American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

October 26, 2023

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

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 nearly 5,000 member hospitals and health systems who work with long term care facilities to serve hundreds of thousands of patients each year, our professional membership groups and affiliates including the American Organization for Nursing Leadership, and our 2,425 post-acute care members, the American Hospital Association (AHA) appreciates the opportunity to provide comment on the proposed rule regarding minimum staffing standards for long-term care (LTC) facilities.

The AHA 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.

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."[1] 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.

[1]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-homestaffing-study-final-report-appendix-june-2023.pdf.

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.

The AHA urges against the implementation of the proposed minimum thresholds of 0.55 hours per resident day (HPRD) of registered nurse (RN) care and 2.45 HPRD of nurse aide (NA) care. This type of standard is a static and ineffective tool that CMS' own commissioned analysis shows does not guarantee a safe health care environment or quality level to achieve optimum patient outcomes. The number of patients for whom nurses and other health care providers can provide safe, competent and quality care is dependent upon multiple factors that are not captured in a raw number of hours — factors like the type and degree of illness, functional status and level of independence of residents, the makeup of the overall care team including caregivers who may not be nurses, the physical layout of the facility, and the experience and tenure of the professionals in question. Because of the complexity and importance of the right staffing makeup to ensure safe and high-quality patient outcomes, the **AHA recommends that instead of implementing these universal standards as proposed, CMS develop a different approach that builds upon the knowledge and experiences of nurses and other caregivers themselves.**

In addition, the AHA is concerned that given the severe structural shortages of RNs across the country which have been building for over a decade, a 24/7 RN staffing standard may simply not be achievable, even with the phase-in periods that CMS has proposed. Furthermore, we are concerned that, if finalized, the standard could inadvertently worsen health care worker shortages across the care continuum.

A MORE PATIENT- AND WORKFORCE-CENTERED APPROACH TO NURSING HOME STAFFING

The AHA shares CMS' recognition that a skilled and caring workforce is integral 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, the AHA 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.**

Several aspects of CMS' proposed overhaul of the facility assessment requirements in this rule could help strengthen that foundation, and we are generally supportive of those proposals. However, CMS would only require a once-yearly facility assessment, and that assessment does not directly address the day-to-day processes that LTC facilities use to ensure safe staffing. Furthermore, as we understand it, the facility assessment process is generally geared toward a broader strategic assessment of the facility, patient types, services, physical layout and a variety of other issues. While the assessment could and should *inform* short-term actions around staffing, it is intentionally designed to provide a longer-range view.

Therefore, rather than adopting one-size-fits-all numerical thresholds, CMS could instead complement the facility assessment process with standards that focus on ensuring nursing homes consistently implement several key processes to ensure their staffing level is well-matched to the needs of their patients. As a starting point, we encourage CMS to explore the development of standards focused on the following topics:

- **Facility-wide staffing policies that are approved and implemented consistent with the facility's policies and procedures.** Nursing homes could be asked to describe which personnel in the organization are delegated the responsibility to set staffing schedules. They also could be assessed on whether they have explicit policies describing how they conduct day-to-day oversight of staffing levels, monitor compliance and allocate resources to support those making staffing plans and decisions.

- **Written staffing plans and schedules for all parts of their facility that describe the estimated level of staffing of each key role group.** Nursing homes could be asked to show how the empirical analysis of their patient mix, facility characteristics and other factors called for in the CMS' proposed facility assessment process informs their approach to staffing. They could also be asked to describe what types of unit-level and/or organization-wide quality and safety indicators they may be tracking to monitor the effectiveness of their staffing plan.

- **Processes for adjusting their staffing plans when either there are disruptions to the availability of staff or unexpected changes to the mix of patients being treated in the facility.** Nursing homes could be asked to ensure they have established processes for attempting to bring in additional staff to meet an unexpected change in patient mix or shortage during a particular shift. They also could be asked to describe any processes to "flex" staff to other parts of the organization, or even how they may choose to physically position staff within a facility to ensure safety.

- **Processes describing how any safety-assisting technologies are used to support staff routinely and when staff may be in temporary shortage.** For example, nursing homes could be asked to describe how they ensure patient call bells are monitored and responded to in the event of staffing shortages. They also could be asked to describe any approaches they are using to monitor bed alarms or other remote monitoring capabilities, and what process they may use to alert staff in the event the facility is under-staffed.

The above areas simply constitute potential starting points for developing further standards. We would strongly encourage CMS to extensively engage patients and the entire health care continuum, including the nursing home and LTC provider community, hospitals and health systems, and others, in dialogue about the most appropriate focus areas. However, this proposed approach to LTC facility staffing standards has several key advantages over CMS' proposed numerical thresholds. First and foremost, it would

give LTC facilities the flexibility to tailor their staffing approaches to the clinical needs of the patients they treat, the physical layout of their facilities, the skills of the care team and the facility's technological capabilities. Instead of being forced by CMS to focus on the question, "How do we achieve the minimum staffing threshold," nursing homes could instead focus on the far more important questions of "What is our ongoing process for safely staffing our facility? How do we respond when we experience staffing shortages or unexpected changes to our patient mix?"

The AHA also believes this approach would support more timely and effective action by LTC facilities to address staffing challenges. As we understand the proposed rule, CMS' expectation is that LTC facilities would meet the minimum staffing thresholds on a continual basis. Yet, compliance would only be determined using CMS's survey process. Absent surveys done in response to specific complaints, LTC facilities are surveyed roughly every three years. If CMS finalizes minimum staffing levels, there would be a significant time lag between being found out of compliance with the minimum staffing level and any enforcement action on CMS's part. By contrast, the AHA's proposed approach focuses on *the ongoing process* of safely staffing facilities and adapting when a facility faces circumstances preventing them from meeting their own plan.

While the AHA believes our proposed approach would be more productive and effective, below we further explain our concerns with CMS' proposed approach. In short, blanket numerical thresholds create inflexible and potentially unattainable standards that fail to account for patient needs, facility characteristics and the realities of the structural staffing shortages faced by the nursing home field. In addition to the conceptual flaws with numerical thresholds, implementation of the rule could severely limit access to nursing home care, particularly in rural and other underserved communities, lead to longer waits for emergency and inpatient hospital care, worsen staffing shortages across the care continuum and hinder innovative, new approaches to delivering quality care.

NUMERICAL STAFFING THRESHOLDS ARE NOT CONSISTENT WITH THE 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 and 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 a LTC facility directly from the hospital (as opposed to the community), leading to an overall higher level of acuity and functional impairment.[2] This means that the "average" LTC resident has fewer physical abilities and requires more assistance than in the past, and may have more specialized needs. [3] As best we can tell, CMS' proposed HPRD standard does not take these changes into account. Furthermore, given how rapidly health care delivery and patient needs evolve, it would be difficult for any set of numerical staffing thresholds to align with the state-of-the-art.

It is important to note that while CMS' proposed staffing standards are based upon data that is adjusted for case-mix of patients, the standards as applied would not be adjusted to account for patient mix in any way. Considering the great diversity in patient case-mix and other patient- and community-level factors that influence health, like fragility and social drivers of health that CMS is working to account for in its other quality programs, it seems incongruous for CMS to conclude that blanket numerical standards of 2.45 HPRD of NA care and 0.55 HPRD of RN care are appropriate for all types of nursing homes regardless of their patient mix.

Finally, 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 have begun to deploy technology-enabled solutions such as virtual nursing models to help with remote patient monitoring in order to help provide an 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.

However, 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

---

[2] "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-Brief-Patients-and-Providers-Faced-with-Increasing-Delays-in-Timely-Discharges.pdf

[3] "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/pandemic-driven-deferred-care-has-led-to-increased-patient-acuity-in-americas-hospitals.pdf

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. Yet, CMS itself has acknowledged the limits of what a minimum staffing level standard could achieve. In its 2022 request for information, CMS cited a 2009 study on the topic concluding that "mandated staffing standards affect only low-staff facilities facing potential for penalties, and effects are small."[4]

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 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 impacted 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

---

[4] Park J, Stearns SC. Effects of state minimum staffing standards on nursing home staffing and quality of care. Health Serv Res. 2009 Feb;44(1):56-78. doi: 10.1111/j.1475-6773.2008.00906.x. Epub 2008 Sep 17. PMID: 18823448; PMCID: PMC2669632.
[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

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 by 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-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

---

[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-of-nursing-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-new-requirements-for-nursing-staff-hours/#:~:text=Finally%2C%20the%20rule%20was%20announced,improve%20enforcement%20of%20existing%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/

would likely be discouraged from doing so knowing they may not be able to recruit enough staff to meet CMS's 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 patient 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 a 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 a 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.

We hope to work with CMS, Congress and the Administration 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.

---

[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

Again, we thank you for your consideration of our comments. Please contact me if you have questions, or feel free to have a member of your team contact Caitlin Gillooley, AHA's director of policy, at cgillooley@aha.org or (202) 626-2267.

Sincerely,

/s/

Stacey Hughes
Executive Vice President