AHCA Summary of CMS' Minimum Staffing Final Rule

Earlier this week, the Centers for Medicare and Medicaid Services (CMS) released the final rule, Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting. The final rule is scheduled to be published in the Federal Register on May 10, 2024. The effective date for this final rule is June 21, 2024. However, several components of the rule have specific implementation dates beyond this effective date.

AHCA has developed the detailed summary of the final rule below, which includes additional information on key components. Please contact the AHCA Regulatory team with questions.

Of note, the minimum staffing and facility assessment requirements only apply to skilled nursing/nursing facilities. They do not apply to assisted living or ID/DD settings. However, the *Medicaid Institutional Payment Transparency Reporting Provisions* in this summary do apply to ID/DD settings.

Hours Per Resident Day (HPRD) and Registered Nurse (RN) Requirements

CMS finalized specific total nurse staffing, nurse aide, and RN HPRD, as well as the 24/7 RN requirements as described below.

- HPRD Requirements
    - The facility must meet or exceed a minimum of 3.48 HPRD for total nurse staffing including but not limited to:
        - A minimum of 0.55 hours per resident day for registered nurses.
            - The Director of Nursing (DON), as well as RNs with administrative duties, likely count toward the 0.55 HPRD for registered nurses as long as they are available to provide resident care when needed.
        - A minimum of 2.45 hours per resident day for nurse aides (NAs).
            - The final rule does not change the definition of NAs, which per the SOM states, "Nurse aides include certified nurses (CNAs), aides in training and medication aides/technicians, which all require training."

- The facility must have an RN onsite 24 hours per day, seven days a week, that is available to provide direct resident care.
    - The DON can meet the RN requirement as long as they are available to provide care.
- Facilities cannot staff only to the numerical HPRD standards stated above. Facilities must continue to ensure sufficient staff with the appropriate competencies and skills sets to assure resident safety and to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments, acuity and diagnoses of the facility's resident population in accordance with the facility assessment.
- Exemptions and waivers are available to these requirements, which are detailed below.

Implementation Timeframes

CMS outlined the following implementation timeframes regarding specific requirement for Facility Assessment, HPRD, and 24/7 RN requirements, and 0.55 RN and 2.45 NA requirements for rural areas and non-rural areas:

- Facilities in rural areas (as defined by the Office of Management and Budget OMB):
    - Facility Assessment: 90 days after the publication date of the final rule
        - August 8, 2024
    - 3.48 total HPRD and 24/7 RN: 3 years after the publication of the final rule
        - May 10, 2027
    - 0.55 RN HPRD and 2.45 NA HPRD: 5 years after the publication of the final rule
        - May 10, 2029
- Facilities in non-rural areas (as defined by OMB):
    - Facility Assessment: 90 days after the publication date of the final rule
        - August 8, 2024
    - 3.48 total HPRD and 24/7 RN: 2 years after the publication of the final rule
        - May 10, 2026
    - 0.55 RN HPRD and 2.45 NA HPRD: 3 years after the publication of the final rule
        - May 10, 2027

Facility Assessment Requirements

CMS finalized the revised Facility Assessment as a standalone section § 483.71, as proposed, and removed from its current location in Administration, § 483.70(e). Various sections of the Requirements of Participation (RoP) were also updated with the reference to the new location of the Facility Assessment at § 483.71.

Facilities will have 90 days to implement updates to the Facility Assessment; the timeframe increased from 60 days in the proposed rule. CMS outlined the below requirements as part of changes to the facility assessment.

- The Facility Assessment must use evidence-based, data-driven methods for the care required by the resident population.
- The facility must use the Facility Assessment to inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care. Specific staffing needs need to be considered for each resident unit in the facility as well as each shift, such as day, evening, night, weekends, and adjusted as necessary based on any changes to the resident population.
- The Facility Assessment must address residents with various diagnoses, including behavioral health needs, along with services provided to them.
- Facility leadership and management must be actively involved in the Facility Assessment process, including (but not limited to) a member of the governing body, the medical director, an administrator, and the director of nursing; and direct care staff, including (but not limited to) RNs, LPNs/LVNs, NAs, and representatives of direct care staff, if applicable.
    - Examples of representatives of direct care staff may include third-party elected local union representatives, business agents, safety and health specialists, or a non-union worker's designated representatives from a worker advocacy group, community organization, local safety organization, or labor union.
    - Additionally, if the facility has specialized units, such as memory care, behavioral health, sub-acute, or ventilator/trach dependent residents, CMS encourages the inclusion or input of staff from those units.
- The facility must solicit and consider input received from residents, resident representatives, family members, and representatives of direct care staff.
- The facility must use the facility assessment to:
    - Develop and maintain a plan to maximize direct care staff recruitment and retention.
    - Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care.

Waiver Options

CMS outlined two existing statutory waiver options for the 24/7 RN requirement that may be available to facilities who meet specific criteria as described below. Dually-certified facilities must meet the requirements outlined for both SNFs and NFS, whichever is more stringent.

- Nursing facilities (NFs only): Waiver of requirement to provide licensed nurses and a registered nurse on a 24-hour basis.
    1. The facility must demonstrate to the satisfaction of the State that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel.

2. The State determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility.
3. The State finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility.
4. A waiver is subject to annual State review.
5. In granting or renewing a waiver, a facility may be required by the State to use other qualified, licensed personnel.
6. The State agency granting a waiver of such requirements provides notice of the waiver to the Office of the State Long- Term Care Ombudsman (established under section 712 of the Older Americans Act of 1965) and the protection and advocacy system in the State for individuals with a mental disorder who are eligible for such services as provided by the protection and advocacy agency.
7. The facility must notify residents of the facility and their resident representatives of the waiver.

- Skilled Nursing Facilities (SNFs): Waiver of the requirement to provide services of a registered nurse for at least 112 hours a week.
    1. The facility is located in a rural area and the supply of skilled nursing facility services in the area is not sufficient to meet the needs of individuals residing in the area.
    2. The facility has one full-time registered nurse who is regularly on duty at the facility 40 hours a week.
    3. The facility either:
        - Has only patients whose physicians have indicated (through physicians' orders or admission notes) that they do not require the services of a registered nurse or a physician for a 48-hours period; or
        - Has made arrangements for a registered nurse or a physician to spend time at the facility, as determined necessary by the physician, to provide necessary skilled nursing services on days when the regular full-time registered nurse is not on duty.
    4. The Secretary provides notice of the waiver to the Office of the State Long-Term Care Ombudsman (established under section 712 of the Older Americans Act of 1965) and the protection and advocacy system in the State for individuals with developmental disabilities or mental disorders; and
    5. The facility must notify residents of the facility and their resident representatives of the waiver.
    6. The waiver is subject to annual renewal by the Secretary.

Hardship Exemptions

In addition to the waiver options, CMS has outlined a hardship exemption process and required criteria as noted below. CMS specifies that one or more of the HPRD requirements (3.48 total, 0.55 RN, and 2.45 NA) and eight hours a day from the 24/7 RN requirement may be exempted for facilities found non-compliant and who meet the outline eligibility criteria. CMS notes that

facilities cannot request, and a State would not conduct, a survey specifically for the purpose of granting an exemption, but rather that facility would be evaluated during a survey, such as the standard recertification survey, to determine if they were eligible for an exemption. Exemptions would be granted for a length of until the next standard survey unless the facility fell into the exclusion criteria.

The following **three criteria** must be met for a facility to qualify for an exemption:

1. The workforce is 'unavailable' – as measured by having a nursing workforce that is a *minimum of 20% below the national average* for the applicable nurse staffing type (calculated using the Bureau of Labor Statistics (BLS) and Census Bureau data).
    - Facilities may qualify for an exemption from one, two, or all three of the requirements (combined HPRD, RN HRPD, and/or NA HPRD).
2. The facility makes a good faith effort to hire and retain staff.
    - Good faith efforts include offering at least prevailing wages, to recruit and retain appropriate personnel. Evidence of this would be through job postings, vacant positions, and wage comparisons.
3. The facility documents its financial commitment to staffing.
    - Facilities will need to provide information on how the facility expends on nurse staffing relative to revenue.

CMS outlined additional requirements for those that receive an exemption:

- The facility must post its exemption status in a prominent, publicly viewable location that is easy to understand, for all residents.
- The facility must inform each *current and prospective resident,* along with the Office of the State Long-Term Care Ombudsman of its exemption status and the degree to which it is not in compliance with the HPRD requirements.
- The list of facilities granted an exemption from this rule and the extent to which they each do not fulfill the requirements will be posted on Care Compare. CMS outlined the following exemption exclusion criteria that would not allow a facility to receive an exemption:
    1. Facilities that failed to submit PBJ data according to re-designated § 483.70(p);
    2. Facilities that have Special Focus Facility (SFF) designation; and
    3. Facilities cited for widespread insufficient staffing with resultant resident actual harm or a pattern of insufficient staffing with resultant resident actual harm or cited at the immediate jeopardy level of severity with respect to insufficient staffing as determined by CMS, within the 12 months preceding the survey during which the facility's non-compliance is identified.

Enforcement and Remedies

CMS touched on the area of enforcement and remedies within the final rule but did not provide specific details on how it would determine non-compliance. Below are key excerpts from the final rule. AHCA will provide more details on enforcement and remedies as we learn more from CMS.

- The remedies that may be imposed include, but are not limited to, the termination of the provider agreement, denial of payment for new admissions, and/or civil money penalties.
- Remedies include all those available under 42 CFR part 488, subpart F- Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

- CMS will survey facilities for compliance with the updated LTC requirements in the rule and enforce them as part of CMS's existing survey, certification, and enforcement process for LTC facilities.
- CMS will publish more details on how compliance will be assessed after publication of this final rule in advance of each implementation date for the different components of the rule.
- CMS will display its determinations of compliance with staffing standards on care compare.
- Facilities will also be required to post a notice when they are out of compliance with the standards.

Financial

- CMS estimates the total cost of the rule at $43 billion over 10 years or about $4.3 billion per year, while AHCA's recalculation of the cost of the final rule is consistent with our analysis of the proposed rule at $6 billion - $7 billion per year.
- There are no provisions requiring Medicare, Medicaid, or other payors to increase payment rates to providers for any of the rule requirements.
- CMS does not estimate how much of the costs would be passed onto payors or how they would be covered – except for its comment that providers might choose to:
    (1) Reduce their margin or profit, subject to current margin levels in a facility;
    (2) Reduce other operational costs, subject to the current level of costs; or
    (3) Increase prices charged to payors, based on the ability to negotiate prices.
- CMS expects that Medicaid share of costs is 67 percent, Medicare is 11 percent, and Other is 22 percent.
- CMS' estimates assume that RN and NA wages will grow annually at 2.31 percent due to increasing demand for direct care staff.
- CMS estimates that the nursing home resident population will be stable over the next 10 years. CMS quotes evidence that the resident population is declining, which could lower cost estimates but acknowledges costs could be higher if patterns change and the nursing home population increases.

Medicaid Institutional Payment Transparency Reporting Provisions

- Within the Minimum Staffing rule, CMS ties in the requirements of the Medicaid Access final rule published on April 22, 2024. States must report to CMS on the percentage of Medicaid payments for services in nursing facilities and ICF/IIDs that is spent on compensation for direct care workers (such as nursing and therapy staff) and support staff (such as housekeepers and drivers providing transportation for residents).
- These new institutional payment reporting requirements apply regardless of whether a state's LTSS delivery system is fee-for-service or managed care.
- This requirement is to address the link between sufficient payments being received by the institutional direct care and support staff workforce and access to and, ultimately, the quality of services received by Medicaid beneficiaries.

- These requirements are consistent with efforts to address the sufficiency of payments for home and community-based services (HCBS) to direct care workers and access to and the quality of services received by beneficiaries of HCBS finalized in the Ensuring Access to Medicaid Services as noted at the beginning of this section.
- States will have to comply with these requirements beginning four years from the effective date of this final rule.

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