November 6, 2023

The Honorable Chiquita Brooks-LaSure
Administrator Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted electronically

RE: Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting, CMS-3442-P

Dear Administrator Brooks-LaSure:

On behalf of our 31 member hospitals, the New Hampshire Hospital Association (NHHA) appreciates the opportunity to provide comments on the proposed rule regarding minimum staffing standards for long-term care (LTC) facilities. In general, NHHA supports the American Hospital Association's (AHA) detailed comments.

NHHA and its members are committed to safe staffing to ensure high quality, safe, equitable and patient-centered care in all health care settings, including LTC facilities. However, CMS' proposal to implement mandatory nurse staffing levels is an overly simplistic approach to a complex issue that, if implemented, would have serious, negative, unintended consequences for not only nursing home patients and facilities, but the entire health care continuum.

The American health care system faces a critical staffing crisis. Staffing shortages are not just present in hospitals and LTC facilities, but at every single touchpoint in the health care system. As a result, patients are forced to go without timely, community-based care or to remain in acute care beds long after hospital-level of care is needed. In hospitals across New Hampshire, there are patients in an inpatient bed who are medically cleared for discharge but unable to leave the hospital. These lengthy, non-medically necessary hospital stays are caused by a number of barriers to discharge, the most common of which is staffing or capacity constraints at post-acute care facilities. During a 2023, one day, point-in-time study, hospitals in New Hampshire reported they had **130 patients, accounting for 8,451 medically unnecessary days**, in the hospital who were medically cleared but awaiting a safe discharge plan.[1] **The only way we will rebuild our once robust health care workforce is to approach this collectively, across the health care**

[1] https://www.nhha.org/wp-content/uploads/2023/10/September-2023-Barriers-to-Discharge-Report.pdf

industry. Staffing requirements will only serve to further strain an already tenuous situation.

We strongly agree with CMS that staffing is an integral part of delivering safe care. Yet, achieving safe staffing entails far more than simply meeting policymaker-set minimum thresholds or ratios. Indeed, CMS' own commissioned analysis in support of this proposed rule asserted that there is "no obvious plateau at which quality and safety are maximized or 'cliff' below which quality and safety steeply decline."[2] That is because safe staffing is a complex, dynamic process centered around the needs of patients that accounts for their acuity, the experience and clinical expertise of the nurses and other health care professionals on the care team, and the technical capabilities of the facility. Organizational leaders, nurse managers, and direct care nurses who know the needs of the patients they serve best must be empowered to collaboratively make staffing decisions, rather than having "one-size-fits-all" thresholds set on their behalf.

A MORE PATIENT AND WORKFORCE CENTERED APPROACH TO NURSING HOME STAFFING

NHHA shares CMS' recognition that a skilled and caring workforce is fundamental to the delivery of high quality, safe, and equitable care in LTC facilities. If CMS is intent on implementing new regulations related to LTC facility staffing, NHHA urges the agency to take a more patient and workforce-centered approach that focuses on ensuring LTC facilities have a solid foundation of policies and processes to continually assess, reassess, and adjust their staffing levels.

NUMERICAL STAFFING THRESHOLDS ARE NOT CONSISTENT WITH MODERN CLINICAL PRACTICE

Mandated nurse staffing standards remove real time, clinical judgment, and flexibility from the practice of medicine, particularly the practice of nursing. Typically, numerical staffing thresholds are informed by older care models that do not consider advanced capabilities in technology or the interprofessional team care model that supports data driven decision-making and collaborative practice. Emerging care models incorporate not only nurses at various levels of licensure, but also respiratory therapists, occupational therapists, speech-language pathologists, physical therapists, and case managers. A simple mandate of a base number of RN or nursing assistant (NA) hours per resident day emphasizes staff roles and responsibilities of yesterday rather than what current and emerging practices may show is most effective and safe for the patient and best aligned with the capabilities of the care team.

Further, patient needs have changed since the advent of research on staffing levels to achieve certain quality objectives. In the past few decades, the percentage of LTC residents with dementia has increased, as has the percentage of residents with psychiatric diagnoses. There are also more residents admitted to an LTC facility directly from the hospital (as opposed to coming

[2] Abt Associates. (2022). Nursing Home Staffing Study Comprehensive report. Report prepared for the Centers for Medicare & Medicaid Services. https://edit.cms.gov/files/document/nursing-homestaffingstudy-final-report-appendix-june-2023.pdf

from the community), leading to an overall higher level of acuity and functional impairment.[3] This means that the "average" LTC resident has fewer physical abilities and requires more assistance than in the past.[4] As best we can tell, CMS' proposed HPRD standard does not take these changes into account.

We are greatly concerned that these rigid standards would stymie innovation in care delivery. The structural workforce shortages that were accelerated by the COVID-19 pandemic have prompted nursing homes, hospitals, and other health care providers to develop and evaluate new team-based care models to support staffing in their organizations. Our members are exploring the use of technology-enabled solutions such as virtual nursing models to help with remote patient monitoring in order to help provide extra support to direct-care nurses and health care professionals. Looking at their non-physician and non-nursing caregivers, some organizations are using these professionals to perform tasks that do not require a physician or nursing license to perform. Enabling practice at the top of one's education and license can lead to greater staff satisfaction while maximizing the use of limited clinical staff resources. Nursing homes need the flexibility to test, evaluate and — when the evidence supports it — implement these new models.

Finally, we are concerned that nursing homes' efforts to advance the field would be overwhelmed by the specter of facing stiff fines or losing the ability to participate in Medicare for failing to meet CMS' proposed numerical thresholds. Indeed, in the proposed rule, CMS notes that states that implemented similar staffing requirements saw increases in staffing for long-term care facilities. Yet, it does not appear that those increases also resulted in commensurate increases in quality or safety performance, suggesting that numerical staffing standards may lead to a lot of effort and cost to come into compliance with state laws, but not a strategy to successfully improve the overall care environment for patients. LTC facilities are under enormous pressure to provide the best care for increasingly ill patients while staying afloat financially. With inflexible standards like those proposed by CMS in this rule, innovative care models — like those using virtual nursing, advanced practice providers and artificial intelligence — would be a far lower priority than meeting federal requirements.

PROPOSED STANDARDS WOULD EXACERBATE DIRE WORKFORCE SHORTAGES ACROSS THE CONTINUUM

Mandating staffing levels is not only a simplistic response to the complex problem of meeting the needs of LTC residents and patients, but also would exacerbate severe long-term shortages of nursing staff across the care continuum. Indeed, even prior to the COVID-19 pandemic, health care providers were already facing significant challenges making it difficult to sustain, build and retain the health care workforce. In 2017, the majority of the nursing workforce was close to retirement, with more than half aged 50 and older, and almost 30% aged 60 and older. These

[3] "Issue Brief: Patients and Providers Faced with Increasing Delays in Timely Discharges," American Hospital Association, December 2022. https://www.aha.org/system/files/media/file/2022/12/Issue-BriefPatients-and-Providers-Faced-with-Increasing-Delays-in-Timely-Discharges.pdf

[4] "Pandemic-Driven Deferred Care Has Led to Increased Patient Acuity in America's Hospitals," American Hospital Association, August, 2022. https://www.aha.org/system/files/media/file/2022/08/pandemicdriven-deferred-care-has-led-to-increased-patient-acuity-in-americas-hospitals.pdf

shortages only accelerated due to the profound disruptive impacts of the COVID-19 pandemic. Indeed, according to a 2022 study in *Health Affairs*, the total supply of RNs decreased by more than 100,000 from 2020 to 2021 — the largest drop observed over the past four decades.[5] An even more comprehensive analysis from a large-scale, biennial survey conducted by the National Council of State Boards of Nursing (NCSBN) and National Forum of State Nursing Workforce Centers (NFSNWC) found a similar number of registered nurses had left the workforce. It also showed that nearly 900,000 — or one-fifth of the 4.5 million total registered nurses — expressed an intention to leave the workforce due to stress, burnout, and retirement. The NCSBN and NFSNWC study also noted that over 33,800 licensed practical nurses (LPNs) and vocational nurses left the field since 2020, disproportionately impacting nursing homes and LTCs.[6]

Unfortunately, our nation's ability to replace those nurses choosing to exit the field is also severely constrained. Indeed, the American Association of Colleges of Nursing notes that nursing schools have struggled for more than a decade to increase enrollments due primarily to an insufficient number of faculty and available clinical placement opportunities for students.[7] In fact, in 2022 the number of students in entry level baccalaureate nursing programs decreased by 1.4%, the first time in 20 years in which schools have been unable to increase enrollment.[8]

In the proposed rule, CMS estimates that 75% of LTC facilities would have to increase staffing to meet the proposed standards, including the new standard requiring 24/7 RN staffing. Another study from the Kaiser Family Foundation estimated that 81% would need to hire more RNs or NAs.[9] Considering the massive structural shortages described in recent studies, it is unclear from where CMS believes this supply of nurses will come. The rule was announced in tandem with a national campaign to support staffing in LTC facilities with $75 million in financial incentives like scholarships and tuition reimbursement for individuals to enter careers in nursing homes. We appreciate the Administration's stated commitment to supporting the LTC nursing workforce and encourage it to continue to invest in these invaluable caregivers. Unfortunately, even this important investment pales in comparison to the sheer size of the challenge; a 2022 study estimated that staffing shortages will potentially cost nursing and rehabilitation facilities, as well as home-health agencies, $19.5 billion per year.[10]

With staffing shortages affecting all parts of the health care sector, the reality is that all parts of the health care continuum are redoubling their efforts to recruit, retain, and support the well-

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[5] Auerbach, David, et al. "A Worrisome Drop in the Number of Young Nurses," Health Affairs Forefront, April 13, 2022. https://www.healthaffairs.org/content/forefront/worrisome-drop-number-young-nurses
[6] https://www.journalofnursingregulation.com/article/S2155-8256(23)00047-9/fulltext
[7] American Association of Colleges of Nursing, Fact Sheet: Nursing Shortage. October, 2022 https://www.aacnnursing.org/Portals/0/PDFs/Fact-Sheets/Nursing-Shortage-Factsheet.pdf
[8] https://www.aacnnursing.org/news-data/all-news/new-data-show-enrollment-declines-in-schools-ofnursing-raising-concerns-about-the-nations-nursing-workforce
[9] Burns, Alice, et al. "What Share of Nursing Facilities Might Meet Proposed New Requirements for Nursing Staff Hours?" Kaiser Family Foundation, September 18, 2023. https://www.kff.org/medicaid/issue-brief/what-share-of-nursing-facilities-might-meet-proposed-newrequirements-for- nursingstaffhours/#:~:text=Finally%2C%20the%20rule%20was%20announced,improve%20enforcement%20of%20e xisting%20standards
[10] "Staffing shortages to cost U.S. care facilities $19.5 billion this year, study finds." Bloomberg, June 2, 2022. https://fortune.com/well/2022/06/02/staffing-shortages-to-cost-us-care-facilities-19-5-billion-this-year-study-finds/

being of health care workers. However, recruitment efforts also are drawing on a finite number of RNs, LPNs, and other skilled health care professionals. By implementing mandatory staffing levels in nursing homes, it is possible CMS will achieve its stated goal of increasing LTC-setting staffing. However, given the shortages we described above, it is inconceivable that LTC facilities will be able to meet these standards without detrimental effects to workforce availability throughout the care continuum.

IMPLEMENTATION OF THESE STANDARDS WOULD HURT ACCESS TO CARE

Faced with required staffing levels, we anticipate skilled nursing facilities and other LTC facilities may be forced to reduce their capacity or even close their doors when they are unable to meet these mandates. Organizations considering opening new LTC facilities would likely be discouraged from doing so knowing they may not be able to recruit enough staff to meet CMS' thresholds. This would have a ripple effect across the entire continuum of care, as general acute care hospitals, inpatient rehabilitation facilities, and other health care facilities already struggle to find appropriate placement for their patients.

Indeed, hospitals and health systems already are experiencing significant challenges in moving patients through the health care continuum generally, and into skilled nursing facility care specifically. The average length-of-stay (ALOS) in hospitals for all patients increased 19.2% in 2022 compared to 2019 levels; for patients being discharged to post-acute care providers, the ALOS increased nearly 24% in the same period. Case-mix index-adjusted ALOS increased for patients being discharged from acute care hospitals to skilled nursing facilities by 20.2%.[11] These longer stays in hospitals are not a mere inconvenience. They result in delays in patients receiving the next level of medically necessary care. They also lead to longer wait times in hospital emergency departments because hospitals are unable to move current patients out of inpatient beds. In other words, constrained access to LTCs is a quality-of-care issue affecting all types of patients across the care continuum.

In part, the above trends reflect the significant shortages of health care workers experienced in skilled nursing and other long-term care facilities. But they also reflect an alarming increase in LTC facility closures across the country, a trend that could be accelerated if CMS' proposed rule is adopted. Since the beginning of 2020, at least 600 LTC facilities have closed while only three have opened so far in 2023 (compared to an average of 64 opening each year from 2020 to 2022).[12]

When an LTC facility closes, medically vulnerable patients have to find residence somewhere else; new, unfamiliar facilities may be far from their families and support systems. Transferring patients to a new facility is a complex, disruptive and traumatic undertaking for patients and families alike. Some patients may prefer to receive in-home care, where staff shortages also persist. These are best case scenarios; it is conceivable that a patient who cannot find placement in an LTC facility may go without care in their home or worse. Again, these likely outcomes are inconsistent with our and CMS' shared goal of improved outcomes for LTC patients.

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[11] AHA Issue Brief, December 2022.

[12] "The Upheaval at America's Disappearing Nursing Homes, in Charts," Wall Street Journal, August 23, 2023. https://www.wsj.com/health/healthcare/the-upheaval-at-americas-disappearing-nursing-homes-in-charts-9aa8d2f9

The Honorable Chiquita Brooks-LaSure
November 2, 2023

We hope to work with CMS, Congress, and other health care providers to develop longer term strategies to improve the quality of care and outcomes in LTC facilities while investing in the nursing workforce and providing healthy practice environments. We do not believe most of the proposals put forth in this rule will achieve those goals and instead urge CMS not to finalize the proposals in favor of more patient- and workforce-centered approaches focused on ensuring a continual process of safe staffing in nursing facilities.

For more information or questions about this document, please contact Brooke Belanger, Vice President, Financial Policy & Compliance at bbelanger@nhha.org or (603) 415-4253.

Sincerely,

Steve Ahnen
President