November 6, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, D.C. 20201

SUBJECT: Medicare Program and Medicaid Programs: Minimum Staffing for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting (CMS-3442-P): (Vol 88, No 171, September 6, 2023)

Dear Administrator Brooks-LaSure:

On behalf of our more than 400 member hospitals and health systems, including approximately 80 hospital-based skilled-nursing facilities (SNFs), the California Hospital Association (CHA) is submitting comments on the Centers for Medicare & Medicaid Services (CMS) proposed rule regarding minimum staffing standards for long-term care (LTC) facilities.

CHA commends CMS' consideration of this issue and recognizes the body of research that demonstrates a strong correlation between staffing levels and quality of care. We appreciate CMS' acknowledgment that SNFs serve a critical role in the continuum of care and are called upon to care for a wide range of individuals with complex medical needs and/or significant functional disability. We support policies that will ensure that SNFs have sufficient staff with the appropriate competencies to provide nursing and related services to assure resident safety and to attain or maintain the well-being of each resident.

In this context, CHA supports the establishment of a minimum standard for nurse staffing, including the proposed requirement for 3.48 hours per resident day (HPRD), as well as the requirement for a registered nurse (RN) to be on-site 24 hours per day and available for patient care as needed. However, we are concerned that CMS' proposal to establish specific thresholds for RN and nurse aide (NA) staffing does not provide sufficient flexibility for facilities to establish a staffing skill mix to best meet resident needs. Though the staffing level proposed by CMS may be appropriate for some SNF residents, caring for the needs of more medically complex residents calls for a staffing mix that utilizes a greater proportion of licensed personnel, including licensed vocational nurses (LVNs).

A SNF is unique in that it encompasses two very different types of patient care:

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1. Post-acute care (PAC) for individuals requiring a continued period of medical care and therapy services following a hospitalization for an acute injury or illness
2. Long-term residential care for persons with chronic medical needs and/or disabilities

Resource needs and staffing configurations will necessarily differ between these types of care. PAC patients in SNFs require greater numbers of RNs and licensed clinical staff, such as LVNs, to support their continued recovery. In contrast, residents admitted for SNF-based LTC will need nursing oversight along with extensive personal assistance, which is most frequently provided by NAs. While CHA agrees that it is appropriate to establish an overall minimum staffing standard for SNF care, we also believe that sound policy should include sufficient flexibility to allow the SNF to adjust the skill mix of assigned staff to meet the specific needs and characteristics of its resident population. **CHA strongly urges CMS to withdraw its requirement for the specific subset staffing levels of RNs (.55 HPRD) and NAs (2.45 HPRD).**

CHA makes this request based on several factors, including our members' experience in providing both acute and PAC in California.

Role of Hospital-Based SNFs

California's hospitals operate approximately 80 SNFs as distinct part units. Compared to freestanding SNFs, hospital-based SNFs admit more medically complex residents and often provide care for individuals who are unable to access care in a freestanding SNF. While total nurse staffing levels in hospital-based SNFs typically exceed the proposed overall level of 3.48 HPRD, their skill mix most often includes a greater proportion of licensed (RN and LVN) staff, and less than the 2.45 NA HPRD currently proposed by CMS.

Flexibility in staffing skill mix allows hospital-based SNFs to match staffing to resident needs and to achieve positive outcomes. As reported on *Care Compare*, hospital-based SNFs in California typically staff a higher level of RNs than their freestanding counterparts (1.1 HPRD, as compared to .4 HPRD in freestanding SNFs) and achieve an overall quality rating of 3.8 stars.

California has recognized the unique role and high quality of care in hospital-based SNFs by differentiating them from freestanding SNFs in the state's staffing regulations. When implementing the staffing minimums referenced by CMS in the proposed rule (3.5 total HPRD, including 2.4 HPRD performed by NAs) hospital-based SNFs were exempted, providing hospital-based SNFs with the appropriate level of flexibility to establish staffing and skill mix configurations to best meet the needs of their residents, while continuing to meet an overall staffing requirement of 3.2 HPRD.[1] **CHA encourages CMS to allow a sufficient level of flexibility for a staffing mix to meet the needs of hospital-based SNFs and the complex patients they serve.**

Intersection with Additional State Staffing Requirements

In addition to routine LTC, California's Medicaid program, Medi-Cal, also provides a unique "subacute care unit" program. It provides a specialized level of skilled-nursing care for patients who do not require hospital acute care but need more intensive care than is available to the majority of patients in a SNF. Subacute care unit patients require special medical equipment, supplies, and treatments such as

[1] https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/SNF35-section-72329-2.aspx

ventilators, tracheostomies, total parenteral nutrition, tube feeding and complex wound management care, or the use of a medical technology that compensates for the loss of a vital bodily function.

California defines a subacute care unit as an identifiable unit in a SNF that meets certain requirements established by the Department of Health Care Services (DHCS), including patient criteria and specific staffing standards. For example, adult subacute care units that are operated as a distinct part of a hospital must provide a minimum daily average of 4.0 licensed nursing HPRD, including one RN on each shift and 2.0 certified nurse assistant (CNA) hours per patient day. Units that do not utilize CNAs must provide at least 4.8 licensed nursing HPRD. Each month, all subacute care units must submit a report to DHCS of their daily census and staffing, and are subject to financial penalties if staffing requirements are not met.

For subacute care providers in California who are already subject to specific RN and CNA staffing requirements and the associated oversight from DHCS, complying with the proposed CMS LTC staffing standards would require them to navigate two separate and conflicting staffing standards. While they would meet or exceed the overall staffing standard and the RN requirements, they would fall short on CNA staffing. **Providing greater flexibility to meet overall staffing levels would help subacute care units meet both state and federal requirements without duplicative staffing and costs.**

Workforce Considerations

The COVID-19 pandemic has underscored significant health care workforce shortages. The limited ability of SNFs to recruit and retain qualified NAs is already impacting access to care, as freestanding SNFs decline to admit patients due to staffing shortfalls. Because it would significantly increase the need for NAs throughout all SNF settings without providing necessary flexibility, CHA believes that CMS' current proposal would exacerbate access to what is an already critical shortage of medically necessary post-hospital SNF services.

In California, CNAs complete an extensive training program, including a minimum of 60 hours of classroom instruction and 100 hours of on-site clinical training. However, access to clinical sites is inadequate, particularly in rural communities, limiting the number of CNAs who can complete training at any given time. As CMS moves to establish mandatory staffing standards, CHA requests that state and federal policymakers take steps to support the development and implementation of additional accessible training programs and provide sufficient timelines to allow for the recruitment and training of a sufficient workforce to meet the increased demands.

Further, we are concerned that CMS' proposed staffing standards do not include LVNs. This omission does not acknowledge the contributions that LVNs currently provide as members of the SNF clinical care team, particularly in hospital-based SNFs that care for more medically complex patients than freestanding SNFs. Staffing shortages are being felt around the country, and excluding all licensure levels of experienced and qualified clinical care workers from staffing standards will further limit SNFs' ability to comply with requirements and constrain their capacity.

Beneficiary Access to SNF Care

Throughout California, hospitals report increased difficulty in accessing SNFs for post-hospital care, leading to delays in discharge from the acute care hospital setting. While this is a complex issue with many contributing factors, in some cases SNFs report limiting admissions due to the inability to meet

rigid staffing requirements. CHA is concerned that an overly rigid staffing configuration requirement for SNFs will exacerbate an already critical shortage of SNFs that can accept and care for some of our most vulnerable patients. CHA urges CMS to develop staffing standards that maximize the ability of hospital-based and freestanding SNFs to reach and maintain overall staffing level requirements.

In summary, CHA supports the establishment of a minimum nursing staffing standard for SNFs. However, CHA requests that any future standards take into account the wide range of patients and residents cared for in SNFs, and that effective and safe staffing levels and configurations vary accordingly. Specifically, CHA requests that CMS consider all or some of the following alternative approaches:

1. Establishment of a minimum standard of total nursing staffing hours per resident day across all facilities, while eliminating the subsidiary requirements for RNs and NAs. This would allow CMS to avoid prescriptive and cumbersome requirements regarding skill mix while communicating that all SNFs must staff according to patient needs and acuity.
2. Provide that part of the overall staffing requirement may be met by including LVN staff.
3. Provide an exemption for certain SNFs that provide specialized levels of care. This includes SNFs operated as distinct part units of acute care hospitals, and subacute care units, as defined by California state regulation.

CHA recognizes and appreciates that CMS has provided a two- to five-year timeline for facilities to come into compliance with new staffing standards, as well as a process to accommodate limited hardship exceptions. **CHA strongly supports this approach.** We urge CMS to continuously monitor the impact of future staffing standards on beneficiary access to medically necessary SNF care.

CHA appreciates the opportunity to comment on the proposed rule. If you have any questions, please contact me at mhoward@calhospital.org or (202) 488-3742, or my colleague Pat Blaisdell, vice president, policy, at pblaisdell@calhospital.org or (916) 494-8478.

Sincerely,

/s/
Megan Howard
Vice President, Federal Policy