National Organization of
State Offices of Rural Health

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NOSORH Comments - CMS Proposed Long Term Care Facility Supplemental Requirements

Introduction

On September 6, 2023, the Centers for Medicare, and Medicaid Services (CMS) issued a Notice of Proposed Rulemaking (NPRM), CMS–3442–P, *entitled Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting*. Within this NPRM are a number of provisions requiring minimum staffing levels within Long Term Care (LTC) facilities. The proposed staffing requirements set minimum hours per resident day for both registered nurse (RN) staff and nurse aide (NA) staff. The proposed guidance also requires there to be a RN on site 24 hours a day, 7 days a week. The aim of these requirements is to improve the quality of LTC services.

In this communication, the National Organization of State Offices of Rural Health (NOSORH) provides input to CMS on the potential impact of the staffing requirements and the proposed timetable for their implementation. NOSORH's comments highlight the special challenges that the requirements could create in rural LTC facilities. The comments include specific recommendations about approaches that CMS might take to improve the quality of LTC services in the nation.

NOSORH was established in 1995 to assist State Offices of Rural Health (SORHs) in their efforts to improve access to, and the quality of, health care for over 60 million rural Americans. All 50 states have a SORH, and each SORH helps their state's rural communities to build effective health care delivery systems. NOSORH and its members work closely with rural providers nationwide, including Critical Access Hospitals, Rural Health Clinics, Federally Qualified Health Centers, and rural hospitals. NOSORH brings its knowledge of rural essential community providers to the provisions of this NPRM.

NOSORH is encouraged that CMS is exploring ways to improve LTC quality. NOSORH understands that appropriate staffing is one factor contributing to this quality. NOSORH does not feel, however, that minimum staffing requirements are necessarily the most effective means of improving LTC quality. In these comments, NOSORH will explore this question and make recommendations for an integrated approach to improving LTC quality.

Background

Nursing home closures have increased nationwide, expanding the number of *nursing home deserts* – areas without LTC services. This trend started prior to the COVID-19 pandemic,

extended through that pandemic, and continues after the end of the pandemic. More than 1,000 nursing home have closed since 2015 - 776 occurring prior to the pandemic, and 327 during that period, according to a 2022 report by the American Health Care Association.

Rural areas have shouldered an inordinate share of recent LTC facility closures. Studies have shown that the majority of recent closures have occurred in smaller facilities with fewer than 80 beds. An NPR report also notes that 10 nursing homes in Nebraska have closed since 2021 and 27 in Iowa – most of which have been in small communities. This is indicative of the situation in other states. Many of the closed facilities are the sole provider of LTC in their community. The closures leave those communities without any LTC services.

The proposed federal staffing requirements will further jeopardize access to LTC services in rural communities. A recent analysis found that 93 percent of rural communities currently do not meet the 24/7 registered nurse requirement outlined by the rule, compared to 76 percent of urban facilities. This places rural facilities at greater risk than urban facilities from the proposed requirements.

NOSORH supports efforts to improve LTC staffing levels, quality, and outcomes. NOSORH feels, however, that the unfunded staffing requirements contained in the NPRM could lead to a reduction in the availability of LTC services, particularly in rural communities. NOSORH believes that the goal of LTC service improvement can best be achieved by appropriate investments in quality improvement, and that a portion of such investments should target the special needs of rural communities.

NOSORH's perspective on the provisions of the NPRM follow. In preparation for this submission, NOSORH facilitated an online listening session with SORHs from across the nation. There were 39 participants in that session, representing states in all regions of the country. The session explored the provisions of the NPRM, and SORHS discussed the likely impact of those provisions in their own states. The views and comments of those SORHs are incorporated into these comments. Specific policy recommendations are also detailed.

Discussion

NOSORH has identified several problematic issues raised by the provisions of the NPRM. These are detailed below.

- **Issue - Impact of Proposed Staffing Requirements**:

  The effectiveness of using minimum staffing requirements to improve the quality of services in LTC facilities is not entirely clear. A recent study, funded by CMS, has challenged the direct relationship between LTC facility staffing levels and improved health outcomes:

  https://kffhealthnews.org/news/article/cms-study-nursing-home-staffing-levels/

This analysis brings into question the use of minimum staffing requirements as the main tool for improving LTC facility quality. The *type of staffing* and *staffing deployment* appears to have an important relation to improved quality.

The Kaiser Family Foundation (KFF) has done an analysis of the percentage of LTC facilities that would meet the staffing requirements proposed by CMS:

> What Share of Nursing Facilities Might Meet Proposed New Requirements for Nursing Staff Hours? | KFF

The analysis is not encouraging. Overall, **about 4 of 5 facilities would *not* currently meet the base requirements**. The results for each state vary, but in 29 states fewer than 25% of facilities would meet the requirements. See the KFF state-by-state mapping for details. CMS is also considering *enhanced* staffing requirements based upon LTC facility resident health and frailty. Nationwide, only .3% of facilities would meet this enhanced staffing requirement. This raises serious questions about the feasibility of reaching the levels specified in proposed guidance.

SORHs participating in the nationwide listening session confirmed these problems. They described the general difficulty in recruiting adequate health care staff to rural communities. SORHs were particularly concerned with the worsening national nursing workforce crisis. Despite efforts to increase the nation's nursing workforce, there is already a severe shortage:

> https://www.aacnnursing.org/news-data/fact-sheets/nursing-shortage

A recent study shows that 30 states, many in the rural West, are facing shortages characterized as critical. As older nurses reduce their work schedules and retire, this shortage is expected to increase, with training and education programs being unable to keep up with demand. SORHs felt that the nursing standards imposed by the NPRM would be impossible to achieve, particularly for rural LTC facilities.

SORHs participating in the nationwide listening session expressed special concern about the failure of the NPRM to recognize the contributions of LPNs to the provision of LTC services. SORHs felt that any staffing requirement which assumes that nursing duties can only be carried out by RNs is unrealistic. Several SORHs described facilities where LPNs with 30 years of experience carry the bulk of nursing duties, once a nursing care plan is established. Given the worsening nursing shortage, the importance of the LPN workforce cannot be ignored. The role of this workforce must be factored into a national response to improving LTC service quality.

There are also questions of the *affordability* of the proposed staffing guidelines. Estimates show that achieving the CMS proposed staffing guidelines nationwide will increase operating costs significantly. One study indicates that the additional cost of staffing to

meet a minimum staffing mandate of 0.55 RN HPRD and 2.45 nurse aide HPD, as well as the 24/7 RN coverage, would be $6.8 billion:

https://www.ahcancal.org/News-and-Communications/Fact-Sheets/FactSheets/CLA%20Staffing%20Mandate%20Analysis%20-%20September%202023.pdf

This is the additional cost for the current level of operations.

The same report indicated that 7,741 out of 13,193 skilled nursing facilities (59%) had negative operating margins (excluding public health emergency funding). The additional burden of meeting minimum staffing requirements with no funding mechanism could potentially increase the number of facilities operating with negative margins. If revenues remain flat – i.e., if there is no change in reimbursement rates – this will create an untenable financial situation.

SORHs participating in the nationwide listening session echoed concerns about the affordability of the proposed staffing guidance. SORHs expressed the thought that the NPRM was an unfunded mandate that would carry a heavy cost. SORHs described multiple cases where rural LTC facilities are already operating with negative or, at best, narrow positive margins. SORHs felt that increased cost of meeting staffing minimums would be unsustainable and would lead to a large number of rural LTC facility closures. SORHs understood the importance of improved staffing for LTC but identified the need for additional funding to achieve any staffing expansion.

- **Issue - Timelines for Implementation of Proposed Staffing Requirements**:

  CMS has established *two* timelines for implementation of the new proposed staffing requirements – one for facilities in urban areas and one for facilities in rural areas. This reflects an understanding of the more difficult workforce challenges faced by facilities in rural communities. Unfortunately, CMS has proposed a definition of *rural* which excludes large numbers of areas historically defined as rural.

  CMS proposes a definition of rural which, based upon Bureau of Census definitions, includes *all population, housing, and territory not included within an urban area.* The problem with this approach is that the Census has recently changed its definition of *urban* from settlements of at least 50,000 to settlements of at least 5,000 people or 2,000 housing units. This redefinition is very controversial and received thousands of protests. Congressional representatives are considering legislation that might reverse the approach.

  The new Census definition would exclude from the *non-urban* category large numbers of communities considered rural under Federal Office of Rural Health Policy (FORHP) or other definitions. The new Census definition is overly limiting and is not consistent with the nation's rural policies. SORHs participating in the nationwide listening session

confirmed this perspective. SORHs felt that the FORHP definition of rural is more accurate in delineating rural areas.

To its credit, CMS is seeking input as part of the NPRM on appropriate definitions for rural and urban. NOSORH believes that alternatives to the new Census definition should be used as a basis for any accommodation made for rural areas.

- **Issue - Exemptions from Proposed Staffing Requirements – Criteria Proposed**:

  The NPRM sets out a mechanism for claiming a '*hardship exemption*' from the new staffing requirements. A hardship exemption is a temporary and is typically awarded for a term of one year. A hardship exemption may be extended, on a year-by-year basis, if the facility continues to meet the exemption criteria described below. There are no limits on the number of exemptions that an eligible facility can be granted.

  A hardship exemption may be granted to a LTC facility which meets 3 conditions:

  - Workforce unavailability,
  - Good faith efforts to hire and retain staff, and
  - A financial commitment to staffing.

  The proposed methodology for identifying *workforce unavailability* identifies two possible criteria:

  - An ***inadequate nurse-to-population ratio***, as calculated by CMS for the area in which a facility is operating, or
  - a ***facility location at least 20 miles away from another LTC facility***, as determined by CMS.

  For the first approach, CMS would use an assessment based upon workforce availability *in a Bureau of Labor Statistics (BLS) defined labor market area*. The BLS definitions break states into multiple metropolitan and nonmetropolitan labor market areas. See link:

  https://www.bls.gov/oes/current/msa_def.htm#N

  The non-metropolitan areas defined BLS ***are questionable as labor market areas***. For example, the BLS-defined *Eastern New Mexico Nonmetropolitan Area* encompasses counties in the far northeast (Union County) and the far southwest (Hidalgo County) corners of the state. This is a distance of more than 500 miles within a single defined market area. Cases such as this bring into question whether BLS nonmetropolitan area definitions delineate rational labor market areas for nurse workforce hiring. NOSORH believes that the use of huge labor market area definitions will not yield an accurate assessment of workforce unavailability in rural areas.

  NOSORH notes that, for some rural areas, there may be two or more LTC facilities within 20 miles distance of one another, and that the simple existence of a licensed facility nearby is not an indication of adequate workforce availability. SORHs participating in the nationwide listening session confirmed this. SORHs felt that the 20-mile distance

requirement was arbitrary. SORHs mentioned instances where two rural LTC facilities were close to one another and neither could effectively recruit and retain the staff that they needed. SORHs felt that, in this case, both should be eligible for hardship consideration.

- **Issue – Guidance for Critical Access Hospital Swing Beds**:

  Critical Access Hospitals (CAHs) are permitted to operate 'swing beds,' i.e., acute care inpatient hospital beds which can be converted for nursing care use. Swing beds can be integrated into a single unit with acute care beds - there is no need for them to be separated into a different unit. CAHs may have up to 25 inpatient beds. Any and all of these beds may be used as swing beds.

  There is a fairly small number of staffing requirements for CAH swing beds in CMS guidance:

  - §485.631(a)(3) of CAH guidance requires that staff be sufficient to provide the services essential to the operation of the CAH.
  - §485.635(d)(2) of the guidance further specifies that a registered nurse or, where permitted by State law, a physician assistant, must supervise and evaluate the nursing care for each patient, including patients at a SNF level of care in a swing-bed CAH.
  - §485.631(a)(5) requires that the CAH must have a registered nurse, clinical nurse specialist, or licensed practical nurse on duty whenever the CAH has one or more inpatients (including patients in a swing bed receiving long term care services).

  Note that the on-duty requirement for nursing care can be met by having *either* a RN *or* a licensed practical nurse (LPN)on duty.

  It is difficult to interpret how the minimum staffing requirements in the NPRM should apply to CAHs. Nursing staff and nurse aides in CAHs may be shared between acute care duties and swing bed duties. It is unclear whether the NPRM guideline would require a specific amount of registered nurse and nurse aide time to be *dedicated* to swing beds or whether on-duty time for all CAH beds could be used to meet the new guideline.

  NOSORH notes that under §485.631(a)(5), once a nursing services plan has been established, licensed practical nurses (LPNs) may be charged with providing nursing care to swing bed patients in a CAH. This use of LPNs is typical of nursing staffing in many CAHs. NOSORH believes that this use of LPNs is appropriate and adds to the quality of nursing care in CAHs. The failure of the NPRM to address the appropriate use of LPNs is problematic.

  There is a need to clarify how any LTC minimum staffing requirements would apply to swing beds in CAHs. The shared use of nursing staff for both acute care and skilled nursing purposes clouds the staffing ratios specified in the NPRM. In addition, the NPRM nursing staff requirements conflict with other guidance already established for CAHS – particularly in the permitted use of LPNs.

SORHs participating on the nationwide listening session indicated that CAHs in their states were concerned about the staffing guidance. SORHs reported that many CAH representatives believe that it would not be feasible for them to meet the staffing minimums, given workforce shortage and financial limitations. This could lead CAHs to close swing bed operations, further reducing the availability of LTC services in rural communities.

SORHs participating on the nationwide listening session also expressed concern about that lack of clarity for how the provisions of the NPRM would be implemented for CAH swing bed operations. SORHs felt that nursing staff in CAHs are effectively shared between acute care and LTC swing beds. SORHs were unclear about whether the NPRM staffing guidelines could be met with staff shared in this manner, or whether the guidance would require staff dedicated to swing bed patients.

Recommendations

NOSORH makes the following recommendations related to the issues raised by the NPRM:

- **Proposed Mandatory Staffing Guidance**: NOSORH recommends that CMS ***rescind the mandatory staffing guidance*** set out in the NPRM. NOSORH believes that the standards are not easily achievable by many LTC facilities, particularly given availability of registered nurse and nurse aide workforce. NOSORH also is concerned that the increased staffing requirements, without accompanying financial support, will not be sustainable. NOSORH is particularly concerned that, as such, the guidance represents an unfunded mandate that will threaten the financial viability of many LTC facilities, particularly in rural areas.

  NOSORH recommends that CMS pursue alternative approaches to improving LTC quality and accessibility. Potential alternative approaches are discussed below.

- **Alternative Recommended Staffing Models**: NOSORH recommends that CMS research the feasibility and sustainability of different LTC staffing models, with the aim of developing recommended staffing for different types of LTC facilities. These models should include alternative mixes of registered nurse, licensed practical nurse, and nurse aide staff, and should include possible staffing models for different size facilities. Model development should include consideration of the special circumstances of rural LTC facilities.

- **Alternative Approaches to LTC Quality Improvement**: NOSORH recommends that CMS explore a mix of different approaches to LTC quality improvement, including technical assistance and training programs for operational and clinical improvement at different size LTC facilities. NOSORH also recommends that CMS use the results of this assessment to develop quality improvement programs for LTC facilities.

- **Funding Mechanisms for Staffing and Quality Improvement**: NOSORH recommends that CMS identify possible funding mechanisms that could be used to provide additional support for staffing and quality improvement in LTC facilities. These approaches should include new programs for these purposes. New programs could include both direct funding for improvements and increased Medicaid/Medicare reimbursement to sustain improvements. NOSORH also

recommends that new funding programs be targeted to rural LTC facilities and their special circumstances.

- **CAH Swing Bed Considerations**: NOSORH recommends that CMS, in its future guidance and policy related to LTC facilities, take into account the special circumstances of the swing bed operations of Critical Access Hospitals.

- **Definition of Rural**: NOSORH recommends that CMS, in its future guidance and policy related to LTC facilities, use more appropriate definitions of *rural*. NOSORH suggests that CMS consider a more inclusive definition of rural such as that established by FORHP for county and subcounty geographic areas in the nation.

- **Definition of Rural Labor Market Areas**: NOSORH recommends that CMS, in its future guidance and policy addressing workforce availability, abandon the BLS rural labor market area definitions and seek a more granular set of market area definitions.

We appreciate the opportunity to submit comments on this important Request for Information and hope you find value in the recommendations outlined.

Let me know if you have questions, would like discussion, or if I may be of assistance.
Thanks so much.

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