LeadingAge Kansas Comments on Proposed Rule CMS-3442-P (Minimum Staffing Standards)

LeadingAge Kansas is the state association for not-for-profit and mission-focused aging services. Its 150 member organizations across Kansas include over 100 not-for-profit nursing homes and long-term care units of critical access hospitals. Our organization has been in operation for nearly 70 years supporting providers serving in predominantly rural and frontier areas of the state. Before the COVID pandemic, our providers started facing workforce shortage challenges with fewer Kansans entering and graduating from nursing programs. Despite state statute requirements, the state of Kansas failed to adequately reimburse Medicaid rates to facilities for multiple years – limiting providers' ability to increase wages and compete in the labor market for direct support staff.

The pandemic exacerbated these challenges leading to more than 47 providers closing or reducing their offerings. All this is happening at a time when more Kansans are aging and needing increased access to care. By 2036, the 65+ population in Kansas will grow by 208,000. Nearly 85,000 Kansans are living in areas with only one nursing and residential care provider within a 30-minute drive and are at risk of joining the 23,000 Kansans already living in a care desert. Care deserts on average double the drive time needed to reach a provider and thereby limit access to care or risk access to friends, family, and loved ones. Due to our rural and frontier landscape, we feel compelled to provide comments on the unintended consequences of the proposed minimum staffing standards.

<u>Formulation of the Rule</u>

CMS used information from the Payroll Based Journaling (PBJ) data, RFI FY 2023 SNF PPS Rule comments, survey compliance data, and Abt Associates 2022 Nursing Home Staffing Study to draft the proposed rule. The problem with the formulation of this rule is the lack of evidence-based data that can support the provisions outlined.

While PBJ data does allow insights into staffing ratios based on resident occupancy and total time worked by direct support staff, it does not allow insight into the specific periods of those times worked. By saying there are facilities already meeting the 24/7 RN requirement, the Centers for Medicare and Medicaid (CMS) negates a critical component of understanding whether those nurses are working overlapping 8-hour day shifts or each on separate shifts. Currently, there is not enough data to support that provision of the rule.

Additionally, the Abt study highlighted no set number of staff can guarantee quality of care as each resident's needs are different – therefore making each provider's needs different. The Abt study also highlighted the significant workforce challenges providers across the United States are facing and the significant financial cost of implementing this rule.

Despite these crucial pieces, CMS continued to implement an unfunded mandate without any policy initiatives to support the nursing workforce pipeline aside from the $75 million they plan to use for scholarships and tuition reimbursement. The $75 million may support the few individuals who choose to enter nursing careers, but it will do nothing to support the longevity of their careers. Simply funding recruitment, without funding retention initiatives will continue to contribute to a declining workforce pipeline.

Despite an inadequate workforce, there is no guarantee of funding to support the implementation of the proposed rule. CMS has looked to the states to enhance Medicaid funding to providers – which is expected to cost millions. CMS proposed the state of Kansas could face a $9 million cost for the 24/7 RN provision and a $24.9 million cost for the staffing ratio provision, however, our analysis indicates the total cost of the rule to providers will be nearly $58 million per year. This is on top of the millions of state general funds our providers seek from the state to simply sustain and keep the doors open.

When it comes to formulation of the rule, CMS picks and chooses which evidence supports its idea of what the rule should be rather than acknowledging all the evidence that conflicts with a mandate.

<u>24/7 Registered Nurse Requirement</u>

This provision would modify the existing requirement 42 CFR §483.35(b)(1) to go from the use of RN services from 8 hours per day, seven days per week to 24 hours per day, seven days per week. The proposed implementation of this provision is two years for urban areas and three years for rural areas from the date of finalization. Per CMS analysis, Kansas would need an additional 71 RNs in rural areas and 38 RNs in urban areas – or a total of 109 additional RNs across the state – to come into compliance.

Annual reports from the Kansas State Board of Nursing indicate there are fewer Bachelor of Science in Nursing (BSN) program admissions year after year – a net loss of 189 admissions from 2018-2022 to be exact. Associate Degree of Nursing (ADN) programs are not doing any better with a net loss of 23 admissions during that same time. The continuing decline in admissions is not the only problem. Nearly 42% of RNs in Kansas are 50 and older and preparing for retirement. Our workforce pipeline is not sufficient to supplement the shortage of nurses we are currently facing and will continue to face over the coming years.

The Kansas Department of Labor (DOL) shows as of August 2023 there were 5,291 job openings for RNs in Kansas. This alone indicates CMS analysis in the rule does not account for the backfilling of open positions that would also be needed. The Kansas DOL also indicates Kansas nursing and residential care facilities only make up 7.87% of employers for RNs – with hospitals making up 65.27%. The proposed rule is looking at an incomplete picture when it comes to an adequate supply of nurses since multiple employers outside of nursing homes are all vying for the same limited RN pool.

The lack of justification for having an RN on-site 24/7, an insufficient RN pipeline, and increased labor costs that come with this provision should be cause for concern.

<u>Minimum Staffing Ratios</u>

The minimum staffing standards would require .55 RN hours per resident per day (HPRD) and 2.45 Nurse Aide (NA) HPRD with a caveat of providers offering more based on resident acuity. The proposed implementation of this provision is three years for urban areas and five years for rural areas from the

date of finalization. Per CMS analysis, 153 Kansas facilities would need an additional 51 RNs and 369 NAs statewide to follow this provision.

The Kansas DOL shows as of August 2023 there were 1,067 NA job openings in Kansas. Unlike RNs, Kansas nursing and residential care facilities are the primary employer for NAs at 56.98%. Despite nursing homes being the primary employer for this sector of the workforce, fewer providers are currently meeting the proposed provision of 2.45 NA HPRD. The shortage of NAs can be attributed to the CNA training lockout.

The concern with this provision of the rule is again related to the inadequate workforce pipeline, the financial burden placed on providers attempting to meet the provision of the rule, and the fact that CMS's study highlighted no set number of staff can guarantee quality of care.

Licensed Practical Nurses in Long-Term Care

The proposed rule will create an unintended consequence of squeezing Licensed Practical Nurses out of the long-term care workforce. The proposed rule does not allow LPN care to count towards either the .55 RN HPRD or 2.45 NA HPRD. LPNs play a critical role in the long-term care workforce, bridging the gap between the CNA and RN roles to offer increased quality care to residents.

The Kansas DOL shows LPNs have found their home in long-term care with nursing and residential care facilities making up 39.67% of the employment industry. The Kansas DOL report on LPNs also indicates over the last five years, only 58 LPNs transitioned on to become RNs. This proposed rule will force a sector of the workforce to make a critical life decision: go back to school or find a new job.

The unintended consequence of not counting LPNs at the 3.0 HPRD staffing standard will be worsening the already struggling long-term care workforce with more LPNs seeking employment in other settings or fields altogether. We do not support the alternative proposal of raising the total staffing standard to 3.48 to include LPNs as that will raise costs even more to an already unfunded mandate.

Enforcement of the Requirements

Enforcement of the rule will come from data from the survey and certification process, in part relying on PBJ data. Remedies for noncompliance could include Civil Money Penalties (CMPs), Denials of Payment for Medicare and Medicaid beneficiaries, or termination of the provider agreement – closures.

Survey compliance data is subject to human interpretation of rules and regulations that can result in an increase of noncompliance or even immediate jeopardy (IJ) tags – simply due to the surveyor's understanding or guidance from enforcement officials. Kansas nursing home providers are currently experiencing an increase in immediate jeopardy tags related to PBJ or insufficient staffing, however, in discussions with our regional CMS office, there seems to be confusion about the interpretation of the rules on the part of the Kansas surveyors. The Kansas City regional CMS office has stated they are working to correct that issue. This example indicates there is too much room for human error in survey data to base enforcement remedies that can include closure for this rule.

The CMP Reinvestment Program was paused by CMS for a couple of months to align all states on CMS's guidance for the application process and types of projects that can be funded. With the announcement of this rule and the $75 million being used by CMS to fund nursing scholarships, providers can no longer

submit applications related to workforce development. Yet again, CMS has taken a one-size-fits-all approach to the workforce crisis without acknowledging the differences between staff needs and limiting the providers' ability to meet them.

Waivers and Exemptions

CMS suggests providers who are truly experiencing hardship in meeting the rule due to workforce shortages can apply to receive a waiver for the 24/7 RN provision or exemption for the minimum staffing ratios. However, these are two separate processes and a provider receiving a waiver or exemption for one provision does not automatically exclude them from the other provision.

The 24/7 RN provision waiver will be updated through 42 CFR §483.35(f) which currently holds the waiver process for the 8-hour per day, seven days a week RN requirement. Providers are required to demonstrate they have done all they can to recruit appropriate personnel including offering wages at the community prevailing rate for nursing facilities and going through a survey process to determine the waiver will not endanger the health and safety of individuals staying in the facility. Providers are subjected to an annual state review of the waiver.

The minimum staffing ratios exemption will require providers to demonstrate hardship through location, good faith efforts, and financial commitment. Location requirements include providers being in an area with 20-40% below the national average provider-to-population ratio or located 20 miles or more from the next closest long-term care facility as determined by CMS. Good faith efforts include detailed recruitment and retention plans from providers including offering prevailing wages based on average wages in the area where the provider is located and showing the number and length of vacancies in the provider's area. Currently, Kansas does not have a waiver process for this provision which would require additional work on the state's part.

However, providers will not be allowed to qualify for the minimum staffing exemption if they fail to submit PBJ data, are a special focus facility, have been cited with "widespread" or "pattern" or insufficient staffing resulting in resident harm, or immediate jeopardy tag concerning understaffing in the preceding year.

The concern we have with these waiver processes is the requirement of providers to open themselves up to additional scrutiny through a survey process to qualify for the waiver. This could mean a provider opens themselves up to exclusion if a surveyor determines their insufficient staffing has resulted in harm or inaccurately cites the PBJ tag as we have been seeing. We are also concerned with the definition of prevailing wages being based on a position in a geographic area. This could mean our providers are competing with wages being offered by private hospitals in the same geographic area without adequate funding to support their efforts. Our final concern is the lack of surveyors the Kansas Department of Aging and Disability Services (KDADS) employs with their Survey, Certification, and Credentialing Commission down 36 surveyors as of September 2023. The lack of surveyors will prevent timeliness issues for annual inspections, let alone special surveys for a waiver or exemption process.

Enhanced Facility Assessment and Medicaid Payment Transparency

The last couple of provisions of the proposed rule includes the enhanced Facility Assessment and the Medicaid Payment Transparency. The Facility Assessment provision requires additional evidence-based data driven by MDS or other quality measures to drive the creation and implementation. The goal of this

provision is to utilize the assessment to drive staffing decisions and ensure quality care based on resident acuity or behavioral health. However, this provision is in direct conflict with the 24/7 RN and minimum staffing ratio provisions of the rule. Those have set standards that do not allow for the facility assessment to be utilized as the intended tool it is supposed to be. Other concerns we have with the facility assessment are the additional administrative burden of drafting and reviewing these documents that will pull time away from engaging with residents as well as the additional engagement from direct care staff with no additional funding for the costs to cover time spent on these activities. Again, this provision is in direct conflict with the other provisions of the rule by requiring direct staff to participate in activities that would pull their time away from residents.

The Medicaid Payment Transparency provision of the rule is one we feel Kansas already follows through our cost-reporting process. The potential concern we have is requiring this provision could result in further administrative burden depending on the reporting process established by the state.

Summary and Recommendations

The proposed minimum staffing standards rule is a perfect example of confirmation bias research resulting in unachievable standards that will further disparities in equity and access for Kansas residents and families with more nursing home closures – furthering the care desert so many already experience. Nursing facilities do not operate in a vacuum and are often tied into a continuum of care model that helps to provide consistency and access to quality care for residents and their facilities – especially in rural areas where services are scarce. We have not even experienced the height of the aging population needing care in Kansas, and already face challenges in finding qualified staff due to inadequate workforce pipelines and policy that limits recruitment. The lack of funding and additional mandates placed on nursing homes continue to negatively impact that workforce pipeline as staff continue to leave the healthcare sector altogether. Simply put – CMS cannot mandate staff into existence. This proposed rule is the equivalent of a parent telling a child, “Do it because I told you so.” Parents are supposed to support and help children grow to be better versions of themselves, while also being open to learning from the experiences of their child. CMS has failed to collaborate and continues to deny the unintended consequences this proposed rule will inevitably bring if finalized.

For these reasons, we would recommend the proposed rule not be finalized until CMS has worked collaboratively with Congress and nursing home stakeholders to identify policies that will enhance the workforce and allocate funding to support those initiatives. The two-to-five-year implementation timeline of the first couple of provisions is not adequate time to address a crisis that has been slowly building since before the pandemic. What we need in place of this rule is:

1. A national campaign effort to address the negative viewpoint of the nursing field that was brought about during the pandemic.
2. Adequate funding for nursing faculty to ensure class sizes for nursing programs can be filled.
3. Additional workforce policies that recognize on-the-job experience, such as apprenticeship programs.
4. Increased funding allocated to nursing facilities to allow providers to offer competitive living wages.
5. Reduced regulations that prevent providers and staff from achieving what they set out to do – provide quality care for residents and their families.