LeadingAge Kansas Comments on the Request for Information: Deregulation (Docket No. OMB-2025-0003-0001)

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Introduction
LeadingAge Kansas is an association representing 150 nonprofit and mission-driven aging services providers across Kansas. Our members serve nearly 25,000 older Kansans daily, offering a continuum of services including skilled nursing, assisted living, memory care, affordable housing, adult day programs, hospice, and home-based care. We appreciate the opportunity to provide input on the federal government's deregulatory initiatives and offer the following comments grounded in our commitment to quality care and operational sustainability.

General Principles for Deregulation
We support regulation that ensures quality and accountability. However, many federal regulations applied to aging services today:

- Fail to reflect the workforce and funding realities in aging services, particularly in rural areas;
- Duplicate existing state or federal requirements, wasting provider time and taxpayer dollars;
- Exceed statutory authority or medical judgment;
- Punish providers through overzealous enforcement instead of supporting quality improvement;
- Impose unfunded mandates that threaten financial viability.

We recommend removing, consolidating, or revising regulations that are outdated, duplicative, overly prescriptive, or harmful to resident-centered care.

1. Minimum Staffing Rule (42 CFR Parts 438, 442, and 483):
Providers strongly oppose the federal minimum staffing rule for nursing homes, describing it as unrealistic, unfunded, and disconnected from the current workforce crisis. Many facilities, especially in rural areas, simply cannot find the registered nurses and nurse aides required to meet the mandate, even if funding were available. The rule threatens to force bed closures, limit admissions, or shut down entire facilities, reducing access to care for older adults. Providers argue that staffing decisions should be based on resident needs and staff competencies, not rigid national ratios. Texas U.S. District Court Judge Matthew Kacsmaryk recently vacated the minimum staffing standards and 24/7 RN requirements of the rule, reinforcing concerns that CMS exceeded its statutory authority. Additionally, the enhanced facility assessment is overly burdensome and goes beyond what is necessary to determine staffing based on resident needs, while the Medicaid payment transparency provisions represent federal overreach into state-level policy. **We recommend rescinding the minimum staffing rule in its entirety and removing associated regulatory language and F-tags used to survey or enforce compliance in long-term care settings.**

2. Medicaid Access Rule (42 CFR Parts 431, 438, 441, and 447):
The final Medicaid Access Rule imposes rigid and unworkable mandates, most notably the 80/20 compensation requirement, that threatens the financial viability of senior living and home- and community-based services providers. By requiring 80% of Medicaid payments for certain services to be spent directly on worker compensation, without commensurate funding increases, the rule ignores the real administrative and operational costs necessary to maintain safe, quality care. This unfunded mandate risks reducing access to essential services, particularly in rural and underserved areas, and may force providers to limit enrollment or exit Medicaid altogether. The lack of clarity regarding the rule's applicability to assisted living further compounds compliance challenges. **For the sustainability of the aging services sector and the well-being of Medicaid beneficiaries, we recommend this rule be repealed for aging services or long-term care providers.**

3. Home and Community Based Services (HCBS) Final Settings Rule (42 CFR Parts 430, 431, 435, 436, 440, 441 and 447):
The 2014 CMS rule on Home and Community-Based Services (HCBS) settings was ill-constructed for aging services providers, as it imposes rigid definitions of what constitutes a "community-based" setting that often exclude or penalize assisted living and other residential care models preferred by older adults. By emphasizing physical characteristics and proximity to institutional settings, the rule creates confusion, restricts access to preferred housing options, and complicates service delivery where housing and care are integrated. This one-size-fits-all approach disregards the needs and preferences of seniors and burdens providers with unnecessary compliance hurdles that do not improve care outcomes. **We recommend the Final Settings Rule be repealed and replaced with a more flexible, person-centered framework that respects the diversity of aging services settings.**

4. Payroll Based Journaling (42 CFR 483.70(o)):

The PBJ Technical Specifications and Reporting Instructions overreach by imposing a rigid interpretation of 8-hour RN coverage per day, which contradicts Congress's intent under OBRA 1987 to ensure a minimum of 8 hours of RN coverage, irrespective of whether the hours are consecutive or spread across multiple shifts. The current guidance fails to acknowledge that multiple nurses working in tandem throughout the day should count toward total coverage, not just consecutive hours by a single nurse. By limiting the definition to consecutive hours worked by one nurse, the PBJ system overlooks the flexibility needed to meet staffing requirements in a practical and functional manner. This policy unnecessarily complicates compliance, distorts the true staffing picture, and harms facilities striving to provide quality care. **We recommend repealing PBJ reporting requirements and the F-Tag enforcement, replacing them with a more straightforward, inclusive approach that recognizes total RN coverage as sufficient, irrespective of how the shifts are structured.**

5. Infection Reporting (483.80, F-Tag F0880):
There are several regulatory and sub regulatory requirements under this CFR that are cited during the survey and certification process for nursing homes under F0880. On the QCOR website, it shows this tag was the most cited tag for nursing homes across the U.S. in 2024 with 40.7% of all providers being cited.

a. **NHSN Reporting – 483.80(g)**
   Providers express strong opposition to ongoing NHSN reporting requirements, particularly for respiratory illnesses, citing that the data is duplicative, no longer necessary post-pandemic, and creates a significant administrative burden without improving resident care. Weekly reporting strains already limited staff capacity diverts resources from direct care and contributes to burnout. Providers also note that state and local public health reporting systems already capture outbreak data, making NHSN reporting redundant. **We recommend removing this requirement from the Code of Federal Regulations and eliminating any associated F-tag used to survey or enforce its use in long-term care settings.**

b. **Enhanced Barrier Precautions - CMS QSO-23-10-NH, F880 Tag**
   Providers oppose Enhanced Barrier Precautions (EBPs) because they are viewed as an unfunded mandate that significantly increases costs, burdens staff and disrupts care. The requirement to use gowns and gloves for routine care of residents with indwelling devices—even when no infection is present—slows down workflows, exacerbates workforce shortages, and undermines resident dignity and trust, especially in dementia care settings. Providers question the clinical necessity of EBPs in non-outbreak scenarios and urge regulators to consider more flexible, evidence-based approaches. **We recommend rescinding CMS's QSO-23-10-NH on EBPs and removing any associated F-tag used to survey or enforce its use in long-term care settings.**

c. **COVID Protocols – CMS QSO-23-02-ALL, F880 Tag, F882 Tag, F884 Tag**
CMS continues to defer to the CDC for COVID-19 protocols, which still recommend isolation for residents with suspected or confirmed COVID-19, as well as outbreak testing. However, this approach, which mirrors the early days of the pandemic, places a significant burden on long-term care providers and residents. The ongoing isolation leads to heightened stress, depression, and a range of negative physical impacts such as loss of muscle mass, ADL decline, and weight loss. Additionally, repetitive testing creates administrative burdens, and many residents feel their environment is less homelike, further exacerbating their well-being. Providers are frustrated with the lack of flexibility, as COVID-19 should be treated in a manner more similar to influenza, focusing on targeted precautions rather than blanket isolation. Moving forward, a more balanced approach is needed, where CMS allows for flexibility in applying CDC guidelines based on a facility's specific context, vaccination status, and the current COVID-19 burden in the community. This would help reduce the emotional and physical toll on residents while maintaining necessary precautions for those at higher risk. Further, this is one of the top tag enforcements against nursing homes with 15% of all U.S. nursing homes being cited. **We recommend removing any associated F-tag used to survey or enforce these practices in long-term care settings.**

6. Survey and Certification (42 CFR 488.300 – 488.335), and Civil Money Penalties (42 CFR 488.430 – 488.445):
The current survey and certification process for nursing homes has become increasingly punitive, resulting in an over-issuance of F-Tags and civil money penalties (CMPs) that divert critical resources away from resident care. Tags such as F689—addressing accidents, supervision, and safety—are often applied in an overly broad manner, penalizing providers with substantial fines for incidents like unpreventable falls or elopements, even when appropriate safeguards were in place. The definition of "immediate jeopardy" now includes the likelihood of harm, granting surveyors wide discretion to issue severe citations based on hypothetical scenarios rather than actual outcomes. CMPs may be imposed per instance or per day, and recent CMS rule changes now allow overlapping penalties, compounding financial burdens and threatening the viability of facilities, particularly those already struggling with narrow operating margins. This enforcement-first model discourages transparency and self-reporting while doing little to support meaningful quality improvement. Further compounding the issue, even survey findings that result in no actual harm to residents can render providers ineligible for Medicaid incentive payments—removing yet another stream of funding that could otherwise be used to care for some of our most vulnerable populations. Surveyors should be required to offer technical assistance and allow providers time to correct deficiencies before issuing citations. Collaboration—not punishment—drives quality. **We recommend removing civil money penalties associated with the survey and certification process for anything non life-threatening, modifying definitions to provide clearer guidance to surveyors on what does and does not constitute harm, removing any non life-threatening survey findings**

from preventing a provider to receive their incentive factor through Medicaid reimbursement, and requiring the process to include an initial collaborative step in which non-life-threatening deficiencies are shared with providers and a defined period for correction is granted before a final determination is made.

7. CMS Home Health and Hospice
We support national LeadingAge's comments on:

- **Home Health Assessments:** Allow qualified therapists to conduct assessments when part of the care plan.
- **Supervision and scope of practice for NPs/PAs:** Align rules with state law and COVID-era flexibilities.
- **Transparency rules and duplicative reporting (e.g., 42 CFR §484.105):** These are redundant, costly, and lack meaningful benefit.

8. DEA & Telehealth
We support national LeadingAge's comments on:

- **Exempting hospice and long-term care settings** from proposed DEA telemedicine restrictions for prescribing controlled substances. Older adults in these settings face significant barriers to timely access when telemedicine prescribing is constrained.

Conclusion
LeadingAge Kansas is committed to collaborating with federal agencies to develop regulations that ensure high-quality care for older adults while recognizing the operational challenges faced by providers. We appreciate the opportunity to contribute to this important dialogue on deregulation and stand ready to assist in crafting policies that balance oversight with practical feasibility.

Respectfully submitted,

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