November 1, 2023

Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attn: CMS-3442-P
P.O. Box 8016
Baltimore, Maryland 21244-8016

Dear Administrator Brooks-LaSure:

LeadingAge appreciates the opportunity to comment on the Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting proposed rule. LeadingAge supports efforts to improve quality and safety in our nation's nursing homes and is committed to ensuring that high quality nursing home care is available for those who need it. We are concerned, however, that the policies proposed will not be implementable and will effectively limit access to nursing home care as our mission-driven providers are forced to reduce the number of individuals they serve or to close altogether due to a lack of available workforce to meet these unfounded and unfunded standards.

By the Centers for Medicare & Medicaid (CMS)'s own estimations, these proposed minimum staffing standards would require 90,000 additional nursing staff to enter the long-term care workforce. We know that the United States is in the midst of a well-documented nurse shortage. According to the Bureau of Labor Statistics, 193,100 openings are expected each year over the next decade for RNs, but the workforce is only expected to add 177,400 by the end of this time period. Nursing schools turned away over 91,000 qualified applicants for the 2021-2022 academic year due to a lack of nurse educators and we know that only 9.28% of working RNs choose to work in long-term care, so the math is not looking good for nursing homes to fill these new positions.

Even if the nurses were available, our not-for-profit and like-minded, mission-driven nursing home providers struggle to cover the costs of hiring and retaining these staff. CMS estimated that the cost of implementing the hours per resident day (HPRD) standards alone would cost nursing homes $4.23 billion per year. LeadingAge conducted our own calculations and found that the cost would be closer to $7.14 billion[1]. As Medicaid is the primary payer of long-term care and average Medicaid rates cover approximately only 84% of the cost of care, CMS is leaving a hefty unfunded mandate in its wake.

CMS has taken $75 million of nursing homes' money from the Civil Money Penalty (CMP) Reinvestment Program to launch a workforce campaign that they claim will help boost the long-term care workforce. Not only is this paltry contribution a drop in the bucket compared to the funding that will be needed to

[1] LeadingAge calculations used daily hours and census rather than the quarterly averages used by CMS. Our calculations also used inflation adjusted hourly wages for contractors and employees respectively that are proportional to the contractor and employee mix at each SNF while CMS used hourly wages from 2021 and did not incorporate wage differentiation between contractors and employees.

train additional nursing staff, but CMS has publicly shared that the workforce campaign will also be used to boost the nursing home surveyor workforce. In other words, nursing homes that are struggling to support higher wages and expanded staff will be paying to train the surveyors that will enforce CMPs against them for their inability to meet the standards, while no additional funding has been put forward to actually recruit and retain staff. CMS has stated that they "welcome" states who wish to discuss increasing Medicaid payment rates but we urge CMS to take greater responsibility and show the federal leadership necessary to make it happen.

Were CMS to push forward with this unfunded mandate, the unintended consequences would cripple the healthcare system. Nursing homes would scramble to lure the limited RN workforce away from other healthcare settings that concurrently struggle with a workforce shortage. Where nursing homes were staffing up to meet minimum standards, home health, hospice, and hospitals would be losing the staff they need and have relied upon to care for the individuals they serve. The health and wellbeing of older adults in the community would suffer without adequate home health support, which could lead to more emergency department visits and admissions to hospitals that struggle to find staff to meet the growing need.

Nursing homes that were unable to meet minimum staffing standards would be forced to deny admissions, take beds offline, or close the nursing home altogether. This would mean that individuals who were no longer safe at home would have nowhere to go and individuals in need of post-acute care after hospitalization would either be stranded in the hospital, occupying valuable acute care beds needed for other individuals, or they would be forced to be discharged back home without the skilled nursing care that they need.

One also cannot ignore the "unintended", yet unavoidable impact enforcement of these standards would have on an entire class of nurses, the licensed practical nurse (LPN). LPNs are an integral part of long-term care, providing hands-on, clinical care in collaboration with RNs and nurse aides. Long-term care employs more LPNs than any other sector and LPNs are employed at higher rates than RNs in nursing homes. This rule marginalizes the contributions of LPNs in the long-term care workforce by focusing exclusively on RNs and nurse aides with no opportunity for substitution of LPNs.

We further note the equity issue that enforcement of these standards would create. According to the Bureau of Labor Statistics, in 2022, nearly half of all employed LPNs identified as people of color. Unless CMS provides funding for additional staff, this rule would disproportionately impact people of color as nursing homes were forced to shift staffing patterns and employ fewer LPNs in order to finance the hiring of additional RNs.

LeadingAge notes that congressional leaders are also recognizing the catastrophic consequences surrounding these proposed standards. In September, 28 Senators led by Senators Jon Tester (D-MT) and James Lankford (R-OK) implored CMS to rescind the rule to avoid nursing home closures and decreased access to care. On the same day, Rep. Michelle Fischbach (R-MN) introduced the Protecting Rural Seniors Access to Care Act (H.R. 5796) that would prevent CMS from implementing the rule until it can be proven that the rule would not result in increased nursing home closures, decreased access to care, and an exacerbation of existing workforce shortages.

In October, 97 members of Congress led by Rep. Greg Pence (R-IN), Rep. Brett Guthrie (R-KY), Rep. Vern Buchanan (R-FL), Rep. Michelle Fischbach (R-MN), Rep. Jared Golden (D-ME), and Rep. Chris Pappas (D-

NH), sent a bipartisan letter to Health & Human Services (HHS) Secretary Xavier Becerra expressing significant concerns and asking HHS to reconsider the rule. House Ways and Means Committee Chair Jason Smith (R-MO), House Energy and Commerce Committee Chair Cathy McMorris Rodgers (R-WA), and Senate Finance Committee Ranking Member Mike Crapo (R-ID) sent a letter to the Secretary on October 31 urging the Administration to withdraw the rule and provide justification for certain provisions by November 30.

Further, we remind CMS that it is irresponsible to proceed with implementation of requirements for which there is no evidence. The 2022 Nursing Home Staffing Study conducted by Abt Associates concluded that recent literature "does not provide a clear evidence basis for setting a minimum staffing standard" and there is "no obvious plateau at which quality and safety are maximized or 'cliff' below which quality and safety steeply decline." The Abt study also noted that the much-lauded 2001 nursing home staffing study failed to identify staffing levels below which quality and safety steeply declined.

Abt Associates stated that the staffing levels identified in the 2001 study, levels at which quality and safety are *maximized* and above which no further improvement occurs, are often misinterpreted by "researchers and industry alike" as minimum levels. CMS appears to be engaging in this misinterpretation, as both the 0.55 RN HPRD minimum standard and the 2.45 HPRD nurse aide standard proposed in this rule are, in fact, within the 2001 study's maximized staffing ranges. Given this willful misapplication of existing evidence and a lack of evidence identifying a clear minimum standard, it is alarming that CMS and the Administration would push forward with a regulatory requirement. Much as CMS would require a nursing home's operational plan to be evidence-based and data-driven, we require no less from our regulatory process.

We also note that a good portion of nursing homes are already subject to state-level staffing standards. Federal staffing standards layered on top of state requirements that are often different including different staff, different standards, and different ways of quantifying these standards, creates an unnecessarily complex system for providers to navigate.

LeadingAge urges CMS not to proceed with these proposed staffing standards. The qualified staff necessary to meet these standards are not available to be employed in long-term care, long-term care is not adequately funded to assist nursing homes in employing additional staff at competitive wages, and the nursing home staffing study ordered by the Administration and commissioned by CMS failed to provide sufficient evidence on which to base minimum staffing standards. In addition to these significant barriers, we have identified the following concerns outlined below.

Sufficient Staff

CMS has proposed minimum staffing standards of 0.55 hours per resident day (HPRD) of registered nurse (RN) time and 2.45 HPRD of nurse aide time. These standards would require, by CMS's estimates, an additional 12,639 RNs and 76,376 nurse aides at more than $4.2 billion per year. As noted above, LeadingAge calculations, based on daily hours and census rather than quarterly averages and including a wage differentiation for contractors, found the cost to be closer to $7.14 billion per year.

LeadingAge does not support finalization of these standards until CMS can assure enough qualified applicants and adequate funding to meet requirements. At such a time that these conditions are met and CMS finalizes and eventually enforces HPRD minimum standards, **LeadingAge advocates that hours**

from all nurse job codes submitted to the payroll-based journal (PBJ) system, including Directors of Nursing and other RNs with Administrative Duties such as Infection Preventionists and nurse assessment coordinators, and nurse aide job codes such as medication aides and nurse aides in training, should be counted in meeting HPRD requirements. These staff provide valuable care and support and their contributions to the quality and safety of residents cannot be overlooked.

Additionally, **LeadingAge advocates that hours of LPNs should be counted toward either the 0.55 RN HPRD or 2.45 nurse aide HPRD requirements.** In the 2022 Nursing Home Staffing Study, Abt Associates noted that a requirement that allowed substitution of nurses across staff types showed minimal differences in safety and quality from requirements that did not allow substitutions across staff types. Allowing nursing homes to substitute LPN hours for the RN and nurse aide HPRD minimum standards would help alleviate workforce concerns, ensuring that more nursing homes were able to meet staffing standards while maintaining quality and safety of resident care.

Alternative Total Nurse Staffing Standard

CMS is soliciting feedback on an alternative total nurse staffing standard of 3.48 HPRD. CMS requests feedback on this standard as part of a 3-part standard, in which a total nurse staffing standard is in addition to the proposed 0.55 RN HPRD and 2.45 nurse aide HPRD, or as a stand-alone standard in place of the proposed RN and nurse aide HPRD standards.

LeadingAge does not support a 3.48 HPRD total nurse staffing standard, either alongside or in place of the proposed 0.55 RN and 2.45 nurse aide HPRD minimum staffing standards. As outlined above, workforce issues will create considerable challenges for meeting the minimum staffing standards as proposed. A total nurse staffing standard would be met with the same challenges and would be similarly unimplementable.

Registered Nurse

CMS has proposed a requirement for an RN on-site, available to provide care 24 hours per day, 7 days per week. This requirement would replace the existing requirement for the nursing home to have an RN onsite for 8 consecutive hours per day, 7 days per week and would require, by CMS's estimates, an additional 3,267 RNs at $349 million per year. As proposed, CMS states that the hours worked by the Director of Nursing, who must be an RN, would count toward satisfying the 24/7 RN requirement; however, CMS expresses concern about the availability of the RN to provide care and so requests feedback on whether these hours should be counted, or should only count in certain circumstances.

LeadingAge does not support finalization of these standards until CMS can assure enough qualified applicants and adequate funding to meet requirements. At such a time that these conditions are met and CMS finalizes and eventually enforces the 24/7 RN standard, **LeadingAge advocates that hours from all RN job codes submitted to the PBJ system, including Directors of Nursing and other RNs with Administrative Duties, should be counted in meeting 24/7 RN staffing requirements.** CMS rationalizes the necessity of RNs in part by pointing out the differences in scope of practice between RNs and other nursing staff. CMS notes that RNs provide, among other services, clinical assessment and supervision of other nursing staff. This description is nearly identical to the services provided by the Director of Nursing and other RNs with Administrative Duties such as the nurse assessment coordinator, infection preventionist, and education coordinator. The hours worked by these nurses unquestionably contribute

to improved quality and safety of resident care and should not be excluded from the requirements that seek to accomplish this goal.

CMS requests feedback on alternatives to having an RN onsite 24 hours per day, such as having an RN available during a 24-hour period. CMS specifically asks under what circumstances and using what definition of "available" should this alternative be considered. **LeadingAge supports the inclusion of "RN available" in the 24/7 RN requirement.** Under §483.30(d) of the Requirements of Participation, CMS requires nursing homes to provide or arrange for the provision of physician services 24 hours per day in case of emergency. Our members have shared examples of how they ensure availability of physician services including being available by phone, via telemedicine, or being able to report onsite within a certain timeframe. Nursing homes should have the flexibility to apply the same parameters used to define availability of physician services to the 24/7 RN requirement when an RN is not available onsite.

Waivers and Exemptions

In current regulation, a waiver exists for the requirement for RN services 8 hours per day, 7 days per week. CMS has proposed to maintain this waiver and apply it to the 24/7 RN requirement. For the HPRD requirements, CMS has proposed an exemption process with criteria that would include consideration of location, good faith efforts to recruit and retain staff, and demonstrated financial commitment to staffing. CMS has also proposed conditions under which a nursing home would be determined ineligible for exemption from the HPRD minimum staffing standards to include designation as a Special Focus Facility, failure to submit payroll-based journal (PBJ) data, and citations for insufficient staffing at scope and severity of pattern or widespread noncompliance with resultant resident harm or immediate jeopardy in the 12 months preceding the survey in which the nursing home is found noncompliant with the HPRD minimum standards.

LeadingAge does not support the waiver and exemption processes as proposed. Having worked with members in the past to attempt to access the 8 hours / 7 days RN waiver, we know that there are systemic barriers to these waivers. In one state, a state contact admitted that in more than 20 years on the job, the contact had never seen a waiver approved. Naturally, we are concerned that an existing waiver process known to be problematic would be grandfathered in for a new 24/7 RN requirement.

We are also concerned with the disparities between the existing waiver and the proposed exemptions. Though they are separate requirements with separate processes, it seems the two should be somewhat uniform in their criteria since they both relate to the same issue of insufficient workforce. However, we note differences in location and workforce availability criteria and an additional criterion proposed for HPRD exemptions that does not exist for the current RN waiver.

The existing waiver of RN services requires that the nursing home be in a rural area *and* the supply of staff is insufficient to meet the needs of the population. LeadingAge recommends that this location criteria be changed to be consistent with the location criterion for the proposed HPRD exemption that allows for exemptions in non-rural, underserved areas. That is, both the waiver and exemption location criterion would determine a nursing home eligible if the nursing home was in an area with insufficient workforce availability *or* was located at least 20 miles from the next nearest nursing home.

Determination of workforce availability must be revised, though. The existing RN waiver provides no detail on how surveyors determine sufficiency of workforce supply. The proposed exemption process would determine workforce availability using data from the Census Bureau and Bureau of Labor Statistics. LeadingAge notes, however, that the Bureau of Labor Statistics data reports on the number of e*mployed* nurses in an area, not the number of nurses with appropriate qualifications who are *available to be employed*. A nursing home may be in an area with a high concentration of nurses but unless these nurses are looking for employment, they are little good to a nursing home seeking staff. True availability of the workforce must be considered when determining eligibility for waivers and exemptions.

The third criterion, financial commitment, applies only to HPRD exemptions as proposed. CMS states that a nursing home must demonstrate financial commitment by providing documentation on the financial resources the nursing home expends annually on nurse staffing relative to revenue. Noting that the nursing home would have already proved that nursing staff are paid adequate and commensurate wages through the second criterion, good faith effort to recruit and retain staff, an undefined criterion that evaluates spending on staffing relative to revenue seems ill-advised when other nursing home expenditures such as capital improvements and resident programming are equally important to the safety and satisfaction of both staff and residents. The financial commitment criterion should, therefore, be eliminated from the exemption process and not be adopted for the waiver process.

One criterion required by both the existing waiver process and the proposed exemption process that causes concern is the requirement that a nursing home must first be cited for failure to meet the requirement before being eligible to begin the waiver or exemption process. While we understand the importance of a survey to ensure that residents are not harmed by the lack of staff, it is unnecessarily punitive that a citation is required to begin this process. A revised process should allow nursing homes to request waivers and exemptions, with the resulting survey of nursing services to ensure the safety and wellbeing of residents, without being forced to wait out the traditional citation and enforcement process.

Based on these concerns, **LeadingAge urges CMS to reevaluate exemption criteria to better serve the goal of balancing the need for safe, high-quality care with access to care by providing flexibility for nursing homes that continue to provide quality care despite insurmountable workforce challenges.**

Lastly, LeadingAge strongly recommends that CMS explore strategies to improve transparency around both the existing waiver process and the proposed exemption process, should requirements be finalized related to both. As noted, both the waiver and the exemption require a survey of nursing services to determine absence of harm, yet no surveyor pathway for the existing waiver is included in the publicly available surveyor resources. Additionally, LeadingAge and our state partners have had considerable difficulty in the past attempting to ascertain information on waivers that have been granted. While the licensed nurse waiver is granted at the state level, the current RN waiver is granted at the federal level and it is assumed that any finalized requirements for 24/7 RN staffing and HPRD requirements would require federal-level waivers. **LeadingAge advocates for CMS to implement a process to improve transparency around these waivers and exemptions** that includes publicly available information on the number of active waivers and exemptions and any pertinent surveyor processes for determining eligibility for the waiver or exemption including any applicable surveyor pathway.

Implementation

CMS proposes staggered implementation of proposed staffing standards across a 5-year period. CMS proposes that Facility Assessment requirements would be implemented 60 days from the date the final rule is published. The 24/7 RN requirement would be implemented 2 years from the date the final rule is published, with nursing homes in rural areas implementing this requirement 3 years from the date the final rule is published. The HPRD requirements would be implemented 3 years from the date the final rule is published, with nursing homes in rural areas implementing this requirement 5 years from the date the final rule is published.

LeadingAge does not support the implementation timelines as proposed. While we appreciate that CMS has given nursing homes a relatively long lead-in time to adjust operations, recruit, and train new staff, we remind CMS that 2-3 years is not sufficient time to produce 90,000 new RNs and nurse aides when there exist more openings than applicants to fill the positions. Additionally, we know that workforce issues are not limited to rural areas. Underserved communities exist in both rural and urban areas throughout the country. Having a staggered implementation timeframe that favors rural areas not only disadvantages underserved communities in non-urban areas, but pits urban and rural areas against each other as staff are first recruited away from rural areas to fulfill the needs of urban nursing homes, then 1-2 years later rural areas are scrapping to bring staff back. **LeadingAge advocates for a single, delayed implementation timeframe for all nursing homes of 3 years for a 24/7 RN requirement and 5 years for HPRD requirements only after CMS can assure enough qualified applicants and adequate funding to comply with requirements.**

Administration

CMS proposes several clarifications and additions to existing requirements related to the Facility Assessment. CMS proposes to relocate Facility Assessment requirements from the Administration section of the Requirements of Participation, §483.70, to a new standalone section §483.71. CMS proposes clarifications to include that the Facility Assessment must be evidenced-based and data-driven and must provide for residents' behavioral health care including behavioral health issues. CMS proposes to clarify that the Facility Assessment should drive the staffing plan and should consider the competencies and skills sets needed to provide for the resident population.

CMS proposes to clarify that the Facility Assessment should be developed with input from staff including leadership, management, direct care staff and their representatives, and staff providing other services. CMS intends that direct care staff representatives could include union representatives and representatives from community worker rights organizations.

Additionally, CMS proposes that the Facility Assessment should be used to address staffing decisions including staffing across day, evening, and night shifts and on weekends and holidays. CMS proposes the addition of a staffing plan to maximize recruitment and retention and to address staff turnover. CMS also proposes to require a staffing contingency plan, based on the Facility Assessment, for circumstances that have the potential to impact resident care but that do not necessitate activation of the emergency plan. Ultimately, CMS proposes that the Facility Assessment will be used to determine additional staffing that may be required beyond the minimum HPRD standards to satisfy requirements for sufficient staffing.

LeadingAge does not support inclusion of external third parties such as labor union representatives in development of the Facility Assessment. We recognize the rights of workers to have third party representation and the importance of being able to communicate directly about facility conditions. Concerns such as these should be heeded and addressed by the nursing home. However, the Facility Assessment is an operational document and inclusion of outside parties in the development of such a document is neither appropriate nor efficient. Communications between the nursing home and third-party representatives may have appropriate influence over aspects of the Facility Assessment such as a staffing plan, but these conversations should be separate from the nursing home's procedures for developing this document.

Additionally, LeadingAge disagrees with the assertion in the proposed rule that representatives "may also help ensure facility assessments are up-to-date and used to inform facility staffing." This enforcement role belongs exclusively to state and federal surveyors and is never in the domain of a third-party representative.

Further, LeadingAge has concerns about surveyor enforcement of enhanced requirements. CMS provides no information in the proposed rule on how compliance with provisions such as the staffing plan would be surveyed. In circumstances where a nursing home is unable to recruit and retain sufficient numbers of staff despite the development of a staffing plan to address recruitment, retention, and turnover, the nursing home should not be evaluated and potentially cited on the sufficiency or effectiveness of the staffing plan.

Medicaid Institutional Payment Transparency Reporting

CMS proposes a Medicaid payment transparency reporting provision that would require states to report annually on the percentage of Medicaid payments per long-term care facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID) that are spent on compensation of direct care workers and support staff. States would report data to CMS that would be publicly reported on the federal Medicaid website, while also being responsible for maintaining the same data on a state-level website.

LeadingAge does not support the Medicaid Institutional Payment Transparency Reporting provision. We fully support transparency and believe increased transparency will demonstrate to the Administration and the public how inadequately long-term care is funded in this country and how hard our mission-driven members work to provide quality care in the face of America's hypocritical disinvestment. We support CMS's goal of transparency. However, this reporting provision will not meet that goal and we worry that the provision, in fact, creates opportunity for inaccurate conclusions to be drawn about Medicaid spending that could negatively and erroneously influence future policies.

Requiring reporting on the percentage of Medicaid payments spent on compensation implies that compensation of direct care and support staff are the only valid uses of Medicaid dollars. Reporting only on direct care staff compensation creates an opportunity for the mistaken assumption that money not spent on compensation is pocketed by the nursing home. This is simply not true and could act as a deterrent in future attempts to adequately fund long-term care.

As stated in our opposition to a similar provision in the Medicaid Access Rule that proposed a certain percentage of Medicaid payments to home and community based services (HCBS) providers must be

spent on compensation, LeadingAge reminds CMS that there are many valid expenses outside of direct care staff compensation on which Medicaid payments are spent. Evaluating, testing, and revising emergency plans and updating resident rooms from multiple-occupancy to private rooms with improved ventilation are important uses of nursing home funds that would be overlooked with a reporting provision such as the one proposed. CMS must be thorough in efforts to increase transparency and not settle for narrowly focused strategies that only tell the buzz-word parts of the story.

Lastly, as CMS pushes up against the immovable force of the workforce crisis, it would do well for the Administration to ask itself why long-term care struggles to attract new workers and what role the Administration plays in this issue. The Administration publicly and repeatedly insists that nursing homes are abusing the trust of older adults and their families by shirking the responsibility to care for vulnerable individuals. President Biden makes accusations that nursing homes, as a whole, are "padding profits on the backs of residents and nurses."

This inflammatory rhetoric might excite pop culture, but it is inaccurate and demoralizes the honest, dedicated, hard-working men and women that make up the majority of long-term care, while effectively nurturing the ageism that is so prevalent in our society. Is it any wonder, then, that nursing homes struggle to attract new workers to the field? When the abhorrence of nursing homes is so systemic that our government is comfortable with the failure to cover the costs of care, is it surprising that RN wages are lower in long-term care than any other healthcare setting? We urge CMS and the Administration to be part of the solution rather than propagating the problem.

Thank you for your consideration of these comments. We welcome the opportunity to work with CMS to address workforce challenges and improve quality and safety in our nation's nursing homes. While some strategies are primarily led by Congress, such as ending the nurse aide training lockout as described in the Ensuring Seniors' Access to Quality Care Act (H.R. 3227 and S. 1749), LeadingAge believes that CMS has the ability to take supportive regulatory action and federal leadership in many ways. Please do not hesitate to contact me at jeyigor@leadingage.org for follow-up. We would be happy to answer any questions and discuss next steps.

Sincerely,

Jodi Eyigor
Director, Nursing Home Quality & Policy

About LeadingAge: We represent more than 5,000 aging-focused organizations that touch millions of lives every day. Alongside our members and 38 state partners, we address critical issues by blending applied research, advocacy, education, and community-building. We bring together the most inventive minds in our field to support older adults as they age wherever they call home. We make America a better place to grow old. For more information: www.leadingage.org