GREATER NEW YORK HOSPITAL ASSOCIATION
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The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3442-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting, CMS-3442-P

Dear Ms. Brooks-LaSure,

On behalf of the more than 60 not-for-profit and public freestanding and hospital-based nursing facilities that comprise the Greater New York Hospital Association's (GNYHA) continuing care membership, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule on Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting. Informed by GNYHA's experience with New York State's nursing facility minimum staffing and minimum spending requirements, our comments focus on CMS's proposal to require facilities to always have a registered nurse (RN) onsite throughout the day, to revise the long-term care requirements to establish a mandatory minimum nurse staffing level, to revise the facility assessment requirements, and require States to report the percent of Medicaid payments spent on direct care worker and support staff compensation.

Thank you for considering our recommendations. Please contact Joe Corwin (jcorwin@gnyha.org) or Roxanne Tena-Nelson (tena-nelson@gnyha.org) with any questions regarding our comments.

Sincerely,

Elisabeth R. Wynn
Executive Vice President, Health Economics & Finance

I. 24/7 Registered Nurse Availability

CMS proposes to require skilled nursing facilities (SNFs) to have 24/7 onsite RN availability. Based on the national nursing shortage, facilities' geographic locations, and recent innovative technology, additional flexibility is warranted to ensure all facilities can meet the 24/7 RN staffing requirement.

The national and statewide nursing shortages are directly impacting our members' ability to hire nurses and other caregivers. The COVID-19 pandemic exacerbated the nursing shortage, and health care providers continue to struggle to both stabilize their workforce and build the pipeline of future nurses. Workforce researchers in New York State found that RNs are among the most difficult to recruit and retain in all health care settings,[1] and the challenges to the future pipeline look grim. In 2022, New York nursing programs reported that admissions were about the same as in 2021, with more than half of the nursing school deans reporting that they had to turn applicants away due to program admission caps and nurse faculty departures.[2] Rural and underserved communities face even greater challenges recruiting and retaining nurses.

One silver lining that emerged from the COVID-19 pandemic was the advancement in innovative technology to improve telehealth and other technology-based solutions to better care for patients across all health care settings. In the recently finalized calendar year 2024 CMS physician fee schedule, CMS extended physicians' ability to bill for remotely supervising residents during virtual patient visits through 2024 and continues to evaluate whether it should approve this practice beyond that year. Physicians embraced this technology and concept during the COVID-19 pandemic, and physicians, stakeholders, and CMS continue to recognize the effectiveness and advantages of this approach. CMS should recognize how telehealth and other technology solutions can help RNs remotely monitor patients' conditions and supervise other staff in nursing facilities to provide high-quality patient care. These technologies and approaches can benefit nursing facilities and serve as an additional solution to 24/7 RN coverage in communities with less RN availability, such as rural and underserved areas.

GNYHA recommends that CMS expand its proposal to allow SNFs to use RN telehealth supervisory and patient-monitoring technologies as an approved substitute for SNFs when an RN is not onsite.

II. Minimum Staffing Standards for Long-Term Care Facilities

CMS is proposing requirements that SNFs staff 0.55 RN hours per resident per day (HPRD), including hours for directors of nursing and nurses with administrative duties and 2.45 nurse aide HPRD, including certified nursing assistants (CNAs), nurse aides in training, and medication aides and technicians. While CMS did not propose or establish a total nurse HPRD threshold in its proposed rule, it is seeking comments on whether it should also implement a 3.48 total nurse HPRD. CMS would implement the proposed regulations three years after publication of the final rule for urban providers and five years for rural providers. GNYHA's comments on this proposal are informed by our experience implementing New

[1] Center for Health Workforce Studies, The Health Care Workforce in New York State: Trends in the Supply of and Demand for Health Care Workers, April. 2023. Health Care Workforce NYS Trends (chwsny.org) (accessed on November 2, 2023).
[2] Center for Health Workforce Studies, Trends in New York State Registered Nurse Graduations, 2019-2022, June 2023. Trends in New York State Registered Nurse Graduations, 2019-2022 (chwsny.org) (accessed on November 2, 2023).

York's minimum nurse staffing law in April 2022 (described below) and the challenges faced by SNFs in meeting these requirements.

Background on New York State's Minimum Nurse Staffing Law

On April 1, 2022, New York codified Public Health Law §2895-b 10 NYCRR §415.13 instituting a mandatory total minimum nurse staffing level of 3.5 HPRD comprised of a minimum 1.1 RN or licensed practical nurse (LPN) HPRD and 2.2 CNA HPRD. The New York State Department of Health (DOH) measures compliance with the minimum nursing staff requirements on a quarterly basis using the CMS Payroll-Based Journal (PBJ). SNFs that fail to meet all three minimum staffing requirements or that fail to submit quarterly PBJ data are subject to civil monetary penalties. DOH can impose penalties for each day, within a quarter, a facility is not compliant. These penalties begin at $500 per day with a maximum of $2,000 per day with progressive penalties increasing with each subsequent quarter of noncompliance. Like the Federal proposed rule, penalties can be mitigated if a facility can demonstrate to DOH factors preventing compliance. DOH defines mitigating factors as: a natural disaster, declared emergency (national, State, or municipal), a catastrophic event, an acute labor supply shortage, or a verifiable union dispute. A facility can also apply for a request for redetermination, which would require a nursing home to submit its daily PBJ data for the designated quarter to DOH, which would then review and recalculate the hours based on each staff type identified when determining compliance.

Even prior to implementation, SNFs expected difficulty in complying with the State's 3.5 HPRD minimum standards due to the severe workforce shortages, especially for direct care workers. Myriad factors contribute to these shortages, including employee burnout and competition for labor from other sectors in the economy that present less physically and emotionally challenging work. GNYHA members have implemented several strategies to recruit and retain nurses since the pandemic, such as providing retention and sign-on bonuses, while also adding other financial and workplace incentives. Despite these efforts, nearly 75% of New York SNFs remain below the required thresholds set forth by the State's minimum staffing law. GNYHA estimates that to comply, SNFs would need to hire enough nursing staff to cover nearly 9,280 additional daily shifts.

CMS's Federal Minimum Nurse Staffing Proposal

GNYHA members are committed to the delivery of high-quality care for their patients and ensuring that their facilities are safely staffed. However, as detailed in the sections below, CMS's proposal would impose a rigid, uniform approach to nursing home staffing that fails to: recognize the national nursing shortage and other workforce challenges facing SNFs and other health care providers, account for differences in case-mix across facilities or for innovative staffing strategies, or consider the financial costs associated with the new requirements. SNFs could be forced to reduce capacity to meet these requirements, impacting access to care across the continuum. **For these reasons, GNYHA urges CMS to not adopt the proposed HPRD staffing requirements.**

Acute Health Care Workforce Shortages

SNFs will face significant recruitment and retention challenges in attempting to hire the staff necessary to comply with CMS's proposed staffing requirements given the severe health care worker shortages. New York State's DOH Commissioner, in consultation with the Department of Labor, recently declared that an acute labor supply shortage existed for RNs, LPNs, and CNAs in all New York State counties from Q2

2022 to Q4 2022. This determination, which GNYHA expects to continue for the foreseeable future, presents a major challenge to any New York State nursing facility attempting to meet the proposed minimum staffing requirement.

As noted above, while GNYHA members have engaged in many innovative recruitment and retention strategies, they still face significant challenges in finding the necessary staff to fill nursing positions. These challenges are not unique to SNFs. A recent survey by the Center for Health Workforce Studies at SUNY Albany found that 95% of hospital respondents reported difficulty recruiting RNs, and nearly 85% reported difficulty recruiting LPNs and NPs.[3] While policymakers and stakeholders at local and national levels are working to increase the pipeline of workers, including with much needed direct funding/subsidies, unfortunately it is a problem that will not be solved in the next couple of years.

As a result, SNFs will face significant challenges in complying with any new requirements. Taking New York's experience as an example, during the first staffing HRPD compliance check, more than 400 of the 620 SNFs in New York State filed an appeal or requested a redetermination due to challenges in recruiting additional workers. Similarly, we estimate that more than 80% of New York SNFs do not currently meet CMS's proposed 2.45 CNA HPRD, and more than 90% do not meet a 3.48 total HPRD. A recent Kaiser Family Foundation analysis found a similar percentage nationwide, estimating that 81% of SNFs across the country would need to add RNs or CNAs to comply with the new standards.

Given the massive structural workforce shortages facing health care providers, where the workforce would come from for SNFs to reasonably comply with CMS's proposal is unclear. We are also concerned that it could create unintended consequences in drawing health care workers from other sectors, exacerbating the acute workforce shortages in other sectors.

Standards Fail to Account for Interdisciplinary Care Teams

CMS's HRPD proposal is rigid in its approach and fails to account for the contributions of other caregivers in the care team to deliver quality patient care. In addition to RNs and CNAs, many SNFs also use other types of staff such as physicians and physician extenders (i.e., nurse practitioners and physician assistants), multiple therapist types, feeding assistants, and various nurse specialties to provide patient care. When evaluating staffing, CMS must consider the use of interdisciplinary teams, innovative strategies including telehealth, and other approaches that enhance direct patient care. As one GNYHA member states: *"When a patient or resident is with a physical, occupational, speech therapist, social worker, or while participating in a recreational activity; all of these moments are time NOT spent with an RN or CNA, but most definitely contribute to the individual's care and wellbeing."*

Unfortunately, CMS's proposed 0.55 RN HPRD threshold narrowly focuses only on RNs and does not recognize hours provided by other nursing staff such as LPNs. LPNs provide direct patient care alongside RNs, and many SNFs rely on them as a major contributor to patient care. While Abt Associates' analysis found limited evidence specific to the role of LPNs in the literature, GNYHA members have noted the

[3] Center for Health Workforce Studies, SUNY Albany, April 2023. Available at: https://www.chwsny.org/our-work/reports-briefs/the-health-care-workforce-in-new-york-state-trends-in-the-supply-of-and-demand-for-health-care-workers-2/.

critical importance and contribution of LPNs within their organizations. As one member noted: *"Our LPNs have worked at our facility for years maintaining the health and wellbeing of our residents. These workers are longstanding employees [and] on average have worked for our organization for over 12 years. Our facilities do not rely exclusively on LPNs to care for our residents. Our care teams are comprised of a 1:1 blend of RN to LPNs. We believe that LPNs working alongside our RNs can promote optimal health of those under our care. We believe strongly that both RN and LPN direct patient care contributions should be included in any professional staffing ratio calculation."*

By limiting staffing requirements to only RNs, the CMS proposal does not fully capture the impact of the comprehensive nursing team's contribution to high quality. In addition, the prioritization of RNs will have a significant negative effect on LPN staffing and hiring across the country, which would further impact quality of care while increasing facility costs.

Similarly, GNYHA members shared that they are hiring other types of staff to carry out necessary tasks that a CNA may have previously handled due to challenges in hiring CNAs. As one member noted: *"Our facility uses home health aides to provide direct care to patients and residents when they need to travel to/from our facility for doctor appointments, tests, and other procedures. Examples of this care include meal provisions, toileting, and self-care."*

Case-Mix Adjusted Hours

CMS's proposal also fails to consider that SNFs appropriately staff in direct response to their patients' case-mix and individual needs. It is puzzling why the agency chose this approach when it currently uses a case-mix adjusted measure in other programs. For example, the total nursing staffing measure in the CMS nursing home five-star quality rating system is a case-mix adjusted measure, which has been identified as an indicator of high-quality care. A case-mix adjusted measure/threshold would more appropriately account for the different patient populations across various SNFs.

Lack of Funding

SNFs will bear the staffing requirement's entire financial burden because CMS is not providing any additional funding to meet the RN and CNA thresholds. The Federal proposal equates to an unfunded mandate that, according to CMS's estimates, will cost SNFs $4 billion to implement nationwide. GNYHA estimates that the cost for SNFs in New York is approximately $415 million, of which $104 million is required for facilities to meet the standalone RN hours and $311 million to meet the CNA requirement. One GNYHA member estimated that it will cost them more than $1.75 million annually just to comply with the CNA requirement. When combining the Federal and State staffing requirement costs, New York State SNFs would need to spend more than $500 million to meet all staffing requirements.

These costs are expected to escalate in future years as recent nursing home labor settlements in New York will increase unionized staff costs by roughly 20% by 2025, and SNFs across the country would be competing with other health care providers to recruit staff from a limited pool of potential workers.

SNFs simply cannot afford to cover these costs without a new funding source. GNYHA and LeadingAge New York's joint nursing home association financial survey of not-for-profit and public SNFs found that median operating margins decreased from -3.0% in 2019 to -15.3% in 2022. In addition, three out of five

respondents projected lower operating revenue in 2023. The growing gap between operating revenues and expenses has further deteriorated GNYHA members' financial positions this year, and they simply cannot withstand another unfunded mandate.

While CMS's goal in proposing nursing home staffing requirements is improved quality, we fear that any such requirements will force future closures and negatively impact access to care for Medicare and Medicaid recipients requiring nursing home care, resulting in access challenges across the continuum of care. States with nurse staffing requirements, such as New York, are still determining the benefit of these programs and discovering what other factors are needed to truly uplift quality. It is imperative that CMS further study the overall staffing component and offer realistic solutions that do not create deleterious financial and operational ramifications for SNFs.

If CMS moves forward with a minimum nurse staffing requirement, GNYHA strongly recommends that it consider the following when developing the requirement: case-mix adjusted staffing hours, hours of additional interdisciplinary team staff types (e.g., physicians, physician extenders, therapists), and additional investments for nursing homes to cover the cost of hiring up to any minimum requirement.

Alternatively, CMS also could evaluate and approve existing state staffing law requirements and develop a waiver process that would allow nursing facilities that operate in states with CMS-approved staffing requirements to only comply with their state's law. This would greatly reduce the burden on SNFs to monitor, track, and fund multiple different staffing requirements aimed at the same goal of improving patient quality.

III. Revised Facility Assessment

CMS proposes to revise the existing facility assessment requirements at §483.70€, which are to take effect 60 days after the final rule is published, to seek an "efficient process for consistently assessing and documenting the necessary resources and staff that the facility requires to provide ongoing care for its population that is based on the specific needs of its residents." Revising the facility assessment process is a major undertaking for nursing facilities that are overburdened by the existing documentation and paperwork requirements. GNYHA is particularly concerned with the burdens created by the CMS proposals to outline behavioral health needs, some if which may be duplicative to minimum data set (MDS) completion and the Preadmission Screening and Resident Review process, which informs a patient's behavioral health needs. Changing the assessment tool also can cause issues with documenting daily shift details that may change due to staff absences and changes.

GNYHA agrees with CMS's direction to better understand the acuity and specific needs of the residents; however, any change in these processes greatly impacts the operations of nursing facilities, especially during a time when staff are already overburdened with monitoring staffing levels, maintaining documentation, and developing plans to appeal existing State staffing requirements. **GNYHA recommends that CMS: 1) delay implementing any facility assessment revision until two years following publication of the rule, 2) seek to reduce the paperwork burden by using any information that facilities are already submitting through the MDS or otherwise, and 3) recognize and fund the costs associated with meeting these documentation and administrative burdens.**

IV. Medicaid Institutional Payment Transparency Reporting

CMS proposes to require state Medicaid agencies to report the percentage of payments for Medicaid-covered services in nursing facilities that is spent on direct care worker and support staff compensation. New York State has implemented a minimum spending requirement for nursing facilities, which requires nursing facilities to spend a minimum of 70% of their operating revenues on direct patient care and a minimum of 40% on resident-facing staffing. In fact, GNYHA supported minimum spending on direct care with full funding, and nearly all GNYHA's members meet this requirement on an ongoing basis.

CMS requests comment on whether its definition of direct care titles includes the necessary titles that are crucial to providing quality care to Medicaid patients. CMS's proposed direct care definition excludes some clinical providers, such as physicians and physician assistants, and support staff, such as security. This differs from New York's approach where any clinical, ancillary, and support staff as defined on New York's Residential Health Care Facility cost reports are counted as direct care staff, and all clinical and ancillary staff are defined as resident-facing staff. New York's minimum spending approach recognizes the broad range of interdisciplinary staff that contribute to quality care of residents, and we encourage CMS to adopt a broader definition of the direct care and support staff team. By recognizing the interdisciplinary team's contribution to resident care, nursing facilities are better incentivized to adopt innovative approaches to high-quality care.[4] In addition, our members are committed to investing in nurses, as well as the rest of the interdisciplinary team, which includes physicians, physician extenders, a range of therapy providers, and support staff, all of whom contribute to high-quality care for residents. Our members also benefitted from CMS permitting temporary nurse aides during the pandemic, who nursing facilities brought on board and learned a great deal from the existing CNAs. CMS should focus attention on the interdisciplinary team and the expenses associated with maintaining a diverse and multifunctional staff that contribute to positive patient outcomes. **GNYHA strongly recommends that CMS include physicians, physician assistants, and support staff such as security in its direct care definition given the importance of these staff to nursing facilities' patient care.**

New York's minimum spending requirement measures nursing home direct care spend out of all-payer revenue. Currently, GNYHA is unaware of any way that facilities can track and measure CMS's proposal to determine how much Medicaid patient revenue nursing facilities spend on direct care worker services. This would be extremely difficult for nursing facilities to implement as they would need to create new processes to track or measure this, which may not be consistent across facilities and states. As previously stated, GNYHA members are already inundated with documentation and other reporting, such as daily New York State data collection on bed capacity and other metrics, so adding new data reporting requirements would further weigh on nursing home staff and lead to increased staff costs and administrative resources. CMS must develop standardized calculations from existing data sources for States to use if they move to implement this proposal. To avoid additional reporting burden and reduce implementation costs, **GNYHA recommends that CMS adopt a minimum spending methodology that focuses on all-payer revenue and has already defined direct-care and resident-facing staff titles.**

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[4] Grabowski, D., et. al., Who Are the Innovators? Nursing Homes Implementing Culture Change, The Gerontologist, Volume 54, Issue Suppl_1, February 2014, pages S65–S75.