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Comments on CMS 3442-P
Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting

October 30, 2023

The Ohio Health Care Association (OHCA) appreciates the opportunity to offer comments on the proposed Centers for Medicare and Medicaid Services (CMS) minimum staffing rule for skilled nursing facilities (SNFs). OHCA represents more than 600 SNFs in Ohio as the state affiliate of the American Health Care Association/National Center for Assisted Living.

OHCA brings a valuable perspective to this rule because Ohio is home to the third-most SNFs in the country and 6.7% of the 158,500 workers SNFs have lost nationally since before the COVID-19 pandemic, per the latest Bureau of Labor Statistics (BLS) data.

OHCA's total membership includes more than 1,200 long-term services and supports (LTSS) providers. In addition to SNFs, our membership encompasses assisted living communities, ICFs/IID, IDD waiver providers, home care agencies, and hospices. Our broad-based membership makes us keenly aware that the proposed rule affects all of these providers, who also are struggling with the current staffing shortage, because they are the most likely targets for losing workers to SNFs trying to meet a staffing mandate. We are providing comments separately on behalf of the other LTSS providers we represent.

Alternative Solution: National Workforce Development Commission.

OHCA opposes the minimum staffing standards because they are impossible to meet – the workers are not available to hire – and because even if they were available, the rule does not offer any funding to hire them. You can't lead a horse to water if the well is dry.

OHCA is a solution-oriented organization. We believe in bringing forward solutions instead of just opposing government proposals. Before explaining in detail why we are against the staffing mandate, we will start by offering two alternative solutions that we think have a chance of success in increasing staffing in SNFs. A third alternative solution appears later in the body of our comments.

We recommend CMS postpone finalizing the proposed rule for six years and the Biden Administration immediately appoint a national LTSS workforce development commission including both federal and state agencies as well as industry and other representatives.

The commission's makeup should be broad, as the issue is broad. It should not be siloed and should consider every possible way of increasing the supply of LTSS workers. The commission should make recommendations on expanding educational opportunities for nurses, immigration reforms targeting LTSS workers, measures to remove impediments to working in LTSS settings, and policies and promotional efforts to expand the number of young people who become nurse aides (or similar occupations in other LTSS settings), nurses, or other vitally needed professionals. The commission should recommend how to fund these programs and how to ensure providers have the resources to employ the additional workers that hopefully would result. The commission must be able to break through long-standing bureaucratic, regulatory, and professional barriers that depress the number of LTSS workers, develop implementation plans that have buy-in by key decision-makers, and specify how to monitor and measure success.

States would be a key component of the commission because many of the necessary policies would need to be implemented at the state level, such as opening up collegiate nurse education programs and high school training opportunities. In many ways, the supply of LTSS workers is regulated at the state level. Other needed changes, like easing instructor qualifications that inhibit offering nurse aide training programs, would have to be done at the federal level.

Most importantly, the nation and the states would have to act on the commission's recommendations to lay the groundwork for increased staffing in SNFs. The supply of workers must increase before SNFs can be expected to employ more of them. The Biden Administration should lead by taking ownership of the commission's recommendations and placing a high priority on making them a reality.

In the first year of the 6-year period, the Administration would convene the commission and it would develop initial recommendations. The remaining five years would be for implementation of the initial recommendations, development of additional recommendations, and analysis of their impact on the workforce. In conjunction with the commission, CMS would continuously evaluate the LTSS job market and its impact on staffing in SNFs, along with consensus measures of quality of care and life in SNFs. At the end of the 5-year period, CMS could re-evaluate the need for the rule and what it should say.

We believe that today, SNF operators in Ohio are making every effort to staff their buildings to support quality care delivery, but the workers simply aren't there. The BLS data show employment in Ohio's SNFs still is 10,629 workers (11.6%) below the pre-pandemic level. The reduced workforce is not by providers' choice. To try to recruit and retain workers, Ohio SNFs

from 2019 to 2022 raised the average wage for nurse aides[1] 33%, from $14.94 to $19.93 per hour, and for registered nurses (RNs) 27%, from $30.31 to $38.62.[2]

At places in the proposed minimum staffing rule, there are suggestions that the SNF labor market is improving, and CMS refers to $75 million in civil money penalty dollars to help fund workforce development. SNF employment has rebounded somewhat since the depths of the pandemic, but it is still far from full recovery. There is no way to know how long it will take supply to return to its previous level, which would still be far below what the proposed rule would require. Sheer demographics – the growing proportion of the population needing care and the shrinking proportion of people of caregiving age – suggests that absent concentrated attention, the staffing crisis will get worse instead of better.

One of the key tasks for the national LTSS workforce commission would be to analyze the current labor market and SNF employment thoroughly and then to monitor how they change over time. Government should not impose requirements with penalties in the hope that at some time in the future it will be possible for regulated entities to comply. Instead, the requirements should take effect when compliance is possible.

Likewise, a one-time infusion of $75 million nationwide to solve a deep-seated workforce crisis is inadequate.[3] It is an average of only $1.5 million per state. Ohio recently spent a million dollars on a promotional campaign targeted at LTSS workforce that ended up having no impact. A much greater investment over an extended period of time is needed. Moreover, there is no silver bullet, which is why a high-level commission is needed to bring high-level attention to the problem and to address it from all angles.

Alternative Solution: Incentives for Higher Staffing.

In addition to a concerted, long-term effort to augment the LTSS workforce as described above, we recommend CMS immediately implement a "carrot-not-stick" approach to staffing levels in SNFs. To the extent there are any more workers to be squeezed out of the existing labor pool, CMS should establish additional incentives to do so.

We recommend adding a bonus to SNFs' Medicare rates based on their acuity-adjusted staffing hours per resident day (HPRD). The bonus structure should be simple and easy for providers to understand so they can react to it effectively. The bonus would be determined as follows:

[1] Certified nurse aides (CNAs) are called state-tested nurse aides (STNAs) in Ohio. We use the CNA acronym in these comments.

[2] Source: Ohio Medicaid cost reports 2019-2022.

[3] We were especially dismayed to read in the recent QSO-23-23-NHs that CMS is specifically prohibiting approval of civil monetary penalty grants for workforce-related projects. We feel regardless of the outcome of the proposed minimum staffing rule, any project that has a reasonable chance of improving the LTSS workforce should be expedited, not rejected.

- Utilize acuity-adjusted HPRD for total nursing staff.
- Utilize the following, CMS-prescribed quintiles of HPRD[4] to determine each facility's bonus, if any:

    - Below 3.029, no bonus
    - 3.030-3.444, 1% of rate
    - 3.445-3.868, 2% of rate
    - 3.869-4.428, 3% of rate
    - Above 4.428, 4% of rate

Not only would this approach incentivize higher staffing, it would factor in acuity and reward staffing levels well above the "alternative" 3.48 HPRD standard in CMS's proposed rule.[5]

To have the quickest possible impact, we recommend CMS include this methodology in the SNF payment rule for federal fiscal year 2025, with payments beginning October 1, 2024. Implementation would be simple because the data already are collected and publicly reported. Using the existing, acuity-adjusted data and cut points as the standard for the incentive would be transparent and knowable for providers. One of our many concerns about the proposed rule is it relies on individual surveyors' subjective judgment to determine whether a SNF's facility assessment properly adjusts for acuity. An objective standard is better.

Ohio already is using an incentive-based approach, albeit with different metrics, and it works. Since January 1, 2020, Ohio has apportioned part of each SNF's Medicaid funding based on performance on four CMS quality measures (QMs): pressure ulcers; ability to move worsens; catheters; and urinary tract infections. The system uses publicly-available CMS data and CMS-specified cut points, and the lowest-scoring group of providers gets no points for each measure.

Beginning July 1, 2024, Ohio will add adjusted total nurse staffing to the mix, along with antipsychotics, falls with major injury, and decline in ability to perform activities of daily living. Ohio chose to factor in these additional measures, including staffing, because experience with the Medicaid quality incentive system shows that monetary incentives are effective in improving performance on the selected QMs, as shown by the table below.[6]

[4] The quintiles come from CMS's *Five-Star Technical Users' Guide*, table A-2, "Adjusted Total Nurse Staffing (Hours per Resident per Day)."

[5] The bonus payments could be characterized as additional market-basket updates. If CMS believes it does not have authority to pay a bonus above the existing market basket, it could apportion the market basket using the staffing tiers.

[6] Source: CMS "State US Average" table, December 2019 and September 2023.

Quality Measure	Ohio Rank 2019	Ohio Rank 2023
Pressure Ulcers	24	19
Ability to Move	26	4
Catheters	11	2
UTIs	7	1

In a world where managed care now makes up more than half of all Medicare beneficiaries, managed care must be part of the solution. We know CMS believes it does not have authority to mandate how Medicare Advantage (MA) plans pay providers. However, to increase the strength of the proposed staffing incentive program, we recommend CMS strongly urge, by whatever means necessary, MA plans to use the same incentive approach in their payments to SNFs.

We further recommend CMS strongly encourage or require, perhaps through revisions to the pending Medicaid access rule, states to incorporate the same incentive structure in their Medicaid payments to SNFs. If all three major pay sources are aligned in creating an incentive for higher staffing levels, it would be powerful indeed.

The Proposed Staffing Mandate is Conceptually Flawed.

Turning to the rule as proposed, we believe it is conceptually flawed because it elevates process standards over outcome standards. CMS long ago recognized that a flexible staffing standard - sufficient staff to prevent negative outcomes - is the correct approach. In the intervening years, CMS repeatedly considered and rejected proposals to impose numbers-based staffing standards on SNFs. CMS was right to do so then and should not reverse course now.

The current CMS certification regulations largely gauge sufficiency of staffing based on outcomes. The full set of regulations is replete with outcome-oriented requirements. These rules not only measure SNF performance in each outcome area, but also underlie the existing staffing standard. Surveyors judge whether observed negative outcomes result from the facility not having enough staff or whether they are caused by other factors such as lack of competence, ineffective oversight, inadequate policies and procedures, insufficient physical plant or supplies, or mistakes or bad acts by individual caregivers.

There is a place for process standards in regulating SNFs. The regulations contain many of them. Most process standards, though, are clear-cut, such as the requirement to use the MDS as a nationwide, uniform resident assessment or to outfit the building with a functional sprinkler system. Failure to comply with these process requirements has a clear and inevitable negative outcome. If a facility does not complete the MDS, its data cannot be compared against others or against objective standards derived from compliant data. If a center does not have a working sprinkler system, it has no protection against a fire.

Staffing numbers are different because a large set of variables, many highly subjective, determine whether a particular staffing level is appropriate for a given SNF. Because of this distinction between numerical staffing standards and other process requirements, it is preferable to judge

sufficient staffing by outcome: whether the number of workers contributed to negative outcomes for residents.

The multiplicity and nature of the factors that determine appropriate staffing levels on a building-by-building basis is why a one-size-fits-all staffing requirement is not the way to ensure quality care. With 15,000 SNFs scattered across the country, each having its own defining characteristics, no single staffing standard is right for all of them.

Factors such as facility size, location, configuration, age, and equipment come into play. The Abt study tried to adjust for some of those things, but did not include many other factors affecting sufficiency of staffing that are difficult or impossible to quantify accurately for use in a regression model. Resident characteristics are very important but are not fully captured by using PDPM case mix to adjust staffing levels.[7] The most significant, and most unmeasurable, factors relate to characteristics of the workers and the work environment. Experience, education, training, attitude, workplace culture, agency vs. employed status, and other "soft factors" make an incredible difference in the quality of care, as summed up in the old saw, "I'd rather have one great nurse aide than four bad ones."

A one-size-fits-all staffing standard disregards all of those variables, whereas an outcome-based standard incorporates them. The question becomes, did the facility's staffing, all things considered, lead to negative outcomes? One-size-fits-all requirements assume a one-to-one correlation between staffing numbers and outcomes that doesn't exist.

The Abt study clearly demonstrated the lack of a one-to-one correlation. Abt concluded that *on average*, there is a relatively weak relationship between RN and CNA staffing numbers and certain selected measures of quality. Averages are not a good way to set regulatory requirements that every building must meet on pain of penalties. But the proposed rule is much more stringent than the average. By combining multiple numerical standards and overlaying increased facility assessment requirements, the rule creates a mandate that is far beyond average and that only a tiny fraction of the nation's SNFs, if any, could meet.

Alternative Solution: A Better Way to Apply Staffing Standards.

There is a place for process standards in regulating SNFs, even relative to staffing. Instead of minimum standards as stated in the rule's title, it would impose requirements far above minimum. A true minimum is a staffing number below which quality outcomes *cannot* be achieved, no matter where a facility stands on the many other relevant factors that define staffing adequacy. Abt concluded that there is no such staffing ratio from a purely analytical standpoint. But common sense tells us that there must be such a ratio, which would be the true minimum. It would be a standard that virtually all SNFs currently meet, so it would be

[7] Because it was designed for a statutorily-constrained payment system, PDPM had to use time-and-motion data that are nearly 20 years old and do not necessarily reflect current resident characteristics and caregiving practices.

unconscionable to allow any to fall below it. With that true minimum standard as the floor, outcomes would drive the ultimate determination whether a given facility has sufficient numbers of staff to meet the needs of its patients.

Ohio is a good example of this approach. Ohio's SNF licensure rules[8] mandate:

> Each nursing home shall have sufficient direct care staff on each shift to meet the needs of the residents in an appropriate and timely manner and have the following individuals provide a minimum daily average of two and one-half hours of direct care and services per resident per day as follows:
>
> (1) Nurse aides;
>
> (2) Registered nurses, including registered nurses who perform administrative and supervisory duties; and
>
> (3) Licensed practical nurses, including licensed practical nurses who perform administrative and supervisory duties.

This standard incorporates a clearly-defined floor (2.5 HPRD) plus an outcome standard: meeting the needs of the residents in an appropriate and timely manner. The floor is a true minimum, not a standard that virtually no one can meet.

According to the most recent PBJ data, all but 21 of Ohio's SNFs meet the 2.5 HPRD requirement. The Ohio rule sets a true minimum process standard and appropriately puts the emphasis on outcomes. In contrast, only 19 Ohio SNFs meet the combination of three standards that CMS proposes, while 910 buildings do not.

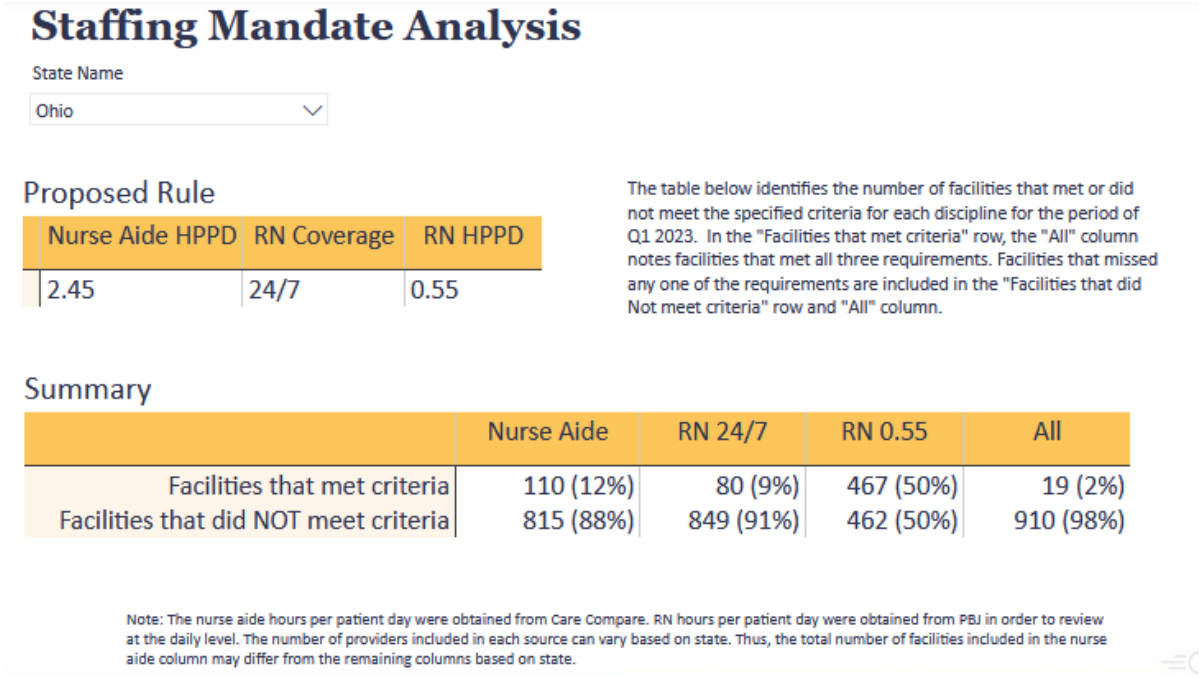
The existing CMS regulation is similar to Ohio's licensure rule, although instead of a minimum process standard of total nurse staffing HPRD, its minimum is the Congressionally-mandated 8 hours of RN coverage per day. CMS cannot replace the RN standard because it is in statute, but could augment it with a minimum total nursing HPRD requirement like Ohio's. It should be a true minimum, not an optimal or "stretch" goal that very few if any can meet.

While stretch goals are good in the right places, we do not feel they should appear in a regulatory system backed by various penalties up to and including closure of people's homes. Stretch goals are fine for an incentive-based system, such as the one we suggested earlier in these comments, which rewards higher staffing levels than 3.48 or even 4.2 HPRD.

[8] Ohio Administrative Code 3701-17-08(C), https://codes.ohio.gov/ohio-administrative-code/rule-3701-17-08.

Compliance with the Proposed Standards is Impossible.

It is incontrovertible that nationally and in Ohio, only a tiny fraction of SNFs meet the combined standard in the proposed rule. CMS included data in the rule's preamble showing how many SNFs in Ohio currently meet each of the standard's three prongs: 24/7 RN coverage[9]; 0.55 HPRD of RN time; and 2.45 HPRD of CNA time. The data in the rule, however, do not show how many facilities meet all three prongs, which is what the rule requires. According to a CliftonLarsonAllen (CLA) analysis using PBJ data, Ohio's figures when considering compliance with all three prongs are as follows:



Staffing Mandate Analysis

State Name

Ohio

Proposed Rule

Nurse Aide HPPD	RN Coverage	RN HPPD
2.45	24/7	0.55

The table below identifies the number of facilities that met or did not meet the specified criteria for each discipline for the period of Q1 2023. In the "Facilities that met criteria" row, the "All" column notes facilities that met all three requirements. Facilities that missed any one of the requirements are included in the "Facilities that did Not meet criteria" row and "All" column.

Summary

	Nurse Aide	RN 24/7	RN 0.55	All
Facilities that met criteria	110 (12%)	80 (9%)	467 (50%)	19 (2%)
Facilities that did NOT meet criteria	815 (88%)	849 (91%)	462 (50%)	910 (98%)

Note: The nurse aide hours per patient day were obtained from Care Compare. RN hours per patient day were obtained from PBJ in order to review at the daily level. The number of providers included in each source can vary based on state. Thus, the total number of facilities included in the nurse aide column may differ from the remaining columns based on state.

For Ohio, the CMS proposal is the opposite of a minimum standard. Instead of 2% of Ohio SNFs *not complying* with the standard, as is the case for the state licensure minimum requirement, only 2% *would comply*.

In the preamble to the proposed rule, CMS asked for comments on adding a 3.48 total nurse staffing HPRD requirement to the other standards. The added requirement would include licensed practical nurses (LPNs), who otherwise were left out of the proposal. While it would give a degree of recognition to LPNs, who are critically important to delivering quality care to SNF

[9] The analysis understates the number of SNFs that do not comply with the 24/7 RN mandate because PBJ does not have shift-by-shift data, so CMS assumed compliance if total reported RN hours were at least equal to clock hours. Under this view of the data, a facility with 2 RNs working a 12-hour day shift and none working night shift would appear to meet the requirement but does not because an RN isn't on duty all 24 hours of the day.

residents all across the country and particularly in Ohio,[10] this addition would make it even harder for providers to comply.

We support a minimum standard that uses only total nurse staffing HPRD instead of combining that measure with other numerical requirements, but it would need to be a true minimum like Ohio's standard.[11] A standard based on total nurse staffing HPRD would give providers the flexibility to design their staffing mix in a way that is appropriate to their residents' needs. The outcome-based component of our proposed standard would ensure that each provider's staffing choices either are successful or lead to regulatory consequences.

While few SNFs comply with the proposed staffing mandate in the rule, CMS has stated publicly that it is "achievable." The rule, however, doesn't contain evidence showing its requirements are achievable, which would mean there are sufficient workers available to hire and SNFs have the resources to hire them. The notion that the proposed requirements are achievable suggests that the thousands of SNFs that are not in compliance all are turning away willing workers because they just don't want to hire them. This assumption is not true. We at OHCA hear every day from members who are trying desperately to find workers, in competition with a multitude of other businesses that are doing the same thing. The reality is the workers do not exist. Even if they did, most SNFs do not have the money to pay for their wages and benefits.

Staffing before the pandemic was challenging enough. Long-term care work, particularly for nurse aides, is counter-cyclical. Unemployment was 4.4% in Ohio at the end of 2019, so the job market was tight. SNFs' agency use had begun to rise, which always happens in times of scarce labor. SNF operators need to staff their buildings, and when they cannot find workers to hire, they are forced to turn to agency. No one wants to use agency labor. It is much more expensive and is detrimental to continuity and quality of care, plus it affects the morale of employed staff. As a result, increased agency use is a clear indicator of a constricted labor market supply.

Then the pandemic came and destroyed the supply of workers. SNFs (and other health care providers) lost thousands of employees. The difference for SNFs is supply did not rebound even to the pre-pandemic level when the threat of COVID-19 waned. As discussed earlier in these comments, Ohio SNFs are down more than 10,000 workers compared to before the pandemic. Nationally, other health care sectors have recovered to the same or higher levels of employment, but SNFs remain 10% below.

It was not for lack of trying. Ohio SNFs increased wages significantly from 2019 to 2022. They offered bonuses and flexibilities and tried every other hiring and retention technique they could. Still the staffing crisis remains. Unable to hire enough workers, SNFs had to fill in by greatly increasing their use of agency personnel. Per Ohio Medicaid cost report data, SNFs spent $415 million more on agency staff in 2022 than in 2019, an increase topping 400%.

[10] In Ohio, LPNs make up 21% of SNF staffing compared to RNs at 11% and CNAs at 40%.

[11] 3.48 HPRD is not a true minimum. In Ohio, for instance, a majority (54.5%) of SNFs currently do not meet the 3.48 HPRD requirement standing alone.

According to BLS, as of May 2019, Ohio had 166,000 nurses and 64,000 CNAs with active licenses or certifications. In May 2022, the numbers were 167,000 nurses and 58,000 STNAs.[12] According to state workforce projections,[13] Ohio will require 1,498 additional nurses and 234 additional CNAs *every year* going forward just to meet growing need for caregivers in our state. These projections do not include any new staffing mandates. In contrast to the reduced CNA supply, the number of nurses grew slightly over the three-year period cited above, but there is fierce competition for nurses. The most-posted opening in health care in Ohio is for RNs, at roughly 11,400 postings annually, which accounts for 39% of all open health care positions.[14]

In addition to or instead of using agency, another tactic for providers who cannot find enough staff is limiting or stopping admissions. As the organization representing most of the state's SNFs, we have heard from many members that they had to turn away admissions, despite heavy pressure from hospital partners seeking to discharge patients from acute care. No SNF operator wants to limit admissions. Facilities do so only when absolutely necessary to prevent risk to patients from lack of staff.

Moreover, in excess of 30 Ohio SNFs closed their doors in the last three years, requiring relocation of their residents and reducing access in the local community. At least two of these facilities were county-operated. Reduced census and inability to staff the buildings are common themes in many of the closures, along with rising costs (mainly for labor) not covered by current reimbursement sources.

The proposed rule would raise the bar from sufficient staffing to meet resident needs – which providers already are struggling to meet – to an extremely stringent numerical standard. According to CMS's own analysis, Ohio SNFs need to hire 6,793 more RNs and CNAs to meet the proposed requirements. CLA's analysis places the number at 7,046 more workers. The number of workers needed would be even higher under a 4-prong mandate that adds 3.48 total nurse staffing HRPD to the mix.[15] None of these numbers include an estimate of the additional workers that would be required by facility-specific acuity adjustments under the beefed-up facility assessment process in the proposed rule.

At minimum, CMS is demanding a 15% increase in RNs and a 27% increase in STNAs working in Ohio SNFs. As projected by CLA, the rule would require Ohio SNFs to find at least 1,066 more RNs

[12] Source: "Occupational Employment and Wage Statistics," https://www.bls.gov/oes/tables.htm.
[13] https://ohiomeansjobs.ohio.gov/wps/wcm/connect/gov/553d6fdb-cff6-497a-ae0d-60b737ea36de/TJ_All_Regions.pdf?MOD=AJPERES&CVID=nXVsWUx
[14] https://ohiolmi.com/_docs/OMJ/reports/O202308S00.pdf
[15] CLA found that Ohio SNFs would need to hire 36 more LPNs to meet a 0.48 HPRD standard for LPNs.

and 5,980 more CNAs.[16] It is an impossible task, even if providers were able to raise wages more than they already have, which they can't at today's reimbursement levels.

It is difficult to imagine the workforce will grow by the necessary amount within the proposed phase-in period of 2-5 years, especially given the built-in growth required to serve an expanding population of people needing care and to replace workers who leave the profession through retirement or resignation. It certainly will not be possible without a massive, multi-faceted workforce development initiative such as the one we recommend at the beginning of our comments. If undertaken, those efforts would have to be extraordinarily successful to generate the workforce required by the proposed rule, but at least there would be a chance. Without them, there is no chance.

The proposed rule would be a major boon to temporary staffing agencies. One of the clear learnings from the pandemic is that agencies prosper when supply is severely constrained, as it was when SNF workers left in droves during the public health emergency. Agencies draw workers away from providers by offering significantly higher wages that they then pass along (with mark-up) to their customers. SNFs, on the other hand, cannot raise the prices they charge Medicare, Medicaid, or managed care to cover increased costs.

The same phenomenon will occur, only much more so, under the proposed rule. With demand for 1,000 additional RNs and 6,000 additional CNAs in Ohio, agencies will rush to fill the demand by offering inflated wages and renting workers back to SNFs at exorbitant rates. It happens whenever demand outstrips supply in the marketplace.

Given that per CLA, nationwide the need is for 102,000 more workers, the right answer is to do everything necessary to increase the workforce, not to require providers to hire workers that do not exist or to shift even more nurses and aides to agencies.

Unfunded Mandate.

Let us suppose there was sufficient workforce to meet the proposed requirements or the supply improved in the future. As CMS explained in the rule, adding that many workers would be extremely costly. Whether the cost is $4 billion per year as CMS estimated or $6-7 billion per year as CLA estimated,[17] it is money that, like the workers, is not available. In Ohio, the annual cost

[16] These numbers are the low end of the hiring need because of the unknown quantity of workers necessary to meet the 24/7 RN requirement and the heightened facility assessment mandate, as well as the additional staffing potentially required for the 3.48 HPRD standard.

[17] We believe both of these cost estimates are too low because they assume current wages with minimal inflation adjustments going forward. In reality, for SNFs to compete in a crisis-level labor market and draw workers away from other employers, they would have to offer significantly higher wages. They also would have to pay those higher wages to currently-employed personnel. The additional cost not included in the CMS or CLA projections would be staggering. In a simplified example, a SNF with 40 CNAs making $20 an hour that needs to hire 5 more CNAs and has to raise wages to $25 an hour to recruit

would be $305.5 million (CMS) or $359 million (CLA) for the 3-pronged mandate.[18] The current Medicaid payment system in Ohio would not reimburse providers for that cost. Neither would Medicare or managed care.

CMS clearly states in the rule that it is not proposing anything to address the funding situation. Although CMS may lack authority to provide funding directly, such as by grants, it missed a golden opportunity to lay the groundwork on the Medicaid side when it proposed amendments to the Medicaid access rule earlier this year. The rule as proposed does not require states to establish Medicaid rates for SNFs (or other providers) that are adequate to ensure beneficiaries have access to quality services. Through the lenses of access and quality, CMS possesses ample statutory authority to require states to demonstrate that their Medicaid rates accommodate the added costs of complying with the staffing rule. If CMS decides to move forward with the proposed rule or something similar, we strongly urge CMS to revise the access rule to include a requirement that state Medicaid rates cover the cost of compliance.

A better approach, if CMS adopts our suggestion for a commission on the LTSS workforce, is to make part of its charge recommending ways to fund the cost of employing additional workers, as well as infrastructure costs such as more nursing schools and instructors. Congressional action undoubtedly would be required to address the funding issues and to give CMS and other federal agencies the necessary authority to allocate the funding. Without funding, though, providers cannot comply with the rule even if the workforce becomes available.

We have seen suggestions that SNFs across the country receive $100 billion in Medicare and Medicaid funding and so should be able to afford billions in added costs for staff. By focusing only on revenue, this argument ignores the cost side of the equation. According to the most recent analysis by MedPAC, the average all-in margin for a SNF in America in 2019 was a paltry 0.6%.[19] In Ohio, despite a recent increase in Medicaid rates, the average rate is still $37 per day below the average cost. With current reimbursement levels, there is no room for Ohio SNFs to pay an additional $300+ million per year to comply with an unfunded federal mandate.[20]

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them would incur $468,000 per year in added costs just for the raise, on top of the cost of hiring 5 more people.

[18] CLA found that the fourth prong, 3.48 HRPD of total nurse staffing, would add another $2.4 million to the annual cost in Ohio.

[19] March 2023 report to Congress on Medicare payment policy, https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_v2_SEC.pdf, page 216. MedPAC notes that all-in margins were higher in 2020 and 2021, but points out, "Higher all-payer total margins during the pandemic were largely due to the general and targeted funding that nursing homes received during the PHE, the changes in Medicare policies, and the increases in Medicaid rates made by many states, though some of these are temporary." We believe with end of the PHE and pandemic-related funding, the 2019 margin is more representative of the current situation, based on anecdotal comments from OHCA members.

[20] Ohio SNFs were able to raise wages to their current level only because of three separate infusions of one-time COVID-19-related money, followed by a permanent Medicaid rate increase in 2023. Ohio's Medicaid system does not include any funding for compliance with a new staffing mandate.

Outmoded and Harmful Punishment Orientation.

The proposed rule relies on punishment, an outmoded "stick" approach to getting a desired result. In this case, the desired result is quality of care and life for SNF residents. The stick is the whole array of penalties that CMS can impose on a facility that does not meet one or more requirements listed in federal certification regulations. These penalties include fines for each day of non-compliance, which would mount up quickly for a facility that cannot find workers to meet the mandate, and denial of payment for new admissions, which is automatic after 90 days of non-compliance. The ultimate is termination of the facility's participation in Medicare and Medicaid, which almost invariably puts it out of business.

As discussed above, the vast majority of SNFs in Ohio and across the nation would be out of compliance with the rule as currently written and would face the prescribed penalties. Although CMS proposed waivers in the rule (one, for the HPRD standards, is termed a "hardship exemption"), the rule has such stringent requirements for waivers that very few providers would qualify. Waiver authority for the current, 8-hour-a-day RN requirement has existed for many years, but we are unaware of any Ohio SNF ever receiving such a waiver despite the nurse staffing challenges.

If CMS agrees with our suggestions for a more effective approach to improving staffing and quality in SNFs, there would be no need to expand the existing RN waiver or create a new hardship exemption. If, however, CMS decides to retain the provisions of the proposed rule or something like them, the waivers in the proposed rule should be replaced by a single waiver that has the following elements:

- Open to all SNFs with no exclusions.
- Can be requested in advance, without having to wait to be cited.
- Applies to RN requirements, HPRD mandates, and any additional staffing that surveyors feel is necessary based on a facility assessment.
- Granted by the state survey agency, not CMS.
- Simplified criteria that consider only whether the facility is unable to secure workers to meet the requirements despite making good-faith efforts, including offering competitive wages.

The underlying problem with the rule is it posits the staffing mandate as a determinant of quality. The Abt study showed that there is no staffing level that assures high quality and there is no staffing level that assures poor quality. Abt found a relationship with the measures it used, but the relationship is relatively weak and by no means ironclad.

Under the approach in the proposed rule that requires a SNF to meet all three (our four) prongs of the mandate to be considered in compliance, almost every Ohio facility with a four or five-star rating in the CMS Five-Star Quality Rating System would be out of compliance and subject to penalties. For 15 years, 5-Star has been CMS's gold standard for informing the public about the

quality of SNFs. Under the 3-prong mandate, 98% of Ohio SNFs would be non-compliant, obviously including the vast majority of 4 and 5-star buildings.

The following table shows this effect for Ohio facilities under each of the proposed HPRD standards.[21]

Standard	Total Not Meeting	5-Star Not Meeting	4-Star Not Meeting
2.45 CNA	815	110	151
0.55 RN	464	34	58
3.48 total	505	46	71

The table shows that under *each* of the HPRD proposals – let alone all the prongs combined – large numbers of Ohio SNFs would be out of compliance even though CMS designates them as 4 or 5-star centers. In other words, many centers that CMS deems as being at the upper end of the quality scale would not comply. These data demonstrate that pure staffing numbers do not equate with high quality as defined by CMS's own, well-publicized quality rating system. Hundreds of Ohio SNFs would be subject to penalties and even closure under the proposed rule even though CMS lists them as high quality.

Impact on Access and Health Equity

The proposed staffing mandate would have a negative impact on access to SNF care, which is already restricted by the current staffing crisis. All Americans need to have SNFs available to them within a reasonable distance and at an appropriate level of quality. People who need SNF care cannot be served by home and community-based services or by hospitals. They require access to SNFs that are close to their families and friends. Access is particularly tenuous in rural and inner-city communities, but it is an important consideration for everyone.

The proposed rule threatens access in two ways. First, by proposing standards that measure staffing against the number of residents in a facility (HPRD), the rule encourages a center that cannot find or afford additional workers to meet the standards by reducing census. The staffing crisis, along with other impacts of the pandemic, already has lowered census. In Ohio, the most recent National Healthcare Safety Network (NHSN) data show SNF occupancy at 80.3% compared to 81.8% before COVID-19. Occupancy dropped as low as 69.2% in early 2021.

Reducing census means refusing admissions and/or discharging existing residents. If a single facility takes those steps, it would not necessarily create an access problem because the individuals could go to a different SNF if one is available in the community. But under the rule, all SNFs would be constrained by the same requirements and may have to resort to limiting census, which truly would reduce access. Providers also might choose to close their facilities when faced

[21] The table does not include the impact of the 24/7 RN requirement or combining the three prongs because the state of the PBJ data makes it impossible to determine accurately whether a facility complies with the 24/7 requirement.

with the Hobson's choice of cutting census or incurring regulatory penalties (or sharply increased costs with no source of funding).

According to CLA's analysis of the proposed rule, if all of Ohio's SNFs had to comply by lowering census, they would have to discharge 16,351 current residents. One out of every 4 or 5 Ohio SNF residents would have to find another home. Medicaid residents undoubtedly would make up the vast majority of individuals displaced.

Second, the penalties for non-compliance jeopardize access. Denial of payment for new admissions would choke off admissions. Heavy civil monetary penalties could make it financially infeasible for a center to continue operating and serving patients. Termination of participation would require discharge of all residents.

In recent times, CMS has strongly emphasized health equity in a variety of regulatory and payment contexts. The proposed minimum staffing rule is problematic from a health equity standpoint because the burden falls more heavily on SNFs that predominantly serve Medicaid beneficiaries. In Ohio, 65% of the average SNF's census consists of Medicaid beneficiaries, but many buildings have higher Medicaid utilization, some verging on 100%. As shown in the table below, CLA's analysis for Ohio demonstrates that the more Medicaid beneficiaries a SNF serves, the more likely it is not to meet the proposed staffing standards. None of the 98 Ohio SNFs with Medicaid utilization of 76% or more meet all three prongs. This finding stands to reason because high-Medicaid facilities have fewer resources to hire staff.

Percent of Facilities Meeting Requirements by Medicaid Mix

	Meet 0 of 3	Meet 1 of 3	Meet 2 of 3	Meet 3 of 3
Low < 49%	41%	39%	18%	2%
Mid 49 - 63%	42%	48%	7%	3%
Mid-High 64 - 75%	58%	33%	8%	2%
High >= 76%	71%	24%	4%	

Payment Transparency Provisions.

We have concerns about the proposed payment transparency provisions that CMS appended to the minimum staffing rule. These requirements, which would apply to ICFs/IID as well as SNFs, are unworkable as written and could create additional administrative burdens for providers on top of the burdens on states. We address the proposed reporting requirements from the ICF perspective in separate comments. In these comments we will discuss the requirements as they relate to SNFs.

We do not oppose transparency for financial and workforce data. Ohio's Medicaid cost reports are public record, and OHCA publishes to members reports with detailed, aggregate data on all types of costs and average wages and hours for each staff category. These data separately cover

both SNFs and ICFs/IID. While we do not publish these reports by provider, we have access to provider-specific data, as does any other member of the public.

That being said, we do not see the value of the reporting and public disclosure requirements in the proposed rule for individuals who are searching for a SNF for themselves or a loved one. CMS already publishes on Care Compare a wealth of data that consumers might find helpful in selecting a SNF. An important missing piece, customer satisfaction, is supplied in Ohio by the state's long-term care consumer guide.[22] We do not believe that consumers care about the proportion of a facility's spending that goes to compensation for certain groups of workers. They may care about comparative staffing levels, but that information already is prominently posted in Care Compare. Anyone else who is interested in facility spending on compensation (e.g., researchers, regulators) easily can get it from publicly-available cost reports.

We recommend CMS remove the transparency provisions from the proposed rule, but in the event CMS believes they truly provide value for the public that offsets the additional administrative burdens on states and providers, we have some suggestions for fixing problems with the rule as written.

The proposed transparency requirements are unworkable because they mandate that states report the proportion of each facility's Medicaid payments that is spent on staff compensation. Neither a state nor a provider can determine this proportion accurately.

Ohio requires SNFs to report their revenue items and their expense items in detail, along with resident days under multiple pay types. Ohio also requires SNFs to report aggregate amounts of wages paid and hours worked by all categories of staff and, separately, expenses for agency staff (termed "purchased nursing").

However, revenue and expense can be related to each other only at the aggregate level. Providers do not keep their books or report to the state in a way that connects revenue from a particular source (e.g., Medicaid) to any specific expenses. It would be incorrect to do so. All revenue, aggregated together, is used to pay all expenses, aggregated together. Reimbursement for services provided is not like a grant where the funding awarded can be used only for certain expenses within specific limits. As detailed as the cost report data are, the state cannot use them to determine the portion of a provider's Medicaid revenue that is used to pay any specific expense. Requiring providers to earmark portions of revenue items to pay specific expenses, just for reporting to the states and CMS, would be incredibly burdensome.

The correct way to structure compensation reporting, if it is needed at all, is as a proportion of total expenses. The states could report three numbers for each facility: total allowable costs (expenses); total costs for direct care staff compensation (sum of wages, fringe benefits, and employee-related expenses); and total costs for support staff compensation. Expenses for

[22] https://ltc.ohio.gov/

contracted (agency) personnel should not be included in compensation reporting because providers pay an all-inclusive fee to the agency, not compensation to the individual workers. In addition to compensation, the fee includes the agency's administrative costs and profit. For this reason, Ohio's Medicaid cost report separates agency spending from compensation paid to employed workers. CMS should use the same approach and require reporting total agency costs separately from employed-worker compensation data.

In conclusion, the rule as proposed would be extremely harmful to SNFs and to the people they serve. The laudable goal of improving the quality of care in SNFs would be better achieved by substituting the measures we recommend in these comments for the provisions in the proposed rule. If you have any questions about our comments, please contact Pete Van Runkle at pvanrunkle@ohca.org or 614-361-5169.