MHA Michigan Health & Hospital Association | Leading Healthcare

November 6, 2023

The Clinical Standard Group's Long Term Care Team
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

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

Dear Administrator Brooks-LaSure:

On behalf of Michigan's 130 community hospitals, the Michigan Health & Hospital Association (MHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule for Minimum Staffing Standards for Long-Term Care (LTC) Facilities.

The MHA is the statewide membership organization representing all community hospitals in Michigan. Membership ranges from critical access hospitals in rural areas of the Upper Peninsula to large, urban, tertiary care centers in the heart of Detroit – and everything in between. Our mission is to advance the health of individuals and communities.

The MHA has significant concerns about the impact that mandatory staffing standards for long-term care facilities will have on patients and the entire healthcare ecosystem of our state. Long-standing staffing issues across the continuum of care became exacerbated during the COVID-19 pandemic. While the MHA is in full support of healthcare reforms that improve care, a one-size-fits-all approach to mandatory staffing is not the answer. **Thus, the MHA opposes the proposed rule and strongly advises CMS not to finalize a mandatory minimum staffing standard for LTC facilities.**

Impact of COVID-19 on healthcare workforce; Workforce shortages; Recruitment and Retention

Nursing homes lost more than 15% of their workforce during COVID-19, leaving more than 250,000 positions unfilled.[1] While staffing levels have improved since the end of the pandemic, there are still 150,000 more LTC job openings than there were prior to the pandemic.[2] In addition, a recent study revealed 20% of the nursing workforce, accounting for roughly 1 million nurses, intends to leave the field by 2027.[3] **Given the number of current nurse vacancies, coupled with the expected retirement or departure from the field of thousands more nurses, compliance with a minimum staffing standard is unrealistic.**

The CMS anticipates that this staffing standard would require LTC facilities to hire nearly 13,000 registered nurses (RNs) and more than 76,000 nurse aides, impacting three-quarters of United States nursing homes.[4] Using Michigan as an example, 75% of licensed RNs living in the state are already

[1] *Skilled Nursing Unfunded Mandate.* (n.d.). American Health Care Association. https://www.ahcancal.org/Advocacy/IssueBriefs/NEW%20unfunded%20staffing%20mandate_IB.pdf
[2] See reference #1
[3] *National Nursing Workforce Study.* (n.d.). National Council of State Boards of Nursing. https://www.ncsbn.org/research/recent-research/workforce.page
[4] *CMS Issues Proposed Rule on Minimum Staffing in Nursing Homes.* (2023, Sept. 1). American Hospital Association. https://www.aha.org/system/files/media/file/2023/09/Special-Bulletin-CMS-Issues-Proposed-Rule-on-Minimum-Staffing-in-Nursing-Homes.pdf

employed[5, 6] and 33.5% are at or near retirement age[7], making it nearly impossible for nursing homes in the state to comply with this mandate. To that end, acute-care hospitals have been working to hire nurses to fill 8,500 vacant positions with little success, demonstrating the staffing crisis extends well beyond the post-acute setting.[8] **All healthcare facilities are actively trying to hire additional staff; the qualified individuals to fill these roles simply do not exist at this time.**

What CMS outlines as part of a 'good faith effort to hire and retain staff' indicates that nursing homes must offer prevailing wages, yet nursing homes continue to struggle with recruitment and retention of nursing staff, in part due to low wages.[9] Low wages are a direct result of poor reimbursement rates from insurers, which puts LTC facilities at a distinct disadvantage as they are unable to compete with acute-care hospitals who can pay significantly more for equivalent positions.[10, 11] Even with better wages, hospitals still have extensive nursing vacancies as discussed previously, which means that LTC facilities who cannot match these salaries will have an even harder time attracting staff and as a result, will not be able to comply with the mandate. **Salaries for direct care workers in LTC should be equivalent to comparable roles in other care settings (such as hospitals) to ensure LTC facilities can offer competitive wages.**

Nursing home reimbursement should be sufficient to pay direct care workers a living wage; one that tells staff they are valued and is commensurate with the services they provide. The CMS has acknowledged that many direct care workers earn poverty level wages, half live below 200% of the federal poverty level, are disproportionately women of color, and often rely on public benefits despite working complex and demanding jobs.[12, 13] Even for qualified staff, the low pay and difficult working conditions in nursing homes does not make this an attractive job.[14] Studies have shown that **higher wages are associated with lower nurse aide turnover,** and thus should be a key focal point of LTC staffing reform.[15] If individuals could make a living wage in this profession, staff would be highly engaged, and turnover would decrease substantially; two things that would lead to improved clinical outcomes.

Further, nursing homes offering wages that are competitive with one another is inconsequential if staff can make twice as much working retail or food service; two environments without the strict regulations, exposure to harmful pathogens and education barriers seen in healthcare. **Ensuring that wages are competitive with other industries who require similar education and training** will enable LTC to hire and retain staff who are qualified, competent, and committed to their work.

Lastly, with the number of vacant nursing positions, it is unreasonable to expect that issuing a staffing standard will resolve the current workforce shortage and create nurses to fill the open positions. **Addressing the nursing shortage will require global solutions such as reimbursement reform and investments in the talent pipeline to ensure qualified staff are available to meet the demand.**

Financial Burden

As proposed, the minimum staffing standard is unfunded and the CMS anticipates that compliance would cost nursing homes between $4B - $6B annually, while saving Medicare nearly half a billion dollars per

---

[5] *Occupational Employment and Wage Statistics Query*. (n.d.). U.S. Bureau of Labor Statistics. https://data.bls.gov/oes/#/home
[6] *Comparison Between Nurse Population & Survey Respondents.* (2022 Jun.) Michigan Public Health Institute. https://www.minurse.org/survey/2022/2022-nurse-pop-to-survey-respondent-comparison.html
[7] See reference #6
[8] *Michigan Nurses; More than a Number.* (n.d.). Michigan Health & Hospital Association. https://www.mha.org/issues-advocacy/key-issues/nurse-staffing-ratios/
[9] *Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting*. (2023, Sept. 6). Department of Health and Human Services, Centers for Medicare & Medicaid Services. https://public-inspection.federalregister.gov/2023-18781.pdf
[10] See reference #9
[11] Wagner, L., et. al. *The Association of Race, Ethnicity, and Wages Among Registered Nurses in Long-term Care.* (2021, Sept. 9) Medical Care. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8428870/
[12] See reference #9
[13] See reference #9
[14] See reference #9
[15] Sharma, H and Xu, L. *Association Between Wages and Nursing Staff Turnover in Iowa Nursing Homes.* (2022, Feb. 5). Innovation in Aging. https://academic.oup.com/innovateage/article/6/4/igac004/6522981

year ($465 million).[16] Given that more than half of America's nursing homes are already operating at a loss, adding an additional financial burden is not sustainable and will result in reduced facility capacity and/or facility closure.[17] **Thus, if CMS intends to implement a LTC staffing standard, there should be adequate funding available to support efforts to comply.**

The CMS's suggestion to offset the financial implication of this proposed rule on LTC facilities was that payors could increase post-acute reimbursement rates to help cover costs.[18] Without a mandate to require this, it is improbable that an insurance company would willingly increase expenses, thereby minimizing profits, to help another industry comply with a federal regulation that has no bearing on them. **Instead, the CMS could require payors to increase LTC reimbursement to more effectively cover operational costs, and programming around resident safety and quality,** enabling LTC facilities to offer better salary and benefit packages to their staff. Medicaid is the primary payer for nursing home residents, accounting for 62% of LTC residents, making Medicaid reimbursement a strong place to start with payer reform initiatives.[19]

One potential solution to consider as an alternative to a mandatory minimum staffing standard is a Medicaid wage pass-through, which has been shown to increase nurse aide hours per resident day (HPRD) between 3-4% in the years following adoption.[20] This would increase HPRD as noted in the proposed rule, without presenting an unbearable burden on already struggling LTC facilities.

Closure of beds and facilities; Impact on equity

The CMS communicated their intent to ensure this proposal did not create access issues, recognizing the importance of LTC services as part of a comprehensive healthcare system.[21] Learning from the experience of LTC facilities during COVID-19, it is reasonable to expect that facilities who are unable to comply with the staffing standard will cease operations and be forced to close.

During COVID-19, more than 500 LTC facilities across the U.S. closed, many due to the inability to maintaining adequate staffing - demonstrating the significant impact of insufficient staffing on facility operations.[22] Not only does facility closure reduce the number of LTC beds and create barriers to access, it puts additional strain on hospitals who cannot discharge medically stable patients and results in fewer beds for patients with higher acuity or emergent needs. Thus, **closure of LTC facilities impacts the entire healthcare ecosystem,** and the experience of all healthcare facilities should be considered when new rules are proposed.

The potential impact of this proposed rule is incredibly concerning given the rapidly growing older adult population. It is estimated that residents in LTC facilities will double by 2030 as baby boomers continue to age,[23] with studies suggesting that 70% of people over 65 will receive some type of LTC service during their lifetime.[24] **Given the projections about increased need for LTC services, it is critical that any regulation aimed to improve quality of care does not inadvertently restrict access to services that are desperately needed.**

We are deeply concerned that implementing mandatory staffing requirements for long-term care facilities will lead to further access issues for long-term care services in the state of Michigan and across the entire country due to facility closures.

[16] See reference #9
[17] See reference #1
[18] See reference #9
[19] Chidambaram, P. *A Look at Nursing Facility Characteristics Through July 2022.* (Aug. 24, 2022) Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/a-look-at-nursing-facility-characteristics-through-july-2022.
[20] Feng, Z. et. al. *Do Medicaid Wage Pass-through Payments Increase Nursing Home Staffing?* (2010, May 3). Health Services Research. https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1475-6773.2010.01109.x
[21] See reference #9
[22] See reference #1
[23] Rubin, E. *Long-term care statistics.* Consumer Affairs. https://www.consumeraffairs.com/health/long-term-care-statistics.html
[24] *How Much Care Will You Need? (2020, Feb. 18)* Administration for Community Living. https://acl.gov/ltc/basic-needs/how-much-care-will-you-need

The number of vacant nursing positions is not distributed equally across Michigan, and healthcare facilities in rural areas consistently report more challenges hiring staff due to a smaller pool of qualified candidates. Thus, the lack of qualified staff in rural areas will lead to rural LTC facilities bearing a disproportionate share of facility closures. The MHA has engaged with the National Rural Health Association and their membership on the issue and agrees that **the minimum staffing standard will close rural nursing homes at a higher rate than those in urban areas.** These consequences for rural America are in direct conflict with the Biden Administration's Nov. 3 announcement about investments in rural health access, quality, and workforce.[25] While these investments are critical and appreciated, many of the announced efforts will take years or decades to create more workers and more access – and in the meantime, rural residents will have lost LTC access due to short-term staffing mandates.

Another aspect of facility closures which cannot be overlooked is the impact that will be felt by disadvantaged and underserved communities**. There is a strong likelihood that the facilities who close are those who serve a high volume of Medicaid residents, further exacerbating gaps in health equity and health disparities.**[26]

Quality of Care

Part of the impetus for this proposed rule is to improve the quality of care provided to residents of LTC facilities, which is undoubtedly an important goal. However, the CMS highlighted a study of Massachusetts nursing homes which concluded that facilities with minimum staffing standards ***did not*** see a significant difference in outcomes when compared to a control group without staffing standards.[27] **Based on the results from this pilot study, deploying a similar standard nation-wide and expecting different results is unrealistic.**

Additionally, this proposed rule does not account for the importance of inter-personal relationships developed between residents, their families and direct care workers. These relationships are essential to individualized care, which is a result of staff taking time to build personal relationships with the residents they care for to better understand their personal needs. Nursing assistants report that resident relationships are a major reason for staying in their job, demonstrating that relationships foster a stronger commitment to the work, which ultimately benefits the resident and the quality of care they receive.[28] **If facilities close and residents are relocated to new facilities, those relationships are broken, and patient outcomes will begin to suffer.**

In many cases, residents who are moved to a new facility will be moved further from home – especially in rural settings – which presents additional challenges for friends and family who wish to visit. During the COVID pandemic, studies routinely demonstrated the adverse impacts on health for residents who were separated from their family members including reports of increased physical pain[29], deterioration of physical abilities [30], increase in loneliness, agitation, and depression,[31] reduced cognitive ability[32] and increase rate of premature death[33]. In addition, moving LTC residents further from home will disproportionately impact low-income populations who do not have the resources to travel to support their family member(s) receiving LTC treatment/care. **While the minimum staffing standard intends to improve quality of care for vulnerable elderly adults, this proposed rule will lead to adverse health**

[25] *The Biden-Harris Administration is taking actions to improve the health of rural communities and help rural health care providers stay open.* (2023, Nov. 3). U.S. Department of Health and Human Services.
[26] See reference #9
[27] See reference #9
[28] Parsons, S. et. al. *Determinants of Satisfaction and Turnover among Nursing Assistants: The Results of a Statewide Survey.* (2021, May 5). Journal of Gerontological Nursing. https://journals.healio.com/doi/abs/10.3928/0098-9134-20030301-11
[29] Hugelius, K. et. al. *Consequences of visiting restrictions during the COVID-19 pandemic: An integrative review.* (2021, Sept.) International Journal of Nursing Studies. https://www.sciencedirect.com/science/article/pii/S0020748921001474
[30] Paananen, J. et. al. *The impact of COVID-19-related distancing on the well-being of nursing home residents and their family members: a qualitative study.* (2021, Nov.) International Journal of Nursing Studies. https://www.sciencedirect.com/science/article/pii/S2666142X21000138
[31] See reference #29
[32] See reference #29
[33] Abbasi, J. *Social Isolation – the Other COVID-19 Threat in Nursing Homes.* (2020, July 16). *Journal of the American Medical Association.* https://jamanetwork.com/journals/jama/fullarticle/2768640

outcomes for the residents it is intended to protect as a direct result of facility closures for sites who are unable to staff to the standard.

While the proposed rule intends to add more staff to LTC facilities, as previously mentioned, this rule does not create the qualified staff that are needed for facilities to comply. Further, simply increasing the number of nursing staff in a LTC facility does not inherently improve quality of care which was demonstrated by a study of 72 nursing homes across 5 states which linked nurse aide job satisfaction to work schedule, training, and rewards.[34] These factors not only impact turnover, but also the quality of care, as turnover and quality of care were closely linked.[35] **Thus, there are other ways to improve quality of care in LTC facilities that should be considered before issuing a minimum staffing standard that will likely cause disastrous impacts to quality and availability of care.**

Other considerations

In an era where minimum staffing standards largely do not exist, healthcare institutions are already struggling to hire staff. The workforce shortage detailed above is a significant contributor to the current state of healthcare staffing, and this proposed rule would effectively penalize facilities for something they have no control over – the number of available RNs or nurse aides seeking work. **Further, implementation of a minimum staffing standard will add additional strain to the relationship between LTC and hospitals as facilities fight over a finite number of employable staff.**

The other consideration for a minimum staffing standard that this proposed rule neglects is the substantial contribution of LPNs to the long-term care workforce. In 2022, 655,000 LPNs[36] and 3.2 million RNs[37] held nursing positions, though these roles were not distributed evenly across care settings. Estimates suggest that between 30%-35% of LPNs practice in LTC settings,[38, 39] compared to only 4-6% of RNs.[40, 41] Given the large proportion of LTC nurses who hold an LPN license, their impact on patient care and facility operations should not be undervalued. **Thus, if CMS intends to implement a LTC staffing standard, LPNs should be included in the final rule.**

Because the proposed rule does not incorporate LPNs, it would force LTC facilities to focus hiring practices and salaries towards roles that do – such as RNs and nurse aides. If this proposed rule were to pass as written, LPNs would face a critical juncture; work as a nurse aide for reduced compensation and scope of work, become an RN to remain employable as a nurse, or find a new career altogether. While not the intent, this proposal would make LPNs largely unemployable as they would not count towards the LTC staffing standard and are typically not employed in acute-care hospitals. **It is important that a proposed rule does not neglect the contributions of a large sector of the LTC nursing workforce and the impact that would have on nursing home staffing, bed availability and quality of care.**

Revision to Facility Assessments

The proposal that LTC facilities use the annual facility assessment to make informed staffing decisions to better meet resident needs is problematic for LTC facilities and CMS surveyors alike. **If implemented, it is critical that upon completion of the facility assessment, LTC facilities know whether their results require them to staff above the minimum staffing level.** Even for well-intentioned facilities, there will likely be a scenario where facilities complete the assessment but are uncertain whether they need to staff above the minimum requirement, and if so, how far beyond it they need to go.

---

[34] Castle, N., et. al. *Job Satisfaction of Nurse Aides in Nursing Homes: Intent to Leave and Turnover.* (2007, Apr.) The Gerontologist. https://academic.oup.com/gerontologist/article/47/2/193/683663
[35] See reference #34
[36] *Licensed Practical and Licensed Vocational Nurses: Work Environment.* (2023, Sept. 6) U.S. Bureau of Labor Statistics. https://www.bls.gov/ooh/healthcare/licensed-practical-and-licensed-vocational-nurses.htm#tab-3
[37] *Registered Nurses: Work Environment. (2023, Sept. 6).* U.S. Bureau of Labor Statistics. https://www.bls.gov/ooh/healthcare/registered-nurses.htm#tab-3
[38] See reference #3
[39] See reference #36
[40] *The 2020 National Nursing Workforce Survey.* (2021, Apr.) Journal of Nursing Regulation. https://www.ncsbn.org/public-files/2020_NNW_Executive_Summary.pdf
[41] See reference #37

Additionally, without objective survey criteria, facilities will be surveyed differently by different people, resulting in inconsistent and unpredictable outcomes for LTC facilities, leading to added stress and confusion. **It will be important, if implemented, that this is evaluated on an 'all or nothing' basis, or, that LTC facilities are provided specific action items which should be accomplished based on the results of the assessment.**

Using the results of the facility assessment to determine training needs for LTC staff will be complicated and difficult to enforce, for the same reasons mentioned above. Unless it is clear from the results of the facility assessment what topics nursing homes are required to provide training on and which staff should participate, holding them to these criteria as a condition of participation is not appropriate nor will it improve quality of care.

Requiring that the facility assessment identify and document resident-specific needs is burdensome and will create duplicative work given that this information is included in resident care plans. Additionally, the frequency with which long-term care residents are transferred or discharged makes updating this facility assessment with each patient change, an onerous expectation.

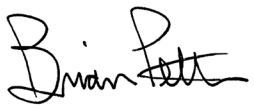
Lastly, identifying the strategies facilities are using to maximize recruitment and retention is an important component to better understanding current initiatives to improve staffing. **To ensure the staffing plan is effective and provides the type of information the CMS is seeking, it will be important that the CMS outline a clear methodology for how this information will be reviewed and audited**. Otherwise it is likely that facilities will provide a wide range of plans, some of which may not be helpful. As stated previously, given the subjective nature of the proposed language, there may be situations where well-intentioned facilities are penalized for not including the specific information a surveyor is interested in. Thus, by providing a set of core elements that facilities must include in their staffing plan, facilities will be better able to meet the intent of the proposed rule and provide objective criteria by which surveyors can assess it.

After reviewing the CMS proposed rule to implement minimum staffing standards in LTC facilities, the Michigan Health & Hospital Association sent a letter to our Michigan Senators expressing our concern with the proposed rule. A copy of that letter has been attached as part of our comment letter submission. The MHA also supports the comment letters submitted by the American Hospital Association and the National Rural Health Association, and their position that a staffing mandate will be dangerous for access to care for our nation's aging population.

Thank you for the opportunity to comment on this proposed rule and for considering our comments. We look forward to continuing our collaboration and support the CMS's commitment to improving healthcare for seniors. If you have questions, please contact MHAs Director of Health Policy Initiatives, Kelsey Ostergren at kostergren@mha.org.

(Enclosures)

Sincerely,



Brian Peters
Chief Executive Officer
Michigan Health & Hospital Association