

November 6, 2023

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3442-P,
P.O. Box 8016, Baltimore, MD 21244-8016

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

Dear Administrator Brooks-LaSure,

On behalf of the Medicaid Health Plans of America (MHPA), we thank you for the opportunity to provide input on the Minimum Staffing Standards for Long-Term Care Facilities (LTC) and Medicaid Institutional Payment Transparency Reporting Proposed Rule (CMS-3442-P).

MHPA is the only national trade association with a sole focus on Medicaid, representing more than 130 MCOs serving more than 50 million Medicaid beneficiaries in 40 states, the District of Columbia and Puerto Rico. MHPA's members include both for-profit and non-profit, national, regional, as well as single-state health plans that compete in the Medicaid market. Nearly three-quarters of all Medicaid beneficiaries receive health care through MCOs, and the Association provides research and advocacy services that support policy solutions to enhance the delivery and coordination of comprehensive, cost-effective, and quality health care for Medicaid beneficiaries. Below you will find our comments in response to this rule.

[Long-Term Care Facility Nurse Staffing Proposals](#)

MHPA shares the Administration's stated goal of ensuring safe and quality care in LTC facilities, which play a critical role in providing services to adults who require assistance to perform activities of daily living. LTC facilities serve an important function in health care, offering post-acute and rehabilitative care for individuals who are planning to return to their home, or long-term care for individuals who can no longer be supported in their community.

However, we are concerned that the staffing standards in this proposed rule, which CMS notes are currently not being met by 79% of Medicaid and Medicare certified LTC facilities, will divert resources away from home and community-based services (HCBS) and exacerbate the ongoing direct care workforce shortage. Mandatory coverage of institutional care under Medicaid with optional coverage for HCBS contributes to Medicaid's structural bias towards institutional care. In states electing to provide HCBS coverage, there are often significant waiting lists that prevent beneficiaries from receiving services in the setting of their choice.

To help address this institutional bias, policymakers at the state and federal level have focused on rebalancing long-term services and supports (LTSS) away from institutional settings and towards HCBS settings, including through incentives via managed LTSS to increase beneficiary access to HCBS and increased uptake of section 1915(c) waivers. Although some states have made significant progress in

reducing wait times to receive services in HCBS settings, a November 2022 report¹ by the Kaiser Family Foundation notes that 37 states continue to have waiting lists for HCBS as of 2021. The same report indicated that people on waiting lists waited an average of 45 months to receive HCBS waiver services, which was up from 44 months in 2020. Individuals with intellectual or developmental disabilities face the longest wait times, averaging 67 months, or five and a half years, before being transferred to the setting of their choice.

The tension between payment adequacy requirements from the Ensuring Access to Medicaid Services Proposed Rule, if finalized, and this requirement is likely to exacerbate the existing workforce shortage and could negatively impact the ability of HCBS providers to increase staffing levels and meet the existing needs of the most vulnerable Medicaid beneficiaries. We are concerned that these provisions will cause a regression in the progress that state and federal policymakers have made in rebalancing LTSS from LTC facilities towards HCBS settings.

We agree with CMS' proposal to require LTC facilities to require a nurse to be on site 24 hours a day, 7 days a week as a minimal standard, and recommend that CMS finalize their alternative proposal to allow the facility's Director of Nursing (DON) to be a qualified staff to meet this requirement, in addition to registered nurses (RNs). Having a nurse on staff at all times will ensure that patients with complex needs in LTC facilities always have skilled medical professionals available should issues or complications arise. DONs are qualified to fulfill this need should a RN not be available, as they hold RN licensures in addition to advance degrees, such as a Master of Science in Nursing, Doctor of Nursing Practice, or Doctor of Nursing Science.² Allowing a DON to fulfill this requirement will alleviate the burden on LTC facilities to meet new staffing requirements.

However, we have concerns that the mandatory staffing ratio proposal could cause nursing homes to go out of business which could lead to significant access issues for Medicaid's aging population and LTSS members. Therefore, **we respectfully encourage CMS to withdraw nurse staffing ratio provisions and instead focus efforts on workforce development for direct care workers and other providers in the industry.** A one-size fits-all approach to increasing staffing levels in LTC facilities, especially one that only addresses nursing staff rather than an interdisciplinary staff, will not increase access to or quality of LTSS for Medicaid beneficiaries. We recommend that CMS focus efforts on investing in the development of training, credentialing, and licensing to introduce additional medical professionals to the labor market to meet the existing need for LTSS staff, before implementing minimum staffing requirements across the board. State approaches should be individualized based on the needs of their population and available staff, with the objective of improving staffing ratios as a long-term goal within the next five to 10 years.

We are also concerned that state-level minimum staffing standards may conflict with proposed federal standards in this rule. In Pennsylvania for example, recently updated standards require staffing minimums for Licensed Practice Nurses (LPNs), where nursing homes will be required to achieve a minimum nurse staffing level of 3.2 hours per resident day (HPRD), including a minimum number of LPNs. The addition of federal standards would require nursing homes in Pennsylvania to meet a much higher standard than other

¹ <https://www.kff.org/medicaid/issue-brief/a-look-at-waiting-lists-for-home-and-community-based-services-from-2016-to-2021/>

² <https://www.nursingworld.org/resources/individual/how-to-become-a-director-of-nursing/#:~:text=As%20a%20top%20Drinking%20administrator,procedures%20and%20establishing%20departmental%20goals>

states that do not have similar LPN requirements. We encourage CMS to consider existing state requirements as they pursue approaches to address workforce challenges in LTC facilities.

Finally, we recommend that CMS promote programs which support diversity in the direct care workforce, in order to advance CMS' strategic pillar of advancing equity and addressing health disparities in our health system. Approaches to improving diversity in the workforce could include hiring employees that have different values, beliefs, or backgrounds, to ensure that staff understand the culture in the community they are serving. In addition, programs can promote workforces with different credentials and licensures to provide services to the majority of patients in one location.

Medicaid Institutional Payment Transparency Reporting Proposal

On the proposal surrounding Medicaid Institutional Payment Transparency, we raise concerns with the proposed definition for "direct care workers." The omission of Direct Support Professionals (DSPs) and Home Health Aides (HHAs) reinforces the institutional bias against HCBS and is not aligned with the definition included in the "Ensuring Access to Medicaid Services" Notice of Proposed Rulemaking. We encourage CMS to modify their proposed definition in the final version of this rule to align definitions across recent rulemaking and to acknowledge the role that DCPs and HHAs play in the LTSS care continuum.

In addition, we are concerned that new reporting requirements in this rule will further strain the resources of State Medicaid Agencies, that are currently navigating the unwinding period and will soon be standing up a high volume of reporting requirements tied to other recent rulemaking. New reporting requirements on compensation for direct care workers and support staff as a percentage of Medicaid payments will require significant efforts from LTC facilities and State Medicaid Agencies alike; we have concerns that smaller more specialized LTC facilities being particularly under-resourced to collect, analyze, and regularly share this information in a streamlined fashion.

Today, Medicaid programs across the United States are in the process of redetermining the eligibility of over 90 million Americans who receive health coverage under Medicaid and CHIP. States are currently facing significant bandwidth constraints as they work through a three-year backlog with staff that have in some cases never processed an eligibility verification. Providers are concerned about the impact of a potential increase in the number of uninsured individuals. We are concerned that the implementation of this new reporting requirement could impede efforts by states to mitigate coverage losses for Medicaid enrollees. States will likely be navigating new regulatory requirements tied to the expected finalization of proposals in the Ensuring Access to Medicaid Services Proposed Rule, the Medicaid Managed Care Proposed Rule, and the Medicaid Drug Rebate Program Rule, all which have been released in the past year. In addition, states are in the process of implementing the Mandatory Medicaid and Children's Health Insurance Program (CHIP) Core Set Reporting Final Rule and the HCBS Settings Final Rule. Although some provisions are likely to take effect after the unwinding period has concluded, states will be required to begin implementation in parallel with redeterminations to achieve compliance with new requirements.

We also call attention to the potential for duplication of efforts with existing state reporting requirements, which could create significant complexity and administrative burden due to variation on how reporting is conducted. For example, in Pennsylvania, Massachusetts, New York, and New Jersey, laws already require reporting on the percentage of nursing facility revenue that is spent on direct resident care. In each case, there are likely to be fundamental differences in how the information is collected and reported. And in

Massachusetts, New York, and Pennsylvania, the state laws provide a more holistic picture of the facilities' operations by looking at all revenues rather than just Medicaid spending.

We encourage CMS to withdraw this provision and instead focus efforts on assisting states in navigating the unwinding period, implementing existing requirements from recently released final rules, and preparing for the finalization of outstanding proposed rules. Should CMS move forward with this provision, we recommend the frequency of reporting be reduced to every three years to minimize the reporting burden on states and LTC facilities.

Once again, thank you for the opportunity to provide comments on the Minimum Staffing Standards for LTC and Medicaid Institutional Payment Transparency Reporting Proposed Rule (CMS-3442-P). Supporting access to care and services for Medicaid beneficiaries is of paramount importance to MHPA. We appreciate the opportunity to share our perspective to address access challenges and barriers and look forward to continuing to work with CMS and our state partners to make a meaningful difference in the lives of Medicaid beneficiaries.

Please feel free to reach out to me directly at sattanasio@mhpa.org with any questions or should you need any additional information.

Sincerely,

/s/

Shannon Attanasio
Vice President, Government Relations and Advocacy