RURAL POLICY RESEARCH INSTITUTE
RUPRI Health Panel
Keith J. Mueller, PhD, Chair
Alva O. Ferdinand, DrPH, JD
Alana D. Knudson, PhD
Jennifer P. Lundblad, PhD, MBA
A. Clinton MacKinney, MD, MS
Timothy D. McBride, PhD
Nancy E. Schoenberg, PhD
https://rupri.org/

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The Rural Policy Research Institute Health Panel (Panel) was established in 1993 to provide science-based, objective policy analysis to federal lawmakers. The Panel is pleased to offer comments in response to this proposed rule, Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting.

General panel comments

The panel concurs with the CMS goal of improving resident safety and quality while preserving access to critical services. Achieving this balance will be especially challenging in rural areas, for reasons identified throughout the discussion of the proposed rule. As stated in several places in the Executive Summary (beginning on FR 61353), a remarkably high percentage of nursing homes (more than 75 percent, FR 61353) would not currently meet the new staffing standards. That stark fact, along with evidence that employment in the long-term care sector has not yet recovered to levels seen before the public health emergency (2020),[1] requires a ramp-up time to meet the new requirements, and for some facilities even that timeline may not be sufficient to keep the facility open. We comment specifically on both the implementation timeline and the designation of hardship cases below.

In discussing reasons for ramp-up time and hardship waivers, CMS acknowledges the challenges of recruiting and retaining nursing staff in long-term care facilities, which include: local and regional labor market conditions; working conditions including physical and psychological safety; career opportunities within the organization; and compensation. Addressing many of these considerations will require, as recognized by CMS in this proposed rule, additional investments. While not within the scope of this proposed rule to resolve, CMS should explicitly recognize the critical role of adequate funding to support workforce recruitment and retention strategies. For most long-term care facilities, the leading source of patient revenue is Medicaid payment. Hence, CMS should consider insufficient Medicaid payment to support

[1] Data are presented in the Proposed Rule, FR 61376, comparing March 2020 with January 2022 and June 2023. Trend data are available from an Altarum report in October 2023., Exhibit 3.

competitive long-term care staff compensation when establishing implementation timelines and hardship waivers.

Alternative Strategies and Policies

This proposed rule is grounded in literature and background studies completed by CMS. However, with resident safety and quality improvement being the desired outcome, other strategies could be employed to complement the staffing ratio approach. Responding to CMS's request for alternative strategies and policy (FR 61371) the Panel has three recommendations.

First, we recommend increased base funding, and funding for training and technical support for state surveyors, as well as better coordination between state surveyors and the CMS-designated Quality Innovation Network Quality Improvement Organizations (QIN-QIOs). State surveyors, when fulfilling a role including technical assistance and consultation, are a potential source of guidance for quality assurance and providing referrals to others. They should work in coordination with the designated QIN-QIO, who are experts in quality improvement. Together, they can provide the needed technical assistance to nursing homes to identify and address potential quality issues before a problem occurs and continuously improve care and services. A coordinated approach focused on working with nursing staff would mean quality activities become less disruptive and part of the workflow of the staff.

Second, we recommend creating a policy focus to increase the quantity and composition of the staffing pool in a way that does not pull resources from elsewhere. It is important to remember that skilled nursing facilities compete for nurses with other parts of the health sector, already beleaguered by shortages stemming from the public health emergency. Increasing the staffing pool and ensuring the appropriate type of personnel in rural communities will be challenging, given the finite pool of personnel available implied by the data provided by CMS (FR 61377). To address this challenge in rural places, we encourage decentralizing training programs into rural environments, and pooling staff in geographic regions. This approach may include setting personnel per resident standards for that region including all providers (including licensed practical nurses).

Third, we suggest that CMS consider implementing, to the extent possible within statutory jurisdiction, other recommendations of the Committee on the Quality of Care in Nursing Homes, National Academies of Sciences, in their Consensus Study Report in 2022. These recommendations advance a comprehensive approach important to improving the health and well-being of nursing home residents, including but going beyond staffing recommendations. Within the staffing realm, Goal 2 of that report is to "ensure a well-prepared, empowered, and appropriately compensated workforce," and the Panel concurs with the associated set of recommendations. In particular, Recommendation 2B of the report is specific to minimum staffing requirements and recommends including a full-time social worker with a minimum of a bachelor's degree in social work, and an infection prevention and control specialist. These may be challenging goals for many rural facilities, but rather than saying they cannot be achieved the approach should be parallel to what this proposed rule describes – extended timelines to achieve, and hardship exceptions.

Consideration of Licensed Practice Nurses (LPNs)

Nationwide, there is a higher percentage of nursing homes meeting licensed practical nurse (LPN) requirements than those meeting RN requirements. However, LPNs were excluded in the

new ratios and standards regulation. In rural communities, CMS should consider including all nurse staffing categories to deliver services available to and needed by these underserved areas. These categories include LPNs, which is particularly important in rural communities as there are more training opportunities for LPNs than registered nurses (RNs) in underserved areas. The panel recommends including LPNs in the new regulations and policies regarding staffing mandates. In response to a request for comment on FR 61369, we recommend LPNs be allowed to substitute for nurses' aides (NAs) in locations unable to recruit and retain sufficient NAs to meet residents' needs. LPNs have more comprehensive training and broader scope of practice than NAs. Criteria for this standard could include meeting the criteria for hardship designation. Similarly, to address barriers preventing health care professionals at all levels from providing care services, the panel recommends encouraging states to allow professionals to practice to the highest level of their license.

Responses to requests for comments on specific elements of the proposed rule

Rural Definition (FR 61381)

The panel recommends using the same definition of rural used in determining eligibility to participate in the Medicare Rural Hospital Flexibility Program as a designated Critical Access Hospital (22 CFR 45.610(b)(5). Specifically, rural is defined as outside of Metropolitan Statistical Area (MSA), or inside an MSA, but qualified to be "treated" as rural based on the Goldsmith Modification, as determined by the Federal Office of Rural Health Policy (42 CFR 412.103). The definition offered by CMS in this proposed rule is based on designation of urban places by the Bureau of the Census. Using that definition would preclude many communities located well outside major urban areas (with core cities of at least 50,000) because of the definition of urban place being any city of 5,000 or more. We believe CMS intends to recognize the special circumstances of rural places (sparsely populated with distinct labor force constraints) and the need to maintain access to essential services for all communities. Given those policy needs, we believe the same considerations in designating CAHs apply here.

Hardship Exemption Mileage Criterion (FR 61378)

The Panel agrees with the need to establish a process by which facilities can qualify as exempt from the new rule in places where the required workforce is not available, especially rural and other underserved areas. We also concur with the statement that exempt status does not exempt facilities from upholding *optimal* resident safety and quality of care standards. We believe the requirement to demonstrate a good faith effort to hire and retain staff is appropriate. Other criteria for hardship designation are based on limited evidence of impact on facilities most vulnerable to closing because of an inability to meet new staffing requirements. These criteria need to be tested. We recommend the detailed conditions for hardship status be assessed 6 and 12 months after the effective date of the rule and annually thereafter.

Longer Implementation Timeframe (FR 61381)

Imposing mandates such as the nursing home staffing requirement, if done abruptly, could lead to closures of rural facilities that may be or are more likely to be unable to meet minimum staffing level requirements. Fewer than 1 in 5 nursing facilities currently meet the required number of hours for RNs and NAs nationwide, which means over 80% of facilities would need to hire nursing staff – a significant challenge in rural and other underserved areas.

CMS recognizes the special challenges of quickly meeting new standards that are currently met by fewer than 75 percent of all facilities. The panel supports the CMS response to that problem, an extended timeframe. We also support a longer extended timeline for rural facilities: an extra year to obtain an RN 24/7 and 2 extra years to obtain the minimum standards of 0.55 HPRD for RNs and 2.45 HPRD for NAs.

Excluding Swing Bed Hospital Services (FR 61369)

The panel agrees with CMS and supports the exclusion of swing bed hospital services from payment transparency reporting, including the requirement to report all Medicaid payments to nursing facilities and ICF/IIDs for Medicaid-covered services. We agree that this requirement may pose a burden on rural hospitals that also provide LTSS to a small number of beneficiaries. This burden, which may occur in conjunction with staffing shortages, should be a consideration.

Respectfully submitted,

Keith J. Mueller, PhD
Chair, RUPRI Health Panel
University of Iowa
College of Public Health
145 N Riverside Drive
Iowa City, IA 52242
Keith-mueller@uiowa.edu
www.rupri.org