inability to recruit needed staff, most mission-driven providers opt to limit admissions to ensure existing staff is not overly stressed and quality of care is maintained. This strategy comes at a significant cost as those empty beds (on top of lower occupancy due to reconfiguration to single rooms to improve infection control strategies in many facilities) further erode financial health of the organization. Signing bonuses have the danger of increasing costs and turnover without lasting return if they incentivize staff churn from one employer to another. The staffing crisis has also led to exorbitantly high staffing agency costs. By using these agencies, desperate providers create a market dynamic that incentivizes employed staff to shift to staffing agency work, thereby further increasing staffing costs to unsustainable levels. There is little that individual nursing homes can do to mitigate these risks. Adequate funding and policies to address them would help; staffing requirements would likely exacerbate them.

Finally, CMS should reconsider the regulatory requirements that limit nurse aide training options and discourage qualified candidates from seeking or remaining in nursing home careers. For example, nursing homes are prohibited from operating nurse aide training programs based on certain survey

citations. Another example is that nursing home staff, alone among all health care workers, are subject to routine COVID testing if they are not "up-to-date" in their COVID vaccinations. Because this requirement cannot be met by testing at home, some nursing home staff (i.e., those who work on shifts when facility-based testing clinics are not in place) must come into the facility on days off to be tested. With jobs and training programs available in hospitals, clinics, and physician practices, many are choosing to pursue careers elsewhere.

**Staffing RFI Question 8:** ***What fields and professions should be considered to count towards a minimum staffing requirement? Should RNs, LPNs/LVAs, and CNAs be grouped together under a single nursing care expectation? How or when should they be separated out? Should mental health workers be counted as direct care staff?***

*Any staffing requirements should be flexible enough to recognize the different approaches organizations may use, different models of care, diverse resident needs, and the variety of staff that may be involved in providing care to residents. They should also be sufficiently adaptable to facilitate or encourage new and innovative approaches to care. Aggregate hour targets meet these goals better than specific, multiple requirements. The COVID-19 pandemic and workforce crisis have only highlighted the need to maintain workforce flexibility.*

Arbitrary "one-size-fits-all" staffing requirements do not ensure high-quality care for residents whose care needs vary considerably and often involve personnel other than nurses and aides. Other professionals and paraprofessionals, including medication assistants, dietary aides, feeding assistants, recreation therapists and activities staff, rehabilitation therapy personnel, and chaplains all play important roles in supporting health and quality of life. In addition, nurse practitioners, physician assistants, physicians, and social workers contribute to the well-being of residents. Homes that provide specialized care to specific target populations may have additional staff that represent an especially critical direct care component, e.g., behavioral health professionals. Directors of Nursing (DONs) and RNs/LPNs with Administrative Duties are critical in developing and implementing person centered care plans and should be included in direct care staff calculations.

CMS has asked also whether administrative nursing time should be included in establishing a staffing standard. While nurses with administrative duties are not always delivering hands-on care, they have been integral to ensuring appropriate direct care staffing levels during the current staffing shortages. Among our members, nursing leaders and executives frequently assume direct care roles, including nurse aide roles, as resident needs demand. It is not always feasible to clock in and clock out as roles change or to schedule these changes in duties. As a result, this direct care time is not always captured in PBJ data. Administrative nurses should be counted in staffing standards without requiring unnecessary operational hurdles.

In New York, the recently enacted staffing standards require a minimum of 1.1 licensed nurse hours per resident day, a minimum of 2.2 hours of C.N.A. time per resident day. These arbitrary allocations discourage facilities that serve medically-complex residents from delivering higher numbers of nurse hours per resident day, at the expense of C.N.A. hours. Likewise, they force facilities that serve residents with lower nursing needs and greater socialization needs to deliver care with nursing staff rather than activities staff.

Federal staffing standards should be based on the results of a thorough staffing study that examines the levels and types of staff necessary to ensure quality of care and quality of life. In addition, they should provide for the exercise of discretion by medical directors, administrators, and directors of nursing who are most familiar with their residents' needs and with the competencies of their staff.

**Staffing RFI Question 12:** ***Have minimum staffing requirements been effective at the State level? What were facilities' experiences transitioning to these requirements? We note that States have implemented a variety of these options, discussed in section VIII.A. of this proposed rule, and would welcome comment on experiences with State minimum staffing requirements.***

*NY's recent experience with implementing minimum staffing requirements has been problematic for providers. Many that have already closed units and limited admissions due to staff shortages are forced to further reduce occupancy in a desperate attempt to meet the staffing requirements. This is deepening their financial distress, making it extremely hard for them to provide the type of wage increases required to recruit and retain staff or pay agency fees exceeding $100 per hour for RNs and $50 per hour for Aides. The prescriptiveness of the staffing requirements is causing some to deploy RNs and LPNs to fulfill Aide hours and may result in a decrease in the licensed nurse hours residents receive.*

NY enacted minimum staffing levels in 2021. Despite an Executive Order that established and continues a statewide disaster emergency due to staffing shortages in hospitals and other healthcare facilities, the state moved forward to implement the nursing home requirements. The new requirements set a minimum of 1.1 licensed nurse hours per resident day, a minimum of 2.2 hours of C.N.A. time per resident day, and at least 3.5 total nursing hours per resident day. Although subject to enforcement beginning in April 2022 with fines that may be as high as $2,000 per day, final regulations have not been issued. Based on PBJ data from the fourth quarter of 2021, we estimate that 80 percent of the state's nursing homes are not in compliance with these standards.

The staffing standards require inflexible nurse and aide hours per resident day, overriding the professional judgment of clinicians and potentially limiting access to care. These one-size-fits-all requirements apply to all nursing homes, regardless of size, location, physical layout or the actual care needs of residents. The significant demand for staff that this legislation has created may further deprive home and community-based services agencies and other institutional alternatives (e.g., adult care facilities and assisted living) of the staffing they need. We have observed a number of challenges regarding the requirements and their implementation in New York that may help inform CMS efforts. These include:

- The staffing requirements established in New York State are inconsistent with 5-star calculations. The New York requirements exclude DONs and RN/LPNs with administrative duties and are not adjusted for case mix. This has caused uncertainty for providers trying to understand the requirements and is likely to be confusing for residents and families as well.
- In the current labor market, it is especially difficult, if not impossible, for providers to find and hire staff. In fact, the requirements took effect during an active, statewide disaster declaration due to healthcare staffing shortages. This has exacerbated the cost and stress for providers struggling to recover from the epidemic.

- The state did not implement any initiatives to increase the availability of applicants, expand training programs, or attract dedicated people into the field prior to implementing staffing requirements.
- Although the state appropriated funds to support nursing home staffing in the 2021-22 and 2022-23 state budgets, it has not distributed any of that funding. Funding for a new mandate should be made available **in advance** to allow providers to prepare by hiring and training staff.
- As full implementation became effective in April, our informal poll of nursing home members found that 41% would be forced to restrict admissions further (on top of already closed units and limited admissions due to staff shortages). Lack of nursing home capacity is already creating back-ups in hospital discharges in many parts of the state.
- The New York statute risks chilling effective staffing arrangements by refusing to consider other staff such as therapists, physicians, extenders, social workers, and activity staff.
- Prescriptive staffing standards can result in unintended consequences whereby homes need to deploy RNs and LPNs to work as Aides to fulfill the specified Aide hour requirement.
- Legislation recently passed by both houses of the Legislature that penalizes mandatory overtime for nurses in New York further impairs the ability of homes to comply with staffing mandates.
- State policies have failed to consider health care staffing issues holistically, opting to address individual provider types separately. In addition to the nursing home staffing mandates, the state recently enacted an increase in the minimum wage for home care workers and is investing over $5 billion in the home and community-based services workforce using federal American Rescue Plan Act funds. The danger that this approach poses is that provisions in one health care sector cause staff disruptions in other sectors.
- Staffing policies must be informed by the demographic realities of rising dependency ratios, otherwise they are a cruel hoax on residents and families, and empty promises for existing staff.

**Staffing RFI Question 15:** ***Are there unintended consequences we should consider in implementing a minimum staffing ratio? How could these be mitigated? For example, how would a minimum staffing ratio impact and/or account for the development of innovative care options, particularly in smaller, more home-like settings, for a subset of residents who might benefit from and be appropriate for such a setting? Are there concerns about shifting non-nursing tasks to nursing staff in order to offset additions to nursing staff by reducing other categories of staff?***

*A potential unintended consequence of minimum staffing requirements would be the shift away from effective but atypical staffing arrangements that optimizes quality of care and quality of life for residents by involving a wide array of staff, in favor of a standardized, minimum nursing hours approach. This may be true in a conventional nursing home setting as well, but is likely to be especially true in innovative models such as greenhouse or small house models that are homelike settings. The most effective way to mitigate the problem would be to ensure that staffing requirements are sufficiently flexible to accommodate such arrangements.*

The NY state approach demonstrates the danger that specifying the numbers of hours that must be furnished by specific type of staff may lead to unintended consequences. For example, several LeadingAge NY members *exceed* the overall nursing hours requirement but provide *less than* the

specified sub-requirement of nurse aide time, while exceeding the required nurse time**.** Given financial constraints occasioned by the pandemic and financial stress, the requirements may require these facilities to lay off nurses in order to hire more C.N.A.s. Similarly, facilities that serve greater numbers of residents with dementia who are ambulatory and require more social activities and supervision than clinical care, may have to lay off recreation and art therapy staff to hire more C.N.A.s. 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. This "cookie cutter" approach to minimum staffing hours should be avoided in favor of a more resident-centered, realistic, and flexible approach. This includes striving to make universal workers and other staff efficiencies more common.

Policymakers should fundamentally reevaluate the concept of minimum staffing requirements with an eye on how they help the development of innovative models. If the goal is to build a sustainable long term care system that seeks to increase the number of individuals in home-like settings and respects and pays workers competitive wages, inflexible staffing requirements are likely not helpful. Rather than mandating staffing ratios, the focus should be on ensuring appropriate funding (both Medicare and Medicaid) to enable homes to pay competitive wages, assisting struggling nursing education programs and subsidizing the cost of nursing education, and expanding access to aide training and certification.

Nursing homes serve the most vulnerable individuals among us. As such, homes are already responsible for ensuring adequate staffing under federal and state regulations. Their staffing is subject to survey, reported through the PBJ system, and measured, publicized, and incentivized through the CMS 5 Star System and the NYS Nursing Home Quality Pool. Leveraging the existing, extensive regulatory structure to monitor staffing at nursing homes that raise concern, especially given the availability of auditable PBJ data, is a better approach than imposing arbitrary requirements that might negatively impact the quality of care and quality of life of residents. Imposing penalties for failing to meet those requirements will only deplete nursing homes of the resources they need to recruit and retain staff and deliver high quality care.

**Value-Based Purchasing Program- Additional Measures**

***We support the expansion of the VBP program to include more than a single measure. We are concerned about staffing and turnover measures being incorporated during a staffing shortage and are wary of the potential of duplicative penalties/impacts.***

We believe that expanding the VBP program by incorporating measures with which providers are familiar and which are already being used in QRP or 5-star is an efficient approach. We support the use of the SNF Healthcare-Associated Infections Requiring Hospitalizations measure currently in use in the SNF QRP as it can be reliably measured and is an important indicator of quality.

We do *not* support the inclusion of the Total Nursing Hours per Resident Day Staffing Measure in the QRP, while providers are experiencing a staffing shortage that may be expressing itself differently in different parts of the country. While we understand the importance of staffing and appreciate that the measure would be familiar to providers, a number of the challenges discussed above regarding staffing levels also apply to the hours per resident day quality measure. Specifically, homes that include therapy, recreation, social work or physician/nurse practitioner staff as part of their care model

may be providing optimal care but score low on a measure that is keyed exclusively to RN/LPN/Aide staff. Finally, we question the purpose of including a measure that homes are already likely highly motivated to score well on to attract admissions and maximize their overall 5-star rating.

Similarly, we do not support adding the staff turnover measure to the VPB program until the staffing shortage has resolved at least somewhat. Several New York members question whether the thresholds in the turnover calculation are long enough to ensure that employees in states that offer generous leave policies are not inadvertently counted as separated when on leave, to the detriment of the facility's turnover rate.

**Acceleration of the MDS Update**

***We are concerned that the accelerated timeframe for implementing MDS 3.0 v1.18.II allow providers sufficient time to become fully familiar with the updates, train staff and develop new procedures and that vendors and other entities essential to the process have sufficient time to design, test and deploy the necessary systems updates to accommodate the change.***

The intensifying staffing crisis as well as the continuing disruptions due to COVID make it especially difficult for providers to make the type of large-scale change that deployment of the MDS 3.0 v1.18.II would require. Making major changes to a document whose accurate completion is critical in ensuring care planning and resident care, as well as appropriate reimbursement, may be more appropriate when provider finances have had an opportunity to recovered somewhat from the pandemic. It seems that it would be more appropriate to solicit feedback and make implementation decisions once the draft form has been released and interested parties have had a chance to review it and are able to better gauge what level of time and effort implementation would entail. For states like NY that continue to rely on RUG categories for Medicaid reimbursement, the MDS change may provide an opportunity to update their Medicaid payment methodologies but would likely require additional time for both the states and their providers to develop and implement.

**Request for Information: Isolation**

***We ask that CMS consider a broadening of the infection isolation code definition to include residents who are quarantined at admission due to their vaccination status or during an outbreak in the SNF***.

We support the comments on this question submitted by our national LeadingAge staff. We would also ask CMS to consider a broadening of the infection isolation code to include residents who are quarantined at admission due to their vaccination status or during an outbreak in the SNF. The care delivered to residents who are quarantined, but who do not have a confirmed SARS-CoV-2 infection, is also more costly than typical care. Under CDC guidance, staff who care for these residents should use the same PPE as those who are treating residents with confirmed infections. Like residents in isolation, these residents require greater individualized attention to ensure that they are eating, engaging socially (either virtually or with staff), and receiving any therapies in their rooms.

**SNF Quality Reporting Program (QRP)**

***We support staff vaccination data reporting, although note the potential for confusion as well as duplicative penalties in states, including New York, that already require such reporting.***

We support Quality Reporting approaches that are sufficiently targeted to allow providers to focus on making quality improvements. In order to facilitate improvement efforts, the measure calculation details should be sufficiently explicit to allow providers to readily understand them and, where possible, validate them by replicating the calculation. To that end, data should be shared in sufficient level of detail to allow providers to review and improve their processes. Patient-level detail should be available to providers for all CMS measures that rely on such data. Similarly, the multitude of publicly reported measures requires that they be accompanied by understandable instructions to allow consumers to interpret them, including clear explanations in those instances where measures may be suppressed, not comparable across providers, or influenced by extenuating factors.

We also support the LeadingAge comments seeking inclusion of Medicare Advantage data in calculating the SNF QRP program. Medicare Advantage plans enrolled approximately 3.7 million New Yorkers in May of 2022, approximately 48% of eligible New Yorkers, based on CMS data reported here. Advantage enrollees accounted for more than 25 percent of New York Medicare nursing home days in 2019. The use of fee-for-service data alone in calculating these measures calls into question the validity of the measures and does a disservice not only to nursing homes, but also to the members of the public and regulators who rely on them.

While we recognize the importance of including Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431) in the QRP, we note that unlike most of the other QRP measures that are MDS- or claims-based and do not require additional reporting, this one would add a new requirement for homes to submit the data to the NHSN, albeit once a year. This would require effective communication to providers, as well as a sufficiently long window for providers to submit the data to allow the resolution of any problems. While seemingly a straightforward process, we have often seen providers encounter technical problems and delays with reporting to NHSN COVID modules.

NY state providers are already required to report this information to the state, and compliance with both reporting AND the reported vaccination rates are measures in the state's Nursing Home Quality Initiative. This may be true in other states as well. We urge CMS to work with states to ensure that new requirements minimize duplication and inconsistencies in data definitions to the extent possible and do not replicate the current COVID data reporting situation where providers, at least in New York, are required to devote significant time reporting the same or similar data to the state (on a daily basis) as well as to NHSN.

**Conclusion**

Despite New York State's public and non-profit providers facing one challenge after another, they remain dedicated and committed to their mission of providing the highest quality of care and the best quality of life to the residents they serve. They are as eager as we are to partner on common goals. Thank you for your work and for the opportunity to provide input on the proposed rule. If you have any questions on our comments, please contact me at (518) 867-8383 or dkirstein@leadingageny.org.

Sincerely,

Darius Kirstein
Dir. of Financial Policy & Analysis