



Lutheran
Services
in America®

October 23, 2023

The Honorable Chiquita Brooks-LaSure

Administrator, Centers for Medicare and Medicaid Services

Attention: CMS-3442-P

P.O. Box 8016

Baltimore, MD 21244-8016

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

Dear Administrator Brooks-LaSure:

As President and CEO of Lutheran Services in America, I appreciate the opportunity to submit comments on CMS-3442-P: Medicare and Medicaid Programs: Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting.

Lutheran Services in America is a national network of 300 Lutheran health and human services organizations that reaches one in 50 people in America each year. Recognized by The Chronicle of Philanthropy and Forbes as one of the nation's top nonprofit organizations, the Lutheran Services in America network operates with more than \$23 billion in combined annual revenue. Headquartered in Washington, D.C., Lutheran Services in America leads innovative collaborations with partners in philanthropy, academia, healthcare and others to address the most critical challenges [in over 1,400 communities](#) and empower people to lead their best lives.

As one of the largest non-profit networks caring for older adults, we have been providing faith-based long-term care for people to age with dignity, respect, and abundance in the United States for well over a century. Our 200 providers operate 20% of the senior residential living beds among the top 200 nonprofit providers in the country. The nursing home residents we care for are frail, cannot live independently, require round the clock care, and have extremely limited resources. The longstanding public-private partnerships that our health care providers have with the Administration are rooted in a common goal—to ensure that older Americans receive the high-quality care they need to be safe and well. Serving older adults and those who are chronically ill is an essential part of our

faith-based mission, as is achieving greater levels of health equity and serving traditionally underserved communities.

Our members, who are open to all, currently provide access to quality care across the country—and we are dedicated to maintaining this strong level of care for all the individuals and communities we serve. As such, we are concerned about the impact of this proposed unfunded mandate to require minimum staffing levels as well as 24/7 RN staffing at skilled nursing facilities (SNFs). Given the current and deepening workforce crisis in direct service, implementing the proposed rule, especially with no additional funding support, will further exacerbate the existing staffing shortage and directly lead to fewer older adults being able to receive skilled nursing care they need. Moreover, we also worry about additional nursing home closures, especially in rural and other underserved areas where access to care is already limited and demand exceeds availability.

WORKFORCE CRISIS

Unfortunately, instituting a mandate for minimum staffing requirements with no additional funding support will exacerbate the current workforce crisis and make it even more difficult to hire the staff needed to provide care. Nationwide, skilled nursing facilities will need to hire an additional 150,000 staff to get back to pre-pandemic levels. This does not include those needed to comply with this rule and is an impossibility with the current labor shortage.

The workforce shortage is acute across the board (nurses, behavioral health, food service) but is most serious in positions like Certified Nursing Assistants (CNAs) and Direct Service Professionals (DSPs.) In a survey of our providers who provide skilled nursing care, 80% of respondents report staffing vacancies of 11% or more, with over 16% having vacancies greater than 31%. Because of this, 90% of respondents say that since March 2020, they have had to reduce services, close a location, or reduce the number of people served because they don't have enough staff—or they anticipate doing so. Thus, there is an existing, pressing need to recruit and retain enough staff to support individuals with complex needs in this care setting. The pandemic has revealed and greatly exacerbated workforce challenges in nursing homes including by the increasing reliance on contract nursing assistants.

Cost and lack of availability of essential workers are causing providers to take extraordinary measures to retain staff and cover staffing shortages, including paying exorbitant fees to temporary staffing agencies, multiple rounds of

bonuses and wage increases, and executive and administrative staff covering shifts. Despite these efforts, workforce vacancies remain at historically high levels and are already forcing many providers to close or consolidate facilities, which results in further reductions in access to care for some of our country's most vulnerable. Because workforce costs are already skyrocketing as compensation has increased to compete for workers and exorbitant fees are paid to fill temporary positions, this rule will only further exacerbate the existing crisis. For example, in our recent member survey, half of providers have increased permanent staffing expenditures by 11% or more and 40% have increased temporary staffing expenditures by 30% or more. And in the case of a small independent SNF provider in Texas with 115 beds, they spent \$233,000 on fees to temporary staffing agencies in 2020, and \$376,000 in 2021—representing a total increase in their budget for nursing costs of 27% in two years on temporary staff needed simply to remain open and serve existing residents.

Particularly challenging in the proposed rule is the requirement to have a Registered Nurse (RN) onsite 24 hours a day, seven days a week, who is available to provide direct resident care. A minimum of 5 RNs would be needed to cover all shifts every 8 hours, 7 days a week, with each RN working 5 days a week. Nationally, 22% of nursing facilities would have to hire registered nurses just to comply with this portion of the rule—and once the additional requirement of 0.55 hours per resident day (HPRD) for RNs is factored in, 36% of SNF would have to hire additional RNs. Given the extent of existing staffing shortages, this is an impossibility.

LIMITING ADMISSIONS AND FACILITY CLOSURES

The critical workforce shortage has already led to long waiting lists for skilled nursing, older adults languishing in hospitals because of the lack of availability of skilled nursing beds, and vulnerable older adults without any access to quality care. The result of the current workforce shortage is that more than 575 facilities have closed since 2020, 54 percent of nursing home providers say they are limiting new admissions due to staffing shortages, and patients are now spending nearly 24% more time in hospitals awaiting discharge than they did in 2019.

Nonprofit providers, especially faith-based providers, consistently receive the highest star ratings. On average, nonprofit and similar mission-minded nursing homes provide 42 more minutes of care each day compared to nursing homes generally. They simply do not accept new patients or residents if they do not

have the staff to support them. Therefore, when they are forced to reduce services or close, it means that higher-quality providers are further limited in their ability to serve their communities and older adults will not be able to find care.

Nonprofit facilities, which rely most heavily on state Medicaid payments and cannot simply charge consumers more for services, require additional funding to meet current challenges and offset the increased costs and inflation that have arisen out of the pandemic. The system is not sustainable. It cannot serve all those in need of care.

And while the current shortages are significant, we know the continuing trends will pose even greater challenges in the near future. According to a report by PHI on “Direct Care Workers in the United States,” from 2020 to 2060, the population of adults aged 65 and older in the U.S. is projected to increase dramatically from 56.1 million to 94.7 million. The number of adults aged 85 and older is expected to nearly triple over the same period from 6.7 million to 19 million. This demographic shift is the primary driver of job growth in the direct care workforce. In contrast to the rapid expansion of the older adult population, the population of adults aged 18 to 64 is expected to remain relatively stable, which means that there will be fewer potential paid and unpaid caregivers available to support older adults. Currently, the ratio of adults aged 18 to 64 to adults aged 85 and older is 30 to 1, but that ratio is projected to drop to 12 to 1 by 2060.

So, even if an increased minimum staffing standard may benefit a few residents at select facilities around the country, many more residents, especially in nonprofit facilities, will face further disruption or displacement as their current home is sold or entire wings of facilities are shuttered. A minimum staffing standard which fails to consider the individual nuances of each state and community only further exacerbates existing challenges and will lead to additional closures and a reduction of beds available to serve our nation’s older adult population. In fact, per a report by accounting and consulting firm CliftonLarsonAllen, 18% (or more than 205,000) of nursing home residents would be at risk for displacement, as facilities would be forced to reduce their census to meet a minimum staffing ratio.

In another example from a rural provider in our network, a facility which was licensed pre-pandemic for 100 beds now has a multi-step plan to reduce licensure to 44 beds if they cannot find sufficient additional staff. Currently, they have 31 people actively waiting for placement in the nursing home. In a town of

just over 3,000, that's the equivalent of 1% of the population waiting for a spot in this nursing home.

MEDICAID AND UNSUSTAINABLE COSTS TO PROVIDERS

Given the many factors cited above, simply stated, with fewer and fewer people entering the healthcare field, our providers cannot recruit against other employers given current funding levels. This is why we are so concerned that with no funding included in the proposal, nursing facilities would need to spend an additional \$4 billion per year or approximately \$300,000 per facility to attempt to meet the new requirements. Medicaid, as the primary payer of long-term care, has not fully met the true costs of care for years, much less the significantly increased costs of care today with rising workforce and operating costs. The Medicaid and CHIP Payment and Access Commission has reported that current basic Medicaid reimbursement rates only cover 86% of nursing home costs today. Providers need higher reimbursements to support a family sustaining wage for caregivers and maintain quality and access for residents.

For example, a SNF in Kansas received \$230.52 per resident per day in Medicaid reimbursement for the first half of last year while it cost them \$321 a day to provide services. This means that this provider in our network lost over \$90 a day on each Medicaid resident—60% of the people in their facility—which is unsustainable and leaves them unable to offer competitive wages. The limited workforce in communities like these chooses other employment with higher, family-sustaining wages, further reducing access to quality care.

DISPARATE IMPACT ON RURAL AND OTHER UNDERSERVED AREAS

The proposed application of a uniform minimum staffing requirement will have a larger impact on underserved and rural communities where the workforce crisis is most acute, resulting in less access to care in these communities. A one-size-fits-all approach will have unintended consequences within an already challenging landscape.

Rural communities currently have more limited options for older adults and will be disproportionately affected: for example, many SNF providers are the only healthcare option in their geographic area, as other services such as critical access hospitals or home- and community-based services are not available. Major medical centers are often several hours away, so access to any form of care is very limited and becoming more so as additional providers close. Older adults

will continue to experience longer waiting lists for services and additional closures of local facilities.

Not only is this an access to care issue, but it is also a health equity issue. CMS defines health equity as the attainment of the highest level of health for all people, whereby every person has a fair and just opportunity to attain their optimal health regardless of their race, ethnicity, disability, sexual orientation, gender identity, age, socioeconomic status, preferred language, and geography—including whether they live in a rural or other underserved community. Reduction in access to quality care in these communities will result in continued health disparities for their residents.

The proposed extended compliance timelines and the exemption process for rural facilities will only postpone implementation of mandates that many rural areas will never be able to meet. Further, the rule also comes amidst a wave of closures of rural nursing homes over the past several years and the long-term care landscape is already more complex and challenging in predominantly rural states. In Montana, 16% of the state's nursing homes closed in 2022, while that same year in Iowa, 13 of 15 nursing homes closures occurred in rural areas. This lack of post-acute care beds has ripple effects in rural areas, with many older adults unable to get access to needed care in their local communities and hospitals unable to discharge patients who no longer require inpatient care and cannot safely return home. These minimum staffing requirements will devastate nursing homes and intensify placement challenges, putting patient safety and access to care at risk in rural communities throughout America. We ask CMS to consider further flexibilities for rural facilities to protect access to care as rural health care deserts grow.

SUGGESTED CMS ACTIONS

Given all our aforementioned concerns, especially the ongoing financial and staffing crisis, we ask that CMS not finalize this rule as proposed. Instead, we encourage CMS to proceed in a thoughtful and deliberate manner and to adopt the following alternatives:

1. Any minimum staffing requirement must be funded.
2. Allow a five-year phase in for any requirement for both urban and rural locations due to limited workforce capacity throughout the country.
3. The renewal of any exemption to new staffing requirements based on localized workforce shortages should not require a facility to be cited

for noncompliance before being approved and should be automatic if conditions persist.

4. Don't expand facility assessment as it will only create more paperwork processing for both facilities and surveyors. Existing CMS requirements for facility assessment are centered on resident needs and staffing resources and already determine capacity and capabilities of staff in the facility.
5. Rather than adhering to a new, narrower definition of "rural," use the previous, broader definition which more accurately captures the needs and experiences of rural providers.
6. Allow for greater flexibility within Hours Per Resident Day (HPRD) requirements, recognizing that employees with different official job titles often perform similar functions.
7. As part of this flexibility, LPNs should also be counted in the 0.55 RN HPRD requirement, creating one "professional nurse" category.
8. Flexibility must be afforded to providers so that each SNF is able to assess their appropriate staffing levels based on the number of residents and their specific needs.
9. One size should not fit all in terms of RN staffing requirements: rather than a universal requirement for RN staffing 24 hours a day, seven days a week, allow on demand, virtual RN support of LPNs on evenings and nights for nursing facilities of less than 120 beds, or similar flexible, innovative solutions based on facility needs and capacities.

We also ask CMS and the Administration more broadly to commit to meaningful solutions to expand the long-term care workforce and its pipeline, including providing access to training and career advancement opportunities to recruit and retain workers. The agency should also develop a national Medicaid reimbursement strategy, to include specific recommendations on how states should set their Medicaid rates to ensure providers can pay livable wages.

As part of workforce improvements, we encourage updates to immigration and refugee policies that would increase availability of workforce including people from immigrant countries and communities to strengthen the direct care workforce. For example, one immediate option would be to ease the pathway for people entering the country to secure work visas. Allowing special visas to fill CNA vacancies and instituting a waiver process for immigrants and refugees in the United States who want to work in direct care and who already have foreign licenses/degrees may ease some of the workforce challenges across the country.

Additional focus on building an internal recruitment/training/retention pipeline is also needed. Allowing greater flexibility for SNFs to provide onsite training for new hires and existing employees, especially CNAs, would help with recruitment and retention, since it would help SNFs expand their own workforce. Loan forgiveness, tax credits, and other incentives for new and existing staff are also needed.

Finally, policymakers must pursue increased Medicaid reimbursements sufficient to cover the actual cost of providing skilled nursing care and paying a livable wage.

CONCLUSION

We appreciate the opportunity to comment on this proposed rule and welcome any additional opportunities to share our insights and ideas towards our shared mission of ensuring that older Americans receive the high-quality care they need.

Sincerely,

A handwritten signature in black ink that reads "Alesia Frerichs". The signature is written in a cursive, flowing style.

Alesia Frerichs
President and CEO