October 29, 2023

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3442-P

Submitted electronically to: http://www.regulations.gov

Re: Medicare and Medicaid Programs; Minimum Staffing for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting (Docket Number: CMS-3442-P)

Dear Administrator Brooks-LaSure:

Premier Inc. appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the *"Medicare and Medicaid Programs; Minimum Staffing for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting (CMS-3442-P)"* proposed rule which was published in the Sept. 6, 2023 *Federal Register*.

In our detailed comments below, Premier urges CMS to:

- Not finalize its current proposal at this time and work with stakeholders to further study and understand the impact of staffing ratios on access to quality care for residents;
- Advance a multi-pronged policy approach to holistically address healthcare workforce challenges;
- Develop policies that incentivize long-term care (LTC) facility and post-acute providers to implement electronic health records and electronic clinical surveillance technology to provide meaningful assistance with infection control;
- Consider streamlining the process for hardship exemptions, extending the exemption time period, and adding an exemption for unforeseen circumstances; and
- Abandon the proposal for state Medicaid reporting and focus on reporting channels already in place, such as the skilled nursing facility (SNF) Quality Reporting Program (QRP), that can provide facility level data on staffing and patient outcomes.

I. BACKGROUND ON PREMIER INC.

Premier is a leading healthcare improvement company and national supply chain leader, uniting an alliance of 4,350 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's work is closely aligned with healthcare providers, who drive the product and service contracting decisions using a data driven approach to remove biases in product sourcing and contracting and assure access to the highest quality products. In addition, Premier operates the nation's largest population health collaborative, having worked with more than 200 accountable care organizations (ACOs).

A Malcolm Baldrige National Quality Award recipient, 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. Headquartered in Charlotte, North Carolina, Premier is passionate about transforming American healthcare.

II. MINIMUM STAFFING STANDARDS FOR LTC FACILITIES

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. For the reasons detailed below, ***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.***

Proposed minimum staffing standards are unworkable given workforce limitations

Premier believes the minimum staffing 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.[1] 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. There are 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 that are 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.[2] 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,

[1] "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
[2] "CMS Proposed Staffing Mandate: In-Depth Analysis on Minimum Staffing Levels". CliftonLarsonAllen LLP. September 2023. CLA Staffing Mandate Analysis - September 2023 (ahcancal.org)

soaring inflation and funding instability due to the lingering effects of the COVID-19 public health emergency. ***Premier believes 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***.

Proposed national approach does not account for state variation

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 facility 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[3], research was presented that indicates that SNFs with a higher proportion of beneficiaries covered under Medicaid or by Medicare Part D's low-income subsidy (LIS) are associated with lower staffing levels. Therefore, ***Premier is concerned the staffing mandate is highly likely to have a disproportional, negative impact on SNFs with lower-income residents, 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.[4] 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. IMPLEMENTATION TIMELINE AND EXEMPTIONS

Implementation timeline

CMS proposes to phase in the requirements as follows:

- Phase 1 - Compliance with the facility assessment requirements would be required for facilities in both urban and rural areas beginning 60 days after publication of the final rule;

[3] https://www.medpac.gov/wp-content/uploads/2023/03/October2023_MedPAC_meeting_transcript_SEC.pdf
[4] "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

- Phase 2 - Compliance with the proposed requirement for an RN to be onsite 24/7 would be required for facilities in urban areas beginning two years after the publication of the final rule and for facilities in rural areas beginning three years after the publication of the final rule; and
- Phase 3 - Compliance with the proposed minimum staffing requirement of 0.55 HPRD for RNs and 2.45 HPRD for NAs would be required for facilities in urban areas beginning three years after the publication of the final rule and for facilities in rural areas beginning five years after the publication of the final rule.

Premier appreciates that CMS has recognized that LTC facilities face additional challenges in rural areas and, therefore, proposes to provide additional time for rural providers to comply with the requirements. However, additional time is not enough to alleviate the workforce concerns we describe above. ***Premier urges CMS to abandon the proposal in its entirety, including the implementation timeline, until the policy or any alternatives can be met. CMS should work with stakeholders to further study and understand the impact of staffing ratios on access to quality care for residents*** because as it currently stands, "the evidence of the relationship between quality and total staffing is mixed." For example, in that MedPAC October 2023 session mentioned above, it was reported that the Commission plans to provide an updated staffing analysis in its June 2024 report.[5] Given that current research is inconclusive, any mandates prior to further study would be premature. Furthermore, any future rulemaking must incorporate rural and small providers in the development process to better understand impact to their operations.

Hardship exemptions

In the rule, CMS proposes a hardship exemption to the proposed HPRD requirements of the minimum staffing standards applicable to RNs and NAs. A hardship exemption would be granted for a one-year period and could be extended for additional one-year periods. The hardship exemption would not apply to the 24/7 RN requirement, but that requirement would be eligible for waiver under separate existing statutory waiver processes. The proposed exemption criteria are: 1) LTC facility location in area with shortages of RNs and NAs or 20 plus miles from nearest LTC facility; 2) good faith effort to hire and retain staff; and 3) demonstrated financial commitment.

Premier supports hardship exemptions that account for obstacles that prevent certain providers from complying with requirements. The three exemption criteria that CMS proposes are reasonable and will help some providers navigate an eventual pathway to compliance. However, overall, Premier believes the proposed exemption process places a significant administrative burden on LTCFs and urges ***CMS to consider: 1) streamlining the process to ease the administrative burden on LTCFs; and 2) extending the exemption time period to two or more years to account for LTC facilities that will likely need to seek an exemption for consecutive years***. Furthermore, as discussed above, unforeseeable circumstances could arise for facilities, such as natural disasters or other unpredictable circumstances. As such, ***Premier encourages CMS to consider adding a special exemption category should that become necessary.***

Policy approaches to support the LTC facility workforce

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***.

LTC facility staff can also be empowered to work more effectively and maximize their workflow by providing long-term and post-acute care (LTPAC) providers with incentives to adopt health information technology more readily

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

to standardize patient data, improve care quality and reduce costs. Unfortunately, clinical analytics technologies are currently not widely used in nursing homes and other 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 Clinical Health (HITECH) Act excluded LTPAC providers. ***To further bolster the capabilities of LTC facility staff and improve patient care, Premier encourages CMS to advance 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. MEDICAID INSTITUTIONAL PAYMENT TRANSPARENCY

CMS proposes to require states to annually report the percentages of Medicaid payments claimed by the state for Medicaid-covered nursing facility services and intermediate care facilities for individuals with intellectual disability (ICF/ID) services that are spent on direct care worker and support staff compensation. This reporting requirement would apply for both fee-for-service and managed care delivery systems. ***Premier strongly supports efforts to improve transparency in healthcare, however, Premier is concerned that the proposed reporting requirement will place a significant burden on state Medicaid programs while yielding data that is uninformative in crafting policy solutions. Instead, Premier encourages CMS to focus on reporting channels already in place, such as the SNF QRP, that can provide facility level data on staffing trends and patient outcomes.***

V. CONCLUSION

In closing, Premier appreciates the opportunity to submit these comments on the *"Medicare and Medicaid Programs; Minimum Staffing for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting (CMS-3442-P)"* proposed rule. Premier looks forward to working with CMS and other stakeholders to develop policies that strengthen and support our nation's LTC facilities and the vulnerable populations they serve.

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.

Sincerely,

Soumi Saha, PharmD, JD
Senior Vice President of Government Affairs
Premier Inc.