November 6, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting [CMS–3442–P] RIN 0938-AV25

Dear Administrator Brooks-LaSure:

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) represents more than 14,500 long-term and post-acute care facilities, including nursing homes and skilled nursing facilities (SNF), assisted living communities, and intermediate care facilities for individuals with disabilities. We represent the majority of SNFs across the country and a rapidly growing number of assisted living communities. We appreciate the opportunity to provide comments on the "***Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting***" published by the Centers for Medicare & Medicaid Services (CMS) of the Department of Health and Human Services ("HHS") on September 6, 2023, 88 Fed. Reg. 61352 (the Proposed Rule).

Since this policy was first put forth by President Biden in February 2022, we have repeatedly voiced concerns about unfunded staffing mandates and called for more meaningful and practical solutions. Now with the Proposed Rule in hand, we must reiterate these concerns, both overarching and specific to this proposed regulation.

One thing we must reiterate from the outset is our shared desire to continue to enhance the care nursing home residents receive while also strengthening our long-term care workforce. AHCA has reached out to the Biden Administration on numerous occasions, putting forth robust reform packages such as the Care For Our Seniors Act and thoughtful quality improvement policies.

However, an unfunded federal staffing mandate will neither improve care nor address persistent staffing challenges. Without workforce development programs, staffing mandates do not create more caregivers, nor do they drive caregivers to work in long term care.

Without funding, staffing mandates do not help nursing homes offer more competitive, higher-paying jobs. And without flexibility, this one-size-fits-all national standard does not guarantee improved quality care for residents—a conclusion made by your agency's own commissioned report to inform this proposal.

More specifically, the CMS Proposed Rule before us today is problematic because it establishes impossible standards, harsh penalties, and an arduous waiver process. Almost 95 percent of nursing homes do not meet at least one of the three proposed staffing requirements, if not more than one. The current structure of the mandate calls for significant citations, fines, and potential removal from the Medicare/Medicaid program if these impossible staffing requirements are not met. The phase-in provisions are frankly meaningless considering the growing caregiver shortage, and the hardship exemptions are a misnomer with their cumbersome processes. We are deeply concerned that CMS has underestimated the true impact of this Proposed Rule and is setting nursing homes up for failure, which would have a devastating impact on those we serve and the entire health care system.

If CMS proceeds with this Proposed Rule, it will severely limit access to care for our nation's seniors and individuals with disabilities. Without a pipeline of new caregivers and resources to recruit, nursing homes will be forced to downsize in order to meet these requirements or close entirely. Nearly 300,000 residents could be displaced from their current nursing home, and countless other seniors and family members will be forced to wait longer and search farther for the care they need. This will also have a ripple effect across the entire health care continuum, overwhelming hospitals and other settings as they must care for patients who should be discharged to a skilled nursing facility but have no options.

Particularly concerning is the disproportionate impact the Proposed Rule has on nursing homes that predominantly and valiantly care for residents on Medicaid. Those facilities with a high proportion of residents on Medicaid are less likely to meet these proposed standards. The program's chronic underfunding means these facilities will not have the resources to recruit more staff or bear steep fines, threatening closures in underserved communities.

We strongly urge CMS to rescind this impossible, unfunded proposed staffing mandate. It will only result in negative, unintended consequences for residents, staff, and the entire health care system. We must protect access to care for our nation's growing elderly population, find more productive ways to address our nation's growing caregiver shortage, and advance more innovative, evidenced-based care approaches in this modern age.

Our enclosed comments expand upon these arguments, and while we strongly believe this policy should be rescinded, we have also suggested significant modifications to the Proposed Rule should CMS proceed. In addition, we have provided input on the specific questions CMS posed to commenters regarding the Proposed Rule.

AHCA/NCAL welcomes the opportunity to continue our dialogue with CMS. We stand ready to work with the agency on more meaningful efforts to accomplish its intent of improving care in America's nursing homes. Please do not hesitate to contact us if you have any questions.

Sincerely,

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Mark Parkinson
President & CEO

Table of Contents: Proposed Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting

1. General Comments

We all agree that it would be great to have more staff in every health care setting, including nursing homes. Unfortunately, the proposed minimum staffing requirements are impossible to implement for two reasons: the workers are not available and even if they were, the cost to hire them is prohibitive. The unintended consequences of this policy will be detrimental to our residents, their families, our staff, and the entire health care community. Furthermore, we have serious concerns that CMS has failed to fully account for a number of issues as well as the ultimate impact of the Proposed Rule and does not have the authority to implement such a rule.

The proposed minimum staffing standards are impossible to implement because the workers are not available.

The Proposed Rule would require nursing homes to hire more than 102,000 additional caregivers, according to an analysis by CLA (CliftonLarsonAllen LLP) titled "CMS Proposed Staffing Mandate - In-Depth Analysis on Minimum Nurse Staffing Levels". While we fully support boosting the nursing home workforce, the reality is that nursing homes cannot meet increasing, unfunded staffing requirements when they cannot find caregivers to hire. Nursing homes are still battling a historic workforce crisis and—as CMS acknowledges in the Proposed Rule—the lingering effects of the COVID-19 pandemic, which had a disproportionate impact on our personnel. Long term care providers have been working tirelessly to rebuild our workforce, and we have made some progress, but we still need more than 150,000 workers to return to our pre-pandemic workforce levels. Facilities around the country continue to experience significant challenges in finding qualified caregivers, and vacant positions often sit open for months.

Meanwhile, there is a growing shortage of nurses throughout health care, as hundreds of thousands are expected to retire or leave the health care profession entirely in the coming years. Nursing schools are not able to produce an adequate supply of replacements, as a shortage of nursing faculty has contributed to a decrease in nursing program enrollment for the first time in more than two decades. With a limited pool of qualified caregivers throughout the health care continuum, a federal staffing minimum would mean nursing homes would have to try to pilfer workers away from other health care settings. Even if they were successful, which would be detrimental to our health care system, this is unsustainable given our nation's rapidly growing elderly population.

In addition, the Proposed Rule is impossible to implement because there are no funds to pay for it.

Already, more than 500 nursing homes have closed over the course of the pandemic, and nearly 60 percent of facilities have negative operating margins. Chronic Medicaid underfunding and soaring inflation mean many facilities are operating on shoestring budgets or are on the brink of closure, and these unfunded mandates could push them over the edge—severely impacting seniors' access to quality care. The CLA analysis also found that these mandates would cost $6.8 billion annually to cover the cost of hiring the more than 102,000 additional caregivers necessary to meet the requirements. This number far exceeds even CMS's estimate of an average of $4 billion annually over the first ten years, and yet does not account for any future wage increases or adjustments.

The proposed mandate is impossible to manage and implement for nearly all providers, but especially facilities in underserved communities.

If the proposed requirements were finalized today, nearly 94 percent of facilities would not meet one or more of those requirements. A phase-in does not alleviate this problem, especially without funding and workforce development programs to help address the growing caregiver shortage during this time period.

The Proposed Rule has a disproportionate impact on nursing homes that are committed to serving some of our nation's most vulnerable. Nursing homes that do not meet at least one of the requirements are more likely to have a majority of their residents relying on Medicaid (56 percent average Medicaid census) compared to facilities that meet the criteria (43 percent).

If there is one single instance in which the nursing home doesn't meet these requirements, they're in danger of being cited, fined, or even worse, removed from the Medicare/Medicaid program. Meanwhile, the hardship exemptions as proposed are virtually impossible for a facility in need to meet. The process is cumbersome and imposes all-or-nothing criteria. For example, facilities are required to be surveyed and cited before being eligible for the hardship exemption from the HPRD requirement. However, there is a survey backlog due to a shortage of surveyors. The Proposed Rule sets impossible standards that lack awareness of real-world situations.

A nationwide, one-size-fits-all staffing policy will not work and will not improve care despite the Proposed Rule's intent.

There is a reason that prior Administrations, including the Obama Administration, have rejected a nationwide minimum staffing requirement: it is impossible to operationalize without a major influx of workers and funding. Past Administrations also rejected the idea due to concerns with possible unintended consequences.

The Proposed Rule's inflexible nationwide approach also ignores the different local circumstances that make different staffing levels appropriate (and higher levels impracticable) in different areas of the country. The states differ dramatically. State Medicaid rates vary from $170 a day to over $400 a day. It makes no sense to have the same requirement in every state, which is why 46 states have adopted their own minimum staffing policy. In addition, there are nursing homes in New York City with over 600 residents and nursing homes in Iowa with less than 40. A one-size-fits-all staffing policy does not make sense with varying complexities among states, nursing homes, and residents. That approach is also contrary to what research shows. Abt Associates, commissioned by CMS to analyze this policy proposal, concluded in the Nursing Home Staffing Study Comprehensive Report ("2022 Minimum Staffing Study") that there was "no obvious plateau at which quality and safety are maximized or 'cliff' below which quality and safety steeply decline."

Moreover, other independent organizations, including – but not limited to – MedPAC, LeadingAge, American Hospital Association, National Association of State Veterans Homes, National Rural Health Association, Catholic Health Association of the United States, Lutheran Services in America, and the Association of Jewish Aging Services (AJAS) share our concerns about the proposed federal mandate.

Ultimately, the Proposed Rule poses unintended, detrimental consequences to our residents by jeopardizing their access to necessary care.

Already, nursing homes are having to limit new admissions, downsize their facilities, or close their doors completely because they cannot find the workers they need to continue serving their residents. If nursing homes are unable to increase their workforce to meet these proposed requirements, facilities will likely need to further reduce their census. The Proposed Rule puts more than 285,000 residents at risk of being displaced from their nursing homes, causing frail seniors and their families to wait longer and search farther for the nursing home care they need. Furthermore, as facilities are forced to lower census to meet requirements, it could jeopardize the facilities' ability to support existing staff wages—meaning potential layoffs and further restrictions in access to care. These unintended consequences are devastating to residents, families, staff and the larger health care system overall.

And while the Proposed Rule would allow for exemptions under certain circumstances, the limitations on those exemptions make them no solution for the ongoing nationwide shortage in nursing staff. As a result, the most likely impact of the Proposed Rule will be to reduce access to care by forcing long term care (LTC) facilities to reduce the number of people they serve or to cease operations altogether—the opposite of what CMS claims the rule is intended to do.

CMS's calculations are flawed and result in underestimating the true impact of the Proposed Rule.

As mentioned, the CLA report analyzed the impact of this proposed federal staffing mandate on nursing homes. The firm utilized the latest available fiscal year cost reports in the calculation and resulted in dramatically higher estimates than CMS.

Among CLA's findings:

- Nursing homes would need to hire more than 102,000 additional full-time employees (80,077 nurse aides and 22,077 RNs).
- The proposed mandate would cost nursing homes approximately $6.8 billion per year – significantly higher than even the $4 billion per year estimate from CMS.
- Based on current data, 94 percent of skilled nursing facilities in America will be out of compliance with at least one of the three proposed staffing requirements.
- More than 285,000 beneficiaries in nursing homes, which is nearly one quarter of residents, will be at risk of losing necessary care if nursing homes are unable to increase their workforce to meet these new requirements.

The proposed rule has a significant economic impact throughout the profession, including on a substantial number of small entities. According to the National Investment Center for Seniors Housing & Care, nearly two-thirds (63 percent) of nursing homes belong to operators with 10 or fewer facilities, of which 31 percent are run by single property operators. CMS should perform a Regulatory Flexibility Act analysis and revisit its decision to certify this regulation. Further, CMS should prepare an initial regulatory flexibility analysis as is required when a regulation's impact is found to be "significant" under the Regulatory Flexibility Act.

While we believe CLA's analysis reflects a more accurate, up-to-date analysis of the Proposed Rule, even CMS agrees that this proposal will cost billions of dollars each year to hire tens of thousands of additional caregivers. CMS has not adequately assessed whether the profession can absorb these additional staffing costs. It plainly cannot. While CMS purports to be "striking a balance between cost and benefit for LTC facilities, nursing staff, and residents," the expected cost of the Proposed Rule to nursing home providers—CMS estimates an average of over $4 billion a year across 10 years, while CLA estimates nearly $7 billion a year—is more than an order of magnitude higher than the expected cost savings.

CMS acknowledges that its expected savings to Medicare, which it estimates at only about $0.3 billion per year over the first 10 years, is likely overstated because increases in registered nurse (RN) and nurse aide (NA) costs will be met with labor substitutions – the practice of providers adjusting staff hours per resident day (HPRD) in other direct care and support areas to minimize provider cost. *See* 88 Fed. Reg. at 61363, 61407, 61417. The savings will also be lower because CMS does not consider the number of facilities that it estimates will meet exception criteria for initial exemption from the proposed 2.45 NA HPRD requirements (24 percent) or 0.55 RN HPRD requirement (28 percent). These drive up the overall net cost of the proposal.

Likewise, CMS has not adequately assessed whether there is a sufficient supply of RNs and NAs to fill the estimated 89,000 new positions that the proposed requirements would require (as estimated by CMS; CLA estimates 102,000 additional nurses and nurse aides would be needed), including dramatic increases in the staff required in particular areas (e.g., a need to nearly *double* the number of RNs in urban areas in Louisiana). *See id.* at 61377, 61411. Nowhere near that number of staff is available or will become available by the time compliance would be required, meaning that the Proposed Rule would force scores of nursing homes to reduce their capacity or close their doors entirely. That result is flatly inconsistent with Congress's goal of ensuring that Medicare and Medicaid recipients will have access to care.

There is also a fundamental mismatch between the problems CMS has identified and the solutions it proposes. For example, CMS asserts that a subset of nursing homes is currently unable to meet existing staffing requirements. *See* 88 Fed. Reg. at 61353, 61356. Imposing far more onerous requirements on the entire industry—which CMS expects to require staffing increases by about 80 percent of all nursing homes, *id.* at 61380—is not a reasonable solution. Nor are the proposed HPRD standards for RNs and NAs a reasonable "floor," as CMS suggests. Indeed, these supposed "floors" are *higher* than many of the standards adopted by the 38 states that have established minimum staffing standards for nursing facilities. *See id.* at 61359.

Furthermore, we believe CMS lacks statutory authority to promulgate the proposed minimum-staffing requirements.

Congress has already prescribed specific staffing requirements for nursing homes that participate in Medicare and/or Medicaid. First, a nursing home "must provide 24-hour licensed nursing service which is *sufficient to meet nursing needs of its residents*." 42 U.S.C. §1395i-3(b)(4)(C)(i) (emphasis added); *accord id.* §1396r(b)(4)(C)(i). Second, a nursing home "must use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week." *Id.* §1395i-3(b)(4)(C)(i); *accord id.* §1396r(b)(4)(C)(i). The Proposed Rule departs markedly from these

statutory standards. As to the former, the Proposed Rule would impose a fixed, one-size-fits-all quantitative standard that requires LTC facilities across the country to adhere to the same rigid HPRD requirements, rather than the qualitative and context-sensitive standard that Congress adopted. And as to the latter, the Proposed Rule would dramatically raise—indeed, triple—the number of hours per day that a nursing home must have a RN available and would potentially alter how available a RN must be, unlawfully substituting CMS's judgment for the standards enacted by Congress.

The establishment of nationwide minimum-staffing standards is a major policy decision with massive economic and political significance. By CMS's own estimates, it will require about 80 percent of U.S. nursing homes to collectively hire nearly 90,000 additional nursing personnel, at a cost of more than $40 billion over the next decade. *See* 88 Fed. Reg. at 61354, 61377, 61380, 61407. Imposing this massive unfunded mandate on the nursing home industry would likely force many facilities to limit their capacity or close entirely, threatening to displace hundreds of thousands of nursing home residents. Given the importance and potential impact of the Proposed Rule, as well as the fact that Congress has already spoken to this issue, CMS must identify "clear congressional authorization" to adopt standards that exceed those established by Congress. *West Virginia v. EPA*, 142 S. Ct. 2587, 2609 (2022) (quoting *Util. Air Regul. Grp. v. EPA*, 573 U.S. 302, 324 (2014)). No such clear authorization exists.

CMS has not adequately explained its proposed decision to depart from its longstanding practices and previously expressed views regarding nursing home staffing standards.

For nearly half a century, CMS and its predecessors have repeatedly rejected calls to impose minimum staffing requirements on nursing homes. *See, e.g.*, 39 Fed. Reg. 2238, 2239 (Jan. 17, 1974); 45 Fed. Reg. 47368, 47371 (July 14, 1980); 52 Fed. Reg. 38582, 38586 (Oct. 16, 1987); 80 Fed. Reg. 42168, 42199-201 (July 16, 2015); 81 Fed. Reg. 68688, 68754-58 (Oct. 4, 2016). Many of the agency's reasons for this longstanding position remain equally valid today. For example, the agency has previously recognized that "the variation from facility to facility in the composition of its nursing staff, physical layout, patient needs and the services necessary to meet those needs precludes" any one-size-fits-all approach, and that "[a] minimum ratio could result in all facilities striving only to reach that minimum and could result in other facilities hiring unneeded staff to satisfy an arbitrary ratio figure." [39 Fed. Reg. at 2239; *see* 81 Fed. Reg. at 68758 (expressing "concern about utilizing a minimum staffing standard" because "LTC facilities are varied in their structure and in their resident populations"); 80 Fed. Reg. at 42201 (emphasizing the importance of "taking acuity levels into account").

In addition, the agency has recognized that minimum staffing requirements risk creating "a situation in which needed nursing home beds are unavailable to program beneficiaries because facilities cannot meet staffing requirements." 52 Fed. Reg. at 38586. CMS has also expressed concern that requiring 24/7 RN presence in every LTC facility "could negatively impact the development of innovative care options, particular[ly] in smaller, more home-like settings." 81 Fed. Reg. at 68755. Even assuming CMS had the authority to depart from the standards Congress has already established, CMS has failed to identify any adequate justification for abandoning its longstanding view that it is not appropriate to mandate a one-size fits all approach to staffing, whether ratio, HPRD or 24/7 RN.

The Proposed Rule also fails to adequately account for the reliance interests of nursing homes and their residents. For decades, nursing homes have operated on the understanding that—as the relevant statutes explicitly state—they need to offer a nursing service "sufficient to meet nursing needs of [their] residents" and to "use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week." [42 U.S.C. §§1395i-3(b)(4)(C)(i); *accord* 1396r(b)(4)(C)(i).] The onerous staffing requirements of the Proposed Rule threaten to drive scores of nursing homes out of business and potentially displace tens if not hundreds of thousands of residents whom they serve. Nothing in the Proposed Rule indicates that CMS has given any thought to the substantial reliance interests that the Proposed Rule would disrupt or provides any adequate explanation for why disrupting those reliance interests would be warranted.

We urge CMS to consider rescinding this impossible-to-implement proposed staffing mandate for nursing homes, as it will not improve quality or the labor crisis. It will only reduce access to care for our nation's seniors.

If CMS proceeds with advancing a minimum staffing mandate, this proposal needs significant modifications including, but not limited to:

- Withdraw the proposed 24/7 RN requirement and maintain existing 24-hour licensed nurse requirement.
- Allow the 24/7 RN requirement to be met via remote access to RNs or other licensed clinicians, not only onsite presence.
- Allow for a broader 24/7 RN waiver that is available to all facilities, not limited only to facilities located in rural areas.
- Count all RNs, including but not limited to RNs with administrative duties, and Nurse Practitioners, in any RN requirement.
- Withdraw the proposed hours per resident day (HPRD) requirement, as it is a one-size-fits-all approach that will drive unintended consequences for the overwhelming majority of nursing homes, reducing their ability to care for the nation's seniors. That requirement will also cause negative impacts on the entire health care continuum, including hospitals and other post-acute care providers.
- Count all LPNs with RNs, as both LPNs and RNs are licensed nurses.
- Maintain the existing facility assessment requirement that CMS intentionally designed in 2016 to allow each facility to determine the resources necessary to care for its unique resident population. The proposed changes to the facility assessment requirements are unnecessarily burdensome and would require facilities to divert time and resources to administrative and paperwork compliance, as well as cause unintended consequences for both facilities and surveyors.
- Provide a real waiver process that is 1) available to all facilities without exclusions; 2) does not entail pre-penalty or citation of those seeking waiver; 3) is attainable by any facility in need that is making good faith efforts; and 4) provides support from Quality Improvement Organization (QIO) or another party to assist facilities in securing resources to meet applicable needs while under waiver. This is the right approach to prioritize support to facilities in need so the residents and staff can experience future improvements.

- Allow at least 5 years for any new requirement to take effect after the date of the final rule, with an additional at least 36-month allowance period for facilities to hire staff once the workforce is available.
- Provide adequate and sustained funding to cover all costs associated with the mandate.

Nursing homes are widely recognized as a critical part of the health care continuum and when nursing homes are prioritized for support, positive results are widely seen. We encourage CMS to focus on helping nursing homes rebuild the workforce rather than advancing a rule with minimum staffing requirements that cannot be met and will drive major unintended consequences to the LTC workforce, residents living in nursing homes, their families who rely upon nursing homes, and the larger health care community that would be destabilized by loss of nursing homes.

2. Responses to Specific Questions Posed by CMS Related to Minimum Staffing Standards for Long-Term Care Facilities

a. Alternative Options

CMS Request: 88 Fed. Reg. at 61357, *We seek… information in anticipation that additional comments and recommendations will assist us in ensuring that we finalize appropriate minimum staffing standards to ensure the health and safety of residents and provide staff the support they need to care for residents while also considering the limited resources including the local supply of RNs and NAs, that may exist as the long-term care sector recovers from the COVID-19 PHE and an increased demand due to a growing older population.*

AHCA Response: As CMS acknowledges in the Proposed Rule, the COVID-19 pandemic has left a significant impact on staffing in long-term care. Nursing homes disproportionately lost more workers than any other health care sector during the pandemic. While other health care sectors have largely recovered, nursing homes still need nearly 190,000 workers to return to pre-pandemic levels. At the current pace, this job recovery will not occur until late 2026 at the earliest. Further data showing this crisis:

- According to the National Council of State Boards of Nursing (NCSBN), 100,000 RNs left the workforce during the pandemic.
- The NCSBN also estimates that almost 900,000, or one-fifth of RNs, intend to leave the profession by 2027.
- Enrollment in nursing programs decreased for the first time in more than two decades last year.
- A May 2022 analysis from McKinsey (McKinsey Analysis) estimated that by 2025, the United States could have a gap of between 200,000 to 450,000 nurses available for direct patient care, equating to a 10 to 20 percent gap. This already alarming projection included a growth rate that did not happen in 2020 due to the pandemic – thus the trajectory is even worse.
- This RN gap is in the face of a growing aging population and an increased demand for the entire health care system. **The existing demands on the health care system show**

that there will likely be more patients in the United States who will need care than nurses available to deliver it.

- This analysis clearly demonstrates the **instability in the RN workforce that will be exacerbated by further demand such as this Proposed Rule requiring more RNs in nursing homes.** Such a policy will not only cause nursing homes that cannot meet the RN requirement to close and displace the residents living in those nursing homes, it will also **cause unintended consequences** on other parts of the health care system such as hospitals and home and community based services, who are also in demand for RNs because increasing RN staffing requirements on 15K nursing homes will further drain the nation's already inadequate supply of RNs in the workforce.
- This systemic problem of the lack of available RNs in the workforce will not resolve in 2-5 years when these proposed staffing requirements would take effect, for these reasons –
  - 1) We know it takes at least 2-4 years to train each new RN. The McKinsey analysis cited above shows that **there are currently not enough graduating nurses to replace the nurses who are leaving. The McKinsey analysis also notes that to meet the demand, the United States would need to more than double the number of new graduates entering and staying in the nursing workforce every year for the next three years straight.**
  - 2) **To double the number of new graduate RNs, our nation needs more RNs with advanced degrees to serve as nursing instructors.** We know that there is a massive shortage of RN instructors to train those new graduate RNs. To be qualified, nursing faculty typically need **more than 15 years of education and experience, including 6-10 years of education and 10 years of work experience**. The American Association of Colleges of Nursing reports that **one third of the nursing faculty workforce are expected to retire by 2025.**
  - For these two reasons, this is the perfect storm that **must be handled with care.**
- In summary**, before** any further demand is created from any requirements increasing RNs in nursing homes, the **RN workforce must be built up to improve the trajectory of RN supply to the point that demand is fully met.**

The labor shortage has caused nursing homes to rely on costly, contracted staff. However, these temporary contracted caregivers are associated with poorer outcomes, and staffing agencies are charging 22 to 28 percent more than pre-pandemic levels for contract nurses.

The proposed minimum staffing mandates will exacerbate access problems. AHCA's data, obtained from CMS and news reports, demonstrates that more than half of the nation's nursing homes are already restricting new admissions and nearly one-quarter have downsized their facility due to labor shortages. More than 500 nursing homes have closed over the course of the pandemic, often due to an inability to find workers. More than 4 in 10 of these closures were highly rated four- and five-star facilities.

Unfortunately, this labor situation is not going to improve in the short term, and nursing homes do not have a pipeline of new nurses to replace the ones that have left. The changing demographics of the country also demonstrate that with a rapidly growing elderly population, we

will not have enough younger caregivers to care for the seniors requiring nursing home care in the future.

This evidence shows it would be impossible for nursing homes to implement this proposed staffing mandate. The proposed mandate will only exacerbate this situation and accelerate the burnout of existing staff as well as the reliance on agency staff, creating unintended consequences for the quality of care for residents. This will also cause more nursing homes to close, creating an access issue that disproportionately impacts our nation's most vulnerable.

CMS Request: 88 Fed. Reg. at 61370, *We are soliciting comments on establishing a total nurse staffing standard such as 3.48 HPRD among other alternatives, in place of a requirement only for RNs and NAs, or in addition to a requirement for RNs and NAs.*

AHCA Response: **AHCA does not support a 3.48 total nurse staffing HPRD mandate.** CLA, which analyzed the impact of this proposed federal staffing mandate on nursing homes, estimated the annual cost of meeting a total nurse staffing standard such as 3.48 HPRD **(**0.55 RN HPRD, 0.48 LPN and 2.45 nurse aide HPRD), as well as the 24/7 RN coverage, at $7.1 billion, or almost $300 million per year higher than its estimated annual cost of the current proposal. A total of 105,000 FTEs would be needed under this scenario, including almost 3,000 more LPNs. Additionally, a 3.48 HPRD mandate would be a one-size-fits-all approach that is not appropriate given the varying needs of residents and the different resources and workforce challenges in various parts of the country.

CMS Request: 88 Fed. Reg. at 61363, *CMS is seeking comments on whether, in addition to the 0.55 RN and 2.45 NA HPRD standards, a minimum total nurse staffing standard, such as 3.48 among other alternatives, should also be required.*

AHCA Response: **There are inherent problems with advancing a one-size-fits-all, unfunded nationwide staffing mandate as is currently proposed.** In 2016, CMS expressly acknowledged that establishing minimum staffing was "a complex issue" and did "not agree that a one size fits all approach is best." *See* 81 Fed. Reg. at 68755. The results of a one-size-fits-all approach will include negative health policy outcomes and greater access issues, and closures, particularly in underserved communities. In addition, the one-sized-fits all mandate will not have the intended impact CMS suggests. Indeed, the 2022 Minimum Staffing Study commissioned by CMS undercuts rather than supports the Proposed Rule. The study indicates that while literature underscores the relationship between nursing home staffing and quality outcomes, ***"it does not provide a clear evidence basis for setting a minimum staffing level".*** The study also concludes that while quality and safety do increase with staffing levels, there is "***no obvious plateau at which quality and safety are maximized or '"cliff"' below which quality and safety steeply decline."*** This claim is further supported by the existing nursing homes that achieve Five-Star overall ratings while not staffing at the proposed RN or Nurse Aide HPRD thresholds.

CMS points to the 2022 Minimum Staffing Study in support of its minimum staffing proposal, yet CMS inexplicably ignores key points from that study. As a result, CMS proposes an arbitrary staffing standard that may not have the desired impact on all facilities and has the risk of numerous unintended negative consequences. The fact is that every nursing facility is different, and every resident has unique needs, which means a one-size-fits-all staffing approach will not

work to improve quality and should not be implemented, which is exactly what the latest CMS study shows us.

The Proposed Rule also fails to recognize that non-nursing professional staff are critical to and deeply involved in direct resident care. To better address the residents' needs, facilities are moving to staffing models that incorporate a diverse set of professionals, such as behavioral health specialists, social workers, activity staff, rehab therapy, food and nutrition staff. Non-licensed staff also provide valuable support to help meet residents' needs. These individuals can play a key role in a residents' care and quality of life. It is important that CMS support the use of these professionals as they are key to assisting with the physical and mental well-being of residents. A staffing model that focuses only on nursing staff is counter to CMS's own guidance that facilities must meet the comprehensive needs of residents to ensure they attain or maintain their highest practicable level of function. *See* 42 C.F.R. 483.24. Also, CMS conducts surveys of facilities to ensure they are "furnishing quality of care," and measures "indicators such as medical, nursing, and rehabilitative care, dietary and nutrition services, activities and social participation, and sanitation, infection control, and the physical environment"; it is illogical to acknowledge these staff "furnish quality of care" but not allow for them to be counted in a staffing mandate. *See* 42 U.S.C. 1396r. CMS should allow facilities to determine the right mix of staff for resident needs instead of mandating a one-size-fits-all approach that does not allow for facilities to be responsive to changing and diverse resident populations.

If CMS proceeds with a minimum staffing requirement, AHCA recommends CMS establish a broad definition of staff who are allowed to be counted in the requirement. We recommend this definition: *Any individual who is employed or contracted by the facility and through interpersonal contact generally provides residents direct assistance with personal care or activities of daily living or has direct access to provide care and/or services to residents including but not limited to support with their living space, maintenance of personal items, socialization, and other activities desired by the resident. There are a variety of job titles/roles that may be captured within this definition, including but not limited to licensed nurse; nurse aide; personal care aide; medication assistant; physician; physician assistant; nurse practitioner; licensed physical or occupational therapist or licensed therapy assistant/aide; registered respiratory therapist; licensed speech-language pathologist; infection preventionist; mental health worker; social worker; activity staff; dining assistant; paid feeding assistant; housekeeper; hospitality aide; life enrichment assistant; recreational staff; universal worker; other health care professionals licensed or certified in the respective state and other roles designed or determined by the facility to support the needs of the resident(s).*

CMS Request: 88 Fed. Reg. at 61369, *We solicit comment on the need to allow for substitution, such as substituting LPN/LVNs for NAs, in extraordinary cases and specifically what extreme circumstances would appropriately allow for such substitution.*

AHCA Response: **LPNs/LVNs should be counted as an appropriate substitute for a RN, not a nursing assistant as CMS inexplicably suggests, when acting within the LPN scope of practice. Both LPNs and RNs are licensed nurses and should be recognized accordingly**. CMS apparently wholly misunderstands and undervalues how LPNs provide valuable care and services in a nursing home. According to BLS data, LPNs/LVNs held about 655,000 jobs in

2022, and 35 percent of those were in nursing homes. That accounts for nearly 230,000 jobs across the country. In a time of a very real and well documented nursing crisis, it would be incredibly short-sighted to discount the importance of LPNs and their role as licensed nurses in nursing homes. In terms of education, clinical and practical experience and licensure requirements, LPNs are much more akin to RNs than to nursing assistants.

As a country, we need to promote accessible nursing career pathways to solve this workforce crisis. Discounting the importance of LPNs in this proposed minimum staffing mandate effectively discourages individuals who may not have the ability or means to pursue a RN degree from even bothering to become an LPN. It also severely limits nursing home providers from recruiting and retaining LPNs. The LPN career path is an important and desired career path that is important to maintain as a complement to the RN career path. It is not uncommon for LPNs to work in health care facilities, including nursing homes, while pursuing their RN degrees. The LPN career path opens to a wider range and more diverse group of Americans. In fact, the National Council of State Boards of Nursing workforce survey showed that LPN/LVNs were more racially and ethnically diverse than their RN counterparts, with approximately 34 percent of LPN/VNs identifying as racial minorities and 11.5 percent identifying as Hispanic/Latino, as compared to only 20 percent of RNs identifying as racial minorities and 6.9 percent of RNs identifying as Hispanic/Latino.

CMS should consider that, to comply with the proposed requirement, facilities could be forced to hire inexperienced RNs to replace experienced LPNs. This could have unintended, negative consequences to residents' quality of life and quality of care. **LPNs should be allowed to count with RNs at all times. We do not see a reason to limit this to "*extraordinary cases*" or "*extreme circumstances*," as LPNs are fully capable of providing nursing services consistent with their licensed status.**

CMS Request: 88 Fed. Reg. at 61371, *What alternative policies or strategies should we consider ensuring that we enhance compliance, **safeguard resident access to care**, and minimize provider burden? Are there are other alternative policy strategies we should consider?*

AHCA Response: **This Proposed Rule will not safeguard resident access to care. This unfunded mandate, proposed during a time when there is an all-time high workforce shortage, would further jeopardize seniors' access to care. This impossible standard only threatens to shut down more nursing homes and could have ramifications more broadly for the health care system.** Already, nursing homes are having to limit new admissions, downsize their facilities, or close their doors completely because they cannot find the workers they need. Nursing homes that are unable to increase their workforce will need to reduce their census to meet these new mandates. A September 25, 2023 analysis by CLA found that 280,000 nursing home residents are at risk of displacement from their nursing homes. Frail seniors and their families will have to wait longer and search farther for the nursing home care they need. This will cause a domino effect, overwhelming our entire health care system. More hospitals will be over capacity with patients waiting to be discharged, increasing costs to taxpayers. As facilities are forced to lower their census to meet requirements, it jeopardizes the facilities' ability to support existing staff wages—meaning potential layoffs and further restrictions in access to care.

As we discussed in the solutions laid out above, if CMS proceeds with minimum staffing requirements, the agency should adopt a broad definition of staff who count toward that minimum that includes other staff types that provide direct care to residents. This includes licensed nurse; nurse aide; personal care aide; medication assistant; physician; physician assistant; nurse practitioner; licensed physical or occupational therapist or licensed therapy assistant/aide; registered respiratory therapist; licensed speech-language pathologist; infection preventionist; mental health worker; social worker; activity staff; dining assistant; paid feeding assistant; housekeeper; hospitality aide; life enrichment assistant; recreational staff; universal worker; other health care professionals licensed or certified in the respective state; and other roles designed or determined by the facility to support the needs of the resident(s). All these staff contribute to the residents' quality of care and quality of life and should be considered as counting toward staffing requirements. Isolating specific staff types minimizes the important role that these other professionals play and may limit the nursing home's ability to hire staff to improve the wellbeing of and meet all the care needs of their residents through an integrated care team.

Further, CMS's proposal inhibits nursing homes' abilities to implement innovative staffing strategies and approaches that improve resident quality of care beyond the traditional staffing model. In 2016, in the preamble to the final rule, Medicare, and Medicaid Program; Reform of Requirements for Long-Term Care Facilities, 81 Fed. Reg. 68688 (Oct. 4, 2016), CMS responded to comments regarding the implementation of minimum staffing requirements with concern that mandated ratios could result in unintended consequences such as staffing to the minimum, input substitution (hiring for one position by eliminating another), and task diversion (assigning non-standard tasks to a position), as well as stifling innovation, and would not result in the improved quality and person-centered care that CMS seeks in facilities. *Id.*at 68755. CMS recognized that nursing homes are varied in their structure, size and population, and acknowledged in 2016 that the capabilities of facilities are likely to be different, requiring facilities to need the flexibility to make thoughtful, informed staffing plans and decisions that are focused on meeting resident needs, including maintaining or improving resident function and quality of life. *See* 81 Fed. Reg. 68758. In the Proposed Rule, CMS has not provided a reasoned basis for dismissing these concerns and changing course. If anything, these concerns are even more acute seven years later when the workforce crisis has persisted and facilities have not fully recovered from the COVID-19 pandemic.

Financial support for resources and initiatives that increase training and workforce availability are critical to developing the existing workforce and building a new workforce. Just recently, in September 2023, CMS limited providers' ability to apply for CMP Reinvestment Program funding to improve nursing workforce availability. The rationale from CMS was that the funds are not needed because CMS plans to launch a national campaign to help increase the nursing workforce in nursing homes. However, CMS has not released any additional information and the shortages are not improving. **One campaign by a federal agency is not enough to fix the workforce crisis.**

b. RN Requirement

AHCA recommends CMS withdraw the proposed 24/7 RN requirement and maintain the existing 24-hour licensed nurse requirement.
If CMS nevertheless proceeds with a 24/7 RN requirement, AHCA recommends CMS:

- **Allow the 24/7 RN requirement to be met via remote access to RNs or other licensed clinicians, not just onsite presence;**
- **Allow for a broader 24/7 RN waiver that is available to all facilities, not limited only to facilities located in rural areas; and**
- **Count all RNs, including but not limited to RNs with administrative duties, and Nurse Practitioners, in any RN requirement.**

CMS Request: 88 Fed. Reg. at 613, *We welcome comments regarding our proposed requirements for each LTC facility to have an RN on site 24 hours a day, 7 days a week that is available for direct resident care.*

AHCA Response: While we appreciate the intent to improve care, if the mandate were to be finalized as proposed, 80 percent of facilities currently could not meet the 24/7 RN requirement according to an independent analysis by CLA. The Proposed Rule uses a flawed method that underestimates the number of current facilities that could not meet the 24/7 RN requirement. The Proposed Rule assumes RN hours can be moved between days and shifts with no consequences. In other words, it assumes facilities could move RNs working day shifts on Wednesday to overnight shifts on Saturday without having to pay more or sacrificing care delivery, which is not accurate. Facilities staff to accommodate admissions, treatment, and resident needs. Moving staff shifts is not always possible or the right thing to do for resident care. Thus, facilities will have to rely on hiring more nurses to meet this requirement than estimated in the CMS projection.

In 2021, AHCA proposed a 24/7 RN requirement in our Care for Our Seniors Act; however, unlike our proposal, CMS's proposed mandate offers no funding to pay for the new requirement and does not recognize or address the growing shortage of nurses across the country. We need programs to incentivize nurses to choose a career in long-term care. **If CMS proceeds with a 24/7 RN requirement, AHCA recommends CMS allow for the requirement to be met via remote access to offsite RNs or other licensed clinicians, rather than requiring onsite presence as the current proposal does.**

CMS Request: 88 Fed. Reg. at 61372, *If a requirement for a 24-hour, 7 day a week onsite RN who is available to provide direct resident care does not seem feasible, could a requirement more feasibly be imposed for a RN to be "available" for a certain number of hours during a 24-hour period to assess and provide necessary care or consultation [to] provide safe care for residents? If so, under what circumstances and using what definition of "available"?*

AHCA Response: **AHCA recommends allowing a 24/7 RN requirement to be met via remote access to RN, not requiring onsite RNs 24/7**. This would be more feasible to implement considering the massive RN shortages at present and continued shortages in the foreseeable future. This would still provide 24/7 access to clinical consultation and guidance to the onsite LPN through remote engagement. A similar model has already been proven to be effective through remote physician care. Further, many facilities have already effectively incorporated the use of physician/practitioner telehealth or remote RNs when in-person meetings, evaluations and visits were not feasible due to the state of the COVID-19 pandemic. We also

recommend CMS allow counting of Nurse Practitioners and Advanced Practice Registered Nurses in the RN requirement and any licensed nurse requirement.

AHCA also recommends CMS allow for a broader 24/7 RN waiver that is available to all facilities, not just those in a rural area. The national shortage of RNs in the workforce is a crisis that is being felt across the country, not only in rural areas.

CMS Request: 88 Fed. Reg. at 61372, *Should the DON be counted towards the 24/7 RN requirement, or should the DON only count in particular circumstances or with certain guardrails? Please explain why or why not.*

AHCA Response: **AHCA recommends that the DON be counted toward the 24/7 RN requirement.** Directors of Nursing (DONs) who are RNs are available for consultation, assessment, and evaluation of resident condition and their hours should be counted as RN hours. Titles should not be utilized to imply a lack of skills, education, and resources available at a nursing home. Licensure should be the deciding factor and the availability of RNs should be determined based on licensure, not role. In addition to DONs, other Advanced Practice Registered Nurses, Nurse Practitioners, and nurses with primarily administrative duties are routinely called upon to support staff through assessment and evaluation, physician contact, direct patient care, etc., and all should be counted in any RN or licensed nurse requirement.

CMS Request: 88 Fed. Reg. at 61401, *We are also soliciting comments on how the available supply of RNs and potential changes in this supply and demand across different geographical areas over the next 10 years may influence the rule's cost for LTC facilities and other health care providers competing for the same supply of RNs.*

AHCA Response: The shortage of RNs is a well-documented crisis that is impacting the entire nation. The National Council of State Boards of Nursing, an independent, not-for-profit organization, conducts a national survey every two years focusing on the U.S. nursing workforce. Their most recent study collected data from 278,631 RNs and 55,503 LPNs from April through September of 2022. This is the only national-level study specifically focused on the U.S. workforce. The study found several alarming statistics regarding the nursing workforce and the impact of the pandemic. Highlights are as follows:

- Approximately 100,000 RNs and 34,000 LPNs left the workforce over the past two years specifically due to the pandemic.
- 41 percent of the RN total is comprised of nurses with a mean age of 36 and fewer than 10 years' work experience.
- 800,000 RNs and 184,000 LPNs/LVNs indicate they are likely to leave nursing by 2027, which is equivalent to roughly 20 percent of the total licensed RN and LPN/LVN workforces in the U.S., respectively.

These statistics show that the U.S. nursing crisis has only been accelerated by the pandemic, and it is only going to get worse. Nursing homes need solutions and partnership from federal and state governments to improve this very real nursing crisis, rather than an unfunded mandate that is impossible to implement now and into the future.

CMS Request: 88 Fed. Reg. at 61411, *We are also soliciting comments on all the assumptions we used in our estimate, especially how the available supply of RNs and NAs in different areas nationwide may influence the Proposed Rule's cost for LTC facilities and other health care providers competing for the same supply of RNs and Nas.*

AHCA Response: **AHCA recommends CMS reevaluate the estimates shared in the Proposed Rule as they do not align with other industry findings.** The annual and 10-year cost of the Proposed Rule is significantly understated based on the CLA study which was published in September 2023 (after the Proposed Rule). Areas of concern include the impact of inflation on current wage rates for existing staff in the first/base year caused by the hiring of new staff at higher rates. This increase will continue in subsequent years.

Other provider types have also shared significant concern with this staffing mandate. In April 2023, in a joint letter by the American Hospital Association (AHA) and AHCA/NCAL, we wrote about the ripple effect the long-term and post-acute care labor crisis is having on the entire health care system, including general acute care hospitals, inpatient rehabilitation facilities and other health care facilities. Never was this more profound than last fall and winter, as the "tripledemic" led to a surge of patients. Hospitals across the country became overwhelmed with patients who were unable to be discharged because many nursing homes had to deny new admissions due to staffing shortages. This kind of ripple effect has a detrimental impact on patients who must wait days, weeks, or even months in hospital beds awaiting discharge to post-acute care; on the capacity of care providers to serve our communities; and on the costs to the entire health care system. These issues will only get worse if the unrealistic proposed staffing mandate is advanced.

Currently, over 80 percent of nursing homes will need to hire more staff to meet the proposed mandate. Those staff must come from somewhere, so other provider types will be impacted by nursing homes' efforts to meet this arbitrary standard. In fact, other national provider-related organizations, including but not limited to the National Rural Health Association, the American Hospital Association, the National Association of State Veterans Homes, LeadingAge, Lutheran Services in America, the Catholic Association of the United States, and the National Association of Licensed Practical Nurses have all voiced concerns on the adverse impact this proposal will have on resident access to critical long-term care services and the entire health care continuum overall. We urge CMS to consider rescinding this impossible-to-implement proposed staffing mandate for nursing homes as it will not improve quality or the labor crisis. It will only reduce access to care for our nation's seniors and cause significant unintended consequences for the health care continuum.

c. Policy Changes

AHCA recommends CMS withdraw the proposed hours per resident day (HPRD) requirement, as it is a one-size-fits-all approach that will drive unintended consequences for the overwhelming majority of nursing homes, reducing their ability to care for the nation's seniors. It will also cause negative impacts on the entire health care continuum, including hospitals and other post-acute care providers.

AHCA recommends CMS not advance the proposed changes to the facility assessment. AHCA recommends CMS maintain the existing facility assessment requirement that CMS intentionally designed in 2016 to allow facilities to determine resources necessary to care for their unique resident population. The proposed changes to the facility assessment requirements are unnecessarily burdensome and would require facilities to divert time and resources to administrative and paperwork compliance, as well as cause unintended consequences for both facilities and surveyors.
CMS Request: 88 Fed. Reg. at 61366, *We are seeking public comments on the policy proposals outlined…, in particular the feasibility of the proposal, any unintended consequences, and alternatives that we should consider.*

AHCA Response: The Nursing Services (§ 483.35) and Sufficient Staff (§ 483.35(a)(1)) proposals, as written, are unfeasible. There are several reasons the proposals are unfeasible including, but not limited to:

- Workforce- Bureau of Labor Statistics (BLS) data supports the fact that the workforce has not returned to pre-pandemic numbers in nursing homes. According to the BLS data, nursing homes have lost 210,000 jobs over the course of the pandemic (from February 2020 to December 2022) and are at levels not seen since 1994. CMS noted during the National Stakeholder Call on September 14, 2023, that the trend reported from BLS data showed there was a recent shift (summer of 2023), where the workforce appeared to be returning. However, this increase is still far from meeting even current demands. In fact, the workforce is not expected to return to pre-pandemic levels until 2027. In the 2015 Proposed Rule entitled "Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities," 80 Fed. Reg. 42168 (July 16, 2015), CMS expressed concern over the nursing shortage in relation to enacting a minimum staffing requirement. At the time, the agency cited a December 2014 Health Resources & Services Administration (HRSA) report suggesting that "growth in RN supply will actually outpace demand in the period between 2012-2025" but that "the national projections mask a distributional imbalance of RNs at the state level and that there is considerable variation in the geographic distribution of the growth in RN supply." *Id*. at 42200. Unfortunately, the growth in RNs has not, in fact, outpaced supply, and the geographic imbalance not only remains true nine years later but has grown more dire. Without individuals to hire, there is simply no way nursing homes can meet the proposed mandate. **We need the federal government to partner with us to develop solutions to this workforce challenge, not enact mandates that are impossible to meet.**
- Funding- **The proposal is unfeasible for nursing homes under the existing funding structure.** CMS estimates that the cost of the rule over 10 years will be $40.6 billion, with an average annual cost of $4.06 billion. CLA subsequently analyzed the impact of the Proposed Rule and estimated the **annual** cost to implement the rule to be $6.8 billion. The nursing home profession cannot withstand these costs without adequate funding.

  Importantly, CLA found that nursing homes that are not meeting at least one of the requirements are more likely to have a majority of their residents relying on

Medicaid (56 percent average Medicaid census) compared to facilities that met the criteria (43 percent).

The **unintended consequences** of the proposals are significant and include, but are not limited to, the following:

- Access to Care & Facility Closures- Since the pandemic begin in 2020, 584 facilities have closed voluntarily. Staff availability continues to be a significant reason for closures, including closing units or stopping further admissions until staffing can accommodate those admissions. If the proposal is implemented as written, more facilities will have to either close or adjust their census to meet the requirements. CLA estimates that if nursing homes are unable to increase their workforce to meet new requirements, more than 280,000 nursing home residents, or nearly one-quarter of all residents, could be impacted by census reductions. The unintended consequences of forcing closures or limiting admissions are access problems for residents and other individuals in need of nursing home care. This will have a disproportionate impact on smaller, rural facilities, closing or decreasing capacity to remain compliant. This will result in these residents being placed further away from families and friends, in turn affecting the residents' and their families' overall well-being. In the Proposed Rule, CMS acknowledges how important it is for residents to be close to their loved ones, yet the agency has not adequately considered closures as an unintended consequence of this mandate. CMS noted, "According to a 2021 study, 'Travel time has a substantively and statistically significant negative association on visit probability for all age groups.'" MedPAC recently released its own research on the implications of the Proposed Rule. The group highlighted concerns about how closures will affect facilities, particularly those in rural areas, and how these closures will affect access to needed services.
- Licensed Practical Nurses- LPNs are an extremely important group of nurses that provide quality care for residents. For years, LPNs have provided care to residents through medication administration, treatments, providing care in emergency situations, and ensuring proper and quality care for residents' activities of daily living (ADLs). The CMS proposal, as written, excludes these important roles and the contributions they make to care for residents. In attempting to meet the proposed requirements, providers would be forced to prioritize staffing CNAs and RNs and deprioritize the hiring and staffing of LPNs. This will impact the LPN workforce in long-term care and also undermine the importance of the profession as a whole. The path to become an LPN is less burdensome, less resource-intensive and less expensive than the path to become a RN. This opens a nursing pathway to a large portion of the population that may not have the means or resources to become a RN. Making a federal policy which disincentivizes individuals from pursuing nursing careers at a time where the country is dealing with a nursing crisis is incomprehensible.
- Specialized Resident Populations- Some facilities specialize in a particular type of care, such as post-traumatic stress disorder, brain injuries due to substance abuse, ventilator units, or dementia units. These specializations result in a mix of residents that are younger and more mobile, needing less ADL care and more mental health

services. As a result, creating prescriptive minimums without considering the vast differences in care needs across facilities incentivizes a system of staffing to the prescribed one-size-fits-all standard instead of unique resident needs.

- Staffing to the Minimum- Similar to the above, setting a staffing minimum limits nursing homes' ability to be adaptive in staffing to resident needs, leading them to focus on meeting a prescriptive requirement rather than developing sustainable and person-centered staffing practices. Nursing homes who are unable to recruit and retain sufficient staff will turn to agency staff, and this is expected to be a significant problem because of the workforce supply shortage that will be further exacerbated by these mandates. In their efforts to meet the proposed requirements, facilities will be limited in their ability to hire staff that are also important to meet residents' needs, such as therapy staff, activities staff, or other support staff. As noted, CMS has itself identified this as a potential unintended consequence of imposing arbitrary staffing mandates. In its 2015 Proposed Rule "Reform of Requirements for Long-Term Care Facilities," CMS cited a 2011 review of the literature on nurse staffing that concluded that "a focus on numbers of nurses fails to address the influence of other staffing factors (for example, turnover and agency staff use), training and experience of staff, and care organization and management." 80 Fed Reg. at 42200. CMS further explained in the 2015Proposed Rule: "We believe that the focus should be on the skill sets and specific competencies of assigned staff to provide the nursing care a resident needs rather than a static number of staff or hours of nursing care that does not consider resident characteristics such as stability, intensity and acuity and that staffing abilities include professional characteristics, skill sets and staff mix. We are concerned that establishing a specific number of staff or hours of nursing care could result in staffing to that number rather than the needs of the resident population." *Id.* at 42201. In its final 2016 rule on Reform of Requirements for Long-Term Care Facilities, CMS reiterated that "staffing to the minimum" was a key concern preventing it from enacting a staffing minimum. *See* 81 Fed Reg. at 68754.
- Isolation and Human Interaction- Another example of unintended consequences may be learned from COVID-19: that isolation and human interaction is vital to health. Activities staff that engage and address the mental and emotional needs of residents are just as important as CNAs who assist with personal care needs. Therefore, discounting other direct care staff by just basing staffing requirements on specific nursing staff disincentivizes person-centered care and devalues staff who are not counted toward the minimum standard. This could also exacerbate the staffing crisis and further increase agency use, causing agencies to increase their prices even more, which will only serve to reduce the overall quality of care.
- Stifling Innovation- Setting a minimum staffing requirement stifles a nursing home's ability to develop innovative staffing models, something that is vital during this time of staffing shortages. CMS said the exact same thing in its 2016 final rule on Reform of Requirements for Long Term Care Facilities, concluding: "We are also concerned that imposing such a requirement could negatively impact the development of innovative care options, particular in smaller, more home-like settings, for a subset of residents who might benefit from and be appropriate for such a setting." *See* 81 Fed

Reg. at 68755. Again, in the Proposed Rule, CMS has not provided any satisfactory explanation on why this very valid concern no longer applies.

Alternatives to Consider

AHCA strongly supports ensuring quality care for our nation's seniors. We believe there are more effective and appropriate alternative methods to further quality care, instead of the proposed policies noted in Nursing Services (§ 483.35) and Sufficient Staff (§ 483.35(a)(1)).

1. Education/Workforce Development- **AHCA recommends CMS focus efforts on building the workforce with demonstrated results before further considering advancing any staffing mandates**. CMS has acknowledged that it is necessary to invest in the long-term care workforce through the announcement of $75 million for workforce development. While details are not available, a one-time workforce effort is not going to fix the workforce crisis. It is important to note that $75 million is only approximately $5,000 per nursing home in the nation, which would not even pay for training required to develop one RN.

   It is also critical to note that nursing schools are having to turn away nursing applicants, even as we are dealing with a historic nursing shortage. In fact, on October 5, 2023, CNN published a piece specifically dedicated to this very issue. The article noted: "Nearly 78,200 qualified applications were not offered spots at nursing schools last year, according to the American Association of Colleges of Nursing, which represents schools with baccalaureate and advanced degree programs." The article also reported that "nursing schools have nearly 2,000 full-time faculty positions to fill, according to the nursing college association."

   Data released this spring by the American Association of Colleges of Nursing (AACN) concluded that "the number of students in entry-level baccalaureate nursing programs decreased by 1.4 percent last year, ending a 20-year period of enrollment growth in programs designed to prepare new RNs. With declines also recorded in master's and PhD programs, collective action must be taken to strengthen pathways into nursing to ensure the nation's health care needs are met. Despite the decrease in enrolled students, nursing schools turned away thousands of qualified applicants last year due largely to a shortage of faculty and clinical training sites."

   In addition, the National Council of State Boards of Nursing (NCSBN) released a study earlier this year titled "Examining the Impact of the COVID-19 Pandemic on Burnout & Stress Among U.S. Nurses." It found that approximately 100,000 RNs left the workforce due to stress and burnout during the COVID-19 pandemic. NCSBN's research is "considered to be the most comprehensive and only research [on this issue] in existence, uncovering the alarming data points which have far reaching implications for the health care system at large and for patient populations."

   The study also found:

   - Another 610,388 RNs reported an "intent to leave" the health care workforce by 2027 due to stress, burnout or retirement.

- Nearly 200,000 additional RNs younger than 40 years old reported their intent to leave.
- Altogether, one-fifth of RNs across the country are projected to leave the health care workforce.

As is evident from these startling statistics, it will take time to develop more nurses who would enter the long-term care field. It simply will not happen overnight. More also must be done to increase new entry into the workforce and to develop the existing workforce, including workforce development and career paths within the sector that are supported by tuition reimbursement for careers in long-term care, childcare assistance, housing assistance and more. Additional recommendations are included later in these comments.

2. Inclusion of LPNs- As noted previously in this response, nearly 170,000 LPNs working in long-term care have been and continue to be an extremely important part of the long-term care workforce. **AHCA recommends that LPNs, when working in their scope of practice as LPNs, be recognized for their role in the care they provide and be counted with RNs, as both LPNs and RNs are licensed nurses.**

3. Inclusion of other Professionals/Roles- AHCA supports inclusion of other professionals, as determined by the facility's individualized facility assessment. Many other disciplines provide direct care and support to residents outside of nursing and should be included to promote quality care and quality of life for residents. These professions should include, but not be limited to, Physical Therapists/PT Assistants, Occupational Therapists/OT Assistants, Speech Therapists, respiratory therapists, feeding assistants, personal care assistants, behavioral health specialists, and Social Workers, as appropriate based on the facility's individualized assessment. **CMS should allow a broad definition of staff (as noted in an earlier comment) that can be counted toward minimum staffing requirements.**

4. Facility Assessment- **AHCA recommends CMS maintain the existing facility assessment regulation as the approach for facilities to help determine staffing needs, and not advance any HPRD or other new minimum staffing requirements that are prescriptive and will drive unintended consequences.** The facility assessment was designed by CMS in 2016 to allow each facility to determine what resources are necessary to care for its residents during both day-to-day operations and emergencies. *See* 81 Fed Reg. at 68785.

The redesignated proposed changes to the facility assessment (§483.71) unnecessarily expand on the currently utilized facility assessment requirement (§483.70(e)). The existing regulation for facility assessment already includes the requirement for facilities to determine the staffing levels needed to meet the needs and acuity levels of the residents, and nursing homes have shown they are compliant with this requirement. In 2016, CMS noted that "facilities need the flexibility to determine the best way to perform their facility assessments to comply with this requirement" and "if a LTC facility does not objectively assess its resident population and resources, surveyors will be able to detect this during the survey, not only from reviewing the facility assessment but also from the LTC facility's compliance with the other requirements in this final rule." *See* 81 Fed. Reg. at 68760. Since the implementation of the facility assessment in 2017, according to

2023 QCOR data, a very small number of facilities (584) have been cited for failure to comply with this requirement. The Proposed Rule recognizes the importance of the facility assessment in notating the changes in the acuity and characteristics of long-term care residents as well as adjusting staffing levels based on resident assessments and care planning decisions that account for resident acuity, physical/cognitive abilities, conditions, diagnoses, etc." 88 Fed Reg. at 31369. Following existing regulations for facility assessment under §483.70(e) allows facilities to do just that, underscoring that there is no need to add additional process or paperwork burdens that will not deliver better results. **As in the case of the minimum staffing proposals, CMS has not articulated any rational basis for deviating from its prior position of allowing facilities flexibility in conducting their assessments.**

CMS's current requirement for facility assessment is thoughtful, and the survey process and compliance with F725 show that roughly 95 percent of facilities according to 2023 QCOR data are providing "sufficient nursing staff."

Our recommendation is for CMS to continue to use the existing well-established facility assessment process to allow facilities to determine staffing types and needs for their specific population, and to not advance any new minimum staffing requirement. This approach supports the conclusion of the 2022 Minimum Staffing Study that a one-size-fits-all" approach is not appropriate.

CMS Request: 88 Fed. Reg. at 61370, *We solicit comments on the timeframe used to determine compliance with the minimum HPRD, specifically if the lookback period should be longer, for example 1 year to cover a full certification period, or some other timeframe to ensure the most reliable and realistic assessment of staffing data.*

AHCA Response: **AHCA recommends that if CMS moves forward with a final minimum staffing HPRD requirement, then compliance should be determined by reviewing the facility's quarterly average HPRD. The lookback period should be no longer than 1 year.** A quarterly average aligns with what consumers, families, and stakeholders see on CMS Care Compare and is used in CMS Five-Star ratings. Creating consistency helps consumers and providers understand the requirements and monitor performance.

CMS Request: 88 Fed. Reg. at 61372, *Are there alternative policy strategies that we should consider to address staffing supply issues such as nursing shortages?*

AHCA Response: **AHCA urges CMS and policy makers to focus on efforts that will bolster the long-term care workforce and to recognize that these efforts will take time to accomplish.** Below are a few ideas that would make an impact on helping to address the workforce crisis.

- Utilizing qualified personnel from abroad. Both AHA and AHCA/NCAL support augmenting a depleted workforce with qualified personnel from abroad. Currently, 1 in 4 direct care workers are from abroad, and more are badly needed. We are advocating for Congressional action to create a temporary visa option specifically for registered nurses. Ideally, the visa option would include some other much-needed health care occupations such as certified nurse assistants, respiratory therapists, and others. We also strongly support the expedition of visas for foreign-trained nurses.

- Supporting apprenticeship programs for nursing assistants and other critical support staff positions. Registered Apprenticeship Program benefits include building a pipeline of skilled workers, gaining workers with customized skills, and enhancing employee retention and employer reputation.
- Adopting policies to substantially expand loan repayment and other incentive-based programs to retain existing talent and attract new talent, specifically for LTC.
- Allowing the CMP Reinvestment Program to be accessed by facilities and/or partnering organizations for workforce development, recruitment, and retention purposes.
- Forming an initiative to review existing requirements and aiming at identifying and reducing burdensome tasks or requirements for nursing staff.
- Shifting away from the unique strict liability approach imposed by CMS upon nursing homes through regulatory citation and enforcement that drives nursing staff out of LTC due to fear of personal and professional impact and creates an indirect negative impact on meaningful work in LTC.

It could also be helpful to direct the Government Accountability Office to study the business practices of travel nurse staffing agencies during the pandemic, including exorbitant prices and excessive profits, increased margins that agencies have retained for themselves, the impact of increased reliance on travel nurses in rural areas, and how these practices have contributed to workforce shortages across the country.

CMS Request: 88 Fed. Reg. at 61375, *We request comments on the operational challenges or burdens of this provision as well as how CMS can best provide oversight of this proposed requirement.* (related to facility assessment)

AHCA Response: AHCA recommends CMS should not expand or redesignate the existing regulation at §483.70(e) for facility assessment, as it will only divert time and resources toward creating more paperwork processing for both facilities and surveyors with no evidence to support any improvement to outcomes. The proposed changes will cause micromanaging of the facility by state survey agencies and CMS that will risk slowing important operational decisions or restricting facilities from being responsive and innovative to resident needs.

Existing CMS requirements for facility assessment are centered on resident needs and staffing resources and already determine capacity and capabilities of staff in the facility. The proposed changes focus on paperwork compliance and will result in the facility needing to continually update a document for the sake of meeting this proposed expanded requirement. Facilities have existing operational processes for how they address ongoing changes, and these processes do not need to be duplicated and detailed in a facility assessment for the purpose of paper compliance.

In addition, these proposed changes will cause unintended consequences from using both facility and survey resources for this paperwork processing, and the nature of these changes will create high risk for subjective interpretation by surveyors and inconsistency in survey oversight, which is already a problem CMS faces.

CMS Request: 88 Fed. Reg. at 61376, *We request comments on the operational challenges or burdens of this provision, as well as how CMS can best provide oversight of this proposed requirement. (recruitment and retention plans)*

AHCA Response: **AHCA recommends CMS not add any additional requirement to the existing facility assessment regulations at §483.70(e).** Recruitment and retention efforts are a core part of facility operations and do not require regulatory oversight. Such regulatory oversight only serves the purpose of paper compliance. This does not provide any value to resident care and services. To our knowledge, CMS does not require oversight of recruitment and retention plans for all facilities or entities in any other health care setting across the nation.

The need to demonstrate recruiting efforts should only come into consideration if and when a facility is applying for a waiver.

CMS Request: 88 Fed. Reg. at 61417, *We invite comments on this assumption and to what extent the benefits described in this section should be calculated using unadjusted data from PBJ and Care Compare.*

AHCA Response: **AHCA recommends CMS improve payroll-based journal (PBJ) policy so that it allows facilities to report all hours worked by staff including nurses and nurse aides, and offers facilities a reasonable opportunity to appeal/correct PBJ data** (which CMS does not currently allow). Currently CMS policy does not allow facilities to report actual staffing, which does not reflect an accurate picture of care being provided.

<u>Allowing Correction of PBJ Data</u>

We request that CMS allow facilities a reasonable opportunity to submit a request/appeal to CMS to correct PBJ data, highlighting the reason and efforts made, and an opportunity to submit corrected or missing data without penalty.

Providers should be allowed to correct the PBJ data submitted so that information available to residents and families is accurate. Furthermore, accurate and complete data is necessary for CMS's assessment of staffing. Currently, if a facility utilizes a vendor to submit data on their behalf, they are held responsible for errors in the data even if the vendor has made an error outside of the facility's control. For instance, a facility might accurately report its data to a vendor, but the vendor might have an error in its reports that causes it to exclude reporting RN hours. This would have a substantial impact on the facility's Five-Star rating and impact the assessment of minimum staffing hours. In addition to vendor issues, there may be unexpected circumstances where despite a facility's good-faith efforts to timely and accurately submit the PBJ data, there is an error or missed information that is later identified by the facility. Per current CMS policy, there are no options for the facility to correct that data. The result is that consumers do not have all the information available to them.

Correcting historical data is all the more important today because the newly developed PBJ turnover measures reported on CMS Care Compare and used in Five-Star ratings require six consecutive quarters of PBJ data to calculate nurse and administrator turnover. If any quarter of data is missing or unusable, staff turnover rates cannot be calculated or may be flawed, leaving consumers and families in the dark on a facility's true performance. Additionally, with the

scheduled adoption of PBJ-based measures into the Medicare SNF Value Based Purchasing (VBP) Program in the coming years, allowing for corrected PBJ data will help ensure more facilities have their Medicare reimbursement tied to accurate staffing levels and turnover. If a facility has missing or incomplete PBJ data for the VBP measurement windows, their VBP payment adjustment is determined only by other quality measures. The consequences of this CMS PBJ policy are further magnified by the Proposed Rule on minimum staffing.

If CMS is to maintain that facilities are not able to correct their data or submit missing data, we recommend that the impact on a facility's Five-Star rating be qualified to note that the rating is due to a technical issue so that the public does not assume that the drop in rating is a result of poor quality.

We accordingly recommend CMS update its policies to allow a reasonable opportunity for correction of PBJ data, including submission of corrected data without penalty.

Reporting of All Hours Worked by Exempt Employees

We ask CMS to allow nursing homes to report all hours worked for exempt employees using data from time and attendance record keeping, which are auditable by surveyors.

Current PBJ guidance states: "Facilities must submit the number of hours each staff member (including agency and contract staff) is paid to deliver services for each day worked…[I]f a salaried employee works 10 hours but is only paid for 8 hours, only 8 hours shall be reported. If a facility is paying a salaried employee a bonus for additional hours worked, those hours shall be reported under the following conditions: the payment must be directly correlated to the hours worked and must be distinguishable from other payments (e.g., cannot be a performance-based or holiday bonus). Additionally, the bonus payment must be reasonable compensation for the services provided." Electronic Staffing Data Submission Payroll-Based Journal: Long-Term Care Facility Policy Manual at 2-5 (v. 2.6, June 2022).

This policy impacts the accuracy of hours for nearly all exempt employee job classifications unless facilities provide an additional bonus payment, which is not the norm and raises questions with Department of Labor (DOL) regulations on exempt vs. non-exempt status, particularly the statement that the bonus must be "reasonable compensation." The policy results in many exempt employees who provide patient care (e.g., nurses) being unable to count any hours over a typical 35-40 hours worked in a week and results in significant inaccurate information for registered nurse (RN) and total nursing staffing hours per resident per day. Furthermore, the policy is particularly challenging for rural providers, where nurses (including the DON and administrator with a RN) frequently provide care to residents when coverage is needed.

It is concerning that a system meant to collect accurate staffing data uses a policy that essentially directs the underreporting of hours. The goal should be to provide an accurate picture of the total hours per resident day that care is provided.

We recommend CMS update this policy to allow all hours worked to be reported to PBJ.

CMS Request: 88 Fed. Reg. at 61353, *We also intend to display our determinations of facility compliance with the minimum staffing standards on Care Compare. We welcome comments on the most appropriate approach for doing so.*

AHCA Response: **If CMS moves forward with its proposed minimum staffing requirement(s), then AHCA recommends that compliance be measured using a quarterly average of the requirement(s). In addition, we recommend CMS reduce the penalties to either a notation on the Five-Star Rating System or a low-level deficiency without fines, and allow a facility to obtain a waiver if it cannot comply.**

d. Implementation Timeframe

AHCA recommends CMS allow at least 5 years for any new requirement to take effect after the date of the final rule, with an additional at least 36-month allowance period for facilities to hire staff once the workforce is available.

CMS Request: 88 Fed. Reg. at 61381, *We solicit public comments on whether a different definition should be used.* (rural/urban)

AHCA Response: **AHCA recommends CMS extend the phase-in period for both urban and rural facilities for any new requirement to at least 5 years after the date of the final rule, with an additional at least 36-month allowance period for facilities to hire staff once the workforce is available.**

There is a workforce shortage in both urban and rural settings. Our internal analysis showed a similar percentage of rural and urban facilities not currently meeting the proposed requirements. Giving all facilities 5 years for any staffing requirements negates the necessity to define rural and urban.

Percent of Facilities Not Meeting Proposed Requirements

	Rural	Urban
2.45 Nurse Aide HPRD	69 percent	73 percent
0.55 RN HPRD	47 percent	49 percent
24/7 RN	92 percent	77 percent

If CMS insists on differentiating the requirements for rural and urban facilities, AHCA recommends defining a rural facility as either residing in a location not defined as urban by the US Census Bureau *or* being in a county with fewer than 15,000 people. The latter option has been used in states, like Colorado, in identifying rural facilities for possible staffing waivers of state requirements.

CMS Request: 88 Fed. Reg. at 61381, *Is the proposed implementation timeframe appropriate? If not, are there any alternative implementation approaches for these requirements?*

88 Fed. Reg. at 61390, *We invite comments on whether this timeframe is sufficient, whether we should require a shorter or longer timeframe (such as 3 or 5 years) to implement these provisions, and if a shorter or longer timeframe is recommended, the rationale for that shorter or longer timeframe.*

AHCA Response: For the reasons discussed above in these comments, **AHCA does not support the current implementation timeframes as outlined in the Proposed Rule, due to the evident workforce crisis and projected workforce issues in coming years.** BLS data supports the fact that the workforce will not return to pre-pandemic levels until 2027 at the earliest. This is still a prediction and not guaranteed. Implementation of the rule as written would be nearly impossible for facilities, due to their inability to hire enough candidates to meet the requirements, and this situation is not going to improve in a few years without any meaningful government resources devoted to the issue or recruitment programs. The initiation of the proposed implementation timeframe should only begin if and when, in fact, the workforce returns. **AHCA recommends CMS extend the phase-in period for both urban and rural facilities for any new requirement to at least 5 years after the date of the final rule, with an additional at least 36-month allowance period for facilities to hire staff once the workforce is available.**

CMS Request: 88 Fed. Reg. at 61381, *To what extent are facilities and State governments planning to phase in, budget for, and prepare for the requirements before they go into effect? Additionally, what are the anticipated effects on resident health and safety that may be associated with these preparations?*

AHCA Response: AHCA member experience is that Medicaid offices across the country are understaffed and have numerous priorities post-pandemic. **If CMS advances minimum staffing standards, AHCA encourages CMS to set standards for what States should do to prepare for the Proposed Rule and establish advance funding for States (and providers) over the AHCA-recommended five-year phase-in period for both rural and urban facilities.** Providers cannot start using the new standards on the first day of implementation. Significant investment and expenses will be incurred and must be reimbursed. This was recognized by MEDPAC (Medicare Payment Advisory Commission) in its October 2023 meeting, where Commissioners referred to a possible need for a (Medicaid) Wage Pass Through program or an add-on to the existing (Medicare) prospective payment model (See "Examining staffing ratios and turnover in nursing facilities" at pp.7 & 19, MEDPAC 10/5/2023).

The unintended consequences of the Proposed Rule are significant for their effects on resident health and safety. One such highly concerning unintended consequence that has the potential to greatly affect resident health and safety is facility closures.

- Facility Closures- Since the pandemic begin in 2020, 584 facilities have closed voluntarily. Staff availability continues to be a significant reason for closures, including closing units or stopping further admissions until staffing can accommodate those admissions. If the proposal is implemented as written, more facilities will have to either close or adjust their census to meet the requirements. The unintended consequences of forcing closures or limiting admissions will result in access

problems for residents and other individuals in need of nursing home care. It will also result in smaller, rural facilities closing or decreasing capacity to remain compliant. This will in turn lead to placement of residents farther away from families and friends, in turn affecting the residents' and their families' overall well-being. As written in the Proposed Rule, CMS acknowledges how important it is for residents to be close to their loved ones, noting that according to a 2021 study, "[t]ravel time has a substantively and statistically significant negative association on visit probability for all age groups." CMS nevertheless has not adequately considered closures as an unintended consequence of its proposed mandate.

e. Financial

AHCA believes the estimated 10-year cost is grossly understated. CMS estimates an average cost of $4 billion a year over ten years, while CLA estimates nearly $7 billion a year. CMS's methodology for calculating the proposed 24/7 RN requirement is incomplete. Furthermore, the proposed rule does not provide any funding to pay for the costs of this mandate.

CMS Request: 88 Fed. Reg. at 61381, *How might the proposed implementation timeframe impact their finances and their ability to recruit in the same labor market?* (related to Medicaid)

AHCA Response: Providers will face elevated levels of competition in each labor market for RNs and NAs if these staffing requirements are implemented. It will be even more challenging to find and retain qualified staff, leading to further wage inflation. Smaller facilities and those in rural areas will struggle more with recruitment, as they will find it difficult to compete with larger, better-funded organizations in nearby urban areas. Implementing these staffing requirements will also increase operating expenses, and the absence of reimbursement means that health care providers will need to absorb these increased costs, straining their finances considerably in the short term.

CMS Request: 88 Fed. Reg. at 61387, *At this time, we solicit initial suggestions for an appropriate methodology for identifying the percentage of Medicaid payment that has gone to direct care worker and support staff compensation (noting that the underlying elements of the methodology could change should any final reporting requirements change in response to comments received on this Proposed Rule).*

AHCA Response: CMS gathers compensation information on the annual Medicare cost reports filed by each facility. Use of Medicaid cost report data is not feasible as each state has discretion over the form and content of its Medicaid cost report. As with the proposed requirements of "CMS–2442–P RIN 0938–AU68 Medicaid Program; Ensuring Access to Medicaid Services" for measuring compensation as a percent of payments, AHCA recommends that CMS's attempt to determine a percent of compensation paid is only acceptable if CMS increases Medicaid and Medicare payments to reflect the additional cost of this Proposed Rule.

CMS Request: 88 Fed. Reg. at 61387, *We also solicit initial suggestions whether separate methodologies would be appropriate for base payments and supplemental payments, and if so, suggestions for each. Commenters who support adding a requirement to report median hourly wages are also welcome to provide suggestions for a methodology for those calculations.*

AHCA Response: Generally, base payments are intended to cover provider compensation and benefits while supplemental payments may be tied to quality metrics or VBP. **AHCA recommends CMS calculate the percentage of compensation to payment both separately and together and seek public comment on the results before determining a final methodology.**

CMS Request: 88 Fed. Reg. at 61390, *We solicit feedback on the proposed application of the reporting requirement to managed care and the proposed effective date.*

AHCA Response: **AHCA recommends CMS propose to require the same information from managed care plans as it is proposing from Medicaid FFS and other payor sources. We recommend CMS lengthen the timeframe as needed for this reporting to be accomplished effectively.**

CMS Request: 88 Fed. Reg. at 61401, *We are soliciting comments on our assumptions, particularly our assumption that real wage rates for RNs will increase at annual rate of 2.31 percent, and burden estimates.*

AHCA Response: CMS's estimate of a 2.31 percent annual increase in wage rates for RNs is based on multiple studies over almost 20 years. While CMS represents that estimate as reasonable and stable, we are troubled by the agency's final statement that "[g]iven the uncertainty in growth and increased demands for RNs, we assumed that real wages each year would increase at 2.31 percent." 88 Fed Reg at 61400. In reality, providers have experienced double-digit percentage increases in wage growth during the last three years. **AHCA urges CMS to continue to review other labor studies and use the most current Medicare Cost Report data to revise their estimated percentage. This is another example of the need for a SNF-specific wage index based on audited cost reports, as AHCA has advocated for many years.**

CMS Request: 88 Fed. Reg at 61410, *We welcome any comments regarding the methodology that resulted in an estimated cost of approximately $40.63 billion over a 10-year period for the Comprehensive Minimum Nurse Staffing Requirement and on the potential State and Federal Medicaid impact, as well as the potential impact on Medicare and other non-Medicare/Medicaid payors.*

AHCA Response: **The estimated 10-year cost is grossly understated. The methodology for calculating the 24/7 RN proposed requirement is incomplete.** CMS excluded facilities in Guam and Puerto Rico and 3 percent of facilities for which there was not data available in the August 2023 data. Also, the estimate is based on current cost, which ignores the impact of demand on staff wages and benefits and the continued impact of nurse agency/registry cost. Competing studies such as the CLA study show an annual cost of $6.8 billion annually, 60 percent higher than the CMS estimate. Additionally, the CMS estimates for the impacts of the 24/7 RN, 0.55 RN and 2.45 can HPRD, and the alternative 3.48 total HPRD, as reflected in Tables 15, 20, 21, 22, 28, 31, and 32 of the Proposed Rule (88 FR 61400 through 61420), assume no ramp-up costs for each requirement, ignoring their impacts on Medicare, Medicaid, and Non-Medicare/Medicaid payors. It is implausible that SNFs would instantaneously hire new staff on the exact effective date of each requirement, as the effective date is the target date and not the start date for achieving the proposed staffing thresholds.

f. Hardship Exemption

AHCA recommends CMS create a real waiver process for all new minimum staffing requirements that 1) is available to all facilities (without exclusions), 2) does not entail pre-penalty (citation), 3) is attainable by any facility that is in need and that is making good faith efforts (reasonable process), and 4) includes support from QIO or another party to assist facilities in securing support resources to meet applicable needs. The "hardship exemption" process as set up in the Proposed Rule is unattainable, cumbersome, and not-user friendly.

CMS Request: 88 Fed. Reg at 61379, *We welcome comment on this mileage and the factors we should consider in determining an appropriate mileage criterion.*

AHCA Response: **AHCA first recommends CMS allow flexibility in what is a geographic barrier beyond a set mileage distance.** Traffic, public transportation availability, and many other factors impact whether staff, residents, and family can reliably access a facility.

We recommend CMS consider factors that affect where staff live relative to the facility. Given the income inequality and socio-economic segregation in our society, staff are not always able to find affordable housing near a facility and are dependent on long commutes via public transportation or other means. Facilities should be allowed to demonstrate these barriers and have them factored into hardship determinations.

If CMS sets a base distance, we recommend CMS consider driving distance instead of a straight-line distance calculation based on facility location coordinates. In the Proposed Rule, CMS estimates that there are 422 LTC facilities without any other facility within 20 miles. This estimate appears to be based on straight-line distance based on our testing of options. When we used Google Maps API to look at driving distance between facilities, and thus accounted for natural barriers like mountains and lakes that need to be circumnavigated, there were nearly double the number of facilities without another facility within 20 miles of driving distance.

We also recommend the distance should be within 10 miles of driving distance. Depending on location, driving 10 miles can take up to one hour. To avoid barriers for families being able to visit with residents or for staff commuting between work and home, we recommend lowering the distance to 10 miles.

CMS Request: 88 Fed. Reg. at 61380, *What are additional data sources that CMS can use to verify LTC facility hardships based on location or workforce unavailability and shortages or grant hardship exemptions? For example, the review of health professional shortage areas (HPSAs). Which data source or criterion, or combination of data sources or criteria, could accurately indicate hardship while minimizing burden to facilities?*

AHCA Response: **AHCA first recommends CMS remove the PBJ reporting failure exclusion or fix its PBJ policies so that it offers facilities a reasonable opportunity to appeal or correct PBJ data.** Currently, CMS policy does not allow facilities to submit PBJ data even a day after the deadline or when an unexpected situation occurs that did not allow the facility to submit the data by the deadline. This policy is already detrimental to impacted facilities, and will

become even worse with the proposed hardship exemption process because the HPRD requirements deem a facility ineligible for the exemption if the facility was unable to submit PBJ data. Failure to fix these policy issues will drive unintended consequences for the proposed minimum staffing requirements.

Additionally, we recommend CMS allow flexibility in the hardship determination process by setting up a process to allow facilities to submit waiver requests regardless of any community workforce data or geographic proximity to other facilities. Several states, such as Colorado and Delaware, have waivers to their state staffing requirements that are not contingent on workforce data or geographic proximity. Workforce availability data is not timely or relevant enough to determine hardship exemptions. It is best for waivers to be determined based on reviewing and monitoring good faith efforts to come into compliance. This allows the waiver process to be more prospective than reactive. If a state has the resources, they can oversee the waiver process for facilities in their state. Otherwise, CMS should oversee the process.

We are concerned with CMS's proposal to use BLS OES data, due to the facts that OES data only comes out annually, is not industry specific, and is not available for geographic areas smaller than a metropolitan statistical area.

When we modeled the proposed workforce availability measures using the latest BLS OES data from 2022, we were concerned that 19 states had over 75 percent of their counties showing no NA workforce shortages. Ten of those states had over 90 percent of their counties with no NA shortages. For RNs, ten states had over 75 percent of their counties without a shortage.

We can use Nebraska as a case example of why the BLS OES data and proposed measure is flawed. Nebraska has 75 percent of counties showing no NA or RN shortage with the proposed measures. Yet, if we look at BLS QCEW data that is more recent and current through March 2023, we see that Nebraska nursing homes have lost 7.1 percent of their workforce since the start of the pandemic in February 2020. From BLS data we know that 61 percent of the workforce is comprised of nurse aides and RNs, meaning that it is highly probable that most of the 7.1 percent workforce decrease is among nurses. Yet only 10 (6 percent) of Nebraska SNFs meet the proposed RN medium- or low-shortage definition, which can be attributed to BLS OES being older data and not industry-specific.

Allowing facilities to submit hardship exemptions without any contingencies will better allow for more relevant and timely data to be used in determining hardship exemptions and allow facilities and CMS to work together in identifying barriers and solutions to workforce challenges.

CMS Request: 88 Fed. Reg. at 61380, *Is 20 miles the right distance from the next closest LTC facility to warrant a hardship exemption? What distance from the next closest LTC facility results in a hardship for resident families?*

AHCA Response: As previously mentioned, AHCA recommends CMS consider driving distance rather than straight-line distance since mountains, lakes, and other factors can require long drives to facilities that seem relatively close on a map. This should also not be a limiting factor in determining hardship. There may be two facilities side by side in a rural location and neither are able to obtain staff due to workforce availability. **We also recommend the distance should be within 10 miles of driving distance.**

CMS Request: 88 Fed. Reg. at 61380, *Are there other criteria CMS should consider for a facility to demonstrate good faith effort to hire and retain nursing staff? Should CMS use BLS's median OES data to determine prevailing wage?*

AHCA Response: BLS OES data is produced annually at the national, state, and metropolitan/nonmetropolitan area level. However, it is usually one year behind. The latest report, dated April 2023, is for May 2022, and so is not useful to determine prevailing wages. In addition, the data is not regional enough to be accurate. AHCA recommends CMS collect data from all long-term providers using the most recent Medicare Cost Reports or engage a consultant for a current wage survey to define the prevailing wage for each region. AHCA routinely comments in the annual SNF PPS proposed payment rule on the need for an SNF-specific wage index. CMS's intent to use a 2.31 percent inflation factor for wages is troubling as providers have experienced double-digit percentage increases in wage growth during the last three years.

CMS Request: 88 Fed. Reg. at 61380, *Is 12 months the right look-back time frame for exclusions? If not, what is the best time frame? Should it be 15 months? Should it be to and including the last recertification survey?*

AHCA Response: **AHCA recommends CMS remove all the proposed exclusion criteria because all facilities should be afforded an opportunity for waiver.** If CMS proceeds with exclusions, twelve months is a sufficient look-back time frame for exclusions. We do not recommend tying the look-back time frame to the last recertification survey because surveys' timing can vary and be impacted by extraneous factors, as we saw in the recertification survey delays during and after the COVID pandemic that are still present today.

CMS Request: 88 Fed. Reg. at 61380, *Are there additional hardships that CMS should consider? If so, how will such considerations support quality care and protect resident health and safety?*

AHCA Response: **AHCA recommends CMS create a real waiver process for all new minimum staffing requirements that 1) is available to all facilities (without exclusions), 2) does not entail pre-penalty (citation), 3) is attainable by any facility that is in need and that is making good faith efforts (reasonable process), and 4) includes support from QIO or another party to assist facilities in securing support resources to meet applicable needs.** The "hardship exemption" process as set up in the Proposed Rule is unattainable, cumbersome, and not user-friendly.

Very few will qualify for the proposed hardship exemption, and in seeking an exemption, the facility is required to be cited first and may be fined. Then, if the facility is cited at a scope and severity that is too high, the facility is deemed not eligible for the exemption. Or, if the facility has a single occurrence of not being able to submit PBJ data due to a technical issue or vendor issue, even when the facility has the data and wants to submit it to CMS, the facility is deemed ineligible for the exemption. The remaining alternative for a facility that has been deemed ineligible for an exemption by this proposed CMS process is to begin the process of closing the facility, as the imminent regulatory and enforcement trajectory will drive the facility to close because a waiver was not afforded.

AHCA recommends CMS remove all the proposed exclusion criteria because all facilities should be afforded an opportunity for waiver.

AHCA agrees with CMS's proposal for a waiver/exemption for a 1-year period with extensions available for additional 1-year periods.

Additionally, the proposed 24/7 RN waiver excludes urban facilities, including those predominantly serving Medicaid residents, and disparately impacts disadvantaged communities. **AHCA recommends CMS allow for a broader 24/7 RN waiver that is available to all facilities, not limited only to facilities located in rural areas.**

CMS Request: 88 Fed. Reg. at 61380, *Should CMS provide an exemption for facilities based on financial difficulty/constraints? If so, what would be an appropriate judgment of a LTC facility's financial status and/or financial effort? Considering the Medicaid transparency proposal discussed in this Proposed Rule, should CMS identify minimum spending thresholds for direct care staff that facilities must meet before being considered for an exemption? Is there a specific spending to revenue threshold that would be appropriate? What type of data and/or data sources can be used to maximize transparency and provide an objective determination?*

AHCA Response: The fact that CMS is looking for feedback on five questions in this section points to the complexity of the Proposed Rule. **AHCA recommends CMS provide waivers/exemptions based on financial hardship such as changes in financial performance as it relates to provision of care and services to residents. This should include financial exemptions based on customary accounting measurements such as changes in operating income, variances versus annual budget or prior year performance, and changes in cash flow.**

Regarding the Medicaid Transparency proposal and minimum spending thresholds for direct care staff, CMS should not set spending thresholds. Designating a standard percentage of an FFS payment does not consider the total adequacy of the payment amount to cover the full costs of the provider. Without a full understanding of the total cost of operations, a percentage should not be used at the provider level as it would be in a medical loss ratio standard for an insurance company. A one-size-fits-all approach does not work.

In regard to financial difficulty/constraints, they are best measured through the inspection of annual financial statements of the nursing facility prepared by an independent accountant, or by the financial statements which are required as part of annual Medicare and Medicaid Cost reports.

CMS Request: 88 Fed. Reg. at 61380, *Are there additional steps that CMS can take to increase transparency and address staffing shortages? For example, this regulation discusses a proposal to require States to report to CMS on the percentage of payments for Medicaid-covered nursing facility services that are spent on direct care workers and support staff. Are there additional efforts that CMS and facilities can take to promote transparency and accountability related to funding for and supporting staffing?*

AHCA Response: **AHCA has advocated in previous comments on notices of proposed rulemaking (NPRMs) that CMS must develop an SNF-specific wage index based on submitted and audited cost report data.** In this manner, CMS's proposal to require State

reporting on the percentage of payments spent on direct care workers and support staff can largely already be determined through use of existing Medicare cost report data and perhaps individual state Medicaid cost reports. CMS can promote transparency by focusing on auditing this data and identifying gaps which require additional reporting.

3. Medicaid Institutional Payment Transparency Reporting Provision Estimated Burden Hours

CMS Request: 88 Fed. Reg. at 61385, *We request comment on our proposed definition of compensation, particularly whether the definition of compensation should include other specific financial and non-financial forms of compensation for the workers included in these proposed provisions.*

AHCA Response: CMS's definition of the components of compensation is a good starting point and matches the approach used in Medicare Cost Reporting. **AHCA recommends CMS also consider aligning the definition with items normally reported on IRS form W-2**.

CMS Request: 88 Fed. Reg. at 61385, *We request feedback on our proposed definition of direct care worker at § 442.43(a)(2). We specifically request* [*feedback on*] *whether there are categories of staff we should add to, or remove from, our proposed definition.*

AHCA Response: CMS is proposing minimum staffing requirements for RNs and NAs, but then seeks comments on using a definition of direct care staff that would align with other reporting entities in a separate home and community-based services (HCBS) Proposed Rule. *See* 88 Fed. Reg at 61385. These additions include many workers who complement or supplement shortfalls in RN and other long-term care staffing. This includes nurse practitioners, clinical nurse specialists, licensed physical therapists, occupational therapists, speech-language pathologists, respiratory therapists; physical therapy assistants, occupational therapy assistants, and respiratory therapy technicians; social workers; personal care aides; medication assistants, aides, and technicians; feeding assistants; and activities staff. CMS further states: "Our proposed definition of direct care worker is intended to broadly define such workers to ensure that the definition appropriately captures the diversity of roles and titles that direct care workers may have,.... This difference is intentional as we are more closely aligning our proposed definition of direct care worker …**.** to provide a more consistent picture of the direct care workforce for individuals receiving (services) …. across LTSS settings." *Id.* **AHCA supports a broad definition of the staff that would count towards any minimum staffing requirement, and submits that long-term care facilities should be allowed to count at least the same direct care personnel that CMS proposes to use in the HCBS context. As noted previously in these comments, AHCA recommends the following definition of staff that should count towards minimum staffing requirements for nursing homes:**

Any individual who is employed or contracted by the facility and through interpersonal contact generally provides residents direct assistance with personal care or activities of daily living or has direct access to provide care and/or services to residents including but not limited to support with their living space, maintenance of personal items, socialization, and other activities desired by the resident. There are a variety of job titles/roles that may be captured within this definition, including but not limited to licensed nurse; nurse aide; personal care aide; medication assistant; physician; physician assistant; nurse practitioner; licensed physical or occupational therapist or

licensed therapy assistant/aide; registered respiratory therapist; licensed speech-language pathologist; infection preventionist; mental health worker; social worker; activity staff; dining assistant; paid feeding assistant; housekeeper; hospitality aide; life enrichment assistant; recreational staff; universal worker; other health care professionals licensed or certified in the respective state; and other roles designed or determined by the facility to support the needs of the resident(s).

CMS's attempt to distinguish the use of two different definitions simply because certain categories of staff are included for reporting wages and compensation is not consistent with CMS's proposal for only counting RN and CNA staffing hours as determinants of quality. **CMS should be consistent in these policies and allow facilities to count towards minimum staffing requirements all staff that impact resident care and services, as reflected in the broad definition recommended above.**

CMS Request: 88 Fed. Reg. at 61385, *We are particularly interested in ensuring that this provision includes staff who can be instrumental in helping residents achieve the level of health or develop skills needed to transition from nursing facilities back into the community, assess residents for readiness for transition, and support in discharge planning.*

AHCA Response: AHCA agrees that staff with these duties should be included in the definition of direct care workers.

CMS Request: 88 Fed. Reg. at 61385, *We request feedback from the public as to whether our proposed definition appropriately includes workers who provide these services, or if we would need to include such staff as a distinct category of staff within this provision. We also request comment on whether we should adopt the definition of direct care staff at § 483.70(q)(1), instead of our proposed definition of direct care worker. If commenters support adopting the definition of § 483.70(q)(1), we request that they also provide information on whether this definition would include the staff who help residents achieve the level of health or develop the skills needed to transition from nursing facilities back into the community, assess residents for readiness for transition, and support in discharge planning, or if these staff would still need to be specified as a separate category.*

AHCA Response: **AHCA recommends CMS align the reporting of these hours and dollars across all financial and cost reports so that a consistent method is used to measure HPPD and dollars per hour. CMS should proceed with this proposed definition to capture all staff either employed or under contractual relationship.**

CMS Request: 88 Fed. Reg. at 61386, *We request comment on whether there are other specific types of workers, such as security guards, who should be included in the definition.*

AHCA Response: AHCA agrees with CMS that security guards should be included in the support services workers grouping.

CMS Request: 88 Fed. Reg. at 61386, *We solicit comment on whether this component of our proposed definition adequately captures the universe of potential employment or contractual relationships between institutional facilities and relevant direct care workers.*

AHCA Response: AHCA supports CMS's proposed definition, as it appears to capture the range of potential staffing arrangements for direct care workers.

CMS Request: 88 Fed. Reg. at 61386, *We are also soliciting comment on whether any of the types of workers listed in this proposal should be excluded from the definition of support staff. We also request comment, generally, on our proposal to include support staff in this proposed reporting requirement.*

AHCA Response: AHCA agrees that staff with these duties should be included in the definition of support staff.

CMS Request: 88 Fed. Reg. at 61386, *We solicit comment on whether, for FFS payments, we should instead request reporting on only the percent of base payments spent on such compensation, or separate reporting on the percent of base payments and on the percent of aggregated payments (base plus supplemental payments) spent on such compensation.*

AHCA Response: **AHCA recommends CMS should not narrow its proposal. If states are to report FFS payments, they should report the total payment *and* the portion intended to be for compensation. CMS should be aware of the administrative burden of additional reporting and be receptive to State alternative suggestions.**

CMS Request: 88 Fed. Reg. at 61386, *We request comment on whether annual reporting is reasonable, or if we should reduce the frequency of reporting to every other year or every 3 years.*

AHCA Response: Annual reporting is reasonable; however, **AHCA recommends CMS be aware of the administrative burden of extensive reporting and be receptive to State alternative suggestions.** Timely data on Medicaid is critical as rates can be too low and not updated frequently. This leads to provider losses and access issues for beneficiaries.

CMS Request: 88 Fed. Reg. at 61387, *We solicit feedback from the public on whether including cost-sharing payments for services that were primarily paid for by Medicare would provide a more accurate picture of the relationship between Medicaid payments and worker compensation.*

AHCA Response: **AHCA recommends CMS require that all payments for services be reported to determine if there is, or is not, a relationship between these payments and worker compensation.** CMS can modify this position in future rule making cycles if it determines it is not a factor.

CMS Request: 88 Fed. Reg. at 61387, *We also request comment on whether excluding cost-sharing payments would increase or decrease burden on States and providers.*

AHCA Response: AHCA has commented on the additional administrative burden of extensive reporting multiple times in the rule. **We recommend CMS require that all payments for services be reported. CMS may modify that decision in future rule making.**

CMS Request: 88 Fed. Reg. at 61387, *We welcome feedback on whether commenters believe beneficiary contributions should be excluded.*

AHCA Response: **AHCA recommends CMS require that all payments for services, including beneficiary contributions, should be reported, as they may vary between types of services and settings.** CMS may modify that decision in future rule making.

CMS Request: 88 Fed. Reg. at 61387, *We request comment on whether we should allow States the option to exclude, from their reporting to us, payments to providers that have low Medicaid revenues or serve a small number of Medicaid beneficiaries, based on Medicaid revenues for the service*, the *number of Medicaid beneficiaries receiving the service, or other Medicaid utilization data including but not limited to Medicaid bed days.*

AHCA Response: AHCA recommends CMS require that all payments for services, including payments to low utilization providers, be reported. CMS may modify that decision in future rule making.

CMS Request: 88 Fed. Reg. at 61387, *We also request comment on whether we should establish a specific limit on such an exclusion and, if so, the specific limit we should establish, such as to limit the exclusion to providers in the lowest 5th, 10th, 15th, or 20th percentile of providers in terms of Medicaid revenues for the service, number of Medicaid beneficiaries served, or other Medicaid utilization data (including but not limited to Medicaid bed days.)*

AHCA Response: **AHCA recommends CMS not establish an exclusion and all services be reported. Furthermore, CMS should report percentiles for all the metrics for revenues, beneficiary count, and utilization data**. CMS may modify that decision in future rule making.

CMS Request: 88 Fed. Reg. at 61387, *We solicit comment on our proposal that information be reported at the facility level, particularly on any concerns about potential burden on providers and States.*

AHCA Response: AHCA supports transparency. Facility-level reporting can be burdensome, which CMS should minimize. CMS recognizes its responsibility to "specify a reporting methodology as part of the reporting instrument, which would be submitted separately through formal public comment." **We encourage CMS to involve providers and states in the development of "a reporting methodology to allow for increased flexibility to refine and adapt the reporting methodology as States and CMS gain experience with the process."**

CMS Request: 88 Fed. Reg. at 61387, *We request that commenters also provide feedback on whether the reporting should be on salary/wages, or on total compensation (salary/wages and other remuneration, including employer expenditures for benefits and payroll taxes), and whether the information should be calculated for all direct care workers and for all support staff, or further broken down by the staff categories specified in our proposal at § 442.43(a)(2) and (3).*

AHCA Response: **AHCA recommends that the reporting requirement include median totals and be based on total compensation for each category.**

CMS Request: 88 Fed. Reg. at 61388, *We request comment on whether the reported average should be the average of only the per diem base payment rates, or the average of the per diem base payment rates plus supplemental payments.*

AHCA Response: **AHCA recommends CMS report on the average of each component (base and supplemental) separately.**

CMS Request: 88 Fed. Reg. at 61388, *We request comment on which option interested parties believe would provide the most useful snapshot of payment for these services.*

AHCA Response: **AHCA recommends CMS hold a town hall or stakeholder meeting to review reporting formats after the rule is finalized and the first reporting period data is available.**

CMS Request: 88 Fed. Reg. at 61388, *We request comment (in the context of future rule making) on whether we should require that a minimum percentage of the payments for Medicaid-covered nursing facility services and ICF/IID services be spent on compensation for direct care workers and support staff.*

AHCA Response: **AHCA does not support this proposal for multiple reasons:**

1. AHCA applauds CMS's recognition of the lack of data for initial decisions in this area. AHCA suggests that even in future rule making cycles, establishing a minimum percentage would be erroneous and potentially harmful to providers.
2. Requirements that mandate certain HPRD levels (with or without compensation reporting standards) must be accompanied by funding from Medicare, Medicaid, and Medicare Advantage payers. Any gap in funding will continue to drive financial impact on self-pay residents as well.
3. Any mandate for a minimum percentage of payments to be spent on compensation limits providers' ability to effectively compete in an open market.

CMS Request: 88 Fed. Reg. at 61389, *We request comment on this proposal, including whether this timeframe for website review is sufficient or if we should require a shorter timeframe (monthly) or a longer timeframe (semi-annually or annually).*

AHCA Response: **Transparency in reporting is important. States should expect managed care plans to maintain their websites on a monthly basis at a minimum.**

CMS Request: 88 Fed. Reg. at 61389, *We request comment on whether these requirements (that States include prominent language on the website explaining that assistance in accessing the required information on the website is available at no cost to the public and include information on the availability of oral interpretation in all languages and written translation available in each non-English language, how to request auxiliary aids and services, and a toll-free and TTY/TDY telephone number) are sufficient to ensure the accessibility of the information for people receiving nursing facility or ICF/IID services and other interested parties.*

AHCA Response: **AHCA supports the methods to which CMS refers as they appear sufficient to ensure access and availability of information.**

CMS Request: 88 Fed. Reg. at 61390, For States with managed care delivery systems under the authority of sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Act and that include coverage of nursing facility services and/or ICF/IID services in the MCO's or PIHP's contract, we are proposing to provide States until the first managed care plan contract rating period that begins on or after the date that is 4 years after the effective date of the final rule to implement these requirements. *We invite comment on this approach, particularly regarding any additional guidance we would need to provide or actions we would need to take to facilitate States' implementation of these proposed provisions.*

AHCA Response: **AHCA supports the CMS implementation date in this section if the rule is finalized as proposed.**

CMS Request: 88 Fed. Reg. at 61390, *We request comment on whether we should propose that States implement an interested parties' advisory group in parallel with proposed requirements at § 447.203(b)(6) in the Ensuring Access to Medicaid Services Proposed Rule (88 FR 29260).*

AHCA Response: **AHCA recommends CMS require States to implement an advisory group.**

4. Estimated Burden Hours

AHCA believes CMS has grossly underestimated the burden hours for this proposal.

a. Information Collection Requirements (ICRs)

i. Nursing Services

CMS Request: ICRs Regarding § 483.35 Nursing services: *We are requesting comment on our estimated number of burden hours for the proposal for each of the activities and total annual burden and cost for each facility.*

AHCA Response: **CMS's estimate of the burden in hours for this proposal as only two hours of administrator time, three hours for DON time, and one hour for administrative assistant time is grossly underestimated.** There are many activities that facilities would need to complete, including reviewing and modifying nurse staffing policies and procedures to become compliant with the requirements, developing or modifying contracts with staffing agencies, and engaging in budget modifications, staffing model reevaluations including both clinical and non-clinical staff, facility capacity reevaluations based on staff available to meet requirements, and resident placement efforts when facility cannot be compliant with the requirement, to name a few. **CMS should assess the impact of this provision in an initial regulatory flexibility analysis (IRFA) that CMS has not yet performed.**

ii. Facility Assessment

CMS Request: ICRs Regarding § 483.71 Facility Assessment: *We are requesting comment on our estimated number of burden hours for the proposal for each of the activities and total annual burden and cost for each facility.*

AHCA Response: **CMS's estimate of the burden in hours for this proposal as only 22 staff hours is grossly underestimated.** There are substantial changes proposed to the Facility Assessment. A facility would need significant hours spent by multiple staff to implement and execute all the changes, which would not be only at one point in time but would require ongoing intensity of staff time to ensure compliance. AHCA acknowledges it is difficult to quantify the total number of additional hours that would be required to meet these proposed changes, as the hours continually increase depending on the number of revisions required to the facility assessment, influenced by changes in resident population and staff in the facility. The proposed changes would require extensive time commitments throughout each year. **CMS should assess the impact of this provision in an initial regulatory flexibility analysis (IRFA) that has not been performed yet.**

iii. Regulatory Flexibility Act Analysis (RFA)

AHCA believes CMS should perform the Regulatory Flexibility Act analysis and revisit its decision to certify this regulation. CMS should also prepare an initial regulatory flexibility analysis.

CMS states at 88 Fed. Reg. at 61425 that the RFA requires agencies to analyze options for regulatory relief if a proposed rule has an impact on a substantial number of small entities. CMS stated the annual cost in Table 20 (88 Fed. Reg. at 61407) at $40.6 billion over 10 years, for an average of over $4 billion per year. In Table 36 – Regulatory Flexibility Act Analysis (88 Fed. Reg. at 61425), CMS then calculated the discounted cost for providers using discount rates of 3 percent and 7 percent resulting in annual costs between $3.733 billion and $3.93 billion. Then, dividing these costs by annual revenue of $162.451 billion returns calculated costs as a percentage of revenue at 2.3 percent to 2.42 percent respectively. Since both numbers are lower than the 3 percent threshold used by CMS to determine a significant impact on small businesses, the CMS Secretary certified that the proposed rule will not have a significant economic impact.

AHCA Response: **CMS has underestimated the total annual cost and the proposed rule does have a significant economic impact on a substantial number of small entities.** Based on the CLA study commissioned by AHCA, the estimated annual cost is $6.8 billion, or $68 billion over 10 years. Applying these annual cost totals to Table 36 – Regulatory Flexibility Act Analysis, the 3 percent floor would be $4.873 billion and the upper end of 5 percent would be $8.122 billion. AHCA has determined that using a discount rate of 3 percent on the CLA analysis, the estimated average cost per year over a 10-year span would be $5.800 billion. This falls within the 3-5 percent range of $4.8 billion to $8.12 billion. Other studies by the Kaiser Family Foundation and Leading Age also show annual costs above CMS's estimate. Additional total annual burden and costs will also come from the facility assessment and nursing services requirements, as noted above.

Based on these calculations, we think CMS should perform the Regulatory Flexibility Act analysis and revisit its decision to certify this regulation. CMS should also prepare an initial regulatory flexibility analysis, as is required when a regulation's impact is found to be "significant" under the Regulatory Flexibility Act.

Conclusion

As described above, we believe CMS lacks statutory authority to promulgate the proposed minimum-staffing requirements. But even if CMS had that authority, the 2022 Nurse Staffing study indicates that while the literature underscores the relationship between nursing home staffing and quality outcomes, ***"it does not provide a clear evidence basis for setting a minimum staffing level".*** The study also indicates that while quality and safety do increase with staffing levels, there is "***no obvious plateau at which quality and safety are maximized or "cliff" below which quality and safety steeply decline."***

We urge CMS to consider rescinding this impossible-to-implement proposed staffing mandate for nursing homes as it will not improve quality or resolve the ongoing labor crisis in the industry. It will only reduce access to care for our nation's seniors.

We'll get you there.

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CMS Proposed Staffing Mandate

In-Depth Analysis on Minimum Nurse Staffing Levels

Forward-Looking Statements — Disclaimer

Certain information set forth in this presentation contains “forward-looking information,” including “future-oriented financial information” and “financial outlook” (collectively referred to herein as forward-looking statements). Except for statements of historical fact, the information contained herein constitutes forward-looking statements and includes, but is not limited to, (i) projected median operating margin performance of national skilled nursing facilities; (ii) projected occupancy levels; and (iii) projected inflation. These forward-looking statements are provided to allow industry professionals and policy makers the opportunity to understand CLA’s beliefs and opinions with respect to the future so that they may use such beliefs and opinions as one factor in evaluating the performance of the skilled nursing industry.

These statements are not guarantees of future performance and undue reliance should not be placed on them. Such forward-looking statements necessarily involve known and unknown risks and uncertainties, which may cause actual performance and financial results in future periods to differ materially from any projections of future performance or result expressed or implied by such forward-looking statements.

Although forward-looking statements contained in this presentation are based on what CLA believes are reasonable assumptions, there can be no assurance that forward-looking statements will prove to be accurate, as actual results and future events could differ materially from those anticipated in such statements. CLA undertakes no obligation to update forward-looking statements if circumstances or industry estimates or opinions should change. The reader is cautioned not to place undue reliance on forward-looking statements.

Executive Summary

On September 1, 2023, the Centers for Medicare and Medicaid Services (CMS) issued the long anticipated proposed rule on the Minimum Staffing Standards for the long-term care (LTC) facilities. CMS has "long identified staffing as one of the vital components of a nursing home's ability to provide quality care … ."[1] CMS is currently using various methods to analyze an appropriate "minimum level and type of staffing needed to enable safe and quality care in nursing homes."[2] CMS states they are basing the proposed minimums on their new 2022 staffing report[3] that found "statistically significant differences in safety and quality care" at certain minimum levels.

The proposed rule mandates hours per resident day (HPRD) for two disciplines: registered nurses (RNs) at 0.55 HPRD and nurse aides (NAs) at 2.45 HPRD. The rule does not require any licensed practical nurse staffing minimums. In addition, the proposed rule would require an RN to be on-site 24 hours a day, seven days a week and able to provide care. This is a separate requirement from the 0.55 HPRD RN requirement.

Utilizing Payroll-Based Journal (PBJ) data and hourly rates from Medicare cost reports, we have estimated the additional staff necessary to meet the staffing requirement, as well as the costs associated with the additional staff. The analysis demonstrates the financial and workforce challenges for skilled nursing facilities (SNFs) to provide direct care staffing at the levels CMS has indicated in the proposed rule.

1. Centers for Medicare & Medicaid Services Minimum Staffing Standards for Long-Term Care. 2023-18781.pdf (federalregister.gov)
2. https://www.cms.gov/blog/centers-medicare-medicaid-services-staffing-study-inform-minimum-staffing-requirements-nursing-homes
3. The Nursing Home Staffing Study Comprehensive Report (cms.gov)

CMS has also proposed additional facility assessments related to the staffing mandate. CMS states that its “goal is to ensure [these minimums] are both implementable and enforceable, as determined through both the PBJ System as well as on-site surveys.”[1] The agency also wants to work against any inverse incentives to reduce staffing to these minimums. Therefore, CMS proposes the following:

- Clarifying that evidence-based methods must be used when care planning for residents
- Requiring use of facility assessments to assess specific needs of each resident and adjust as necessary based on any significant changes in resident population
- Requiring input of staff including leadership, management, direct care (nurse staff), representatives of direct care, and staff who provide other services
- Requiring development of a staffing plan to enhance recruitment and retention of staff

1. Centers for Medicare & Medicaid Services Minimum Staffing Standards for Long-Term Care. 2023-18781.pdf (federalregister.gov)

Summary of Findings and Conclusions

The cost of staffing to meet a minimum staffing mandate of 0.55 RN HPRD and 2.45 nurse aide HRPD, as well as the 24/7 RN coverage, is estimated to be $6.8 billion. The CLA 37th Annual SNF Cost Comparison and Industry Trends report identified that 7,741 out of 13,193 SNFs (59%) had negative operating margins (excluding public health emergency funding). The additional burden of meeting minimum staffing requirements with no funding mechanism could potentially increase the number of facilities operating with negative margins.

The $6.8 billion in estimated annual cost is associated with the wages and benefits required to hire more full-time equivalents (FTEs) to meet the proposed requirements. The SNF industry would need to hire approximately 102,000 additional full-time equivalents (FTEs). Although there have been improvements in workforce availability in some areas of the country, SNFs in many parts of the nation are still challenged to find the appropriate workforce. Some facilities may need to reduce admissions or number of beds in a facility to meet staffing ratios. If SNFs are unable to increase their workforce, hundreds of thousands of residents could be impacted by census reductions.

Summary of Findings and Conclusions

The following table summarizes the potential impact of the proposed staffing mandate on the skilled nursing facility industry.

	Nurse Aide (2.45 HPRD)	RN 24/7 Coverage	RN (0.55 HPRD)	All/Total
Facilities that met criteria	4,079 (28%)	2,970 (20%)	7,642 (52%)	896 (6%)
Facilities that did NOT meet criteria	10,532 (72%)	11,729 (80%)	7,057 (48%)	13,803 (94%)
Estimated Annual Cost ($ in Millions)	$ 4,794	$ 610	$ 1,455	$ 6,860
Estimated FTEs to Meet Criteria	80,077	6,897	15,180	102,154
Potential Census Impacted	186,920 (16%)	96,528 (8%)	147,167 (12%)	287,524 (24%)

The additional cost and FTEs for 24/7 RN coverage does allow some facilities to meet the RN HPRD requirement. The RN HPRD estimated annual cost and additional FTEs to meet the 0.55 HPRD is in excess of the RN 24/7 coverage.

The estimated $6.8 billion annual cost exceeds the CMS estimated annual cost of $4 billion dollars primarily due to the fiscal year cost reports utilized in the calculation. CLA utilized the most currently available reports, including some FYE 2022 reports, which represent higher compensation costs than FY 2021.

Data and Methodology

Data and Methodology

Hours and census

PBJ data from first quarter 2023

Classification consistent with CMS Nursing Home Five-Star Quality Rating System Technical Users' Guide

- RN includes DON, RN with administrative duties, and RN
- Nurse aide includes CNA, aides in training, and medication aides / technicians
- Care Compare data from first quarter 2023

Action description	Total facilities
Annualized one quarter for each provider included to produce average annualized hours. Thus, each provider was only included once.	15,011
Removed facilities that did not report hours per resident day. A total of 400 facilities were removed.	14,611
Final facility count	**14,611**

Hourly rates

Annual Medicare cost reports released by CMS as of July 2023

- Includes fiscal years ended between December 31, 2021, and December 31, 2022
- S-3, Part V, column 5 Median Hourly Wage (includes salaries and allocated benefits)
  - Did not include or weight hourly rates for contract labor*
- State median hourly wages were used for facilities missing cost report data (approximately 6%)
- RN hourly wage rates utilized in median were capped at $150 per hour

** The hourly rates for contract labor were excluded from the calculation, based on the assumption the costs associated with contract labor are higher than employed hourly rates. The analysis provides the lowest financial impact of a staffing minimum, without the consideration of the financial impact of the use of contract nursing to meet a minimum staffing requirement.*

Methodology

CLA documented the potential cost and FTE requirements based on CMS proposed rule utilizing the following:

- By discipline
  - RN
  - Nurse aide
- RN coverage 24 hours per day, 7 days per week — Per rule, 24/7 coverage to be met prior to and regardless of RN HPRD coverage

Results are presented by discipline and in total

- For example, a facility that failed to meet the threshold for “all” did not meet any one of the criteria for Nurse aide HPRD, RN HPRD, or RN 24/7 coverage

Average total daily census (ADC)

- The sum of the ADC for facilities that do not meet the specific staffing criteria

Census impacted

- The number of residents impacted if facilities meet the mandate by reducing their ADC

Findings and Conclusions

Results — Facility Level

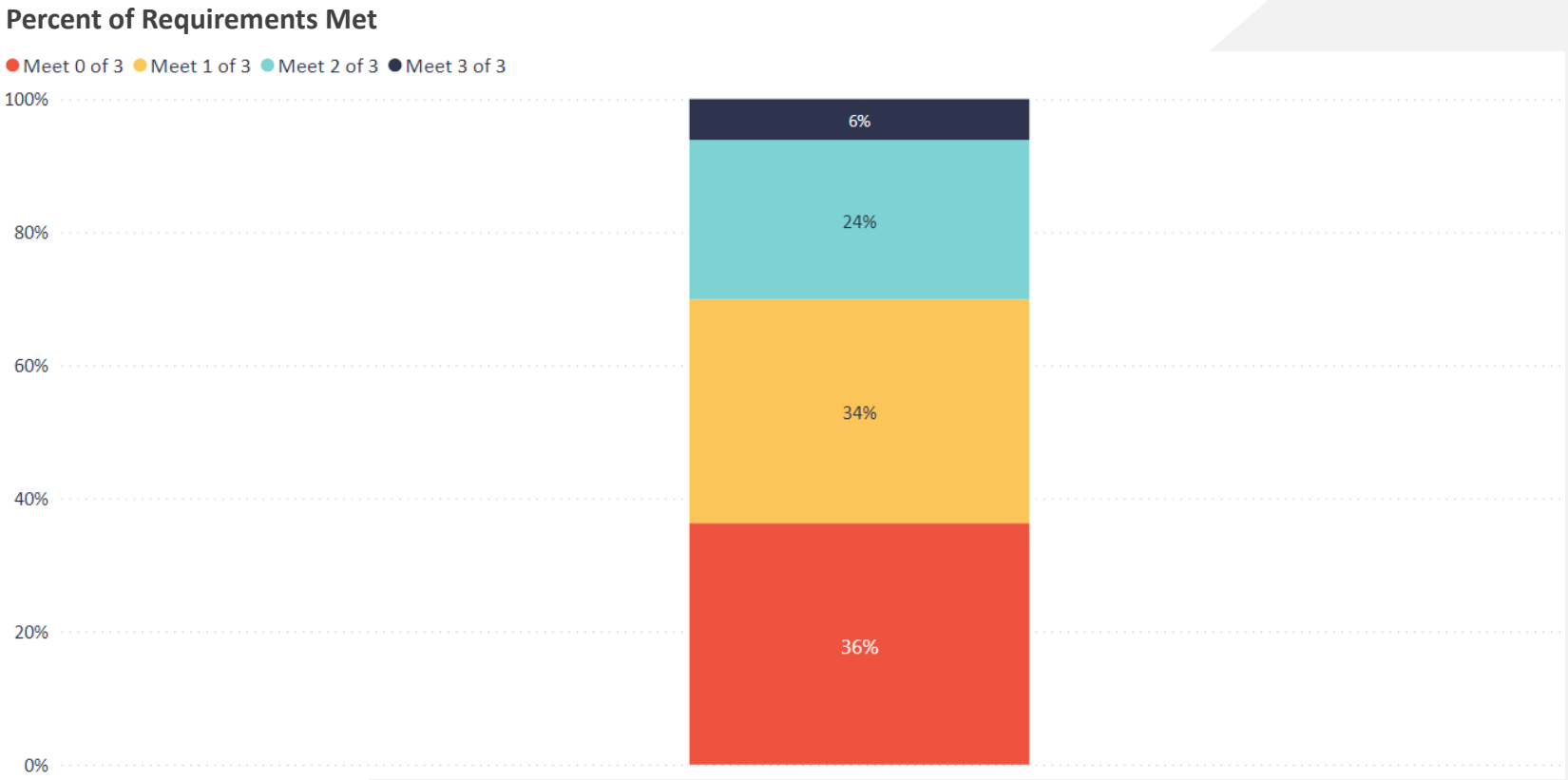
	Nurse aide	RN 24/7	RN (0.55)	All
Facilities that met criteria	4,079	2,970	7,642	896
Facilities that did NOT meet criteria	10,532	11,729	7,057	13,803

	Nurse aide	RN 24/7	RN (0.55)	All
Facilities that met criteria	28%	20%	52%	6%
Facilities that did NOT meet criteria	72%	80%	48%	94%

The tables above identify the number of facilities that **met** or **did NOT meet** the individual staffing requirements for first quarter 2023. The "All" columns identify facilities that either did or did not meet at least one of the criteria. In summary, 94% of facilities either did not meet the nurse aide criteria of 2.45 HPRD, the 0.55 RN HRPD, or the 24/7 RN coverage. A total of 13,803 facilities did not meet part or all of the HPRD and coverage requirements.

The total number of facilities included in analysis for RN 24/7 coverage is 14,699 based on the daily PBJ data.

Results – Facility Level



Note: Puerto Rico and Guam were excluded from the analysis above.

Results — Cost to Meet Criteria

Estimated Annual Cost ($ in Millions)

Nurse aide	RN 24/7	RN	Total
$ 4,794	$ 610	$ 1,455	$ 6,860

CLA used the average hourly rates from Medicare cost reports to determine the costs to the industry for meeting the staffing minimum per requirement.

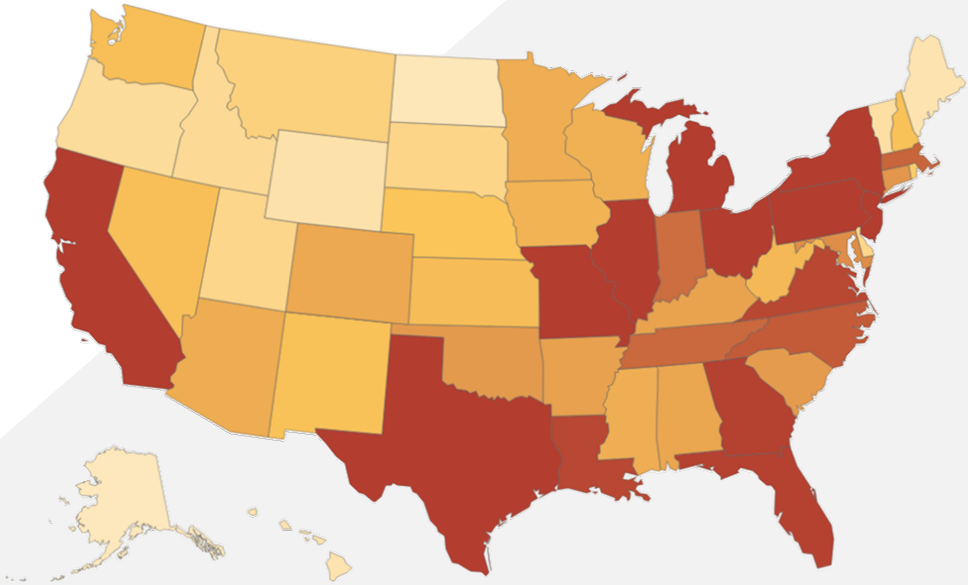
The estimated annual cost for facilities to meet both the nurse aide and RN HPRD requirement, as well as a 24/7 RN requirement, is $6.8 billion.

The cost estimate includes the analysis of the 24/7 RN first, followed by the incremental cost of adding additional RNs to meet the 0.55 HPRD RN criteria. The additional $1.46 million for RN HPRD assumes a portion of this criteria is met by the additional 24/7 coverage.

The estimated $6.8 billion annual cost exceeds the CMS estimated annual cost of $4 billion dollars primarily due to the fiscal year cost reports utilized in the calculation. CLA utilized the most currently available reports, including some FYE 2022 reports, which represent higher compensation costs than FY 2021.

Financial Impact at State Level

The overall workforce and financial impact of the staffing mandate varies by state. Certain states have more workforce challenges and will require the hiring of more FTEs to meet the mandate.



Results — Medicaid Occupancy Impact

Medicaid Payor Mix

	Nurse aide	RN 24/7	RN (0.55)	All
Facilities that met criteria	45%	54%	49%	43%
Facilities that did NOT meet criteria	58%	55%	61%	56%

Displayed in the table above, of facilities that met all three criteria, forty-three percent of their total days were Medicaid. Conversely, of the facilities that failed at least one of the requirements, fifty-six percent of their days were Medicaid. (Medicaid days and total days were obtained from Medicare cost reports, schedule S-3 Part I. Approximately 7% of cost reports did not have days reported and thus are excluded from the analysis.)

Requirements Met Based Upon Facility Medicaid Occupancy

Medicaid Occupancy Percent	Met 0 of 3 Requirements	Met 1 of 3 Requirements	Met 2 of 3 Requirements	Met 3 of 3 Requirements
Low < 49%	704 (19%)	1,294 (35%)	1,282 (34%)	454 (12%)
Mid 49 – 63%	1,357 (37%)	1,279 (35%)	875 (24%)	188 (5%)
Mid High 64 – 75%	1,576 (44%)	1,202 (33%)	679 (19%)	135 (4%)
High >= 76%	1,776 (49%)	1,088 (30%)	651 (18%)	128 (4%)

Results — Estimated FTEs to Meet Criteria

In order to meet both the nurse aide and RN hours per resident day criteria and the RN 24/7 coverage, facilities will need to hire an additional 80,077 nurse aides and 22,077 RNs for a total of 102,154 FTEs. If CMS only requires the RN 0.55 HPRD requirement, with no 24/7 RN coverage, a total of 19,880 RN's would be needed.

Nurse aide	RN 24/7	RN	Total
80,077	6,897	15,180	102,154

If the appropriate workforce is not available to fill these positions, facilities may need to reduce admissions or discharge current residents.

Results — Resident Impact

Nurse aide	RN 24/7	RN	All
908,758	839,844	84,536	1,109,779

Census Impacted if Facilities Met Mandate by Reducing Average Daily Census

Nurse aide	RN 24/7	RN	All
186,920	96,528	147,167	287,524

In the top table, we show the sum of the number of residents, or average daily census (ADC), in facilities that would not pass the staff mandate for the nurse aide and RN HPRD, in total for the HPRD, and for the RN 24/7 coverage. A total of 1.11 million residents are in facilities that do **NOT** meet at least one of the staffing criteria.

In order to provide care for these residents at the proposed hourly rates per patient day, either additional staff would need to be hired or census would have to be reduced. The bottom table shows the number of residents impacted if facilities reduced census by denying admissions to meet the mandate.

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Appendix

Staffing Mandate Analysis – Bed Size

Percent of Facilities Meeting Criteria by Certified Bed Size

	Nurse Aide	RN 24/7	RN 0.55	All
91+ Beds	21%	28%	41%	7%
76 - 90 Beds	28%	12%	51%	5%
46 - 75 Beds	36%	9%	63%	5%
31 - 45 Beds	50%	7%	82%	5%
0 - 30 Beds	67%	13%	93%	8%

Percent of Facilities Not Meeting Criteria by Certified Bed Size

	Nurse Aide	RN 24/7	RN 0.55	All
91+ Beds	79%	72%	59%	93%
76 - 90 Beds	72%	88%	49%	95%
46 - 75 Beds	64%	91%	37%	95%
31 - 45 Beds	50%	93%	18%	95%
0 - 30 Beds	33%	87%	7%	92%

Note: Puerto Rico and Guam were excluded from the analysis above.

CLA utilized the 2023 Q1 Care Compare file to determine bed count. As the number of providers in the Care Compare file differs from the number in PBJ, any providers not in Care Compare are not included in the table to the left.

The “All” columns identify facilities that either meet all three requirements or inversely, in the bottom table, missed at least one of the requirements.

Staffing Mandate Analysis – Urban vs Rural

	Nurse aide	RN 24/7	RN (0.55)	All
Facilities meeting criteria	3,551	2,724	6,715	763
Urban	2,608 (26%)	2,459 (24%)	4,939 (49%)	655 (7%)
Rural	943 (26%)	265 (7%)	1,776 (50%)	108 (3%)

	Nurse aide	RN 24/7	RN (0.55)	All
Facilities NOT meeting criteria	10,103	11,009	6,939	12,970
Urban	7,475 (74%)	7,681 (76%)	5,144 (51%)	9,485 (94%)
Rural	2,628 (74%)	3,328 (93%)	1,795 (50%)	3,485 (97%)

For purposes of this analysis, the urban and rural definitions are based on the CBSA designations as reported on the Medicare cost reports. The CBSA designations may differ from the US Census definition used in the proposed rule. Approximately 7% of facilities did not report this distinction, and thus are not included in the table above.

The “All” columns identify facilities that either meet all three requirements or inversely, in the bottom table, missed at least one of the requirements.

Note: Puerto Rico and Guam were excluded from the analysis above.
Variances from 100% in the percentages above are due to rounding.