National Rural Health Association

November 6, 2023

The Honorable Chiquita Brooks-LaSure
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

RE: CMS–3442–P; Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting.

Submitted electronically via regulations.gov.

Dear Administrator Brooks-LaSure,

The National Rural Health Association (NRHA) is pleased to offer comments on the Centers for Medicare and Medicaid Services' (CMS) proposed rule putting forth minimum staffing requirements for nursing facilities. We appreciate CMS' continued commitment to the needs of more than 60 million Americans that reside in rural areas and urge the agency to support these communities in the final rule.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, long-term care providers, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

II. Minimum Staffing Standards for Nursing Homes in Response to the Presidential Initiative.

NRHA urges CMS to rescind its minimum staffing standards proposals. If withdrawal of the policy is not possible, **CMS should exempt rural facilities from the requirements.** NRHA appreciates the Administration's strong interest in and commitment in improving patient safety and outcomes in nursing facilities, particularly following the COVID-19 pandemic. We agree that this is a worthwhile cause and is of utmost importance to our organization and its members. NRHA does not take poor patient outcomes and safety risks lightly. Nonetheless we believe the proposed staffing standards come at an inopportune time for the long-term care sector and will significantly impact rural access to these services.

Poor outcomes and quality cannot be fixed by imposing staffing mandates. In fact, nursing home closures are often unrelated to the quality of care provided considering that almost 40% of closures since 2020 were 4- or 5-star facilities.[1] In reality, minimum staffing standards are more likely to close a facility than improve outcomes, impacting already dire access in rural communities. **Between 2008 and 2018, 472 rural nursing homes shuttered resulting in 10.1% of rural counties becoming**

[1] AMERICAN HEALTH CARE ASSOCIATION, *Access to Care Report* (August 2023), https://www.ahcancal.org/News-and-Communications/Fact-Sheets/FactSheets/Access%20to%20Care%20Report%20August%202023.pdf.

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nursing home deserts.[2] Even prior to the pandemic rural nursing homes were struggling, and access was declining for rural residents. Those numbers have worsened during COVID-19 which hurt long-term care more than other health care sectors.[3]

The rural nursing home closure crisis has persisted.[4] This is especially the case in largely rural states such as Montana where 16% of the state's nursing homes closed in 2022.[5] During the same year in Iowa, 13 of 15 nursing home closures were in rural areas.[6] Similarly, two-thirds of nursing homes that closed in Texas between 2018 and 2022 served rural communities. South Dakota has experienced 17 nursing home closures since 2016.[7] One NRHA member, a health system serving the upper Midwest, saw 13 rural nursing homes close since December 2021.

A myriad of factors plays into the challenge of keeping rural nursing homes open and viable, most of which stem from workforce shortages. **NRHA stresses that implementing federal staffing mandates will not increase availability of interested and qualified workers where they do not exist.** Nationally, long-term care is experiencing the worst labor shortage, making now an inopportune time to propose staffing standards.[8] **CMS and the Administration must focus on curing the root cause – the supply of nurses – before imposing one-size-fits-all staffing mandates on nursing facilities.**

Another driver of rural nursing home instability is insufficient reimbursement, especially from Medicaid. In rural areas, Medicare and Medicaid are predominant payers given certain characteristics of rural residents. Medicaid is the primary payer for 62% of nursing home residents making adequate Medicaid payments paramount to nursing home financial viability.[9] Additionally, rural residents are

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[2] Sharma, et al., *Trends in Nursing Home Closures in Nonmetropolitan and Metropolitan Counties in the United States, 2008-2018*, RUPRI Center for Health Policy Analysis (Feb. 2021), 1 https://rupri.publichealth.uiowa.edu/publications/policybriefs/2021/Rural%20NH%20Closure.pdf.

[3] American Health Care Association, *Long Term Care Jobs Report*, 6 (Jan. 2023) https://www.ahcancal.org/News-and-Communications/Fact-Sheets/FactSheets/LTC-Jobs-Report-Jan2023.pdf.

[4] *See* Lauren Coleman-Lochner & Martin Braun, *Rural America Is Losing Nursing Homes, and Small Towns Are Reeling*, BLOOMBERG (Oct. 11, 2023) https://www.bloomberg.com/news/articles/2023-10-11/us-rural-nursing-homes-are-closing-hollowing-out-small-towns?utm_source=website&utm_medium=share&utm_campaign=email&leadSource=uverify%20wall#xj4y7vzkg.

[5] Tony Leys, *Wave of Rural Nursing Home Closures Grow Amid Staffing Crunch*, KAISER FAMILY FOUNDATION (Jan. 24, 2023) https://kffhealthnews.org/news/article/wave-of-rural-nursing-home-closures-grows-amid-staffing-crunch/.

[6] *Id.*

[7] South Dakota Association of Healthcare Organizations, *Nursing Home Closures*, SDAHO.org, https://sdaho.org/nh-closures/ (last visited Oct. 25, 2023).

[8] Alice Burns, et al., *What Share of Nursing Facilities Might Meet Proposed New Requirements for Nursing Staff Hours?*, KAISER FAMILY FOUNDATION (Sept. 18, 2023) https://www.kff.org/medicaid/issue-brief/what-share-of-nursing-facilities-might-meet-proposed-new-requirements-for-nursing-staff-hours/#:~:text=Among%20all%20nursing%20facilities%2C%20fewer,need%20to%20hire%20nursing%20staff ("As of June 2023, employment levels were still more than 11% below pre-pandemic levels for workers in skilled nursing care facilities."); AMERICAN HEALTH CARE ASSOCIATION, *supra* note 1.

[9] Priya Chidambaram, *A Look at Nursing Facility Characteristics Through July 2022*, KAISER FAMILY FOUNDATION (Aug. 24, 2022) https://www.kff.org/medicaid/issue-brief/a-look-at-nursing-facility-characteristics-through-july-2022/#:~:text=Deficiencies%20In%20Certified%20Nursing%20Facilities%2C%202015%2D2022&text=As%20of%20July%202022%2C%20Medicaid,%2Dpocket%2C%20etc.

more likely to be unemployed or work lower wage jobs and rely upon Medicaid.[10] In most cases, Medicaid payment rates are not sufficient to cover the cost of care,[11] which has an outsized impact on rural nursing homes. States with adequate Medicaid payment show a relationship to higher staffing rates.[12] For example, Alaska is projected to meet CMS' proposed standards across the state in all facilities, likely related to their favorable Medicaid rates for nursing facilities.[13] Further, rural populations are typically older, so Medicare is a dominant source of coverage. However, Medicare payment has not kept up with inflation and related cost pressures.[14]

NRHA urges CMS to look at the underlying causes of quality to address issues such as workforce retention and incentives, payment rates, regulatory burden, and financial stability rather than enacting federal staffing levels. Rural nursing homes need additional federal support, not unfunded mandates, to thrive and effectively serve their communities.

B. Provisions of the Proposed Regulations.

1. Nursing Services (§ 483.35).

a. Sufficient Staff (§ 483.35(a)(1)).

CMS proposes that all nursing facilities meet minimum quantitative standards of 0.55 hours per resident day (HPRD) for RNs and 2.45 HPRD for nurse aides. Nationally, estimates show that only 19% of nursing facilities would currently meet the minimum hours per resident day (HPRD) requirement and the remaining 81% would have to hire more registered nurses (RNs) or nurse aides.[15] Based on Payroll-Based Journal (PBJ) data, less than 25% of rural nursing homes would meet the proposed nurse aide staffing ratio. PBJ data also shows that as of 2022 less than 30% of rural nursing homes would meet the proposed RN ratio. CMS itself notes that both the 0.55 and 2.45 HPRD proposals are higher than any minimum staffing levels in place in all states. In addition, CMS' proposals go above and beyond the levels at which quality no longer increases according to the 2022 Nursing Home Staffing Study (2022 Study).[16]

Many NRHA members will not be able to meet the proposed staffing standards. One member noted that they would need to obtain additional staff under contract. However, contract labor rates are not sustainable for rural nursing homes. Although they have decreased since their peak during the COVID-19 pandemic, our member notes that contract rates in their area are about $66/hour for RNs, $59/hour for LPNs, and $36/hour for nurse aides. They estimate that the cost of meeting these

[10] Jack Hoadley, et al., *Medicaid in Small Towns and Rural America: A Lifeline for Children, Families, and Communities*, GEORGETOWN UNIVERSITY HEALTH POLICY INSTITUTE AND NORTH CAROLINA RURAL HEALTH RESEARCH PROGRAM, 1 (June 2017) https://ccf.georgetown.edu/wp-content/uploads/2017/06/Rural-health-final.pdf.
[11] MACPAC, Estimates of Medicaid Nursing Facility Payments Relative to Costs, 1 (Jan. 2023) https://www.macpac.gov/wp-content/uploads/2023/01/Estimates-of-Medicaid-Nursing-Facility-Payments-Relative-to-Costs-1-6-23.pdf.
[12] *Id.* at 9.
[13] Burns, *supra* note 8; Department of Health, State of Alaska, Current Medicaid Payment Rates, https://health.alaska.gov/Commissioner/Documents/RateReview/Rate-Memo-20230701.pdf.
[14] See NRHA's comments on the proposed fiscal years 2023 and 2024 Skilled Nursing Facility Prospective Payment System rule.
[15] Burns, *supra* note 8.
[16] Alan J. White & Lauren E.W. Oslo, *Nursing Home Staffing Study: Comprehensive Report*, Abt Associates (June 2023) https://edit.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf.

standards across their rural nursing homes in the state would exceed $7.5 million per year. That added cost would be untenable for this NRHA member.

Since CMS released its request for information on minimum staffing standards last summer **NRHA members have consistently voiced that mandated staffing levels will close rural nursing homes.** CMS' mission is to provide access to high quality care; however, instituting federal mandates that will close rural nursing homes and take away local access to post-acute care is detrimental to achieving this goal. While rural beneficiaries could seek care at another non-local facility, they may also opt to stay home because it is closer to their support system. Home-bound patients that are not receiving clinical care are less likely to get proper care, nutrition, and medication management, especially considering the lack of home- and community-based services for older adults in many rural areas. Leaving their local community may cause isolation or behavioral health conditions that lessen beneficiary quality of life. Rural beneficiaries and their families will face the difficult choice of moving further away from their community or forgoing care altogether. This does not serve to improve patient outcomes or quality.

In addition, the nurse aide HPRD ratio is unmanageable for rural nursing homes. There are many jobs available that pay the same as nurse aide positions, but do not require licensure or special training and are not as intensive or hands-on as a nurse aide role. Competing with other jobs drives up nurse aide salaries, which is an additional cost that rural nursing homes cannot bear. Further, nurse aides see some of the highest levels of turnover in nursing homes. Estimates of annual average nurse aide turnover rates range from 55% to 78%.[17] Turnover has many contributing factors, but the difficulty of the job relative to pay is one reason rural nursing homes have trouble recruiting and retaining an adequate nurse aide workforce.

The proposed staffing standards would be part of nursing home conditions of participation which are the basis for survey and certification activities. Nursing homes will be assessed for compliance through existing survey, certification, and enforcement activities. Nursing homes that do not comply with the proposed standards could face various penalties including termination of the provider agreement, denial of payments for all Medicare and Medicaid residents, and civil monetary penalties. The threat of these penalties may lead rural nursing homes to turn away residents to continue to meet the HPRD ratios, furthering access issues, or decide to close entirely.

Losing access to local long-term or post-acute care is unacceptable, but the ripple effects of minimum staffing standards go even further. The long-term care sector and patients will feel the direct effects of compliance, but other rural providers will experience eventual downstream effects. Across all hospitals, the average length of stay increased 19% altogether while the length of stay for patients being discharged for post-acute care providers increased 24%.[18] When nursing homes close, the rural crisis of lack of post-acute care beds worsens. Hospitals are then unable to discharge patients who no longer require inpatient level acute care but cannot safely return home. For Critical Access Hospitals (CAHs) delayed discharges are a particular issue because they are subject to an annual average length

[17] Ashvin Gandhi, Huizi Yu, & Daid Grabowski, *High Nursing Staff Turnover in Nursing Homes Offers Important Quality Information*, 40 HEALTH AFFAIRS 384, 384 (2021) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7992115/pdf/nihms-1680230.pdf; Katherine Kennedy, Robert Applebaum, & John Bowblis, *Facility-Level Factors Associated with CAN Turnover and Retention: Lessons for the Long-Term Services Industry*, 60 GERONTOLOGIST 1436, 1440 (2020) https://pubmed.ncbi.nlm.nih.gov/32726449/.

[18] AMERICAN HOSPITAL ASSOCIATION, *Issue Brief: Patients and Providers Faced with Increasing Delays in Timely Discharges*, 1 (Dec. 2022) https://www.aha.org/system/files/media/file/2022/12/Issue-Brief-Patients-and-Providers-Faced-with-Increasing-Delays-in-Timely-Discharges.pdf.

of stay of 96 hours.[19] This leads to hospitals facing the difficult choice of turning away admissions or transfers because of post-acute placement concerns. For beneficiaries, delayed discharge is associated with increased risk of mortality, hospital-acquired infections, behavioral health concerns, and reductions in patients' mobility and activities of daily living.[20] Additionally, lack of inpatient beds could lead to early discharges to the home which is not the ideal care setting and could ultimately result in worse patient outcomes and increased readmissions.

NRHA believes that leaving LPNs out of staffing standards unfairly disadvantages rural facilities. Recruiting and retaining professionals in rural areas is a persistent challenge across all provider types. NRHA members have expressed particular concern over hiring RNs, and this is heightened in nursing facilities. Nursing homes are the largest employer for LPNs[21] and they make up 13% of the entire nursing home workforce. Excluding LPNs from the HPRD ratios devalues their crucial role in nursing homes.

NRHA highlights that the 2022 CMS Study suggests that a total licensed nurse staffing threshold, as opposed to a separate LPN threshold, would support adequate levels of licensed nurse staffing while allowing for flexibility in staffing patterns.[22] CMS focuses its rationale on omitting LPNs from staffing standards on the 2022 Study's finding that LPNs do not have a significant positive relationship to quality and safety metrics.[23] Yet CMS leaves out the 2022 Study's suggestion that LPNs could be blended into a staffing standard with RNs to ensure clinical care is completed in a timely manner and to afford flexibility to facilities. Further, CMS ignores the 2022 Study's analysis that suggests staffing requirements that allow substitutions between RNs and LPNs will require fewer nursing homes to increase staffing than the separate requirements. Additionally, this analysis suggests that predicted quality outcomes would be only minimally higher for separate staffing levels compared to blended staffing levels.

If CMS moves to finalize the HPRD proposals, **NRHA suggests that LPNs be included in the RN requirement to allow more flexibility for rural facilities.** Based on information from the 2022 Study and the importance of LPNs in our members' facilities, CMS must consider this flexibility for rural nursing homes.

CMS is also seeking comments on a total nursing staffing standard. **NRHA strongly urges CMS against instituting an additional total nurse staffing standard of 3.48 HPRD.** As discussed, rural nursing homes will struggle to meet the separate levels proposed for RNs and nurse aides. CMS must not add another layer of standards on top of those proposed. Rural facilities must be exempt from a total nursing staff standard if CMS pursues this option.

b. Registered Nurse (§ 483.35(b)(1)).

In addition to the minimum HPRD for RNs and nurse aides, CMS proposes that nursing homes have an RN onsite 24/7. **NRHA does not support the 24/7 RN onsite proposed mandate.** Much like the

[19] 42 C.F.R. § 485.620(b).
[20] Antonio Rojas-Garcia, et al., *Impact and experiences of delayed discharge: A mixed-studies systematic review*, 21 HEALTH EXPECTATIONS 41, 53 (Feb. 2018) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5750749/.
[21] BUREAU OF LABOR STATISTICS, *Licensed Practical and Licensed Vocational Nurses*, Occupational Outlook Handbook, bls.gov, https://www.bls.gov/ooh/healthcare/licensed-practical-and-licensed-vocational-nurses.htm.
[22] White & Oslo, *supra* note 16 at 140.
[23] *Id.*

HPRD requirements, NRHA members have expressed that this will be tremendously difficult for their nursing home to comply with and will be extremely costly. One NRHA member in Louisiana calculated that it would cost at least an estimated $250,000 per year for their facility alone to have an RN onsite 24/7. Even if they are able to recruit and retain RNs, many small, rural nursing homes could not afford the additional cost.

Recruiting and retaining RNs in nursing homes is difficult across the board, but it is worse in rural facilities. Nationally, RNs employed in SNFs are paid about $10,000 to $15,000 less on average than RNs employed in other common health care settings such as hospitals, outpatient departments, and physicians' offices.[24] When examining metropolitan and nonmetropolitan RN salaries, RNs working in nonmetropolitan areas generally have a lower average and median salary than those in metropolitan statistical areas (MSAs).[25] Many nursing homes have increased pay and offered bonuses to attract staff but rural facilities are disadvantaged as they operate on thinner margins and have less flexibility increase wages or offer additional benefits.[26] Lower salaries for rural RNs on average, coupled with lower salaries in nursing homes, makes recruiting at rural nursing homes an almost insurmountable challenge. One NRHA member in Missouri notes that 65% of their open nursing positions are in their nursing homes, meanwhile only 20% of candidates are willing to work in this setting over the affiliated hospital.

Further, RNs in nursing homes deal with more complex and higher acuity caseloads. Residents in rural nursing homes are generally more complicated patients because, on average, rural Americans are older, sicker, and poorer with more chronic conditions and comorbidities. Challenging caseloads more frequently lead to staff burnout and retainment issues. At the facility levels, fewer staff results in difficulty taking time off and overtime pay, which means higher staffing costs for facilities.

NRHA urges CMS to rescind the 24/7 RN proposal entirely. However, an alternate policy for rural nursing homes is to allow an RN to be "available" 24/7. There is precedent for this type of policy in Rural Emergency Hospital (REH) and CAH conditions of participation because it creates much needed flexibility for rural providers that CMS has acknowledged have more difficulties with staffing than urban providers. For example, physicians must be present at an REH for sufficient periods of time to provide medical direction but may be available through radio or telephone communication or electronic communication.[27] Physicians and non-physician practitioners at CAHs must be on call or immediately available by phone or radio within thirty minutes on a 24/7 basis.[28] **CMS should look to these conditions of participation as an alternative to the 24/7 RN onsite proposal.**

CMS could consider another flexibility for the 24/7 RN proposal. SNFs must have an RN serving full time as Director of Nursing (DON). While the DON is on duty, they should count towards the 24/7 requirement. Currently, the DON can serve as charge nurse only if a facility has an average daily occupancy of 60 or fewer. The average daily occupancy can also be used as a guardrail here to ensure

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[24] BUREAU OF LABOR STATISTICS, *Occupational Employment and Wage Statistics, Registered Nurses*, bls.gov, https://www.bls.gov/oes/current/oes291141.htm.

[25] *See* BUREAU OF LABOR STATISTICS, *Occupational Employment and Wage Statistics, May 2022 Metropolitan and Nonmetropolitan Area Occupational Employment and Wage Estimates*, bls.gov, https://www.bls.gov/oes/current/oessrcma.htm.

[26] AMERICAN HEALTH CARE ASSOCIATION, *State of the Nursing Home Sector*, https://www.ahcancal.org/News-and-Communications/Fact-Sheets/FactSheets/State-of-Nursing-Homes-Infographic.pdf

[27] 42 C.F.R. § 485.528(c).

[28] 42 C.F.R. § 485.618(d).

that only the neediest facilities are utilizing this flexibility rather than allowing it across the board for all nursing homes.

3. Hardship Exemption from the Minimum Hours Per Resident Day Requirements for RNs and NAs.

CMS proposes to allow facilities to apply for a hardship exemption to the staffing levels for RNs and nurse aides, but not the 24/7 RN onsite requirement. To receive an exemption, nursing homes would be required to either meet a distance requirement or low provider-to-population ratio, demonstrate a good faith effort to hire, and document a financial commitment to hiring. Nursing homes would be ineligible if they were cited for insufficient staffing with resultant harm, are designated as a Special Focus Facility, or failed to submit PBJ data. NRHA applauds CMS for recognizing the challenges for rural nursing homes in meeting the staffing levels and for proposing an exemption process. However, **we ask that CMS exempt all rural facilities from the HPRD staffing levels.** We emphasize again that the vast majority of rural nursing homes will not be able to comply with the proposed staffing levels, even with a longer timeframe for implementation, discussed below.

Further, NRHA is concerned that the eligibility requirements will not capture all rural nursing facilities deserving of an exemption. CMS should change the mileage requirement from 20 miles to 15 miles. We believe that this will capture a more accurate group of nursing homes that would benefit from the exemption. According to CMS' analysis, this would include 852 nursing homes, or just 5.6% of all facilities. CMS' 20-mile proposal includes only 2.8% of all nursing homes.

We also urge CMS to remove the provider-to-population eligiblity requirement and allow any nursing home without another facility within 15 miles to qualify. Some rural nursing homes are near or part of a rural hospital or other health care facility which artificially increases the provider-to-population ratio for the nursing workforce despite the fact that these facilities are likely competing for limited staff. Depending on how CMS calculates the ratio, it could impact the provider-to-population ratio compared to national average. This measure for eligibility will cut out nursing homes that would otherwise be deserving of this exemption. Further, when rural nursing homes compete with hospitals for RNs and other nursing staff, they must increase salaries because hospitals often have higher compensation and better benefits, which will drive up costs. Nursing homes located near other health care facilities should not be excluded from this exemption or made to offer untenable salaries to meet staffing levels for nurses because the provider-to-population ratio in the area appears average.

4. Implementation Timeframe.

CMS proposes three implementation phases to avoid unintended consequences to beneficiary care while a nursing home develops policies and procedures to comply with the proposals. Specifically, rural facilities must comply with the minimum staffing levels within 5 years and the 24/7 RN requirement within 3 years after publication of the final rule.

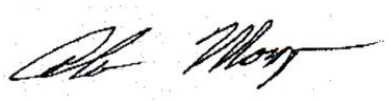
NRHA thanks CMS for considering the capacity of rural nursing facilities to comply with the proposed standards by permitting extended compliance. However, our concerns with the implementation timeframe are twofold. First, even with a longer timeline for compliance, we do not believe rural facilities will be in a place to meet the standards due to historic staffing shortages. Rural nursing homes have higher turnover rates and rural areas lack interested or qualified candidates to fill nursing roles.

Second, CMS proposes to use the Census Bureau definition of rural which is an extremely limiting definition. **Many rural nursing homes will not qualify for the extended compliance timeline under this definition.** In 2022 the Census Bureau made significant changes to the definition of rural, which now includes only areas with a population of less than 5,000. This does not accurately represent rural areas nationwide and excludes a significant number of areas that fall under other federal or state definitions of rural.

As such, **NRHA urges CMS to use the Office of Management and Budget (OMB) definition of rural which has a more accurate portrayal of rural America.** This would include areas with a population of less than 50,000 and this aligns with the retired Census definition and the definition used in other health-related statutes and regulations. If CMS uses the Census definition of rural, many deserving rural facilities will have to comply within a shorter and impracticable timeframe. **We urge CMS against finalizing the use of this definition and to instead adopt the OMB definition.**

Thank you for the opportunity to respond to this proposed rule and for consideration of our comment. We look forward to continuing our work together to ensure access to quality care for rural beneficiaries. If you have any questions, please contact NRHA's Regulatory Affairs Manager, Alexa McKinley, at amckinley@ruralhealth.us.

Sincerely,



Alan Morgan
Chief Executive Officer
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