Documents for the Record – 10/25/23 HE Hearing

Majority:

- October 25, 2023 statement from Premier Inc.
- State HCBS Access Rule Comments (submitted by Rep. Johnson)
- October 2023, Leading Age document on the nursing home federal staffing mandate
- October 10, 2023, letter from Creative Solutions in Healthcare (submitted by Rep. Burgess)
- October 10, 2023, letter to Secretary Becerra and Administrator Brooks-LaSure
- July 3, 2023, letter from the Texas Association for Home Care & Hospice
- October 25, 2023, statement from the American Hospital Association

Minority:

- October 25, 2023, letter from AFSCME
- October 25, 2023, letter from Caring Across Generations
- October 19, 2023, statement from Dennis Heaphy

Statement for the Record

Submitted by Premier Inc.

"Supporting Access to Long-Term Services and Supports: An Examination of the Impacts of Proposed Regulations on Workforce and Access to Care."

House Energy and Commerce Subcommittee on Health

October 25, 2023

Premier Inc. appreciates the opportunity to submit a statement for the record on the House Energy and Commerce Subcommittee on Health hearing titled "*Supporting Access to Long-Term Services and Supports: An Examination of the Impacts of Proposed Regulations on Workforce and Access to Care*" on October 25, 2023. Our remarks focus on how the recent proposed rule from the Centers for Medicare & Medicaid Services (CMS) on minimum staffing standards in long-term care (LTC) facilities will impact access to care. Premier shares CMS' goal of ensuring those receiving care in LTC facilities – one of the country's fastest-growing populations and among the most vulnerable – receive safe, high-quality care. However, Premier is concerned that staffing mandates could exacerbate and create new challenges, as first noted in our statement in response to the proposed rule and as Premier plans to elaborate on in formal comments to CMS.

As the Medicare Payment Advisory Commission (MedPAC) noted in its October 2023 meeting, "the evidence of the relationship between quality and total staffing is mixed."[1] Given that current research is inconclusive, any mandates prior to further study would be premature.

Therefore, Premier urges CMS to not move forward with its current proposal at this time until the policy or any alternative approaches can be realistically achieved. Instead of finalizing a flawed policy, CMS should work with stakeholders to further study and understand the impact of staffing ratios on access to quality care for residents. In addition, Premier urges Congress to help address the root of the problem and advance legislation to alleviate persistent healthcare workforce shortages.

I. Background on Premier Inc.

Premier is a leading healthcare improvement company, uniting an alliance of more than 4,350 U.S. hospitals and approximately 300,000 continuum of care providers to transform healthcare. With integrated data and analytics, collaboratives, supply chain solutions, consulting and other services, Premier enables better care and outcomes at a lower cost. Premier's sophisticated technology systems contain robust data gleaned from nearly half of U.S. hospital discharges, 812 million hospital outpatient and clinic encounters and 131 million physician office visits. Premier is a data-driven organization with a 360-degree view of the supply chain, working with more than 1,460 manufacturers to source the highest quality and most cost-effective products and services. Premier plays a critical role in the rapidly evolving healthcare industry, collaborating with healthcare providers, manufacturers, distributors, government and other entities to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide.

[1] https://www.medpac.gov/wp-content/uploads/2023/03/October2023_MedPAC_meeting_transcript_SEC.pdf

Headquartered in Charlotte, North Carolina, Premier is passionate about transforming American healthcare.

II. CONCERNS WITH CMS PROPOSED RULE

Proposed minimum staffing standards are unworkable given workforce limitations

CMS proposes to require that LTC facilities have individual minimum standards of 0.55 hours per nursing day (HPRD) for registered nurses (RNs), 2.45 HPRD for nurse aides (NAs) and maintain sufficient additional nursing personnel (including Licensed Practical Nurse/ Licensed Vocational Nurse [LPN/LVNs]). Additionally, CMS proposes to require LTC facilities to have an RN onsite and available to provide direct resident care 24 hours a day, seven days a week. As it stands, Premier believes these proposals are unworkable because of ongoing workforce shortages. There are simply not enough RNs and NAs in the workforce available to meet the demand that would result from the proposed staffing requirements. CMS estimates the rule would require LTC facilities to hire 12,639 additional RNs and 76,376 additional NAs. According to a recent analysis, less than one in five nursing facilities in the nation could currently meet the proposed required minimum HPRD for RNs and NAs.[2] The healthcare sector is still in a historic workforce crisis and the proposal would only exasperate the labor market that expands beyond LTC facilities to all healthcare settings including hospitals. Premier is deeply concerned that the proposal would lead LTC facilities to attempt to pull RNs and NAs away from other healthcare settings which would cause significant disruptions across the continuum of care.

Furthermore, in order to meet the staffing requirements if finalized as proposed, Premier is concerned that LTC facilities will have to limit the number of beds that they staff. As is, there is an insufficient number of LTC beds available to meet current demands, and that schism is expected to worsen as the population continues to age. By limiting the number of staffed LTC facility beds, pressure will be placed on acute care facilities who will be unable to discharge patients to a LTC facility in a timely manner. Therefore, Premier has significant concerns that this proposal will worsen boarding issues at acute care facilities and result in higher overall costs to the healthcare system.

Lack of funding to implement staffing requirements

CMS estimates the proposal will require LTC facilities to absorb an additional $4 billion in wage costs annually. However, that figure understates the potential impact, as it does not consider any future wage increases or adjustments. A September 2023 analysis found the mandate would cost even more than suggested in the rule – $6.8 billion annually to cover the cost of hiring the 102,000 additional caregivers necessary to meet the requirements.[3] However, the proposed rule does not provide any funding mechanism to help facilities offset this expected massive increase in costs. LTC facilities are already grappling with chronic Medicaid underfunding, soaring inflation and funding instability due to the lingering effects of the COVID-19 public health emergency. Premier fears that imposing staffing mandates without any financial support would lead to greater widespread financial instability across the LTC sector that is likely to result in facility closures and compromise access to quality care.

[2] "What Share of Nursing Facilities Might Meet Proposed New Requirements for Nursing Staff Hours?". Kaiser Family Foundation. September 18, 2023. What Share of Nursing Facilities Might Meet Proposed New Requirements for Nursing Staff Hours? | KFF
[3] "CMS Proposed Staffing Mandate: In-Depth Analysis on Minimum Staffing Levels". CliftonLarsonAllen LLP. September 2023. CLA Staffing Mandate Analysis - September 2023 (ahcancal.org)

Proposed national approach does not account for state variation

Additionally, Premier has concerns that the national staffing mandate proposed by CMS fails to account for wide variability across the states within the LTC sector. For example, some states are home to numerous LTC facilities with well over 500 beds, while average LTC facility capacity in other states is much smaller, reflecting different demographic factors and patient access needs. Further, state Medicaid rates for LTC facilitiy care vary from $170 a day to more than $400 a day. Given these vastly different dynamics, it is unreasonable to have the same requirement in every state, which is why 46 states have adopted their own minimum staffing policies.

Consideration for variation across skilled nursing facilities (SNFs)

Premier is also concerned that the proposal does not take into account variation in patient mix across SNFs. Notably, at the October MedPAC 2023 meeting[4], research was presented that indicates that SNFs with a higher portion of beneficiaries covered under Medicaid or by Medicare Part D's low-income subsidy (LIS) are associated with lower staffing levels. Therefore, a staffing mandate is highly likely to have a disproportional, negative impact on SNFs with those patient mixes as it will exacerbate the staffing challenges they are already grappling with.

Emergency preparedness

Premier is concerned about the negative consequences the proposal may have on emergency preparedness. A new HHS Office of Inspector General (OIG) report found that roughly 77 percent of nursing homes in areas prone to natural disasters reported challenges with emergency preparedness activities last year.[5] An estimated 62 percent of nursing homes reported at least one challenge regarding staffing and an estimated 50 percent noted at least one challenge regarding transportation. Some nursing homes also reported issues with securing beds for evacuated residents and planning for infection control and quarantine during emergencies. Given the reality around staffing limitations during natural disasters, Premier encourages CMS to shift its focus away from mandates and, rather, advance policies that provide resources and enable staff to protect patients during emergencies.

III. Opportunities for Congressional Action on Behalf of LTC Facilities

More must be done to bolster the LTC facility workforce and ensure our nation's seniors have continued access to high quality, cost-effective care. ***Premier has called for a multi-pronged approach to holistically address healthcare workforce challenges, including policies to protect workers against violence and increase graduate medical education***.

Congress can also help empower LTC facility staff to work more effectively and maximize their workflow by providing post-acute care providers incentives to adopt health information technology more readily to standardize patient data, improve care quality and reduce costs. Unfortunately, clinical analytics technologies are currently not widely used in nursing homes and other long-term and post-acute (LTPAC) settings to help them combat infection spread during any future disease outbreaks and during their day-to-day operations as programs authorized and funded under the Health Information Technology for Economic

[4] https://www.medpac.gov/wp-content/uploads/2023/03/October2023_MedPAC_meeting_transcript_SEC.pdf
[5] "Nursing Homes Reported Wide-Ranging Challenges Preparing for Public Health Emergencies and Natural Disasters". HHS OIG. September 1, 2023. https://oig.hhs.gov/oei/reports/OEI-06-22-00100.asp

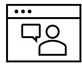
Clinical Health (HITECH) Act excluded LTPAC providers. ***To further bolster the capabilities of LTC facility staff and improve patient care, Premier encourages Congress to consider policies that incentivize nursing homes and other LTPAC providers to implement electronic health records and electronic clinical surveillance technology to provide meaningful assistance with infection control.***

IV. CONCLUSION

In closing, Premier supports CMS' intent of ensuring patients in LTC facilities have access to the highest level of care. However, Premier has serious concerns that the regulatory mandates put forward need further refinement and, as proposed, will have a negative impact on access to care and create instability in the LTC sector. Premier urges Congress to encourage CMS to work with stakeholders to find a workable regulatory scheme that finds an appropriate balance before moving forward with any regulation.

Premier appreciates the opportunity to share these concerns with the Subcommittee and looks forward to working with Congress as it considers these very important issues. If you have any questions regarding our comments or need more information, please contact Shara Siegel, Senior Director of Government Affairs, at shara_siegel@premierinc.com or 646-484-0905.

Medicaid Access Proposed Rule: State Concerns with HCBS 80 Percent Direct Care Compensation Proposal



Overview

Medicaid Home and Community-Based Services (HCBS) offer essential state and federally funded services to help Medicaid enrollees with complex care needs get the supports they need to continue living in their homes in lieu of institutional settings. States elect the HCBS services offered, establish eligibility criteria, set rates for care providers, and generally manage their HCBS programs.

The Centers for Medicare and Medicaid Services (CMS) recently issued the *Medicaid Program: Ensuring Access to Medicaid Services* proposed rule ("Medicaid Access Rule"), which includes a proposal to require that states ensure at least 80 percent of all Medicaid HCBS payments are spent on compensation for direct care workers, such as nurses, home health aides, and others who directly support Medicaid beneficiaries in activities of daily living at home. The remaining 20 percent of payments would be expected to cover all other HCBS operating expenses.

Several states have expressed serious concern with the 80 percent direct compensation proposal, citing lack of data from CMS to support and implement the proposal, potential exacerbation of existing workforce shortage issues especially in small and rural communities, adverse impacts on affordability, and lack of agency authority to implement the policy, amongst other issues. Below are excerpts from several states and associations who submitted comments to urging CMS to not go forward with the proposal. To see your state comment letter, CLICK HERE.

Excerpts from State Comments

California Department of Health Care Services

"… we urge CMS not to hastily adopt a new mandate with such far-reaching implications without providing states adequate time and opportunity to fully assess the impact of said mandate on Medicaid costs and beneficiary access to care…we are highly concerned about unintended short-term impacts to the provider market and to costs and beneficiary access to care."

Colorado Department of Health Care Policy & Financing

*"**Collecting this information is very difficult, bordering on non-feasible**, unless pre-existing sectoral bargaining agreements are in place. Most states, as a practice, do not receive that level of accounting/fiscal information on private businesses. Auditing these numbers as a baseline process illustrates the significant administrative burden it would place on state Medicaid agencies…By creating a blanket requirement, irrespective of existing Medicaid rates, service delivery model(s), provider capacity, geography, and existing market situations (including inflation and lagging job recruitment), **current CMS action will have devastating impacts on HCBS members in Colorado**."*

Alaska, Louisiana, Michigan, Missouri, Tennessee and Vermont State Agencies (joint letter via Brown & Peisch)

*"… **the 80 percent requirement will make impossible some of the strategies that knowledgeable partners have identified as critical to addressing the shortage** (e.g., increased training opportunities and career ladders). The myopic focus on payment rates is thus not only unlikely to solve the problem, but threatens to make these critical programs so expensive that **States will need to seriously consider controlling costs by serving fewer people, growing more slowly, providing fewer services, or cutting back on other aspects of the Medicaid program."***

New Hampshire Department of Health and Human Services

*"It is not clear why these services [home care, home health, homemaker} were targeted…The development of the proposed 80% threshold is not supported in the proposed rule, nor is it clear how this percentage was determined. **Labor market and wage index factors utilized in Medicare suggest a single standard would likely be problematic… With workforce challenges, the increased regulations in this requirement may result in a decrease of agencies willing to provide HCBS services through NH Medicaid.***

Oregon Department of Human Services

*"Additional time is needed to assess and accurately implement this change, **especially with the state's unique use of the 1915(k) authority for its HCBS long-term care system and current workforce shortage and in rural areas**. Rather than setting a national standard through this rule, **Oregon recommends beginning with transparency and reporting requirements** and developing a national standard and exceptions process in collaboration with states."*

Tennessee Department of Finance & Administration, Division of TennCare

*"…the most immediate and obvious result of the rule, if finalized, will be to **limit** the agencies available to provide HCBS to Medicaid beneficiaries to those agencies that can afford to spend less than 20 percent of their revenue on administrative costs. In particular, **we expect new agencies, as well as small agencies in remote or rural areas to be disproportionality impacted by the rule, which will exacerbate access issues in communities where provider shortages are already most acute**."*

National Association of Medicaid Directors (NAMD)

*"Some Medicaid agencies, as noted above, are concerned about the unintended consequences for providers of this policy. **Lack of familiarity and resources to produce cost reports would disproportionately impact smaller providers and may lead to lower overall provider availability for critical Medicaid HCBS**. It is also unclear what the remedy is for providers that are not able to comply with the pass-through requirement – and it clearly should not be terminating a non-compliant agency, as that would exacerbate shortages."*

Potential Impacts

The Partnership for Medicaid Home-Based Care Found that if the 80/20 proposal is finalized:

- 35% of providers would narrow geographies served or service offerings
- Over 93% would be limited in taking on new referrals
- Over 90% of providers would face challenges in serving rural populations
- Providers indicated that the proposal would cause cuts to clinical oversight, training, and non-direct care staff

The Home Care Association of America found that If the 80/20 proposal is finalized:

- A majority of providers serving Medicaid beneficiaries would exit the Medicaid program and focus on other revenue sources
- Over 64% of providers would be reduced in their ability to provide services for underserved or primarily minority populations

THE NURSING HOME FEDERAL STAFFING MANDATE
LET'S GET IT RIGHT

The Centers for Medicare and Medicaid Services (CMS) released the Administration's proposed rule on Minimum Staffing Levels for Long-Term Care Facilities (CMS-3442-P) on September 1, 2023. LeadingAge shares the Administration's goal of ensuring access to the highest quality care in our nation's 15,000 nursing homes. However, the proposed rule works against this shared goal and would be impossible to implement due to its failure to address the chronic reimbursement challenges and workforce shortages plaguing the health and long-term care sectors.

There is no additional funding to hire and retain staff. CMS estimates that 90,000 new staff will need to be hired at a cost of $4.06 billion annually. Independent estimates of cost impacts are even greater, including LeadingAge's estimate of $7.1 billion annually. The costs of delivering quality care already far exceed Medicaid reimbursement levels, and this unfunded mandate will force nursing homes to consider limiting admissions or even closing their doors for good, depriving older adults and their families care in their communities. While CMS has announced $75 million in funding to boost the long-term care workforce, CMS does not identify funding to assist long-term care providers in meeting the new staffing requirements.

There simply aren't enough people to hire. As is true for most retail, food service, and hospitality businesses, a mandate will not solve the long-standing workforce shortages impacting nursing homes and the rest of the long-term care continuum, particularly in rural and underserved areas. CMS estimates that approximately 75% of nursing homes will need to hire additional registered nurses (RNs) and certified nurse aides (CNAs) to meet the proposed staffing requirements. Hiring in long-term care has long been a challenging process, but with historic unemployment at less than 4%, there simply aren't enough workers to fill open positions. Many nursing homes have already been forced to utilize staffing agencies at prohibitive and unsustainable costs.

Licensed Practical Nurses (LPNs) were completely omitted from the staffing requirements. The proposed rule fails to include the essential contributions of Licensed Practical Nurses (LPNs), who comprise 13% of the nursing home workforce and should count toward either the RN or CNA-mandated ratios. LPNs contribute to patient care and quality of life, and these positions offer career ladders that provide opportunities for growth and promote staff retention.

Mandating staffing requirements could decrease access to care. The existing workforce shortages are resulting in backlogs at acute care hospitals, which are unable to discharge patients due to reduced capacity in post-acute, long-term care facilities. Further, home care and hospice providers – already navigating workforce challenges – will be short even more workers if they move to nursing homes. Shuffling the relatively small number of care workers available between settings won't solve the problem. And holding nursing homes to a standard that is impossible to meet because there are not enough workers in the country, then fining them for not meeting that standard, is going to force the quality of care down—not improve it.

We need meaningful workforce development investments and fair reimbursement rates.

Federal action on staffing mandates must be realistic to achieve its intended effect and should be paired with historic workforce investments and fair reimbursement rates. Congress and the Administration must commit to providing the resources necessary to build domestic and international workforce pipelines that will allow providers to attract and retain qualified workers.

Take Action: Delay the proposed rule until there are enough qualified applicants and adequate funding to address staffing levels realistically throughout the long-term care continuum. Cosponsor the *Protecting Rural Seniors Access to Care Act*, to prevent the rule's implementation and instead convene an Advisory Panel on the Nursing Home Workforce. (H.R. 5796, Rep. Michelle Fischbach)

October 10, 2023

The Honorable Michael Burgess, M.D.
United States House of Representatives
Washington, D.C. 20515

Dear Congressman Burgess:

Creative Solutions in Healthcare (CSNHC) owns and operates skilled nursing and assisted living facilities in Texas. With its corporate offices located in Fort Worth, Texas and over 150 facilities across the state, including 4 in your district, CSNHC is proud to serve the needs of thousands of Texans every year. We write to you today to express our concern with the Centers for Medicare & Medicaid Services (CMS) Minimum Staffing Standards for Long-Term Care (LTC) Facilities and Medicaid Institutional Payment Transparency Reporting proposed rule.

While we understand and agree with the agency's intention to ensure that patients receive the highest quality of care, we believe that the proposed rule is short sighted and risks jeopardizing our ability to continue providing for our patients - especially in rural areas. If the proposed one-size-fits all rule is finalized in its current form, we unfortunately do not currently have even one facility that will be able to meet the requirements. In fact, according to the Kaiser Family Foundation, only four percent of nursing facilities in Texas would meet the requirements in the proposed rule.

As we emerge from the COVID-19 pandemic, nursing homes are already at a disadvantage when attempting to fill vacancies. Compared to other health care workforces, which have rebounded from the pandemic, nursing homes still need more than 150,000 workers to get back to pre-pandemic levels. Despite increasing efforts to hire, workers are simply not available; vacancies typically sit for months on end. Again, while well-intended, we believe that CMS' proposed mandate puts the cart before the horse by attempting to enforce requirements without addressing the root of the staffing issues.

Aside from worker shortages, we lack the funds necessary to hire staff at the levels required by the staffing mandate. It is estimated that the proposed rule will cost $40 billion over 10 years - an exorbitant price tag that will exhaust our already underfunded facilities. These costs are likely to be passed on to public and private payers for nursing facility services, including residents and their family members. As an industry that is already underfunded, any additional stretch on financing could result in unnecessary closures and the loss of care for hundreds of Americans.

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(817) 348-8969 OFFICE ℭ (817) 348-8934 FAX

We believe that CMS would be more successful in addressing staffing at long-term care facilities like ours by implementing programs to bolster the recruitment and training of healthcare staff across the country. This includes licensed practical nurses, licensed vocational nurses, and certified nursing assistants which make up a large and invaluable part of our workforce.

As CMS considers feedback to their proposed rule, we ask that you encourage them to engage with industry experts to implement common sense solutions that will provide meaningful relief instead of additional problems. We appreciate your attention to this matter. Please feel free to reach out to our federal governmental relations consultant, David Pore, at dpore@hslawmail.com with any questions or concerns.

Sincerely,

Gary Blake

Gary Blake
CEO & Co-Founder, Creative Solutions in Healthcare

4150 INTERNATIONAL PLAZA ⅁ SUITE 600 ⅁ FORT WORTH, TX 76109
(817) 348-8969 OFFICE ⅁ (817) 348-8934 FAX

Congress of the United States
Washington, DC 20515

October 10, 2023

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Becerra and Administrator Brooks-LaSure:

We are adamantly opposed to the Centers for Medicare & Medicaid Services' (CMS) proposed rule to implement minimum staffing mandates for long-term care (LTC) facilities. While we recognize the need to ensure patients receive high quality health care services, this rule, as currently proposed, would exacerbate existing widespread workforce shortages, profoundly and negatively affect the finances of providers, increase burdensome reporting requirements, and drive patients toward higher-cost, more distant facilities.

The proposed rule requires nursing homes to provide "[registered nurse] RN coverage onsite 24 hours per day, 7 days per week" and "a minimum of 0.55 [registered nurse] RN and 2.45 [nurse aide] NA hours per resident day,"[1] As CMS notes in the proposed rule, "the proposed NA and RN HPRD requirements exceed those of nearly all states," and "…if finalized, these new required floors would increase staffing in more than 75 percent of nursing facilities nationwide...," which indicates that three-quarters of nursing homes would not be compliant, were the proposal in effect today.[2]

By imposing arbitrary requirements on LTC facilities, CMS ignores the workforce constraints and financial pressures facing long-term care facilities across the country. To comply with the hours per resident day (HPRD) requirement in the proposed rule, urban LTC facilities would collectively be required to hire an additional 10,495 RNs (9.7 percent increase) and 61,348 NAs (17.2 percent increase), while LTC facilities in rural areas would be required to hire an additional 2,144 RNs (8 percent increase) 15,028 NAs (15.7 percent increase). Likewise, to comply with the proposed 24/7 RN requirement, an additional 1,909 RNs (1.8 percent increase) would be needed in urban areas, and an additional 1,358 RNs (5.1 percent increase) in rural areas. Collectively, nationwide compliance costs for nursing homes are estimated to be $40.6 billion over 10 years.

Additionally, the rule requires states to collect and report on compensation for workers as a percentage of Medicaid payments for those working in nursing homes and intermediate care facilities. For providers alone, these implementation costs would amount to $9,140,000 per year for four years, or $36,560,002 over four years, and, once the rule goes into effect in year five, an

[1] Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting, 88 Fed. Reg. 61352 (Sept. 6, 2023) (42 CFR Parts 438, 442, and 483)
[2] Ibid.

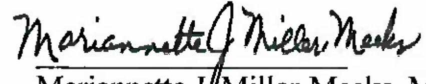
Larry Bucshon, M.D.
Member of Congress

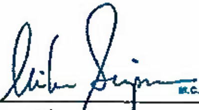
Rich McCormick, MD, MBA
Member of Congress

Neal P. Dunn, M.D.
Member of Congress

Diana Harshbarger
Member of Congress

Andy Harris, M.D.
Member of Congress


Mariannette J. Miller-Meeks, M.D.
Member of Congress


Mike Simpson
Member of Congress

July 3, 2023

Via: Electronic submission
http://www.regulations.gov

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2442-P
P.O. Box 8016
Baltimore, MD 21244-1850

Re: Medicaid Program; Ensuring Access to Medicaid Services

Dear Administrator Brooks-LaSure,

Thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) Medicaid Program; Ensuring Access to Medicaid Services Proposed Rule.

The Texas Association for Home Care and Hospice (TAHC&H) represents over 1,200 licensed Home and Community Support Services Agencies (HCSSAs) across the state of Texas. Many of these licensed HCSSAs are Medicaid providers that provide home and community-based services (HCBS) services to beneficiaries. As such, we welcome the opportunity to provide feedback on the Medicaid Program; Ensuring Access to Medicaid Services Proposed Rule. Our mission is to advocate for ethical practices, quality, and economic viability of licensed providers in Texas. Our membership, like Texas, is very diverse and includes agencies from rural and urban areas, both large and small. TAHC&H remains committed to working with you to improve the Medicaid program through innovations in efficiency and quality that safeguard taxpayers' dollars.

On behalf of Texas homecare providers, TAHC&H offers the following comments and recommendations:

HCBS Payment to Direct Care Workers

In the proposed rule, CMS states that they believe that "ensuring adherence to a Federal standard of the percentage of Medicaid payments going to direct care workers is a concrete step in recruitment and retention efforts to stabilize this workforce by enhancing salary competitiveness in the labor market," and that, "In the absence of such requirements, we are unable to support and stabilize the direct care workforce because we are unable to ensure that the payments are used primarily and substantially to pay for care and services provided by direct care workers." CMS is proposing to require that at least 80 percent of all Medicaid payments, including but not limited to base payments and supplemental payments, be spent on compensation to direct care workers that provide homemaker services, home health aide services, and personal care services within the 1915(c), (i), (j), (k) waivers.

TAHC&H has significant concerns that the 80% payment requirement could have consequential damaging impacts for Medicaid HCBS program providers. Of particular concern is the lack of data used to produce the calculation for an 80% payment threshold. While we agree that direct care workforce pay rates is an issue that needs to be addressed, presently there simply is not enough data available related to State Medicaid HCBS services to substantiate an industry requirement of this magnitude. Due to insufficient data and absent a full understanding of the state by state payment rate structures and regulatory requirements for these programs, it would be reckless of CMS to apply this mandate to states universally.

in payment rate structures and regulatory differences of the Medicaid programs state by state. We believe that by taking this route, CMS and stakeholders will be able to find a workable solution at the most basic fundamental level as opposed to implementing a blanket mandate that will not work due to the differences in the structure of Medicaid programs at the state level. We further recommend that CMS publicly disclose all data and analytical methodologies regarding any future payment thresholds to ensure transparency.

Payment Rate Transparency

In the proposed rule, CMS proposes to rescind § 447.203(b) in its entirety and replace it with new requirements to ensure fee-for-service (FFS) Medicaid payment rate adequacy, including a new process to promote payment rate transparency. This new proposed process would require States to publish their FFS Medicaid payment rates in a clearly accessible, public location on the State's website. Then, for certain services, States would be required to conduct a comparative payment rate analysis between the States' Medicaid payment rates and Medicare rates, or provide a payment rate disclosure for certain HCBS that would permit CMS to develop and publish HCBS payment benchmark data.

TAHC&H supports the proposed requirements of payment rate transparency and believes that this will allow states, providers, beneficiaries, and CMS to have access to much needed data that is necessary to make future industry changes within the Medicaid HCBS program. In regard to how this information is published, TAHC&H believes that states should be able to link to managed care organization (MCO) web pages, with the agreement that states should be required to keep these links up to date and easily accessible on the state website at all times. We believe that states should include all MCO web pages applicable to their particular state to ensure state wide transparency of all managed care entities. We also believe that including instructions for translation in non-English languages is a vital component to the implementation of using websites for public payment rate transparency.

Payment Rate Disclosure

In the proposed rule, CMS is proposing that states be required to publicly disclose information for both the comparative payment rate analysis and payment rates, noting that, "if the rates vary, the State must separately identify the payment rates by population (pediatric and adult), provider type, and geographical location, as applicable. The categories of services listed in paragraph (b)(2) include: primary care services; obstetrical and gynecological services; outpatient behavioral health services; and personal care, home health aide, and homemaker services, as specified in § 440.180(b)(2) through (4), provided by individual providers and providers employed by an agency."

TAHC&H supports the proposed requirement that states publicly disclose additional information related to payment rates beyond the fee schedule and appreciates the careful consideration of identifying specific differences in payment rates, however, the proposed rule does not require states to report on variations in populations served. There are instances where states fluctuate rates for the same service based on targeted populations for the waiver that service is provided under. We believe that including this data in the payment rate disclosure requirement would help to identify potential access to care issues that can arise when a state chooses to have differences in payment rates for the same services but different beneficiary groups.

Justification Required for Certain Rate Restructures

In this proposed rule, CMS seeks "to achieve a more appropriate balance between reducing unnecessary burden for States and CMS, and ensuring it has the information necessary to make appropriate determinations for whether a rate reduction or restructuring a State Plan Amendment (SPA) might result in beneficiary access to covered services failing to meet the standard in section 1902(a)(30)(A) of the Act. In

between interested parties and the State on matters related to the effective administration of the Medicaid program."

TAHC&H supports the revamp of the MCAC and renaming it the Medicaid Advisory Committee. We also support the requirements that states must establish a BAG, of which 25% of BAG members must be current Medicaid enrollees, or their family members or caregivers.

Requirement to Create an Interested Party Advisory Council

In the proposed rule, CMS proposes "that the State agency would be required to establish an advisory group for interested parties to advise and consult on provider rates with respect to service categories under the Medicaid State plan, section 1915(c) waiver and demonstration programs, as applicable, where payments are made to the direct care workers specified in § 441.302(k)(1)(ii) for the self-directed or agency-directed services found at § 440.180(b)(2) through (4). The interested parties' advisory group would be required to include, at a minimum, direct care workers, beneficiaries and their authorized representatives, and other interested parties."

TAHC&H supports the proposed requirement for states to create an interested parties' advisory group to advise and consult on FFS rates specifically targeted to HCBS. With an advisory group focusing payment rates paid to direct care workers in place, this would ensure that stakeholders and other interested parties are directly involved in discussions and planning related to future changes to HCBS programs. Additionally, although CMS considers the group advisory in nature, we support its input and recommendations be considered in instances where additional justification is needed for a state to receive approval of changes to its reimbursements.

Thank you again for the opportunity to submit comments and for your consideration of our concerns.

Sincerely,

Jennifer Elder

Jennifer Elder
Director of Regulatory Affairs
Texas Association for Home Care & Hospice

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Advancing Health in America

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**Statement
of the
American Hospital Association
for the
Committee on Energy and Commerce
Subcommittee on Health
of the
U.S. House of Representatives**

"Supporting Access to Long-Term Services and Supports: An Examination of the Impacts of Proposed Regulations on Workforce and Access to Care"

October 25, 2023

On behalf of our nearly 5,000 member hospitals, health systems who work with long-term care (LTC) facilities to serve hundreds of thousands of patients each year, our professional membership groups and affiliates including the American Organization for Nursing Leadership (AONL), and our 2,425 post-acute care members, the American Hospital Association (AHA) writes to share the hospital field's comments on proposed regulations for minimum staffing standards for LTC facilities and their potential impact on access to care.

The AHA and its members are committed to safe staffing to ensure high quality, equitable and patient-centered care in all health care settings, including LTC facilities. However, CMS' proposal to implement mandatory nurse staffing levels would have serious, negative, unintended consequences not only for nursing home patients and facilities, but the entire health care continuum. Safe staffing is complex and dynamic. It must account for the acuity of patients' needs, the experience and clinical expertise of the nurses and health care professionals on the care team, and the technical capabilities of the facility. Organizational leaders, nurse managers and direct care nurses who know the needs of the patients they serve best must be empowered to collaboratively make staffing decisions, rather than having "one-size-fits-all" thresholds.

The AHA opposes implementation of minimum thresholds for registered nurse (RN) and nurse aide (NA) care. This type of standard is a static and ineffective tool that CMS's own commissioned analysis shows does not guarantee safe health care environments or quality levels that result in optimum patient outcomes. The number of patients for whom nurses and other health care providers can provide safe, competent and quality care is dependent upon multiple factors that are not captured in a raw

number of hours, including the type and degree of illness; functional status and level of independence of residents; the makeup of the overall care team including caregivers who may not be nurses; the physical layout of the facility; and the experience and tenure of the professionals in question.

If implemented, the rule could severely limit access to nursing home care, particularly in rural and other underserved communities. Such access issues can lead to longer waits for emergency and inpatient hospital care, worsen staffing shortages across the care continuum and hinder innovative, new approaches to delivering quality care. **The AHA recommends that, instead of implementing these universal standards as proposed, CMS develop an approach that builds upon the knowledge and experiences of nurses and other caregivers themselves and supports the continual process of safe staffing.**

NUMERICAL STAFFING THRESHOLDS ARE NOT CONSISTENT WITH MODERN CLINICAL PRACTICE

Mandated nurse staffing standards remove real-time, clinical judgment and flexibility from the practice of nursing. Numerical staffing thresholds do not consider advanced capabilities in technology or the interprofessional team care model that supports data-driven decision-making and collaborative practice. Emerging care models incorporate nurses at various levels of licensure, respiratory therapists, occupational therapists, speech-language pathologists, physical therapists and case managers. A simple mandate of a base number of RN and NA hours per resident day emphasizes staff roles of yesterday, rather than what current and emerging practices may show is most effective and safe for the patient and best aligned with the capabilities of the care team.

AHA is concerned that these rigid standards would stymie innovation in care delivery. Our members have begun to deploy technology-enabled solutions such as virtual nursing models to help with remote patient monitoring in order to help provide an extra support to bedside nurses. As they look at their non-physician and non-nursing caregivers, some organizations are using these professionals to take on tasks that may not require a physician or nursing license to perform. Enabling practice at the top of one's education and license can lead to greater staff satisfaction while maximizing the use of limited clinical staff resources. Nursing homes need the flexibility to test, evaluate and — when the evidence supports it — implement these new models.

PROPOSED STANDARDS WOULD EXACERBATE DIRE WORKFORCE SHORTAGES ACROSS THE CONTINUUM

Mandating staffing levels would exacerbate severe long-term shortages of nursing staff across the care continuum. In 2017, the majority of the nursing workforce was close to retirement, with more than half aged 50 and older, and almost 30% aged 60 and older. A comprehensive analysis from a survey conducted by the National Council of State Boards of Nursing and National Forum of State Nursing Workforce Centers showed that nearly 900,000 — or one-fifth of the 4.5 million total registered nurses — expressed an intention to leave the workforce due to stress, burnout and retirement. The study also

noted that over 33,800 licensed practical nurses (LPNs) and vocational nurses left the field since 2020, disproportionately impacting nursing homes and LTCs.[1]

In the CMS proposed rule, the agency estimates that 75% of LTC facilities would have to increase staffing to meet the proposed standards, including the new standard requiring 24/7 RN staffing. Considering the massive structural shortages described by recent studies, it is unclear where this supply of nurses will come. **Given the shortages we described above, it is inconceivable that LTC facilities will be able to meet these standards without detrimental effects to workforce availability throughout the care continuum.**

IMPLEMENTATION OF THESE STANDARDS WOULD HURT ACCESS TO CARE

Faced with required staffing levels, skilled nursing facilities and other LTC facilities may be forced to reduce capacity or even close their doors when they are unable to meet these mandates. Organizations considering opening new LTC facilities would likely be discouraged from doing so. This would have a ripple effect across the entire continuum of care, especially because general acute care hospitals, inpatient rehabilitation facilities and other health care facilities already struggle to find appropriate placement for their patients.

Hospitals and health systems already are experiencing significant challenges in moving patients through the health care continuum generally, and into skilled nursing facility care specifically. Longer stays in hospitals result in delays in patients receiving the next level of medically necessary care. They also lead to longer wait times in hospital emergency departments because hospitals are unable to move current patients out of inpatient beds. Constrained access to LTC facilities is a quality-of-care issue affecting all types of patients across the care continuum.

CONCLUSION

Thank you for your consideration of the AHA's comments on proposed regulations for minimum staffing standards for LTC facilities and their potential impact on access to care. We look forward to continuing to work with you to address these important topics on behalf of our patients and communities.

[1] https://www.journalofnursingregulation.com/article/S2155-8256(23)00047-9/fulltext

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October 25, 2023

The Honorable Frank Pallone
Ranking Member
Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

Dear Ranking Member Pallone:

On behalf of the 1.4 million members of the American Federation of State, County and Municipal Employees (AFSCME), I write to request that this letter be included in the record for the October 25 hearing on "Supporting Access to Long-Term Services and Supports: An Examination of the Impacts of Proposed Regulations on Workforce and Access to Care."

Tens of thousands of AFSCME members work in our nation's long-term care system night and day to provide vital quality services to the elderly, people with disabilities and others. Whether in State Veterans Homes, nursing homes, clients' homes, Intermediate Care Facilities for Individuals with Developmental Disabilities, or in other community settings, the assistance and supports we provide, such as personal care, bathing, cooking and housekeeping, allows people to live with dignity and respect. We are nurses, direct care workers, aides, dietitians and food service workers, therapists, and others.

AFSCME supports the proposed rule by the Biden administration that would establish a federal floor for staffing levels to prevent owners of nursing homes – both public and private – from slashing staffing to unsafe levels. The proposal would require every nursing home facility in the nation, including many State Veterans Homes, to have a registered nurse on-site 24/7, as well as a certain minimum number of registered nurses and nurse aides to provide routine care. This proposed rule on minimum staffing in long-term care facilities represents a long overdue effort to improve the quality of care and working conditions in nursing homes that receive taxpayer dollars. It puts into policy the strong recommendations of health researchers, nurses and other clinical experts who have studied this issue for decades.

And importantly, direct care workers on the front lines agree that this proposal is needed to address inadequate staffing, attract and retain workers and improve quality of care for residents.

As reported recently on AFSCME's website, Rosemarie Kukys, an AFSCME member and Registered Nurse (RN) in Orange County, New York, has been caring for

others her entire life. As a child, she says, she would "take birds that fell out of a tree or care for bunnies that didn't have a mother." In high school, she became a licensed nurse practitioner. Today, she serves residents of Valley View Center in Goshen, a job she has done for 45 years. Her current role is as a clinical instructor, supervising other nurses and nursing assistants who care for older adults.

Like many AFSCME members, Kukys, a member of the Civil Service Employees Association (CSEA) and vice president of Orange County Local 836, went into public service to make her community better. But a nationwide staffing shortage made worse by the coronavirus pandemic has left Kukys and her co-workers struggling at the county-owned and -run nursing home. Staffing issues at for-profit nursing homes are often worse.

Kukys says, "the staffing mandate being put forth in the new rule is definitely a good beginning, and I hope it has a positive effect. More nurses equals higher quality care. Right now, nurses must rush through their tasks and nursing homes are the forgotten land."

Kukys takes great pride in her job at Valley View, which provides long-term care for older adults, including patients with Alzheimer's and dementia, and short-term rehabilitation services. But the last few years have made her worry about the future of such care. "More needs to be done in order to make sure that jobs at nursing homes continue to be attractive opportunities for professionals in the nursing field," she says. "Workers in nursing homes often don't make enough."

During the first two years of the pandemic – March 2020 to March 2022 – skilled nursing care facilities in the U.S. lost some 240,000 employees, according to federal data. Although they have somewhat recovered, as of September 2023 there were still 150,000 fewer such jobs.

These concerns are shared by other AFSCME members.

An AFSCME Council 93 member who is a Licensed Nursing Assistant for the last 30 years and for 12 of those years has worked at a nursing home in New Hampshire, says: "Every day, I see the impact that inadequate staffing has on residents and workers. The workers get stressed out when they are spread so thin. It really takes a toll on our bodies and our health when facilities are understaffed. But it is really the residents that are impacted the most. We are like family to them. When we don't have the time to spend with the residents when there is insufficient staff, the residents notice!

"We really saw things take a turn for the worst during the height of the COVID-19 pandemic. We lost a lot of staff and haven't fully recovered. Some didn't feel safe and got scared they would get COVID. Our third floor was completely shut down because of workforce shortages. This means that there are less spaces to help Seniors who need help. But I think many were tired of being devalued and found work elsewhere.

"To fix these issues, we need to address the root causes of why workers are leaving. They are in financial, emotional and physical distress. They are taking on more and more work and not fairly compensated for it. I barely make ends meet. My husband owns his own business but makes just enough to pay his workers and pay the bills. We are just scraping by. I have asked for overtime every Friday for the next few months to survive. I

will be working 14 additional hours in overtime for a total of 54 hours per week. We are living paycheck to paycheck. Luckily, my kids are grown up and I don't have to pay for child-care like many of the other nursing home workers. I can't even imagine juggling that.

"It is so important that we put the right staffing standards in place. This is not sustainable, and we can't afford band-aid type solutions. We need better pay, better working conditions, and more workers. The CMS rule on nurse staffing is a step in the right direction, I believe it will help attract and retain workers in the nursing home pipeline."

Another AFSCME Council 93 member who is a Licensed Nursing Assistant for 16 years also says, "it is a rewarding job because I know that I make a difference in the lives of so many people. The nursing home residents are like family to me. Some of the residents do not have family, I am the only family they have.

"I was pleased to learn that CMS is working on new staffing standards in nursing homes. I believe that this new rule will improve the care that residents receive. It will also help retain workers who are feeling overwhelmed and overworked. Workloads have increased significantly. At the same time, we are helping residents with more complicated health needs which require more of our time. We want what is best for them.

"The residents are the ones who are impacted and suffering the most. They (and their families) are feeling isolated and have expressed concern over the quality of care that they are receiving. They deserve better. As a result of the staffing shortage, corners are being cut when care is being provided. Residents' needs are not being met in a timely manner which often results in sub-par care. The ratio for residents to staff care is 10-15 residents to 1 staff member (at times). The aides are stretched too thin which leads to inconsistencies in care. The residents don't have a primary staff member. They are getting a "new face" almost every day and are unable to form that bond which is essential and provides the comfort and safety that the residents expect and deserve. Our residents deserve the best quality of care.

"The staffing shortage has a ripple effect throughout the whole facility and its employees. Staff are being taken out of their regular position to help in other departments, or on other floors. They are providing care to residents that are virtual strangers, in terms of those residents' preferences of care and specific routine. The residents crave routine. It provides a level of comfort and safety that is not acquired by having a new aide every day.

"Employees are being begged to work overtime to fill a gap. Employees are tired. Employees also crave the consistency much like the residents do. It is important to mention that as a result of the staffing shortage, we have Maintenance and Nursing staff working in the kitchen. Social Services and Rehab staff are helping in laundry and in the Housekeeping Department. When staff are being pulled they aren't able to get their own jobs done. They are rushed. They are tired. They do not feel appreciated. They experience caregiver burnout. This environment is not safe for all of us here who are trying to provide

a safe, warm and loving environment to our residents. We cannot sustain like this. We all deserve better.

"We cannot afford to go backwards. We need strong nursing home staffing ratios. I urge Congress to work with the administration to finalize the nursing home staffing rule."

Inadequate staffing standards in nursing homes have persisted for far too long. It is challenging to attract and retain workers to this sector, which are often defined by low wages and meager benefits.

According to PHI, the median hourly wage for nursing home workers in 2022 was $17.06. The median annual earnings for nursing assistants was just $25,748 in 2021 (the most recent year available), 39 percent lived in or near poverty (defined as less than 200 percent of the federal poverty line), and 40 percent relied on public assistance programs to meet their basic needs.

We should be rewarding "care work" which is physically and emotionally demanding. According to the Bureau of Labor Statistics, working in a nursing home is one of the most dangerous places to work. Dangers associated with nursing home jobs include lifting and repositioning patients, chemical and drug exposure and workplace violence. Understaffing increases the likelihood of lifting injuries and puts both residents and patients at risk.

Low wages, difficult working conditions and increased workloads all drive the workforce crisis we are seeing in the long-term care industry. We need to take action to address the root causes of these issues by improving job quality for these workers. The proposed rule for nursing home staffing will help stabilize the long-term care workforce and ensure access to high-quality care.

Thank you for considering our views.

Sincerely,

Edwin S. Jayne
Director of Federal Government Affairs

ESJ:DH:dmg

cc: Members of the Committee

Caring Across Generations Statement for the Record
US House Energy & Commerce Subcommittee on Health Hearing on Supporting Access to Long-Term Services and Supports: An Examination of the Impacts of Proposed Regulations on Workforce and Access to Care.

October 25, 2023

To Chairman Guthrie and Ranking Member Eshoo,

Caring Across Generations is a national organization of family caregivers, care workers, disabled people, and aging adults working to transform the way we care in this country so that care is accessible, affordable and equitable— and our systems of care enable everyone to live and age with dignity. We believe that we should all be able to access the care we want and need at every stage of life. We believe that we should be free to live and age in the setting of our choice. We believe that we should all be able to afford the care that makes this possible – all while supporting family caregivers and fairly compensating direct care workers. We appreciate the opportunity to submit written comments for the record on the vital importance of the direct care workforce and the critical rules proposed by the Biden Administration to bolster the direct care workforce.

The direct care workforce is the largest occupation in the country, made up of 4.8 million workers, and the workforce is projected to add more than 1 million jobs between 2021 and 2031[1]. PHI estimates that there will be 9.3 **million** total direct care job openings between 2021 and 2031[2], due to a combination of existing workers exiting the field or leaving the labor force entirely. The need for direct care is growing and will continue to grow, as the population of older adults in the US is expected to nearly double to 94.7 million by 2060[3] and as the number of disabled people continues to grow at an increased rate due to COVID-19's impact as a mass disabling event[4]. Additionally, many older adults and disabled people are already experiencing a severe care crisis, with care needs going unmet. Without a robust, well-trained, well-compensated direct care workforce, families and people who need care are left with few options,

[1] PHI. 2023. *Direct Care Workers in the United States: Key Facts.* Available at: https://www.phinational.org/wp-content/uploads/2023/09/PHI-Key-Facts-Report-2023.pdf
[2] PHI. 2023. *Direct Care Workers in the United States..*
[3] PHI. 2023. *Direct Care Workers in the United States.*
[4] Center for American Progress. 2022. *COVID-19 Likely Resulted in 1.2 Million More Disabled People by the End of 2021. Workplaces and Policies Need to Adapt.* Available at: https://www.americanprogress.org/article/covid-19-likely-resulted-in-1-2-million-more-disabled-people-by-the-end-of-2021-workplaces-and-policy-will-need-to-adapt/

and family caregivers must fill the gaps, with more than 1 in 5 Americans currently acting as unpaid caregivers to meet their loved ones' needs[5]. The economic value of the unpaid care provided by family caregivers is astronomically high, valued at $600 billion in 2021[6].

The direct care workforce is in the midst of a catastrophic shortage, substantially exacerbated by COVID-19. This crisis stems from decades of underinvestment in the services provided to disabled people and older adults and the direct care workers who serve them. Every state reports shortages of home and community-based services (HCBS) workers[7]. The HCBS workforce is overwhelming composed of women of color and over 30% are immigrants[8]. 39% of direct care workers live in low-income households, and 46% of direct care workers rely on public assistance for their own needs, including Medicaid for their own health insurance[9]. Particularly in a tight labor market, where other labor sectors are able to offer increased wages and hiring incentives funded by increased prices and where the risk of illness is lower, providers lack the resources to recruit and retain direct care workers, especially in regards to wages and benefits such as paid time off, health insurance, and retirement plans. . The median wage for direct care workers was $15.43 per hour in 2022, resulting in median annual earnings of just $23,688[10]. Because of low wages and the physical and emotional demands on direct care workers, the median annual turnover for nursing assistants in nursing homes was nearly 100% in 2017-2018 and was 64% in home and community-based settings in 2021[11].

To rectify the longstanding issues exacerbated by the COVID-19 pandemic, direct care workers must be paid a living wage. Caring Across Generations supports the CMS proposal that at least 80% of all Medicaid payments for homemaker services, home health aide services, and personal care services be spent on direct care worker compensation. Given the vast underpayment of this workforce and the growing care crisis, **it is critical that CMS institutes the provisions that ensure the 80% passthrough is landing directly in direct care worker's pockets and that this provision is not removed.**

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[5] AARP. 2020. *Caregiving in the U.S.* Available at: https://www.aarp.org/content/dam/aarp/ppi/2020/05/full-report-caregiving-in-the-united-states.doi.10.26419-2Fppi.00103.001.pdf

[6] AARP. 2023. New AARP Report Finds Family Caregivers Provide $600 Billion in Unpaid Care Across the US. Available at: https://www.aarp.org/caregiving/financial-legal/info-2023/unpaid-caregivers-provide-billions-in-care.html

[7] Kaiser Family Foundation. 2023. *Payment Rates for Medicaid Home- and Community-Based Services: States' Responses to Workforce Challenges.* Available at: https://www.kff.org/medicaid/issue-brief/payment-rates-for-medicaid-home-and-community-based-services-states-responses-to-workforce-challenges

[8] PHI. 2022. *Direct Care Workers in the United States: Key Facts.* New York, NY. Available at: https://www.phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-3/

[9] PHI. 2023. *Direct Care Workers in the United States.*

[10] PHI. 2023. *Direct Care Workers in the United States.*

[11] PHI. 2021. *Key Facts.*

In regards to nursing home staffing standards, Caring Across Generations strongly supports minimum staffing standards in nursing homes and other long-term care facilities. Higher nursing staffing levels in long-term care facilities are critical to the health and well-being of residents of these facilities. Even before the devastating impact of COVID-19 on the residents of long-term care facilities, an increase in staffing levels led to a significant decrease in the proportion of residents with pressure ulcers, physical restraints, and urinary catheters[12]. Increasing nurse staffing has also been shown to reduce on-site resident fatalities in skilled nursing facilities (SNFs)[13]. Higher nursing staffing levels mean fewer COVID-19 cases and deaths. A study of all 215 Connecticut nursing facilities in 2020 showed that even 20 additional minutes of direct care per resident per day by RNs meant 22% fewer cases of COVID-19 and 26% fewer deaths among residents[14]. Additionally, the majority of New York State nursing home deaths from COVID-19 through January 2021 were in the nursing homes with the lowest staffing[15]. Addressing the need for minimum staffing standards in nursing homes and other long-term care facilities is critical for the health and wellbeing of older adults and disabled people, including throughout rural areas.

Addressing the need for minimum staffing standards in nursing homes and other long-term care facilities is also critical for retaining and recruiting direct care workers and nursing staff into these roles. In a survey of nursing home workers[16], 90% named the staffing shortages in the industry as their top concern. When asked about top concerns on the job, staffing levels concerned 86% of nursing home workers, tying with the concern over wages, indicating how extreme the staffing issues are for nursing home workers themselves. 80% of nursing home workers polled agreed that staffing shortages make it difficult for them to do their job. Additionally, nursing home staff have particularly high levels of turnover, especially following the pandemic. Across all types of nursing home workers, lower staffing levels are associated with higher turnover rates[17], which in turn negatively impacts care[18]. **Far from harming direct care workers, minimum staffing standards in nursing homes would improve working conditions for direct care workers, leading to a decrease in turnover and a decrease in workers**

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[12] Zhang & Grabowski, Gerontologist. 2004. *Nursing home staffing and quality under the nursing home reform act.* Available at: https://pubmed.ncbi.nlm.nih.gov/14978317/

[13] Tong. Health Economics. 2011. *The effects of California minimum nurse staffing laws on nurse labor and mortality in skilled nursing facilities.* Available at: https://onlinelibrary.wiley.com/doi/10.1002/hec.1638

[14] Journal of the American Geriatrics Society. 2020. *COVID-19 Infections and Deaths among Connecticut Nursing Residents: Facility Correlates.* Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7323378/

[15] New York State Office of the Attorney General Letitia James. *Nursing Home Response to COVID-19 Pandemic.* Revised January 2021. Available at: https://ag.ny.gov/sites/default/files/2021-nursinghomesreport.pdf

[16] SEIU. 2022. *Nursing Home Workers Poll: Half Say They are Likely to Leave Their Jobs in the Next 12 Months.* Available at: https://www.seiu2015.org/nursing-home-worker-poll-half-say-they-are-likely-to-leave-their-jobs-in-the-next-12-months/

[17] Castle & Engberg. Gerontologist. 2006. Organizational characteristics associated with turnover in nursing homes. Available at: https://pubmed.ncbi.nlm.nih.gov/16452285/

[18] Krein et al. The Journal of Post-Acute and Long-Term Care Medicine. 2022. *"Sometimes it's not about the money… it's the way you treat people…": A Qualitative Study of Nursing Home Staff Turnover.* Available at: https://www.jamda.com/article/S1525-8610(21)01063-X/fulltext

leaving the field, and importantly would improve care and outcomes for residents of nursing homes.

By enacting the Access Rule, specifically the 80/20 provision, and the Minimum Staffing Standards rule, direct care workers will benefit, shoring up the needs of this critical workforce. These policies will also benefit the older adults, disabled children, and disabled adults who need care, both expanding access to care by increasing the workforce, providing greater consistency in services, and ensuring the care is high quality. Finally, these policies will benefit family caregivers who will be able to return to the workforce and increase overall economic growth by adding billions to local economies[19].

We thank you for your focus on addressing the direct care workforce crisis, and we urge you to support the Access Rule and the Minimum Staffing Standards Rule. If you have any questions or would like to discuss further, please contact Tory Cross, Associate Director of Federal Policy & Government Relations at Caring Across Generations, at tory@caringacross.org.

Sincerely,

Tory Cross, Associate Director of Federal Policy & Government Relations
Caring Across Generations

[19] LeadingAge. 2020. *Making Care Work Pay: How Paying at Least a Living Wage to Direct Care Workers Could Benefit Care Recipients, Workers, and Communities.* Available at: https://www.ltsscenter.org/wp-content/uploads/2020/09/Making-Care-Work-Pay-Report-FINAL.pdf

Statement of Dennis Heaphy
Disability Policy Consortium
October 19, 2023

My name is Dennis Heaphy. I am a quadriplegic with complex medical needs unassociated with my spinal injury. For most of the last 40 years I have been hiring, firing and training my personal care attendants through the MassHealth consumer model. Prior to Massachusetts, I lived in New York and relied on agencies for care attendant services. The agency assured me and my family that only tenants would be trained and be on the carrier the task needed for me to live independently. This was not the case. My mother regularly stayed in my apartment in order to help whoever the agency sent that night to put me to bed that night. The mornings it was worse. The agency regularly sent people who would say "I can take care of him" or "they didn't tell me he was in a wheelchair." One might ask of things changed, and the answer is no. A friend of mine, blind due to a brain tumor with minor cognitive deficits struggles with the aides sent to her by her agency. One night when I was visiting just before Covid, a woman came to the door and said "no one told me she was blind". I told her not to worry I would help explain things with the assistance of my friend. I told the aide how to lay out the food on the table e.g. the utensils and plate in a clockwise fashion. I also make sure the one was safe to escort my friend down the hallway to the bathroom. Both the attendant and my friend survived the night, but the attendant never came back. Recently my friends sister had to come from North Carolina to New York and stay with her because the attendant sent were terrible.

So, no I do not think the 80/20 requirement is a burden. Agencies, as with other healthcare entities are increasingly being overtaken by for-profit benefiting from the backbreaking work of care attendants who make very little money compared to those who do nothing but sit back and earn a profit from cutting care. I do think there needs to be a glide path provided with smaller agencies and rural agencies given the opportunity to reach the 80/20 split, but it is time for the dollars go to the direct care workers and at agencies. Yes, agencies will complain about all the work they need to do training and coordinating care attendants, but if you look at the books of the agencies I have no doubt you will find increasingly that costs are going to salaries for executives or investors. It is no surprise we have a workforce shortage.

As for nursing homes, I'm petrified of dying in an SNF. I'm not alone. This is the fear of most people who are cognizant of the poor conditions of SNFs. My grandmother died in the nursing home. My mother was informed that my grandma had died, went to the nursing home and my grandmother was laying on the floor half naked. This was over 40 years ago. Conditions have only become worse. Nursing homes have been reduced to revenue extraction vehicles for venture capitalist enterprises. The stench of nursing homes can be overwhelming, the quality of the staff and best questionable given the low pay. A friend of mine, just weeks away from her retirement died in a SNF for what was supposed to be a short-term stay to resolve pressure sores. She died within a couple weeks.

So years ago hearings were held in Massachusetts to strengthen requirements for SNFs. One SNF representative complained about unfair lowering of their star rating because just one death. The death, a resident had just returned from the hospital. The SNF nurse within the room with the resident when the resident began to bleed out. The nursing home resident talked about

how traumatic the experience was for the nurse who came running out of the room screaming and crying. When I had the chance I asked the nursing will representative why the nurse could not have at least called 911 or held the resident's hand while the resident was dying? He had no response.

Are the new CMS rule requirements for nursing staffing adequate or appropriate. For me, the answer is no. However, it is a start. I am grateful to live in Massachusetts and have the HCBS services I receive. The services enable me to live in the community be employed and be present here today. If I were in a nursing home, I would be laying in bed in soiled diapers waiting to die either because neglect due to understaffing or poor quality staff or an opportunistic infection from another resident. I am a Christian, opposed to suicide but given the choice between going to nursing home and dying at home, I would die at home praying that God would understand.