November 6, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Room 445-G Herbert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

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

Dear Administrator Brooks-LaSure:

On behalf of the Catholic Health Association of the United States (CHA) and Catholic Charities USA (CCUSA), we welcome the opportunity to share our comments on the proposed rule, *Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting* (the NPRM). Providing high quality, accessible and affordable care for those who, because of frailty or chronic conditions, require continuing care in nursing homes is a top priority for our organizations and our members. We appreciate and share the commitment of President Biden's administration, including the Centers for Medicare & Medicaid Services (CMS), to ensuring high quality care in nursing homes and across the continuum of care. **However, we are deeply concerned about the NPRM's staffing requirements, which could negatively impact nursing facilities and their patients. We therefore urge CMS not to finalize the proposed rule.**

CHA is the national leadership organization of the Catholic health ministry, collectively the largest group of not-for-profit providers of health care services in the nation. CHA represents more than 2,200 Catholic health care sponsors, systems, hospitals, long-term care facilities and related organizations across the continuum of care. The Catholic health ministry is the largest group of nonprofit health care providers in the nation. Our members include some of the oldest nursing homes and hospices in the country and address the needs of older adults throughout the life cycle. CHA is a leader in age-friendly health systems, in hospitals, nursing homes, and primary care.

CCUSA is a national membership organization representing 168 diocesan Catholic Charities member agencies. These member agencies operate more than 3,500 service locations across 50 states, the District of Columbia, and five U.S. territories. The diverse array of social services offered by the agencies reached more than 15 million individuals in need last year. These services include skilled nursing facilities, hospice care, and respite care for older adults among a variety of other supportive services to assist older adults in nursing homes or in their own homes.

The NPRM, published in the Federal Register on September 6, proposes to establish minimum staffing standards that would require Medicare- and Medicaid-certified long-term care facilities to provide residents with a minimum of 0.55 hours of care per resident per day (HPRD) from a registered nurse and 2.45 HPRD from a nurse aide (NA). In addition, facilities would be required to have a registered nurse on site and available to provide direct resident care 24 hours per day, seven days a week. CMS also intends to update the existing facility assessment requirement and to require states to report the percentage of Medicaid payments for certain Medicaid-covered institutional services spent on compensation for direct care workers and support staff.

We strongly agree that adequate nurse staffing is essential for the well-being of nursing home residents. Numerous studies demonstrate the link between staffing and quality outcomes. When we survey our members, they cite challenges in getting and keeping nurses and nurse aides as a top priority and a major challenge. **But there is less support for a direct connection between mandated levels and quality**. The key findings of the Abt Associates study commissioned by CMS stated that the recent literature on the topic "does not provide a clear evidence base for setting a minimum staffing level" and that "there is no obvious plateau at which quality and safety are maximized or 'cliff' below which quality and safety steeply decline."[1]

The proposals come at a time when nursing homes are facing unprecedented challenges, leading many to close their doors. Between February 2020 and February 2023, the number of facilities declined by 465 and 54% of nursing homes are not admitting new residents due to staffing shortages.[2] The not-for-profit sector, which includes our members, is shrinking through closures and ownership transfers to for-profit entities.[3] Since 2009, 130 Catholic-sponsored nursing homes have been sold, 54% to for-profit entities, including private equity firms. Insufficient reimbursement and the national health care workforce shortage are creating unbearable stress on the industry.

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[1] Abt Associates. (2023). Nursing Home Staffing Study Comprehensive report. Report prepared for the Centers for Medicare & Medicaid Services, xi. https://edit.cms.gov/files/document/nursing-homestaffing-study-final-report-appendix-june-2023.pdf.

[2] CLA, Economic State of Skilled Nursing Facility (SNF) Industry, February 2023, https://www.ahcancal.org/News-and-Communications/Fact-Sheets/FactSheets/CLA-Economic-State-SNFs-Report-Feb2023.pdf. See also "The Upheaval at America's Disappearing Nursing Homes, in Charts," Wall Street Journal, August 23, 2023. (Six hundred fewer nursing homes now than six years ago). https://www.wsj.com/health/healthcare/the-upheaval-at-americas-disappearing-nursing-homes-in-charts-9aa8d2f.

[3] Stulick, Amy. "Closures, Consolidation, Sales: Skilled Nursing Ownership Goes Through Shakeup," Skilled Nursing News, April 21, 2022. https://skillednursingnews.com/2022/04/closures-consolidation-sales-skilled-nursing-ownership-goes-through-shakeup/.

All health care services experienced sharp drops in employment when the pandemic began. Most began adding back jobs within months with the exception of skilled nursing and eldercare facilities, which have seen the slowest recovery in employment in the aftermath of the pandemic. It took two years for their employment trends to become positive again. Unlike other sectors, their employment levels have yet to reach what they were in February 2020, even though among health sector employees skilled nursing and eldercare facility workers have had the greatest cumulative percentage change in average weekly earnings.[4] Health care providers have faced significant challenges in sustaining, building and retaining the health care workforce since before the pandemic. In 2017, the majority of the nursing workforce was close to retirement, with more than half aged 50 and older, and almost 30% aged 60 and older. COVID-19 made things worse. There were 100,000 fewer RNs in 2021 than in 2020, according to a study in Health Affairs.[5] An even more comprehensive analysis from a large-scale biennial survey conducted by the National Council of State Boards of Nursing (NCSBN) and National Forum of State Nursing Workforce Centers (NFSNWC) found a similar number of registered nurses had left the workforce. It also showed that nearly 900,000, or one-fifth, of the 4.5 million total registered nurses expressed an intention to leave the workforce due to stress, burnout, and retirement. The NCSBN and NFSNWC study also noted that the effect of over 33,800 licensed practical nurses (LPNs) and vocational nurses leaving the field since 2020 had a disproportionate impact on nursing homes and LTCs.[6]

Focusing on set RN and NA staffing levels is also unwise and not reflective of the complexity of long-term care and patient needs, as it ignores the role of clinical judgment and flexibility in the practice of nursing as staff care for patients at varying levels of acuity and fragility. It is grounded in a model of care that does not take into consideration the use of safety-assisting technology or interprofessional team care models. These models incorporate not only nurses at various levels of licensure but also respiratory therapists, occupational therapists, speech-language pathologists, physical therapists, and case managers to effectively and safely address all the needs of residents in a patient-centered manner.

We are disappointed that CMS does not acknowledge the key role played by LPNs in meeting the needs of nursing facility residents. LPNs are an essential part of ensuring nursing home residents receive high quality care. They provide key services to seniors such as medication administration, providing treatments, communication with physicians and families, working with nursing assistants and the interdisciplinary team, among other items. And nursing homes rely upon them. They provide the majority of nursing services in nursing homes, up to 75% of the nursing workforce for some of our members. As of 2018, more than one-third of

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[4] Peterson-KFF Health Systems Tracker, "How Has Health Sector Employment Recovered Since The Pandemic?", 2023. https://www.healthsystemtracker.org/chart-collection/what-impact-has-the-coronavirus-pandemic-had-on-healthcare-employment/#Cumulative%20%%20change%20in%20health%20sector%20employment%20by%20setting,%20February%202020%20-%20June%202023

[5] Auerbach, David, et al. "A Worrisome Drop in the Number of Young Nurses," Health Affairs Forefront, April 13, 2022. https://www.healthaffairs.org/content/forefront/worrisome-drop-number-young-nurses

[6] https://www.journalofnursingregulation.com/article/S2155-8256(23)00047-9/fulltext

LPNs worked in nursing and residential care facilities, compared to 15% in hospitals, 13% in physician offices and 12% in home health care facilities.[7]

Ignoring LPNs as part of the nursing home workforce solution is short-sighted. If we want to have more nurses, we should be supporting LPNs. They play a crucial role in the nursing pipeline. Many nurses begin their careers in community college LPN programs, going on to become RNs or APRNs. Community colleges are more affordable than four-year institutions and serve a higher percentage of non-white students. **LPNs are also important from a diversity, equity and inclusion perspective.** For example, while the majority of both RNs and LPNs are white, a higher percentage of LPNs is Black/African American (18.5 percent) than is the case among RNs (12%). More recent classes of LPNs tend to be more racially and ethnically diverse. Supporting LPNs in their careers and helping them to advance in the profession will contribute to increasing diversity in the nursing workforce across the board.[8]

Against this background, implementing federal staffing requirements as proposed at this time would be unwise at least and could be disastrous for some nursing homes and their residents. CMS' own estimates indicate 75% of long-term care facilities would not be able to meet the 24/7 RN staffing requirement. Other studies paint an even grimmer picture. The Kaiser Family Foundation projects that 81% of facilities currently do not meet the HPRD standard and would have to hire more nursing staff, affecting 90% of for-profit facilities and 60% of not-for-profit and government facilities.[9] And the CLA study reports that *only 6% of facilities* could meet all three staffing mandates, with 48% of facilities missing the RN HPRD standard, 72% of facilities unable to meet the NA HPRD requirement and 80% falling short of the 24/7 RN rule. To meet all three mandates, facilities would have to hire 102,154 new FTEs – 80,077 NAs and 19,880 RNs.[10]

The cost of meeting the proposed standards is staggering. CMS estimates the cost of compliance will be $4 billion in the third year, rising to $5.7 billion by year ten with a 10-year projected cost of $40.6 billion. As CMS recognizes, "LTC facilities would be expected to bear the burden of these costs, unless payors increase rates to cover cost"[11] with no requirement or expectation of increase in Medicare or Medicaid payments.[12] Nursing homes already struggle with underpayment by government reimbursement programs with no immediate prospect of increase.

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[7] National Academies of Sciences, Engineering, and Medicine. 2021. The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity. Washington, DC: The National Academies Press. https://doi.org/10.17226/25982
[8] Ibid.
[9] Burns, Alice, et al, "What Share of Nursing Facilities Might Meet Proposed New Requirements for Nursing Staff Hours," Kaiser Family Foundation, September 18, 2023 (updated September 22, 2023) https://www.kff.org/medicaid/issue-brief/what-share-of-nursing-facilities-might-meet-proposed-new-requirements-for-nursing-staff-hours/#:~:text=Finally%2C%20the%20rule%20was%20announced,improve%20enforcement%20of%20existing%20standards
[10] CLA, CMS Proposed Staffing Mandate: In-Depth Analysis of Minimum Nurse Staffing Levels, September 2023, https://www.ahcancal.org/News-and-Communications/Fact-Sheets/FactSheets/CLA%20Staffing%20Mandate%20Analysis%20-%20September%202023.pdf
[11] 88 Fed. Reg. 61354.
[12] 88 Fed. Reg. 61407.

This means we face the real prospect of fragile elders and vulnerable residents losing access to care they need, a threat to their safety and quality of care. Nursing homes and other LTC facilities unable to meet staffing requirements will have to reduce their capacity, eliminate or cut back on non-nursing services or cease operations altogether. Current and potential future residents and their families will suffer.

We are particularly concerned that the effects of this proposal could run contrary to CMS' commitment to health equity. The struggle to maintain sufficient direct care staff to meet the care needs of residents is even greater in nursing facilities that serve a high share of Medicaid-covered residents. Because such facilities also have a higher share of Black and Hispanic residents, the low staffing rates in these facilities contribute to health disparities.[13] While some may not be allocating enough resources to staffing, many simply cannot pay enough due to insufficient reimbursement rates. Imposing staffing mandates without providing the financial resources necessary to hire and retain staff will not solve that problem. Instead, it will increase the likelihood these facilities will have to close, creating greater disparities in needed access to quality post-acute care.

Equitable access to care in rural areas could be at risk as well. We are hearing great concern from our members who serve rural communities. One rural facility, for example, has already had to get a waiver from the current eight HPRD RN requirement because there were no RNs to hire. This five-star facility is able to provide high-quality care to its residents thanks to the excellence of its LPNs performing within their scope of practice. The new mandate would likely mean the closure of this facility and the disbursement of its residents far away from their loved ones. While we appreciate that CMS has indicated it will grant hardship exemptions in "limited circumstances," we do not believe that will be sufficient to blunt the disastrous impact of the staffing mandate.

The proposal's impact would be felt across the care continuum, not just in nursing homes. Diminished capacity in skilled-nursing and long-term care facilities means hospital patients needing post-acute care will face delays in discharge. Hospitals and health systems already are experiencing significant challenges in moving patients through the health care continuum generally, and into skilled nursing facility care specifically. The average length-of-stay (ALOS) in hospitals for all patients increased 19.2% in 2022 compared to 2019 levels; for patients being discharged to post-acute care providers, the ALOS increased nearly 24% in the same period. Case-mix, index-adjusted ALOS increased for patients being discharged from acute care hospitals to skilled nursing facilities by 20.2%.[14] These longer hospital stays keep patients from receiving the next level of medically necessary care and lead to longer wait times in hospital emergency departments because hospitals are unable to move current patients out of inpatient beds. In other words, constrained access to long term care is a quality-of-care issue affecting all types of patients across the care continuum.

[13] MACPAC Issue Brief, State Policy Levers to Address Nursing Facility Staffing Issues, March 2022.
[14] American Hospital Association Issue Brief, December 2022.

As one of our members put it, this will only increase the cut-throat competition for a depleted nursing pool and add to the shortage of nurses in all health care facilities. With a finite number of RNs, LPNs and other skilled health care professionals, all parts of the health care sector are struggling to hire enough nursing staff to meet patient needs. Simply mandating staffing levels will not increase the number of nurses available to hire. Competition among nursing homes, acute care hospitals, inpatient rehabilitation facilities and home care agencies is already fierce. Nursing homes would not be able to meet these standards without causing even deeper shortages across the care continuum**. While we appreciate and support the pledge to commit an additional $75 million in financial incentives like scholarships and tuition reimbursement for individuals to enter careers in nursing homes, it is simply not enough to meet the need.**

We appreciate that CMS has proposed a phased-in time for meeting the new standards, but we are still concerned that the implementation timelines will not give nursing homes enough time to bring in the needed staff. As proposed, a 24/7 RN requirement would be implemented two years from publication of the final rule, with an additional year for nursing homes in rural areas. The HPRD requirements would go into effect three years from publication, with an extra two years for rural nursing homes. CMS has estimated 90,000 new nursing staff will be needed to meet the requirements and other analyses project a shortage of 102,000 nurses.[15] Two to three years is simply not enough time to generate all the new RNs and NAs that will be needed. Additionally, we know that workforce issues are not limited to rural areas. Underserved communities exist in both rural and urban areas throughout the country. Having a staggered implementation timeframe that favors rural areas not only disadvantages underserved communities in non-urban areas. It also pits urban and rural areas against each other as staff are first recruited away from rural areas to fulfill the needs of urban nursing homes, then one to two years later rural areas are scrambling to bring staff back. **If CMS finalizes the nurse staffing requirements, we urge you establish a single, delayed implementation timeframe for all nursing homes of at least three years for a 24/7 RN requirement and at least five years for HPRD requirements, and only if CMS has determined there will be enough qualified applicants and adequate funding to comply with the requirements.**

We strongly urge CMS to reconsider the mandated-staffing proposal and instead work with providers, patient representatives and Congress to devise realistic and effective long-term solutions to improve quality of care in nursing homes. Policy proposals should include increased funding, recognizing the role of LPNs and robust investment in the training, recruitment and retention of nursing staff. And new, innovative ways of ensuring quality care should be explored. During the COVID-19 pandemic patients and providers were forced to rely on remote strategies for care, demonstrating the power of telehealth solutions. Our members are successfully using virtual nursing models and remote patient monitoring in order to provide support to direct-care nurses and health care professionals, including the post-acute care setting.

CHA, CCUSA and our members strongly agree that it is essential for nursing homes to have sufficient staff to meet the daily clinical, personal hygiene, psychosocial and other needs of nursing home residents. We stand ready to work with CMS to find better solutions to improving

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[15] 88 Fed. Reg. 61399ff; CLA op. cit.

nursing home care for the well-being of residents who need that care. If you have any questions about these comments or need more information, please do not hesitate to contact either of us, or Kathy Curran, CHA Senior Director Public Policy, at 202-721-6300 or Lucreda Cobbs, CCUSA Senior Director, Policy and Legislative Affairs, at 301-236-6243.

Sincerely,

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