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,

[YOUR ORGANIZATION] 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 address these communities in the final rule.

[Add brief paragraph describing your organization.]

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

**[Your organization] urges CMS to rescind its minimum staffing standards proposals.** If withdrawal of the policy isn’t possible, **CMS should exempt rural facilities from the requirements.** We appreciate the Administration’s interest in and commitment to improving patient safety and outcomes in nursing facilities, particularly following the COVID-19 pandemic. We agree that this is an important aim; however, unfunded minimum staffing standards during a nursing shortage is not the answer. [Describe your facility’s quality initiatives or decisions that you have made to improve quality.]

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]](#footnote-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 nursing home deserts.[[2]](#footnote-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.

[Your organization] is concerned that the proposed staffing mandates will cause further rural nursing facility closures. This crisis is persisting, especially in largely rural states. In Montana 16% of the state’s nursing homes closed in 2022.[[3]](#footnote-3) During the same year in Iowa, 13 of the state’s 15 nursing home closures were in rural areas.[[4]](#footnote-4) [Add any information about nursing home closures in your area or your state.]

A myriad of factors plays into the challenges of keeping rural nursing homes open and viable, many of which stem from workforce shortages. **[Your organization]** **stresses that implementing federal staffing mandates will not increase availability of interested and qualified workers where they do not exist.** [Include information about nursing shortages that your facility has faced or that your community is experiencing.] Nationally, long-term care is experiencing the worst labor shortage, making now an inopportune time to propose staffing standards.[[5]](#footnote-5) **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 contributor to rural nursing home instability is insufficient reimbursement, particularly from Medicaid. On average, 62% of nursing home stays are covered by Medicaid, which does not reimburse at levels that cover the cost of care or allow nursing facilities to recruit and retain staff with attractive wages. [Discuss your state’s Medicaid reimbursement rates.]

**Again, [your organization] urges CMS to look at the underlying causes of quality to address issues such as workforce retention, payment rates, regulatory burden, and financial stability rather than enacting federal staffing mandates.** 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).

CMS proposes that all nursing homes 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 HPRD requirement and the remaining 81% would have to hire more registered nurses (RNs) or nurse aides.[[6]](#footnote-6) CMS itself notes that both the 0.55 and 2.45 HPRD proposals are higher than any minimum staffing levels in place at the state level. In addition, CMS’ proposals go above and beyond the staffing levels at which quality no longer increases according to the 2022 Nursing Home Staffing Study (2022 Study).[[7]](#footnote-7)

[Expand on your facility’s challenges hiring and retaining both RNs and nurse aides. Would your facility be able to meet these staffing levels? How much would meeting these levels cost your facility? What would this investment mean for your facility?]

**[Your organization] asserts that mandated staffing levels will close rural nursing facilities.** 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 this goal. While rural patients 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 are less likely to get proper care, nutrition, or 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 and health outcomes.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.

[If possible, describe the loss to your community if your facility closed. Talk about your patient population and the important care that your facility furnishes.]

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. 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. This leads to hospitals being faced with the difficult choice of turning away admissions or transfers because of post-acute placement concerns. 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.

[HOSPITAL RESPONDENTS – describe how a lack of post-acute care beds creates challenges in your hospital. Are you currently dealing with this situation? What would happen if it worsened? NURSING HOMES/OTHER ORGANIZATIONS – if you are experiencing a lack of beds or overcrowding, discuss here.]

**[Your organization] strongly urges CMS against instituting these minimum staffing standards. If CMS moves forward with these levels, we ask that CMS include licensed practical nurses (LPNs) in the RN HPRD staffing level.** This flexibility would help rural nursing homes comply with the otherwise stringent and impracticable RN staffing levels. The current proposal does not include LPNs in any staffing levels. However, LPNs are often the backbone of rural nursing facilities. [Explain how important LPNs are to your facility. Try to stress their importance in providing patient care and what they contribute to your facility.]

In addition to the staffing levels, CMS proposes that nursing homes have an RN onsite 24/7. **[Your organization] does not support the 24/7 RN onsite proposed mandate.** Much like the HPRD staffing levels, this requirement would be tremendously difficult for many rural nursing facilities to meet. [Again, emphasize your challenges recruiting and retaining RNs specifically and why meeting this requirement would be difficult for your facility. If possible, estimate how much this would cost your facility.]

**We urge CMS to rescind the 24/7 RN onsite proposal entirely.** However, an alternate policy for rural nursing facilities is to allow an RN to be “available” 24/7. CMS could allow RNs to be available virtually 24/7 rather than onsite. There is precedent for this type of policy in Rural Emergency Hospital (REH) and Critical Access Hospital (CAH) conditions of participation. 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.[[8]](#footnote-8) Physicians and non-physician practitioners at REHs and CAHs must be on call or immediately available by phone or radio within thirty minutes on a 24/7 basis.[[9]](#footnote-9) **CMS should look to these conditions of participation as an alternative to the 24/7 RN onsite proposal.**

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

[Your organization] appreciates CMS’ proposal to exempt certain facilities from the HPRD ratios. Yet we are concerned that the eligibility requirements will not capture all rural nursing facilities that could benefit from an exemption. **We ask that CMS change the mileage requirement from 20 miles to 15 miles.** We believe that this will capture a more accurate group of nursing homes that need the exemption.

**We also ask that CMS remove the provider-to-population eligiblity requirement and allow any nursing facility without another facility within 15 miles to qualify.** Some rural nursing homes are near a hospital or other health care facility which artificially increases the provider-to-population ratio for the nursing workforce even though these facilities are likely competing for limited staff. This measure for eligibility will cut out nursing facilities that would otherwise be deserving of this exemption. [If you have another nearby nursing facility or hospital, explain how the ratio of nurses may look higher in your community. Do you compete with nearby facilities for nursing staff? Would you be ineligible for this exemption?]

4. Implementation Timeframe.

We thank CMS for providing rural nursing facilities with longer compliance period, but we raise two concerns with the timelines. First, the majority of rural facilities will not be able to comply with the proposed standards even with a longer period of time to do so due to historical staffing shortages previously discussed. Second, **many rural nursing facilities will not qualify for the extended compliance timeline.** In 2022 the Census Bureau made significant changes to the definition of rural, which now considers only areas with a population of 5,000 or less to be rural. This definition of rural is extremely exclusive and does not truly represent rural areas nationwide. [Does your facility fall outside of this definition? If so, explain the importance of a longer timeframe to comply if these proposals are finalized.]

**[Your organization] asks that CMS use the Office of Management and Budget 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. The current Census definition excludes many areas and communities that fall under other federal or state definitions of rural and that otherwise face the same challenges that other rural providers face. If CMS uses the Census definition of rural, many deserving rural facilities will have to comply within a shorter and untenable timeframe. **We urge CMS against finalizing the use of this definition and to instead adopt the OMB definition.**

Thank you for the chance to offer comments on this proposed rule and for your consideration of our comments. If you would like additional information, please contact [Your name or other representative] at [email] and/or [phone number].

Sincerely,

[E-SIGNATURE]

Name

Title

Organization

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>. [↑](#footnote-ref-1)
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>. [↑](#footnote-ref-2)
3. 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/>. [↑](#footnote-ref-3)
4. *Id.* [↑](#footnote-ref-4)
5. 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. [↑](#footnote-ref-5)
6. Burns, et al., *supra* note 5. [↑](#footnote-ref-6)
7. 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>. [↑](#footnote-ref-7)
8. 42 C.F.R. § 485.528(c). [↑](#footnote-ref-8)
9. 42 C.F.R. § 485.618(d). [↑](#footnote-ref-9)