



June 8, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G Washington, DC 20201

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

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 for the Medicare Prospective Payment System (PPS) and Consolidated Billing for Skilled Nursing Facilities (SNF) for fiscal year (FY) 2023. We appreciate CMS' continued commitment to the needs of the more than 60 million Americans that reside in rural areas, and we look forward to our continued collaboration to improve health care access throughout rural America.

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.

III. Proposed SNF PPS Rate Setting Methodology and FY 2023 Update

Payment Rate Update

In this rule, CMS proposes to update payment rates by 3.9%. However, when combined with the proposed parity adjustment of 4.6%, this translates to a net decrease of 0.9%, or roughly \$320 million in payment cuts to SNFs. For rural facilities, this decrease is even larger at 1%. **NRHA strongly opposes this decrease, especially as rural facilities are still struggling in the wake of the COVID-19 pandemic and cannot sustain such payment cuts.**

NRHA believes that the SNF payment update should be adjusted to match inflation. The decrease is incongruous with this time of high inflation, fuel costs that impact every aspect of the

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economy,¹ staffing shortages, and supply chain issues. Payments to SNFs must match inflation and provide adequate resources so that facilities can stay afloat in a time of economic uncertainty.

Over 10% of rural counties are nursing home deserts,² with SNFs in rural areas across the country closing at unprecedented rates. Prior to the pandemic, 400 rural counties experienced at least one nursing home closure from 2008-2018.³ COVID-19 only exacerbated the vulnerability of these critical access points for rural beneficiaries. Drastic payment cuts to SNFs must be viewed in the context of the COVID-19 pandemic. The federal government's Public Health Emergency (PHE) has been effectively extended until at least October 18, 2022, and on the ground, health care settings are still reeling from the effects of COVID-19. Rural areas have been hit disproportionately hard by COVID-19 and need the federal government's continued support and funding, not payment cuts.⁴ Payment cuts during this time are inappropriate and will intensify the impact of COVID-19 on SNFs in rural areas across the country.

Payment Driven Payment Model (PDPM) Proposed Parity Adjustment

NRHA recognizes that by not finalizing the adjustment in FY 2022, CMS provided a one-year delay in implementation of the parity adjustment, which provided needed temporary relief.⁵ However, even with the delay, the parity adjustment is detrimental to SNFs. NRHA understands that the transition to PDPM must be done in a budget-neutral manner, and thus far its costs have exceeded those of the prior model. Nevertheless, the budget-neutral implementation should not be limited to one year given the precarious situation and closures many rural SNF are facing. To offset major reductions in payments to SNFs, **CMS must consider a phase-in approach for the parity adjustment.** A budget neutral outcome can still be achieved through a phase-in approach, while lessening the impact on rural SNFs.

NRHA believes that the PDPM proposed parity adjustment must be phased in. NRHA urges CMS to consider the challenges that rural facilities will face due to this one-time adjustment. Applying the full 4.6% against the FY 2023 payment rate results in dangerously reduced funding to SNFs that could be mitigated by spreading the adjustment over time. **Specifically, NRHA proposes the parity adjustment be phased in over a period of 3 years to lessen the burden on small and rural SNFs.** CMS must proceed thoughtfully by considering that the pandemic is not over for facilities. With many rural facilities facing closure concerns, a 4.6% parity adjustment is ill-timed and threatens their viability. In addition, CMS may consider another one-year delay to monitor the progress of the COVID-19 pandemic and its effects on SNFs. If rural SNFs have another year to

¹ Olivia Rockeman, *U.S. Inflation Hit Fresh 40-Year High of 7.9% Before Oil Spike*, Bloomberg (Mar. 10, 2022), <https://www.bloomberg.com/news/articles/2022-03-10/u-s-inflation-hits-fresh-40-year-high-of-7-9-before-oil-spike>.

² Sharma, et al., *Trends in Nursing Home Closures in Nonmetropolitan and Metropolitan Counties in the United States, 2008-2018*, RUPRI CENTER FOR RURAL HEALTH POLICY ANALYSIS (Feb. 2021), 1 <https://rupri.public-health.uiowa.edu/publications/policybriefs/2021/Rural%20NH%20Closure.pdf>.

³ Sharma, et al., *supra* note 2.

⁴ Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities Proposed Rule. 87 Fed. Reg. 22720, 22734 (Apr. 15, 2022) (to be codified at 42 C.F.R. pt. 413) ("Additionally, a few commenters from rural areas stated that their facilities were heavily impacted from the additional costs, particularly the need to raise wages, and that this could affect patients' access to care.").

⁵ 87 Fed. Reg. at 22743.

adjust to COVID-19 related changes and costs, coupled with a phased-in parity adjustment, may have a less dire impact.

Wage Index Adjustment

NRHA applauds CMS' proposal to limit any decreases to a SNF's wage index to 5% from the previous year's wage index. Ensuring that SNFs are not subject to Medicare payment volatility provides predictability and financial stability, which are incredibly important for rural SNFs.

VIII. Request for Information: Revising the Requirements for Long-Term Care (LTC) Facilities to Establish Minimum Staffing Levels

In this request for information, CMS is soliciting input to help guide its future rulemaking on minimum staffing levels in long-term care facilities, or nursing homes. NRHA appreciates the impact that appropriate staffing levels have on nursing home resident outcomes. Nonetheless, rural nursing homes are historically understaffed, and this problem is even more acute given current workforce shortages facing rural communities.

NRHA has significant concerns about the federal implementation of nursing home minimum staffing requirements. Introducing a staffing mandate will not create new workers where there is no funding to support the proposal. The rural nursing home industry is in the midst of a staffing crisis and qualified, interest workers do not exist in many rural counties. Imposing strict staffing requirements could threaten to close much-needed nursing homes in rural communities, further exacerbating existing nursing home deserts and harming our rural seniors who need care.

Rural areas have fewer home- and community-based alternatives for residents, thus nursing homes are vital access points in these communities.⁶ Nursing homes grow even more crucial as the rural population ages rapidly. Approximately 10.1% of all nonmetropolitan counties are considered nursing home deserts, compared to 3.7% of metropolitan counties.⁷ As noted above, between 2008 and 2018, 10.4% of all rural nursing home facilities closed. For example, the South Dakota Health Care Association notes that 10% of all South Dakota nursing homes closed in the past five years.⁸ These figures will only grow if rural nursing homes are forced to comply with unfunded minimum federal staffing mandates and negative payment updates. **If CMS adopts minimum staffing standards, the mandate cannot go unfunded.** Imposing staffing requirements does not create workers or enhance quality. On the contrary, such a mandate would further harm rural nursing homes that are grappling with a workforce crisis, worsened by the COVID-19 pandemic.

Thank you for the chance to offer comments on this proposed rule and for your consideration of our comments. We very much look forward to continuing our work together to ensure our mutual goal of improving quality and access to care. If you would like additional information, please contact Alexa McKinley at amckinley@ruralhealth.us or 202-639-0550.

⁶ Sharma et al., *supra* note 2, at 7.

⁷ *Id.* at 1.

⁸ Eric Mayer, *SD Health Care Association: 10% of nursing homes have closed in the past five years*, Keloland (May 18, 2022), <https://www.keloland.com/news/local-news/sd-health-care-association-10-of-nursing-homes-have-closed-in-past-5-years/#:~:text=The%20South%20Dakota%20Health%20Care,%2C%20Tripp%2C%20Bryant%20and%20Rosholt.>



Sincerely,

A handwritten signature in black ink, appearing to read "Alan Morgan", is written over a light gray, textured rectangular background.

Alan Morgan
Chief Executive Officer
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Attachment: Response to Nursing Home Minimum Staffing Requirements RFI

Workforce-Related Questions

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

NRHA is deeply concerned with the ability of rural nursing homes to recruit and retain nursing staff. Rural areas have historically faced challenges in recruiting health care professionals. Caseloads are more difficult considering that the average rural American is older, sicker, and poorer. Fewer health care professionals in rural areas leads to difficulty taking time off and overtime pay, meaning higher costs for facilities.⁹ Health care professionals may have concerns with working in rural areas, including travel and commute times, professional isolation, and family considerations.¹⁰

The rurality of nursing homes compounds other challenges that exist nationwide, such as high turnover rates due to low wages and a lack of interested or qualified candidates. Rural nursing homes cannot offer enticing incentives compared to urban or metropolitan facilities.¹¹ For example, wages are low in nursing homes compared to other health care settings. A registered nurse (RN) at a nursing home has an average salary of about \$72,000. For rural nursing homes, this figure is even lower.¹² Their counterparts at hospitals have an average salary of about \$10,000 more.¹³ It is difficult to recruit and retain interested and qualified staff when there are higher paying options in other industries and geographic locations. Every problem that an average nursing home faces in staffing is intensified in rural areas.

As CMS notes in its request for information, the COVID-19 Public Health Emergency has highlighted and intensified concerns about inadequate nursing home staffing. COVID-19 specific challenges like vaccine mandates at facilities and fear of contracting the virus are additional hurdles to hiring.¹⁴ The nursing home industry has struggled during pandemic economic recovery more than any other

⁹ RURAL HEALTH INFORMATION HUB, *Recruitment and Retention for Rural Health Facilities* (Feb. 3, 2022), <https://www.ruralhealthinfo.org/topics/rural-health-recruitment-retention>.

¹⁰ *Id.*

¹¹ AMERICAN HEALTH CARE ASSOCIATION AND NATIONAL CENTER FOR ASSISTED LIVING. *State of the Long Term Care Industry*. (Sept. 2021), <https://www.ahcancal.org/News-and-Communications/Fact-Sheets/FactSheets/Workforce-Survey-September2021.pdf>; Coates, et al., *Toward a Sustainable and Diversified Rural Health Workforce*, NATIONAL RURAL HEALTH ASSOCIATION (Feb. 2022), https://www.ruralhealth.us/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/NRHA-Toward-a-Sustainable-Rural-Health-Workforce-Policy-Brief-2022.pdf.

¹² For registered nurses specifically, see Janice C. Probst, Selina Hunt McKinney, and Cassie Odahowski, *Rural Registered Nurses: Educational Preparation, Workplace, and Salary*, UNIVERSITY OF SOUTH CAROLINA, RURAL AND MINORITY RESEARCH CENTER (Oct. 2019), 11 https://www.sc.edu/study/colleges_schools/public_health/research/research_centers/sc_rural_health_research_center/documents/ruralregisterednurses.pdf#page=11.

¹³ BUREAU OF LABOR STATISTICS, *Occupational Employment and Wages, May 2021* (Mar. 2022), <https://www.bls.gov/oes/current/oes291141.htm>.

¹⁴ *Id.*

health care industry.¹⁵ **CMS must consider the pandemic's effects as they pertain to factors that impact a facility's hiring abilities.** As of March 20, 2022, 28% of nursing facilities across the country reported staffing shortages in at least one area (out of the categories of aides, nursing staff, other staff, and clinical staff).¹⁶ In eight states, at least half of facilities reported such a shortage.¹⁷ According to data from the Bureau of Labor Statistics, nursing homes lost 241,000 employees between February 2020 and March 2022.¹⁸ This loss is on top of the 14% decrease in staffing between 2010 and 2020. When compared against other health care sectors, the nursing home industry has lost the most employees during the pandemic with a decrease of 15.2% in employment from February 2020 to March 2022.¹⁹ The worst shortages are in nursing staff – RNs, licensed practical nurses (LPNs), and certified nurse aides (CNAs). During this nursing home staffing crisis and pandemic, it would be difficult for facilities to comply with new regulations.

CMS references research that shows nursing home staffing remained steady over the course of the pandemic.²⁰ However, this contrasts with what nursing homes are experiencing on the ground. Across the board, nursing homes are asking employees to work overtime to take on extra shifts due to staffing shortages.²¹ Absences due to COVID-19 infections among staff coupled with staff shortages have strangled nursing homes, particularly in rural areas.²² Nursing homes have indicated that, as of the fall of 2021, their ability to hire new staff is very difficult.²³ Worse yet, 78% of nursing homes reported that they were concerned about potentially closing due to staff shortages.²⁴ Throughout the pandemic, 2022 has proved to be the worst year for nursing home staff shortages, with nurses making up the biggest missing piece of staff.²⁵ **The nursing home industry is facing a workforce crisis, worsened by COVID-19, and NRHA urges CMS to reconsider its future rulemaking on minimum staffing requirements at this time.** If CMS moves forward with minimum staffing requirements, NRHA recommends that CMS take steps to mitigate the impact on rural and small nursing homes by considering the policy options described herein.

¹⁵ Lenny Bernstein and Andrew van Dam, *Nursing home staff shortages are worsening problems at overwhelmed hospitals*, Washington Post (Dec. 28, 2021), <https://www.washingtonpost.com/health/2021/12/28/nursing-home-hospital-staff-shortages/>.

¹⁶ KAISER FAMILY FOUNDATION, *Nursing Facility Staffing Shortages During the COVID-19 Pandemic* (Apr. 2022), <https://www.kff.org/coronavirus-covid-19/issue-brief/nursing-facility-staffing-shortages-during-the-covid-19-pandemic/>.

¹⁷ *Id.*

¹⁸ BUREAU OF LABOR STATISTICS, *Occupational Employment and Wages, January 2020 - March 2022*, (Mar. 2022).

¹⁹ BUREAU OF LABOR STATISTICS, *Occupational Employment and Wage Data, February 2020 – March 2022*, (Mar. 2022).

²⁰ 87 Fed. Reg. at 22793.

²¹ American Health Care Association, *supra* note 11 at 4.

²² Rhitu Chatterjee, *The pandemic pummeled long-term care – it may not recover quickly, experts warn*, NPR (Feb. 22, 2022), <https://www.npr.org/sections/health-shots/2022/02/22/1081901906/the-pandemic-pummeled-long-term-care-it-may-not-recover-quickly-experts-warn>; Bart Pfankuch, *Pending closure and poor care at Ipswich nursing home latest outcomes of staffing crisis*, Keloland (Apr. 17, 2022), <https://www.keloland.com/news/local-news/pending-closure-and-poor-care-at-ipswich-nursing-home-latest-outcomes-of-staffing-crisis/?ipid=promo-link-block2>.

²³ American Health Care Association, *supra* note 11 at 5.

²⁴ *Id.* at 7.

²⁵ Stephen Anderson, *States Hardest Hit by Long-Term Care Staff Shortage*, Seniorly (Apr. 15, 2022), <https://www.seniorly.com/resource-center/seniorly-news/states-hardest-hit-by-long-term-care-staffing-shortage>.

7. How should nursing staff turnover be considered in establishing a staffing standard? How should CMS consider the use of short-term (that is, traveling or agency) nurses?

Short-term, traveling nurses fill in critical gaps in care. **Considering the staffing crisis in nursing homes, NRHA supports any method to ensure appropriate staff levels are met with minimal burdens to rural nursing homes.** In order to maximize a rural facility's ability to meet minimum staffing levels, travel nurses and other short-term nurses should be included in a facility's staff count, without penalties related to turnover. Short-term nurses perform the same duties as permanent RNs. Therefore, short-term nurses should not be differentiated from other permanent nurses for minimum staff count purposes and should not count towards nursing staff turnover.

16. Does geographic disparity in workforce numbers make a minimum staffing requirement challenging in rural and underserved areas? If yes, how can that be mitigated?

NRHA strongly believes that a one-size-fits-all approach to staffing levels is not appropriate. Rural nursing homes are not equipped to comply with minimum staffing requirements. If requirements are adopted, CMS can mitigate the challenges that rural nursing homes would face under these requirements by: (1) implementing graduated licensed nurse requirements based upon facility size or number of beds; (2) allowing LPNs and RNs to count towards the same staffing levels; (3) not adopting a minimum hours per resident day measurement or minimum CNA levels; and (4) imposing modified 24/7 RN requirements on rural facilities, including an on-call provision.

One of NRHA's main priorities is reducing the rural health care workforce shortage.²⁶ Rural areas struggle to recruit and retain an adequate health care workforce. Provider-to-population ratios in rural areas are much lower than in urban areas, despite higher need for health care services due to rural Americans being older, sicker, and suffering from more chronic conditions. On top of this historic struggle with rural workforce shortages, nursing homes have high intensity patient loads and are comparatively low paying settings, notably for RNs.²⁷

To mitigate recruitment and retention struggles in rural nursing homes, CMS should create a waiver or exemption process. CMS currently grants one-year waivers to rural health clinics that are unable to hire a physician assistant, nurse practitioner, or certified nurse midwife to comply with the 50% mid-level practitioner on-site requirement.²⁸ NRHA advocates for a similar waiver to be adopted for nursing homes. CMS should allow nursing homes that document their concerted hiring efforts, but fail to successfully hire, to apply for a waiver or exemption from the minimum staffing regulations. There is precedent for this policy in other CMS programs and it must be implemented here to help rural facilities.

Measuring Minimum Staffing Levels

8. What fields and professions should be considered to count towards a minimum staffing requirement? Should RNs, LPNs/LVAs and CNAs be grouped together under a single nursing care

²⁶ Coates, et al., *supra* note 11.

²⁷ Probst, *supra* note 12.

²⁸ CENTERS FOR MEDICARE AND MEDICAID SERVICES, *Rural Health Clinics* (Dec. 2021), <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/RHCs>.

expectation? How or when should they be separated out? Should mental health workers be counted as direct care staff?

To effectively balance staffing hardships faced by rural nursing homes and positive patient outcomes, nursing positions should be grouped together in order to reach a required staffing level. Grouping must be done in a way that provides flexibility depending upon a nursing home's size and capabilities. This would greatly alleviate rural facilities that cannot recruit and retain staff in the same manner as their urban counterparts. Further, grouping jobs like RNs and LPNs together should be done on a facility-size basis so that rural or smaller nursing homes may fill requirements with multiple occupations while larger or urban facilities must fill a requirement with a RN. There is precedent for this type of flexibility in other CMS programs, namely for critical access hospitals (CAH). CAH conditions of participation allow for a nurse practitioner or physician assistant to furnish services in the same manner as physician, which allows for a CAH to run efficiently and still care for patients with a smaller staff.²⁹

NRHA thanks CMS for acknowledging and referencing RN shortages in its request for information. Considering this information, it is especially important that occupations are grouped together to help certain nursing homes reach any potential staffing requirements. CMS notes that between 2019 and 2020, RNs working in nursing homes decreased from 151,300 to 143,250. There is additional BLS data from May 2021 showing that this number decreased further to 131,320.³⁰ Since 2019, nursing homes have become the least popular employment industry for RNs.³¹

On the other hand, nursing homes are the highest employment industry for LPNs. While shortages may still exist, LPNs outnumber RNs in the industry and LPNs earn similar wages in nursing homes when compared to other settings, like hospitals.³² Allowing LPNs and RNs to fill some of the same requirements for staffing levels is practical for smaller and rural facilities. This grouping would also reflect current employment trends in the nursing home industry.

Some state level staffing standards are illustrative. Kansas blends RNs and LPNs for the requirement that a nurse be on duty twenty-four hours a day, seven days a week. Kansas also requires that there be at least one nurse, RN or LPN, for each nursing unit. This model for grouping professions provides flexibility while ensuring that care is available for residents. Meanwhile, nursing homes with more available staff can feel free to practice higher standards individually and not group jobs together. CMS may also consider restricting job groupings for larger nursing homes.

Most states require that nursing homes employ a full-time director of nursing. NRHA looks to states, like South Carolina, that allow a director of nursing to count towards the licensed staff or RN requirements when a facility has a low number of beds.³³ If CMS implements a director of nursing requirement, it must allow for this kind of overlap in jobs for low volume nursing homes.

²⁹ 42 C.F.R. § 485.631(a)(4) ("A doctor of medicine or osteopathy, nurse practitioner, clinical nurse specialist, or physician assistant is available to furnish patient care services at all times the CAH operates.").

³⁰ BUREAU OF LABOR STATISTICS, *Occupational Employment and Wages, May 2021* (Mar. 2022), <https://www.bls.gov/oes/current/oes291141.htm>.

³¹ *Id.* (Out of the categories of hospitals, physicians' offices, home health care services, outpatient care centers).

³² BUREAU OF LABOR STATISTICS, *Occupational Employment and Wages, May 2019* (Mar. 2022), <https://www.bls.gov/oes/2019/may/oes292061.htm>.

³³ 61-17 S.C. Reg. § 605.A.1-2.

10. What should a minimum staffing requirement look like, that is, how should it be measured? Should there be some combination of options?

NRHA believes that a one-size-fits-all approach is not appropriate for determining minimum staffing levels. Characteristics of nursing homes differ, especially between urban and rural facilities. These characteristics must be considered if minimum staffing requirements are developed. Otherwise, rural nursing homes could face unfair sanctions or closures because they cannot meet minimum staffing requirements. CMS cannot successfully regulate staffing levels at the federal level unless much thought is given to small, isolated nursing homes and such regulations account for rural facilities' resources, sizes, and capabilities.

Each state maintains varying minimum staffing regulations, evidencing NRHA's belief that all facilities should not be treated the same. States that have adopted different staffing levels depending upon size and facility needs provide helpful examples of steps that CMS should take if minimum staffing requirements are developed. Pennsylvania's minimum staffing regulation serves as an excellent model, with graduated levels of licensed nurses (RNs and LPNs) on duty based upon the number of residents and time of day.³⁴ Idaho follows a similar model requiring one RN during day shifts and one RN or LPN for both evening and night shifts when a nursing home has up to fifty-nine beds.³⁵ These regulations ensure that small and rural facilities can comply in a way that makes sense given the facilities' resources and characteristics.

Additionally, most state regulations call for a minimum number of hours per resident day in addition to nursing staff requirements.³⁶ CMS issued a study in 2001 recommending that the minimum hours per resident day should be 4.1, including 0.75 RN hours, 0.55 LPN hours, and 2.8 CNA hours.³⁷ Only D.C. has adopted this high standard by law, likely because it is unrealistic for many communities.³⁸ While nursing homes may strive to meet this standard individually, it is unattainable for many rural nursing homes and should not be adopted at the federal level. The largest fraction of hours per resident day is typically CNA time. CNA turnover is a major pain point in the health care industry, especially in nursing homes. A federal mandate for hours per resident day or CNA numbers would be extremely hard for nursing homes to comply with because of high turnover. Nursing homes would struggle to meet direct care hours or other CNA measurements because of the revolving door of CNAs. Hours per resident day is a helpful measure to examine nursing home outcomes, however, it is not suitable for widespread implementation through federal regulations.

³⁴ 28 PA. CODE § 211.12(f)(1).

³⁵ IDAHO ADMIN. CODE r.16.03.02.200.

³⁶ See THE NATIONAL CONSUMER VOICE FOR LONG TERM CARE, *State Nursing Home Staffing Standards*, https://theconsumervoice.org/uploads/files/issues/CV_StaffingReport.pdf ("The following eighteen states have no direct care minimum requirement: Alaska, Alabama, Hawaii, Indiana, Kentucky, Missouri, Montana, North Carolina, North Dakota, Nebraska, New Hampshire, Nevada, Oregon, South Carolina, South Dakota, Texas, Utah, and Virginia").

³⁷ Marvin Feuerberg, *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*, CENTERS FOR MEDICARE AND MEDICAID SERVICES (Dec. 2001), 15 https://www.justice.gov/sites/default/files/elderjustice/legacy/2015/07/12/Appropriateness_of_Minimum_Nurse_Staffing_Ratios_in_Nursing_Homes.pdf

³⁸ CONSUMER VOICE, *supra* note 36, at 5.

14. *The IOM recommended in several reports that we require the presence of at least one RN within every facility at all times. Should CMS concurrently require the presence of an RN 24 hours a day 7 days a week? We also invite comment on the costs and benefits of a mandatory 24-hour RN presence, including savings from resident outcomes, as well as any unintended consequences of implementing this requirement.*

NRHA strongly opposes a 24/7 RN requirement for rural nursing homes. CMS must not burden small, rural facilities with a concurrent staffing requirement. Rural nursing homes do not have the bandwidth to have an RN onsite 24/7 due to workforce shortage concerns. Most state regulations with a 24/7 RN requirement relieve nursing homes of a certain size from maintaining a 24/7 RN.³⁹ CMS should consider alternatives to a 24/7 RN presence in the case of rural nursing homes.

NRHA supports the adoption of exceptions or modifications for the 24/7 RN requirement for rural nursing homes. CMS can look to other state and federal precedents in this regard. Many states have less burdensome regulations for low volume facilities. Some states allow an LPN, rather than an RN, to be onsite 24/7.⁴⁰ Other states add that when an LPN is on duty without an RN, an RN must be on-call and within a certain distance of the facility.⁴¹ CMS may also look to precedent set in CAH regulations in the emergency services context, which use a similar policy.⁴² Generally, a doctor, physician assistant, or nurse practitioner must be available by telephone, within a 30- or 60-minute distance, if they are not on-site. CAHs also allow for flexibility in that a physician, nurse practitioner, clinical nurse specialist, *or* physician assistant must be present at all times.⁴³ Translated to the nursing home context, the 24/7 requirement could mimic these regulations and allow an LPN or RN to be on-site 24/7, with a RN on-call within a 30-minute distance if only an LPN is on-site.

NRHA urges CMS to consider less costly and restrictive safeguards that would nonetheless achieve the same outcomes of ensuring patient safety and positive outcomes. If CMS moves forward with a 24/7 RN requirement for all nursing homes, it would be detrimental, especially to rural facilities. CMS must carve out an exception to this rule for rural nursing homes and facilities unable to retain enough RNs.

³⁹ *Id.*

⁴⁰ *See id.* (AR, CA, DC, FL, GA, HI, ID, IN, KS, KY, LA, MA, ME, MI, NC, ND, NE, NH, NM, NV, NY, OK, OR, SC, SD TN, TX, UT, VT WA, WV, and WY allow the flexibility of an RN *or* LPN to be on duty during any shift or during evening and night shifts).

⁴¹ *See id.* (KS, KY, MN, MO, NJ, PA, and SC allow the flexibility for an RN to be on-call when only an LPN is on duty.)

⁴² *See* 42 C.F.R. § 485.618(d).

⁴³ 42 CFR § 485.631(a)(4).