



November 6, 2023

Chiquita Brooks-LaSure
Administrator
The Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Brooks-LaSure,

On behalf of the nation's Medicaid Directors, NAMD is pleased to offer comments on the proposed rule, [Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting \[CMS-3442-P\]](#). The proposed rule would establish minimum staffing requirements in long-term care (LTC) facilities. It would also strengthen facility assessment requirements and create new institutional payment reporting requirements for Medicaid agencies.

NAMD supports the rule's aim of improving quality and safety in LTC facilities. However, the proposed minimum staffing standards may have unintended consequences on Medicaid-funded home and community-based services (HCBS), given existing workforce shortages. Medicaid Directors also note specific technical and operational concerns with the proposed institutional payment reporting requirements.

NAMD is a professional community of state leaders who provide health insurance to more than 91 million individuals and families through Medicaid and the Children's Health Insurance Program in each of the 50 states, the District of Columbia, and the U.S. Territories. NAMD elevates thought leadership on core and emerging policy matters, amplifies the experience and expertise of Medicaid and CHIP directors, supports state programs in continuous improvement and innovation, and optimizes federal-state partnerships to help millions live their healthiest lives.

The Proposed Rule May Have Unintended Consequences on the Long-Term Care System

NAMD supports the rule's aim of improving LTC facility quality and appreciates the connections between staffing levels and patient safety. It is, however, important to ground discussions of long-term care staffing in the realities of the long-term care workforce. Our country's aging population has increased demand for the direct care workforce, with research estimating [7.9 million new job openings in direct care from 2020 to 2023](#). There are similarly worrisome shortages of nursing staff, with [researchers projecting](#) a national deficit of approximately 918,000 registered nurses (RNs) and widespread nursing shortages by 2030.

This limited supply of nursing staff and other direct care workers is shared between LTC facilities and HCBS providers. As states and territories work to rebalance the long-term care continuum, it is important to ensure the availability of high-quality care – of which staffing is a crucial component – in both facilities and the community. Growing the nursing and direct care workforce will take time and focused investments from the federal government.

Without an adequate workforce, a minimum staffing standard at nursing facilities may inadvertently pull direct care workers (DCWs) and nursing staff from the HCBS sector into institutions. It may also exert budgetary pressure on Medicaid agencies, drawing resources away from HCBS waiver programs and similar efforts to rebalance the long-term care system towards community-based care. Medicaid agencies note that this budgetary pressure may, for example, reduce their ability to sustain investments made in the HCBS system through the American Rescue Plan Act.

To mitigate this, NAMD strongly encourages CMS to work with the Health Resources and Services Administration (HRSA), the Department of Labor (DOL), and other key federal partners to increase the supply of nursing staff and DCWs. This could include investments in workforce pipeline development, direct reimbursement for training activities, and other interventions.

The US Department of Health and Human Services (HHS) has recently issued multiple proposed rules that would impact the long-term care system, including [the proposed access rule](#) and [the proposed reinterpretation of Section 504 of the Rehabilitation Act](#). Together, these rules seek to strengthen HCBS by requiring incident management systems, creating an 80 percent wage pass-through for the HCBS direct care workforce, requiring new reporting, and restricting Medicaid agencies' ability to reduce services or benefits when these reductions may hinder access to HCBS or increase the risk of institutionalization.

This rule, the access rule, and the Section 504 rule each have a commendable aim: enhancing the quality of care in LTC facilities, increasing access to HCBS, and protecting individuals from discrimination on the basis of disability. Taken together, however, these rules would result in significant administrative burden on Medicaid agencies and providers. They may also have unpredictable impacts on the flow of workers between community-based settings, which would be subject to an 80 percent wage pass through, and institutions, which would be subject to minimum staffing standards.

Together, these rules would also limit the important flexibilities states and territories have to adapt to changing budgetary environments. For example, the proposed minimum staffing standards would likely increase costs for Medicaid agencies, shifting state and territory spending to institutional care. Simultaneously, the proposed Section 504 rule would limit the ability of states and territories to reduce benefits or services if these reductions result in increased access to institutional care, in comparison to HCBS.

It is unclear how states and territories would be able to manage this fiscal dynamic without impacts on benefits or eligibility groups.

Medicaid Directors support CMS's aims of increasing the quality of LTC facilities while ultimately rebalancing the continuum towards HCBS. **We urge our federal partners, however, to be mindful of the potential unintended consequences of finalizing three separate proposed rules with significant impacts on the long-term care system and to carefully consider potential interactions.**

The Proposed Minimum Staffing Standards May Not Be Feasible in All States

In this rule, CMS proposes minimum staffing standards of 0.55 hours per resident day (HPRD) for registered nurses and 2.45 HPRD for nursing aides (NAs). Medicaid Directors report a diversity of views on these proposed HPRD standards. **Some states have already enacted similar standards and view CMS's proposed standards as feasible and appropriate. Other states, however, report concerns around the proposed standards, with specific concerns around workforce shortages and fiscal impacts on Medicaid agencies.**

As discussed above, there are substantial workforce shortages among nursing staff and DCWs, with rural states (and rural areas within states) facing particularly acute challenges. Due to these shortages, LTC facilities would likely need to increase wages or hire contract staff, which would result in increased costs. These cost increases may be felt across institutional and community-based settings, as they compete for the same workers, and would likely necessitate Medicaid and Medicare rate increases. CMS does not contemplate additional federal resources to support these potential increases. Medicaid agencies also note questions around oversight, as state survey agencies do not currently have the capacity to oversee these requirements; states would likely need to bring on many additional employees to support oversight and compliance, further increasing the fiscal impact.

CMS seeks comment on alternative HPRD standards, such as establishing a total nurse staffing standard of 3.48 HPRD or establishing a standard that incorporates Licensed Practical Nurses (LPNs) and Licensed Vocational Nurses (LVNs). **Generally, Medicaid Directors support a more flexible standard that allows states to include LPNs/LVNs.** The proposed standard only considers RNs and NAs, which discounts the significant role that LPNs/LVNs play in the long-term care system. If the staffing standard is finalized as proposed, it may result in facilities reducing employment opportunities for LVNs/LPNs in favor of RN and NA staffing, solely to meet the minimum staffing standards. This could have broadly negative impacts on the long-term care workforce, including by limiting career development opportunities for NAs, which could contribute to challenges around staff retention. Medicaid agencies also report concerns that, if LPN hours are not considered, facilities may shift LPN hour classifications

(Payroll Based Journal System job code 8/9) to the Certified Nursing Assistant code (Payroll Based Journal System job code 10), resulting in oversight concerns. **If CMS moves forward with a minimum staffing standard, CMS should consider a more flexible standard that allows states/territories to tailor RN, NA, and LPN/LVN staffing level requirements to local conditions.**

CMS proposes an exemption process for LTC facilities that are facing staffing shortages. **Generally, Medicaid Directors support the creation of an exemption process and report that the proposed exemption criteria are appropriate.** This exemption process would likely be highly utilized in rural areas. Medicaid Directors also generally support the proposed exclusions from an exemption. Some Medicaid agencies who have already implemented minimum staffing standards note that they do not currently allow exemptions or have a different exemption framework; CMS should consider giving these states the option to tailor the exemption process to align with their existing frameworks.

CMS also proposes a requirement for LTC facilities to have a registered nurse (RN) onsite 24 hours a day, 7 days a week. Medicaid agencies report that having an RN onsite 24/7 is good clinical practice and supports the quality and safety of patient care. However, some Medicaid agencies report concerns about the feasibility of this requirement, given RN shortages and maldistributions. **To make this provision more operationally feasible, CMS could consider alternative policies for facilities facing workforce shortages, such as counting an RN who is “on call” or available via telehealth for a certain number of hours per day towards this requirement.**

CMS seeks comment on whether a facility’s Director of Nursing, which is required under existing regulations, should be counted towards the 24/7 RN requirement. Some Medicaid Directors report that it would be appropriate for the Director of Nursing to count towards the 24/7 requirement in smaller facilities (that is, facilities with less than 30 to 60 beds). In larger facilities, a Director of Nursing often has a more supervisory role, which would limit their ability to provide direct patient care.

CMS proposes a staggered implementation timeline for LTC facilities, with a five-year deadline for rural facilities to come into full compliance with the minimum staffing standards and a three-year deadline for urban facilities. Medicaid Directors agree that additional time for rural facilities is appropriate. However, some states note that, given workforce shortages, some rural facilities may struggle to recruit nursing staff. Medicaid Directors also note that, in combination, the proposed exemption process and staggered implementation timelines may result in confusion for long-term care facilities; CMS should provide clear guidance to facilities on their specific implementation timelines and processes for seeking an exemption.

Medicaid Directors Generally Support Strengthened Facility Assessment Requirements

In this rule, CMS proposes to clarify that facility assessments would set a standard above and beyond the proposed quantitative minimum staffing levels for RNs and NAs. CMS also proposes to strengthen existing facility assessment requirements by requiring LTC facilities to use additional data sources, develop staff recruitment and retention plans, and incorporate staff feedback (including direct care worker feedback) into facility assessments.

Generally, Medicaid Directors support these strengthened facility assessment requirements. While this proposal may increase administrative burden on providers, Medicaid agencies report that it would help create a structured mechanism to document facility-level staffing needs and decisions. Medicaid agencies particularly appreciate CMS's inclusion of behavioral health needs in facility assessments.

States note that the proposed 60-day implementation deadline for facilities to come into compliance with the new facility assessment framework may not be feasible. CMS could consider an implementation deadline of up to six months.

The Institutional Payment Reporting Requirements Would Be Burdensome for Medicaid Agencies and Providers

CMS proposes to require Medicaid agencies to report, at the facility level, on the portion of payments for nursing facility and ICF/IID (intermediate care facilities for individuals with intellectual disabilities) services that are spent on compensation for the direct care and support staff workforce. **Medicaid Directors support CMS's aim of transparency around wage data but report serious concerns about operationalizing this provision.**

Medicaid agencies note the intense administrative burden that the proposal would place on Medicaid agencies and providers. Medicaid cost reports typically do not collect salary and benefit data at the level of granularity that would be required by this provision. This means that Medicaid agencies would need to develop new collection tools and reporting mechanisms and providers would need to update their internal recordkeeping processes. Medicaid agencies would likely need to hire additional FTEs to effectuate this reporting.

CMS itself acknowledges the burden of collecting nursing facility wage data in its [April 2023 Medicare Prospective Payment System and Consolidated Skilled Nursing Facilities rule](#). In that rule, CMS notes the substantial resources that would be necessary to collect this data. It is equally challenging for Medicaid agencies to do so, and they would need to do so without the level of resources that CMS could likely muster. As such, NAMD views CMS's proposal in this rule as shifting a reporting burden

to states that CMS considers too difficult and resource-intensive for it to do itself. This is not a reasonable expectation without a commensurate investment of federal resources for Medicaid agencies to achieve this goal.

Medicaid Directors also note specific technical concerns with the proposed reporting. Directors note that it would be extremely difficult to approximate the amount of Medicaid reimbursement received by a facility that is then spent on labor costs only for Medicaid patients. LTC facilities do not and could not realistically track how much time a worker spent on patients covered by Medicaid versus patients covered by Medicare or private insurance. Apportioning total Medicaid payments to a facility by Medicaid utilization is not a good indicator of actual Medicaid spend on worker compensation, as spend varies based on the needs of facility residents. Medicaid agencies also note that many facilities use contract labor (in which the contract price includes wages, benefits, and administrative costs) and all-inclusive contracts (in which a facility pays a monthly rate for labor, supplies, and other items). It is unclear how these costs could be incorporated into the proposed reporting. Finally, Medicaid agencies note challenges with the impact of dually eligible members on cost calculations, as Medicaid does not bear the cost of therapy provision or prescription drugs for dually eligible nursing facility residents.

Many Medicaid agencies note that CMS already collects multiple data sets that could be used to approximate the proposed reporting. Specifically, CMS already collects: direct care salary, benefits, and hours for freestanding nursing facilities using the Medicare Cost Report; Medicaid fee-for-service per diems in upper payment limit reporting; and quarterly supplemental payment information through the Medicaid Budget and Expenditure Systems (MBES) and in CMS-64 reports. **CMS should use existing federal data to approximate the proposed metrics. This would reduce administrative burden and ensure consistent calculations across Medicaid programs.**

CMS seeks comment on their proposed definitions for compensation, direct care workers, and support staff. Medicaid agencies generally report that these definitions are reasonable, although they note that the definitions fail to address universal care workers who provide both nursing services and support services.

CMS seeks comment on the proposed annual cadence of reporting. Although some Medicaid agencies note that annual reporting would ensure data is recent and actionable, others note concerns about the administrative burden associated with the proposed cadence.

CMS seeks comment on allowing Medicaid agencies to exclude, at option, providers with low Medicaid revenue or a small number of Medicaid members. Some Medicaid leaders support this provision, as it would help reduce administrative burden on small

facilities. However, others note that this may incentivize LTC facilities to not admit Medicaid patients due to the additional administrative burden. Some Medicaid leaders also note that they would prefer to exclude out-of-state single-case agreements, due to the difficulties collecting data on out-of-state facilities, and hospital-based providers.

CMS seeks comment on reporting base versus supplemental payments for fee-for-service Medicaid. Generally, Medicaid agencies report that looking at supplemental payments separately is important, as supplemental payments may have defined intents that are not related to wages. However, one state notes that separate reporting would increase administrative burden. Multiple states also note that CMS is already collecting this information through upper payment limit, MBES, and CMS-64 reporting.

CMS seeks comment on adding additional reporting, including reporting on median hourly compensation for DCWs and support staff. Although some Medicaid agencies note that this data would help evaluate the impact of rate increases on staff wages, others are strongly opposed to additional reporting due to the increased administrative burden on states and providers.

CMS seeks comment on a potential future wage pass-through provision (such that a minimum percentage of Medicaid payments be spent on compensation for direct care workers and support staff in LTC facilities) but did not propose such a provision in this rule. **NAMD strongly encourages CMS to extensively engage Medicaid leaders on the design and implementation of a wage pass-through before formally proposing a pass-through in rulemaking.** Medicaid agencies would need to conduct studies of existing compensation levels to understand the impacts of a pass-through on patient access and fiscal stability. Medicaid leaders also note serious concerns around potential unintended consequences, including LTC facilities denying admission of Medicaid patients to avoid the pass-through requirement, alongside the potential difficulty associated with enforcing a pass-through provision.

Conclusion

Medicaid Directors strongly support CMS's aim of improving the quality and safety of care in LTC facilities. However, given current workforce shortages, the proposed minimum staffing standards may not be feasible in all states and territories. NAMD encourages CMS to continue engaging with HRSA, DOL, and other partners on long-term strategies to strengthen the nursing and direct care workforce. NAMD also strongly encourages CMS to consider the potential unintended consequences of concurrent rulemaking on different parts of the long-term care system, including the proposed access rule and the proposed reinterpretation of Section 504 of the Rehabilitation Act.

Thank you for the opportunity to provide comments on this proposed rule. NAMD looks forward to continuing to work with CMS to ensure Medicaid members have access to high-quality long-term care.

Sincerely,

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