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November 2, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3442-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting" (88 FR 61352-61429) (CMS-3442-P)

Dear Administrator Chiquita Brooks-LaSure:

The Association of American Medical Colleges (the AAMC) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule on minimum staffing standards for long-term care facilities (LTC) and Medicaid institutional transparency reporting, published September 6, 2023 (88 *Fed. Reg. 61352)*.

The AAMC (Association of American Medical Colleges) is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members are all 158 U.S. medical schools accredited by the Liaison Committee on Medical Education; 13 accredited Canadian medical schools; approximately 400 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 193,000 full-time faculty members, 96,000 medical students, 153,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers and the Alliance of Academic Health Centers International broadened participation in the AAMC by U.S. and international academic health centers.

The AAMC recognizes the importance of safe nurse staffing to ensure quality of care for patients in LTC facilities and we share the goal of high-quality outcomes and safe care and preventing staff burn-out. However, we are concerned that the proposed mandatory nurse staffing levels unintentionally could have serious negative consequences. In many parts of the country, facilities are facing severe workforce shortages that are jeopardizing access to care. We are concerned that this staffing mandate for LTC facilities may exacerbate these shortages and may result in facility closures, decreasing access to care. This will impact the entire continuum of care, as hospitals will be unable to discharge patients to long term care facilities. Therefore, we urge CMS to work with Congress and stakeholders to identify and implement alternative approaches, including investments in increasing the workforce that would ensure the quality and safety of care in LTC facilities. Our specific concerns and recommendations follow.

Comprehensive Staffing Requirements

To address safety and quality concerns, the rule focuses on establishing comprehensive staffing requirements for LTC facilities. CMS proposes to phase in the provisions in the rule. The first phase, which would take effect 60 days after publication of the final rule, includes enhanced facility-wide staffing assessment requirements, which would require facilities to: assess the needs of each resident, include input from nursing facility staff and residents' families or legal representatives, and develop a plan to meet required staffing levels given residents' needs. The second phase would require all LTC facilities to have a registered nurse on duty 24 hours a day, 7 days a week (24/7), an increase from the current requirement of 8 hours a day, 7 days a week. This phase would take effect 2 years after publication of the final rule for urban nursing facilities and 3 years after publication of the final rule for rural nursing facilities.

The third phase would require LTC facilities to have a minimum of 0.55 registered nurse (RN) hours and 2.45 nurse aide hours per resident day. This phase would take effect 3 years after publication of the final rule for urban areas and five years after the publication of the final rule for facilities in rural areas. The rule also includes a broad hardship exemption that would allow LTC facilities to maintain lower staffing levels if they met certain requirements**.** Requirements would include location in an area at least 20 miles from the nearest nursing facility, or in an area with workforce unavailability (defined as having a provider to population ratio that is at least 20% lower than the national average). LTC facilities would also have to demonstrate good faith efforts to hire and retain staff and a financial commitment to staffing.

While the AAMC recognizes the importance of safe nurse staffing to ensure quality of care for patients in LTC facilities and shares CMS's goals, we are concerned that the proposed mandatory nurse staffing ratios could have serious negative consequences. The agency estimates in the rule that approximately 75 percent of facilities would have to increase their staffing to meet these proposed requirements, though the impact varies by state. To achieve compliance with a mandated minimum staff ratio, there must be an available workforce to meet the

mandates. However, there are significant workforce shortages, especially in nursing.[1] As a result of shortages, nursing homes and hospitals are having difficulty securing adequate staff to meet current needs with rural facilities citing the most difficulties**.** These workforce shortages would be exacerbated by the mandated staff ratios.

In addition to the workforce shortages, we are concerned by CMS's statement in the rule that the overall estimated economic impact for the proposed minimum staffing requirements for LTC facilities would be $32 million in year 1; $246 million in year 2; and $4 billion in year 3. Those costs would increase to $5.7 billion by year 10 and result in a total 10-year estimated cost of $40.6 billion. Labor costs have been exacerbated by pricing practices of staffing agencies that attract nurses to travel and accept temporary assignments. These significant costs and the workforce shortages may force LTC facilities to reduce their capacity or to close if they can't meet the mandates. These policies will disproportionally impact facilities providing care in underserved and rural counties that will be unable to afford the additional costs.

These closures will impact the entire continuum of care, as hospitals will be unable to discharge patients to LTC facilities. As a result, hospitals would have limited capacity to admit new patients needing acute hospital care. Over the past several years, hospitals have faced challenges discharging patients and admitting patients due to staffing shortages. As an example, data from 2019-2022 shows that the average length of stay for hospital patients being discharged to SNFs increased more than 20%.[2]

Prior to establishing staffing mandates, we urge the Department of Health and Human Services (HHS) to implement new initiatives to recruit and retain nurses to increase the workforce. We applaud HHS's recent announcement of a national nursing career pathways campaign to support staffing in nursing homes. CMS's work with the Health Resources and Services Administration (HRSA) and other partners to make it easier for individuals to enter careers in nursing by making investments in scholarship and tuition reimbursement programs, is a good step forward**.**

In addition, we urge HHS to take the following actions to address the workforce shortage.

- Bolster the health care workforce with skilled health care personnel from abroad by reducing green card backlogs and prioritizing health care workers. There are currently thousands of nurses who are stuck overseas due to green card backlogs and bureaucratic delays even though they are working to gain approval or have already been approved to come to the United States as lawful permanent residents**.** At the same time, we are concerned that limiting the aggregate number of green cards each year only shifts the problem from one country to another. This is particularly problematic for nurses who,

[1] A McKinsey consulting and advisory firm report projected the healthcare system could experience a shortage of between 200,000 and 450,000 nurses by as soon as 2025, representing a shortage of between 10 and 20 percent of nurses needed to care for all the patients in the system. Assessing the lingering impact of COVID-19 on the nursing workforce | McKinsey (May 11, 2022).

[2] American Hospital Association. Issue Brief: Patients and Providers Faced with Increasing Delays in Timely Discharges (December 2022). Patients and Providers Faced with Increasing Delays in Timely Discharges | AHA Issue Brief

depending on state licensure requirements, may not be eligible for H-1B specialty occupation visas and instead apply directly for immigrant visas and green cards, potentially facing decade-long wait times while overseas. We urge CMS to support the efforts to pass legislation, such as the Healthcare Workforce Resilience Act, that would authorize the recapture of unused immigrant visas and redirect them to 25,000 immigrant visas for professional nurses and unused 15,000 immigrant visas for physicians. Importantly, these visas would be issued in order of priority date, not subject to the per country caps, and premium processing would be applied to qualifying petitions and applications.

- Support apprenticeship programs for nursing assistants and other support positions that build a pipeline of skilled workers by providing additional training to personnel**.**
- Support policies that increase funding for loan repayment programs for nurses, such as the HRSA Title VIII Nurse Corps scholarship program.
- Explore the business practices of travel nurse staffing agencies, including during the pandemic and the extent to which these practices contribute to workforce shortages.

In addition to our concerns about workforce shortages, we question whether a "one-size-fits- all approach" with ratios of staff to resident days is the most effective approach to ensure safe, high-quality care. The number of patients for whom a nurse can provide safe, high-quality care depends on multiple factors, including the type of illness, functional status of the patients, the overall team, caregivers, and the level of experience of nurses. Staff ratios do not consider the interprofessional team involved in the patient's care, which could include respiratory therapists, occupational therapists, physical therapists, speech-language pathologists, and case managers. These staff play innovative roles in the care of patients that could impact the nursing responsibilities.

The facilities may also specialize in providing different types of services, requiring flexibility in staffing mix. For example, LTC facilities offering ventilator care may determine that more respiratory therapists are necessary to meet the needs of their residents, while LTC facilities specializing in memory care may need music therapists and recreational therapists to best meet the needs of their residents. It is also important to consider that case mix and patients' needs can change, and the intensity of care varies throughout the year. For example, patients may need more intense care during the flu season. Also, patients who are close to discharge may need less intense nursing than patients who have just been admitted. With these factors, it would be very difficult to determine appropriate minimum staffing levels that would apply to all residents. Specific staffing levels should be based on clinical judgment and be uniquely based on the resident population and facility characteristics.

Therefore, we recommend that CMS conduct research to explore circumstance specific staffing mixes that include a variety of professionals with different skills and talents collaborating with the most effective mix of RNs, LPNs, and CNAs to produce the best outcomes. To do so, CMS could consider expanding the health care professionals that can be captured in the Payroll Based Journal (PBJ) System and included in direct patient care hours to include other staff, such as

respiratory therapists, music therapists, and mental health support workers. This will encourage innovation and equip policymakers with more robust information to use when considering staffing and improvements in quality of care.

To make meaningful progress in improving the quality of patient care, it will be important to consider the reality of the staffing shortage and the need for LTC facilities to remain open to serve their communities. We urge the Administration to consider other ways to improve safety and quality in nursing homes, such as investing in and improving educational programs and training programs for nursing and considering innovative team-based models for delivering safe and effective care to patients.

Conclusion

Thank you for the opportunity to comment on this proposed rule. We would be happy to work with CMS and lawmakers to develop solutions that would improve safety and quality of care in LTC facilities while protecting access to care. If you have questions regarding our comments, please feel free to contact Gayle Lee at galee@aamc.org.

Sincerely,

Jonathan Jaffery, M.D., M.S., M.M.M., F.A.C.P.
Chief Health Care Officer

cc: David Skorton, M.D., AAMC President and Chief Executive Officer

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